

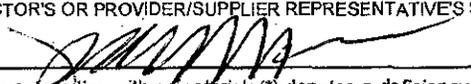
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2012
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 10/10/2012
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NAME OF PROVIDER OR SUPPLIER CENTRAL VERMONT MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CDDE BOX 547 BARRE, VT 05641
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A 000	INITIAL COMMENTS	A 000		11/2/12
A 263	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on staff interview and record review, the Condition of Participation : Quality Improvement and Performance Improvement Program was not met based on the hospital's failure to meet the requirement's for quality improvement and related nursing care and discharge planning prior to	A 263	See Plan of Correction. See Plan of Correction. See Plan of Correction A263 DOC accepted Patient Care R, MS. 11/13/12	9/21/12 9/26/12 11/9/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE President & CEO	(X6) DATE 11-7-12
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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.

PMU

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A 263	Continued From page 1 discharge of one applicable patient in the sample. Patient #1 was placed at risk upon discharge by the hospital's failure to assure that all components required for safe discharge from the hospital had been met prior to discharge. A patient who required specialized equipment subsequent to placement of a tracheostomy was discharged home without assuring that the suction machine was in the home and training provided to the patient and spouse, prior to discharge from the hospital. The hospital completed a root cause analysis subsequent to a patient adverse event report on 5/3/12; however the hospital failed to identify all deficient practice and failed to initiate an appropriate action plan, including documentation of the plan, a system for monitoring progress of the plan and ongoing evaluation and analysis of the plan's progress by the Quality Department.	A 263	<i>A 263 POC accepted Patricia Cummins RN MS 11/13/12</i>		
A 287	Refer to TAGS A 287, A 288, and A 302 482.21(c)(2) QAPI IMPROVEMENT ACTIVITIES [Performance improvement activities must track medical errors and adverse patient events,] and analyze their causes, and ... This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital's QAPI committee failed to develop and document data for a corrective action plan in response to an adverse patient event reviewed during a Root Cause Analysis (RCA) for 1 applicable patient in the total sample of 11 patient records reviewed. (Patient #1). Findings include: Per review of the medical record for Patient #1 and interview with hospital staff from Discharge Planning, Nursing Services, Respiratory Therapy	A 287	<i>See Plan of Correction. A 287 POC accepted Patricia Cummins RN MS 11/13/12</i>	11/7/12	

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A 287	<p>Continued From page 2</p> <p>and Quality Improvement on 8/7/12 and 8/8/12, the hospital's QAPI response to an adverse patient event failed to completely identify causes which contributed to the event during the RCA (Root Cause Analysis) process. The QAPI response failed to show evidence of follow up with corrective action plans and failed to include written data of the audits being completed by responsible department staff (Nursing and Respiratory Therapy). The QAPI response failed to address the lack of patient teaching and care planning regarding self care for a newly placed tracheostomy.</p> <p>A regulatory complaint regarding incomplete discharge planning was investigated after Patient #1 died within hours of discharge from the hospital's medical surgical unit on 4/26/12. The patient had received emergent placement of a tracheostomy after experiencing respiratory failure. The patient was hospitalized at CVMC during the period from 3/21/12 - 4/26/12, excluding a 5 day hospitalization at another hospital from 4/18/12 - 4/23/12. The hospital course included inpatient status in the ICU for almost 1 month. In addition to respiratory failure, diagnoses included multiple co-morbidities contributing to the patient's acute medical condition. The patient was discharged home from the hospital with no evidence of adequate training to assure competency for self care of the new tracheostomy post discharge. CMs (case managers), RTs (respiratory therapists) and RNs (registered nurses) failed to assure that necessary medical supplies, including a suction machine, were available in the home prior to the patient's arrival home. The patient was discharged at 12:35 PM on 4/26/12 and the</p>	A 287	<p>See Plan of Correction.</p> <p>A 287 PO accepted.</p> <p>Patten Cummings RN MS</p> <p>11/13/12</p>	11/7/12

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A 287	Continued From page 4 a potentially dangerous situation for the patient. During the hospital's RCA, staff failed to identify all of the issues that contributed to this event. During interview on 8/8/12 at 4:19 PM, the Medical Director for Quality Improvement stated that s/he felt that they met the priority of the RCA by determining who is responsible for respiratory equipment at discharge. A checklist was designed to assure all necessary referrals/equipment was in place for future discharges home. Although the Director of Cardiopulmonary Services (DCPS) developed an audit form to review all discharges for evidence of appropriate discharge services, and provided education to his staff, he failed to assure written data was completed to show evidence of compliance, adherence to the PI plan and evaluation of needed changes to the interventions in the plan. The DCPS also confirmed that respiratory therapists are responsible for patient teaching on trach self care, a responsibility shared with nursing staff, and that his staff failed to document adequate evidence of teaching/patient/spouse competency for trach self care prior to discharge home from the hospital. At approximately 9 PM on 4/26/12, in the presence of the Home Health RN, the patient collapsed on the bedroom floor and EMS was called to transport to the Emergency Department, where the patient expired. The hospital QA response was not sufficient to assure that a similar situation with potentially life threatening consequences for a patient would not occur again. There was no nursing action plan as a result of the RCA, per interview with the RN Director of Critical Care Services on 8/8/12 at 8:20 AM. S/he stated that s/he was not aware of	A 287	See Plan of Correction A 287 POC accepted Patricia Cummins RN MS 11/13/12	11/9/12

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A 287	Continued From page 5 any QA plans for nurses re: discharge process, patient education and patient care planning. The Director of Quality Assurance, interviewed on 8/8/12 at 3:30 PM also confirmed that she was not aware of any quality response plan for corrective action regarding this patient's care and discharge process from the nursing department. She stated that the usual process for a RCA has been to utilize a tracking tool to monitor what the corrective plan is, where staff are in the process, communication with work groups to assure that process is on-going and evaluation of actions to maintain compliance. The Director stated that she was on a leave of absence during the RCA for this patient. The hospital failed to assure that trained staff were available to carry on QA activities during the Director's absence. In addition, the Director stated that the RCA was not brought to the hospital wide Quality Council meetings for review May and July, 2012. During interview on 8/8/12 at 4:20 PM, the staff member conducting the RCA stated that a committee was devised to determine who was responsible when a patient with a tracheostomy was being discharged home, including what each discipline was responsible for. A checklist document was devised which has not yet been implemented. There have been no follow up meetings or evidence of follow up contact with committee members since the RCA meeting by the responsible Quality staff. The Director of QA, who was also present for the interview, confirmed that the hospital's quality assurance staff had not followed the department's procedural processes for this case.	A 287	See Plan of Correction. A287 Doc accepted Patient Council Review 11/13/12	11/9/12
A 288	482.21(c)(2) QAPI FEEDBACK AND LEARNING [Performance improvement activities must track	A 288	See Plan of Correction. A288 Doc accepted Patient Council Review	11/7/12

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A 288	<p>Continued From page 6</p> <p>medical errors and adverse patient events, analyze their causes and] implement preventive actions and mechanisms that include feedback and learning throughout the hospital.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to assure that it's performance improvement plans were implemented and failed to assure that mechanisms to include feedback and learning extended throughout the hospital regarding patient care for one applicable patient in the sample. (Patient #1). Findings include:</p> <p>Per interview on 8/8/12 at 4:30 PM, the QA staff member who was responsible for conducting a RCA (on 5/3/12) after an adverse patient event confirmed that s/he had not had follow up meetings with the subcommittee to evaluate and monitor the quality improvement process. Although nursing staff was involved in the discharge of the patient on 4/26/12, no performance improvement activities were put into place as a result of the findings of the RCA meeting. The Medical Director of Quality also confirmed that during the RCA they did not acknowledge the lack of of patient/significant other education prior to discharge to assure safe management of the patient's tracheostomy. The RN Director of Critical Care Services confirmed during interview on 8/8/12 at 3:45 PM that he was not aware of any corrective actions put into place for re-education of nursing staff regarding RN teaching of tracheostomy care in preparation for discharge home for the patient /significant other. He also confirmed that there was no care plan for patient/significant other education for tracheostomy care at home.</p>	A 288	<p>See Plan of Correction.</p> <p>A 288 PoC accepted</p> <p>Patricia Cummins RN, MS</p> <p>11/13/12</p>	11/13/12	

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A 288	Continued From page 7 Although the Respiratory Department did initiate some corrective action plans, they were not fully operationalized and there was no evidence of monitoring and assessment of the ongoing corrective action plan by the department director. This was confirmed during interview with the Director of Cardiopulmonary Services on 8/7/12 at 3 PM. The director also confirmed that he was not documenting the chart audits/results data that he was completing as part of the corrective action. During interview on 8/8/12 at 4 PM, the Director of Quality Assurance confirmed that the hospital's improvement plan after the RCA was lacking in follow through and analysis of the needed corrective actions necessary to assure safe patient care and planning related to discharges home with a newly placed tracheostomy requiring self care.	A 288	See Plan of Correction. A 288 POC accepted Dawn Cummings RN, MS 11/13/12	11/11/12
A 291	482.21(c)(3) QAPI SUSTAINED IMPROVEMENT. [The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and] track performance to ensure that improvements are sustained. This STANDARD is not met as evidenced by: Based upon observation, staff interview and record review, the hospital failed to ensure performance improvement actions, previously implemented for infection control deficient practice, were sustained. Findings include: A deficient practice was identified during a complaint survey on 7/31/12, related to failure of all OR (operating room) staff to wear head	A 291	See Plan of Correction. A 291 POC accepted Dawn Cummings RN, MS 11/13/12	11/11/12

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A 291	Continued From page 8 coverings and masks in a manner that covered all areas appropriately during surgical procedures. During interview, on 7/31/12 at 4:00 PM the Infection Control Nurse stated that per hospital policy and standard of care, PPE (Personal Protective Equipment), including head covers that completely cover all hair, and facial masks, completely covering nose and mouth, should be worn by anyone entering an OR in which an active case is in progress. However, during a tour of the perioperative area on 10/9/12 at 11:20 AM with the VP of Medical Affairs and the Director of Ambulatory Nursing Services, in OR #3 the scrub nurse, circulating nurse and anesthesiologist were all observed wearing PPE (hair coverings) that failed to completely cover their hair and jewelry while actively involved in a surgical procedure. Although the Director for Ambulatory Nursing Services confirmed frequent auditing/surveillance of staff in the operating rooms had been conducted, the deficient practice had not been corrected as of 10/9/12, improvement actions associated with this plan to correct this deficient practice and breach of infection control policy had not been sustained.	A 291	See Plan of Correction A 291 POC accepted Datus Cunniff MD, MS 11/13/12	11/12
A 302	Refer to Tag A-0749 482.21(d)(3) QAPI PROJECT DOCUMENTATION [The hospital must document what quality improvement projects are being conducted the reasons for conducting these projects, and] the measurable progress achieved on these projects. This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to assure that a quality	A 302	See Plan of Correction. A 302 POC accepted Datus Cunniff MD, MS 11/13/12	10/1/12

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A 302	Continued From page 9 improvement project initiated after an adverse patient event was properly documented and that measurable progress was achieved regarding the care of one applicable patient in the sample. (Patient #1). Findings include: Per interviews (8/7/12 and 8/8/12) with the QA staff assigned to conduct a RCA after an adverse patient event, there were no transcribed notes from the RCA; no documentation of a corrective action plan for nursing staff re: patient care planning and teaching in preparation for discharge, no documentation of the respiratory department QA audit process and no evidence of written follow up and/or committee meetings to measure progress in the corrective action plan. The hospital completed a root cause analysis subsequent to a patient adverse event report on 5/3/12; however the hospital failed to identify all deficient practice and failed to initiate an appropriate action plan, including documentation of the plan, a system for monitoring progress of the plan and evaluation of the plan's progress by the Quality Department.	A 302	See Plan of Correction. A 302 POC accepted Patricia Cummins RN MS 11/13/12	10/11/12
A 395	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 staff interview and record review, the hospital failed to assure that RNs evaluated, assessed and implemented a plan to provide appropriate tracheostomy self care training to Patient #1 and his/her significant other prior to discharge from the hospital to the home setting. Findings include:	A 395	See Plan of Correction. A 395 POC accepted Patricia Cummins RN MS 11/13/12	11/9/12

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A 395	Continued From page 10 Per record reviews on 8/7/12 and 8/8/12, Patient #1 had a tracheostomy placed during a hospital stay and RNs failed to document adequate teaching of self care for the patient/spouse in preparation for discharge from the hospital to home on 4/26/12. Review of nursing notes from 4/23/12 - 4/26/12 reveals incomplete documentation regarding the skill level of the patient in completing their own trach care. There was no evidence of training in suctioning the tracheostomy if it should become blocked by thick secretions. The patient expressed anxiety regarding responsibility for his/her own care during a meeting with a psychiatrist on 4/25/12. The progress note stated "She looks forward to going home but states she is afraid because if there is a medical complication, she will not have immediate help". There was no evidence that the patient was given any written educational materials regarding tracheostomy care upon discharge on 4/26/12. There was no evidence of any assessment of the patient's capabilities for self trach care. Per review of the Discharge Instructions Sheet, signed by the patient and the RN on 4/26/12 at 12:35 PM, the section regarding patient education was blank. This was confirmed during interview with the RN Director of Critical Care Services on 8/8/12 at 3:45 PM. Refer also to A 396	A 395	See Plan of Correction. 11/9/12 A 395 POC accepted Patricia Cummings RN, MS 11/13/12		
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. This STANDARD is not met as evidenced by: Based on staff interview and record review, the	A 396	See Plan of Correction. 11/9/12 A 396 POC accepted Patricia Cummings RN, MS 11/13/12		

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A 396	Continued From page 11 hospital failed to assure that RNs developed and kept current a nursing care plan for one patient/significant other regarding training of tracheostomy care in preparation for discharge home. (Patient #1). Findings include: Per record review on 8/7/12, there was no nursing care plan developed to address Patient #1's needs regarding education for him/her and the spouse for total care/self care at home for a newly placed tracheostomy during an extended hospital stay. Review of the 'teach back checklist' notes (4/18/12 - 4/26/12) on 8/8/12 revealed that the patient was instructed only briefly regarding instillation of NS (normal saline solution) into the trachea to loosen mucus. There was no evidence of training regarding how to suction the trachea for removal of excessive mucus if needed. Although a RN documented that a booklet with training materials was given to the patient while s/he was critically ill in the ICU, there was no evidence of follow through and return demonstration for all necessary trach care to be carried out by the patient/spouse after discharge home on 4/26/12. The discharge instructions sheet given to the patient by the RN at discharge documented no educational materials regarding trach care in the education section of the sheet. This was confirmed with the Director of Critical Care Services on 8/8/12 at 3:45 PM. Refer also to A395	A 396	See Plan of Correction; 11/9/12 A396 POC accepted Doreen Cummings R.N., MS 11/13/12	
A 466	482.24(c)(2)(v) CONTENT OF RECORD - INFORMED CONSENT [All records must document the following, as appropriate:] Properly executed informed consent forms for procedures and treatments specified by the	A 466	See Plan of Correction. A 466 POC accepted Doreen Cummings R.N., MS 11/13/12	11/5/12

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A 466	<p>Continued From page 12 medical staff, or by Federal or State law if applicable, to require written patient consent.</p> <p>This STANDARD is not met as evidenced by: Based upon interview and record review, the hospital failed to assure that a properly executed anesthesia consent form was obtained for 2 patients in the applicable sample undergoing a surgical procedure (Patients #13 and #27). Findings include:</p> <p>1. Per record review and confirmed with the Charge Nurse on 10/8/12 at 4:50 PM, there was no signed anesthesia consent for Patient #13 who received anesthesia for a surgical procedure on 10/5/12. Per record review and confirmed with the VP, Quality & Nursing/Chief Nursing Officer (CNO) on 10/9/12 at 1:15 PM, the Anesthesia Record for patient # 13 states "anesthesia pre-op, patient medicated and not consentable" and was electronically signed by the Anesthesiologist on 10/5/12.</p> <p>2. Per record review on 10/10/12, there was no signed anesthesia consent for Patient #27, who received spinal anesthesia for a surgical procedure on 10/2/12. This was confirmed by both the Director of Peri-operative Services and the Vice President, Nursing and Quality/CNO during separate interviews on the afternoon of 10/10/12.</p> <p>In addition, per staff interview and confirmed with the VP, Quality & Nursing/CNO on 10/10/12 at 1:15 PM, the facility policy titled Informed Consent with an effective date 8/16/12 states that Surgical or Invasive Procedure Consent should be obtained for General or Spinal Anesthesia and</p>	A 466	<p><i>See Plan of Correction.</i></p> <p><i>A 466 POC accepted</i> <i>Patient coming w/ing</i> <i>11/13/12</i></p>	11/5/12

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A 466	Continued From page 13 Conscious Sedation.	A 466	See Plan of Correction. Utilize A 466 POC accepted Doreen Cummings RN MS 11/13/12 A 749 POC accepted Doreen Cummings RN MS 11/13/12	
A 749	482.42(a)(1) INFECTION CONTROL OFFICER RESPONSIBILITIES The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on observations, staff interview and record review the hospital failed to assure that infection control measures were implemented in an ongoing and consistent manner to assure terminal cleaning in all operating rooms was conducted; appropriate use of PPE (Personal Protective Equipment) by all peri-operative staff was worn in accordance with standards of practice and compliance was maintained by staff regarding the use of PPE when contact precautions are initiated. Findings include: 1. During a tour of the perioperative area on 10/9/12 at 11:20 AM with the VP of Medical Affairs and the Director of Ambulatory Nursing Services, in Operating Suite #3 the scrub nurse, circulating nurse and anesthesiologist were all observed wearing PPE (hair coverings) that failed to completely cover their hair and jewelry while actively involved in a surgical procedure. Per AORN (Association of periOperative Registered Nurses) Journal, January 2012 Vol 95 No 1 "Implementing AORN Recommended Practices for Surgical Attire," Perioperative nurses should not wear jewelry such as earrings, necklaces.....that cannot be contained within surgical attire because of the risk of	A 749		

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A 749	<p>Continued From page 14</p> <p>contaminating the surgical attire" AORN further states, "All personnel should cover their head and facial hair when in the semirestricted and restricted areas. Hair coverings should cover facial hair, sideburns, and the nape of the neck. Perioperative nurses can help minimize the risk of surgical site infections by covering head and facial hair...." AORN further states "Skull caps are not recommended because they do not completely cover the wearer's hair and skin; they fail to cover the side hair above and in front of the ears and the hair on the nape of the neck". The Director of Ambulatory Nursing Services confirmed at the time of observation, staff were not meeting standards of practice and were not in compliance with hospital Infection Prevention and Control Guidelines for Surgical Services last reviewed 1/13/12 which states, per VII., Environmental Control D. - 2 "Hair covering will be donned prior to entering the OR Suite and will cover and contain all hair". This violation of hospital policy and standards of practice was also confirmed on the morning of 10/10/12 with the Manager for Infection Prevention and Control.</p> <p>2. While touring operating room Suite #2 and #4 on 10/9/12 at 11:25 AM and 2:00 PM with the Director of Ambulatory Nursing Services, powder-like dust was observed on the ventilation faceplates covering 2 out take airvents located on the lower walls of each of the operating rooms. The Director acknowledged housekeeping staff assigned to perform terminal cleaning each night in each of OR Suites would be responsible for cleaning the ventilation faceplates. Per review of the hospital's policy Infection Prevention and Control Guidelines for Surgical Services , V. Housekeeping: "Housekeeping will clean the</p>	A 749	<p>See Plan of Correction. 11/1/12</p> <p>A 749 POC accepted</p> <p>Patricia Cummins RN MS</p> <p>11/13/12</p>	

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A 749	Continued From page 15 department according to established department policy and is responsible for floors, walls, cabinets, chairs, and certain equipment....this terminal cleaning will include v. Ventilation faceplates". The policy further states: "Surgical procedure rooms and scrub/utility areas will be terminally cleaned daily, regardless of whether they are used that day. A clean surgical environment will reduce the number of microbial flora present. This means that these rooms should be terminally cleaned once during each 24 hour period during the regular work week". Per interview on the morning of 10/10/12, the Manager for Infection Prevention and Control noted although Environmental Patient Safety Inspections did inspect the Operating Suites, the ventilation faceplates had not been part of their observations. 3. Per observations on 10/8/12, between 2:25 PM and 2:30 PM, hospital staff failed to adhere to orders for 'Contact precautions' when entering and leaving the room of a patient with a suspected infection. Per record review on the afternoon of 10/9/12, on 10/6/12 at 10:27 A.M. Patient #5, who was hospitalized for treatment for cellulitis [a severe inflammation of dermal and subcutaneous layers of the skin], was placed on 'Contact Precautions' [Contact Precautions are methods used to prevent transmission of infectious agents which are spread by direct/ indirect contact with a patient or the patient 's environment]. Per review of Patient #5's medical record, physician progress notes dictated on 10/7/12 at 3:44 P.M. regarding Patient #5's cellulitis stated, "MRSA is likely" . [Methicillin Resistant Staphylococcus Aureus (MRSA) is a	A 749	See Plan of Correction. 11/11/12 A 749 DOC accepted Patricia Cummins RN, MS 11/13/12 See Plan of Correction. 11/11/12	11/11/12

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A 749	<p>Continued From page 16</p> <p>bacterium in infections that has developed a resistance to multiple antibiotics].</p> <p>Per observation of Resident # 5 on 10/8/12 at 2:25 P.M., the facility's Contact Precautions sheet was present on the wall in the hallway, outside the patient's room. The Contact Precautions sheet include: " Perform hand hygiene between all patient contact and before entering and leaving the room. Wear gloves when entering room and for all patient contact. " The precautions also list " wear a gown whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or items in the patient's room. "</p> <p>Per observation on 10/8/12 at 2:25 P.M., a physician entered Patient #5's room with gloves on, but no gown, sat down on a chair across from Patient #5, and performed a procedure on the patient's left wrist. Per review, the Physician's progress note, dictated on 10/8/12 at 2:52 P.M. regarding the procedure on Patient #5 stated, " I did express a small amount of purulence [containing or discharging pus]. at one site ... I sent that for culture ".</p> <p>Per observation at 2:30 P.M. on 10/8/12, after the physician had left the patient's room, a Social Worker entered the room without performing hand hygiene and without doning gloves or a gown. The Social Worker sat down in a chair across from the patient, and after speaking with the patient exited the room without performing any hand hygiene.</p> <p>Per interview on 10/9/12 at 3:09 P.M. both the Physician and the Social Worker confirmed that on 10/8/12 between approximately 2:25 PM and 2:35 P.M. they had each visited with the patient. In addition, they were aware the patient was on</p>	A 749	<p>See Plan of Correction 11/11/12</p> <p>A 749 POC accepted Dante Cummings 11/13/12</p>

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A 749	Continued From page 17 Contact Precautions and that the Contact Precautions sign was posted on the wall outside the patient's room prior to entering. The Physician confirmed during an interview on 10/9/12 at 3:09 P.M. that s/he had only used gloves while touching the patient and obtaining the culture, and stated, "Normally I would gown up". The Physician also confirmed that the lab results from the culture s/he took would not be available until the next day. During this same interview, on 10/9/12 at 3:09 P.M., the Social Worker confirmed that s/he did not perform hand hygiene or don gloves and gown up before entering the patient's room (per the posted Contact Precautions), that s/he had sat down in a chair next to the patient and could not recall if s/he performed hand hygiene after exiting the patient's room. Per observation by this surveyor on 10/8/12 at approximately 2:40 P.M. handwashing and/or sanitizing of the hands was not completed by the Social Worker after exiting the patient's room. Per interview with the Infection Control Nurse on 10/8/12 at 2:35 P.M., s/he confirmed that s/he was present during the observations on 10/8/12, and that neither the Physician nor the Social Worker properly followed the facility's CDC-based Contact Precautions sheet that was posted outside the patient's room. The Infection Control Nurse stated that the facility's Contact Precautions are taken from recommendations from the Centers for Disease Control [CDC] guidelines for 'Preventing Transmission of Infectious Agents in Healthcare Settings'.	A 749	See Plan of Correction. 11/11/12 A 749 POC accepted Patricia Cummins RN, MS 11/13/12	11/11/12
A 799	482.43 DISCHARGE PLANNING The hospital must have in effect a discharge planning process that applies to all patients. The	A 799	See Plan of Correction Tags 808, 810, 820, 822 A 799 POC accepted	11/11/12

Patricia Cummins RN, MS
11/13/12

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A 799	Continued From page 18 hospital's policies and procedures must be specified in writing. This CONDITION is not met as evidenced by: Based on staff interview and record review, the Condition of Participation: Discharge Planning was not met due to the hospital's failure to assure that a comprehensive and accurate discharge plan was devised and implemented prior to discharge of one applicable patient in the sample. Patient #1 was placed at risk of harm/adverse outcome upon discharge by the hospital's failure to assure that all components required for safe discharge from the hospital had been met prior to discharge. A patient who required specialized equipment subsequent to placement of a tracheostomy was discharged home without assuring that the suction machine was in the home and training provided to the patient and spouse, prior to discharge from the hospital.	A 799	See Plan of Correction. 11/9/12 A 799 POC accepted Darius Cummins R, MS 11/13/12	
A 808	Refer to TAGS A 808, A 810, A 820, and A 822. 482.43(b)(3) POST-HOSPITAL SERVICES The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services. This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to assure that discharge planners identified all of the discharge services/equipment needs required post discharge for one applicable patient in the sample. (Patient #1) Findings include: Per record review and confirmed by staff	A 808	See Plan of Correction 11/9/12 A 808 POC accepted Darius Cummins R, MS 11/13/12	

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A 808	Continued From page 19 interview on 8/7/12 and 8/8/12, hospital staff failed to assure that all necessary components of the discharge plan for Patient #1 were completed and/or arranged prior to discharge home on 4/26/12. Hospital staff providing care and services to the patient, including respiratory therapists, RNs and CM all failed to assure that the patient's needs regarding trach care, including necessary equipment and demonstration of competency to complete care was completed prior to discharging the patient home on 4/26/12. Per interview on 8/7/12 at 2:58 PM, the DCPC stated that the respiratory therapist for 4/26/12 had obtained the physician order for home suction equipment at approximate 2:45 PM, more than 2 hours after the patient was discharged from the hospital. He stated that he spoke with the medical equipment driver who said that he arrived at the home with the suction machine at 5:28 PM. He confirmed that the when the CM called to patient's home at 3:30 PM, the CM was told that the patient was short of breath. He stated that the CM called the respiratory department who instructed her to have the patient call 911.	A 808	See Plan of Correction A 808 POC accepted Patricia Clump RW 11/13/12	11/9/12
A 810	Refer also to A 287, A 395, A 810 and A 822 482.43(b)(5) TIMELY DISCHARGE PLANNING EVALUATIONS The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge. This STANDARD is not met as evidenced by: Based on staff interview and record review,	A 810	See Plan of Correction. A 810 POC accepted Patricia Clump RW 11/13/12	11/9/12

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A 810	Continued From page 20 hospital personnel failed to complete a timely evaluation for all of the post hospital needs and services prior to discharge for one applicable patient in the sample. (Patient #1) Findings include: Per record reviews and information received from an anonymous complaint, hospital discharge planners failed to assure that all of the necessary post hospital needs for Patient #1, who had a newly placed tracheostomy, were made prior to discharge from the hospital. The failure to assure that a suction machine had been delivered to the home prior to the patient's arrival home from the hospital, placed the patient at risk of significant harm from a failure to have necessary equipment available and evidence of competency to use the equipment properly. A failure to communicate all of the needs of the patient/spouse by hospital staff including respiratory therapists, staff RNs and CM (case manager) and obtain all necessary physician orders and equipment needed prior to discharge placed the patient at risk of significant harm. The hospital's policy "Discharge Planning", procedure, #8, states "Specific steps in discharge planning undertaken by each discipline must include: (a) an evaluation of need; (b) education and instruction of patient and family regarding the patient's needs, and (c) providing for continuing care following discharge to meet ongoing needs." During interview on 8/8/12 at 2:45 PM, the Director of Discharge Planning confirmed the lack of appropriate discharge planning for the patient and stated that s/he had instituted audits of discharge instruction sheets for accuracy and completeness of documentation in meeting patient needs. Refer also to A 820	A 810	See Plan of Correction. A 810 ROC accepted Jatun Cummings RD 10/13/12	11/9/12	

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A 820	<p>482.43(c)(3) IMPLEMENTATION OF A DISCHARGE PLAN</p> <p>The hospital must arrange for the initial implementation of the patient's discharge plan.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to assure that initial implementation of the discharge plan regarding a physician ordered referral for one applicable patient in the sample was implemented upon discharge. (Patient #1) Findings include:</p> <p>Per review of the Discharge Instructions Sheet dated 4/26/12 for Patient #1 on 8/7/12 and confirmed during interview with the Director of Discharge Planning on 8/8/12 at 3:10 PM, there was no evidence that a mental health referral documented on the section "referral for continuing health care or services at home" was ever implemented prior to discharge. During interview the Director of the department stated that there was no formal process to assure that this referral was picked up by anyone responsible for the discharge process. A consulting psychiatrist's progress note dated 4/25/12 stated "Make referral to WCMH" (a local mental health service) "as well as VNA" (Visiting Nurses Association). At 3:40 PM, the director also confirmed that if the Discharge Instruction Sheet stated WCMH referral was indicated, the CM would be responsible for calling WCMH. There was no way to determine during the review if this had been completed, based on the information obtained from staff and the record reviews. Refer also to A 810</p>	A 820	<p>See Plan of Correction 11/9/12</p> <p>A 820 POC accepted Patricia Cummins RN, MS 11/13/12</p>	
A 822	482.43(c)(5) PREPARATION FOR DISCHARGE	A 822	<p>See Plan of Correction. 11/13/12</p> <p>A 822 POC accepted Patricia Cummins RN, MS</p>	11/9/12

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A 822	<p>Continued From page 22</p> <p>As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care.</p> <p>This STANDARD is not met as evidenced by: Based on staff interviews and record reviews, the hospital failed to assure that the patient/spouse were counseled on all aspects of post discharge treatments/care to be done at home prior to discharge from the hospital for one applicable patient. (Patient#1) Findings include:</p> <p>Based on record review and confirmed by staff interviews on 8/7/12 and 8/8/12, CVMC staff failed to assure that Patient #1 and her spouse received appropriate education and training in the care of a newly placed tracheostomy prior to discharge home on 4/26/12. Staff also failed to provide evidence of written instructions regarding safe care of the tracheostomy upon discharge home. The discharge instructions sheet dated 4/26/12, signed by the RN and the patient, was left blank for the section entitled 'patient education'. Per review, the hospital's policy titled "Patient & Family Education" states: "It is the policy of CVMC to assure that patients and/or their family, significant other, or caregiver are provided with appropriate... 2) training to learn skills and behaviors that promote recovery and improved function, and 3) referrals to assist with care as needed. Staff will work to ensure that patients and others involved in their care, have the necessary information including written instructions to assist in the recovery process...after discharge. All disciplines involved in the care of a patient are responsible for providing appropriate explanations and teaching based on the ongoing assessment of those</p>	A 822	<p>See Plan of Correction: 11/9/12</p> <p>A 822 PCC accepted</p> <p>Patricia Cummins RN MS</p> <p>11/13/12</p>	
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A 822	Continued From page 23 needs." Based on review of the medical record and interviews on the afternoons of 8/7/12 and 8/8/12, the CM was not aware of the need for patient/spouse teaching regarding suctioning and overall care of the tracheostomy until the respiratory therapist asked her questions concerning what post discharge service would be providing a suction machine for the home, and had it ordered by the physician. A nursing progress note dated 4/25/12 at 2234 hours stated "Help...help, I am so anxious I can't breathe..." (patient words). PT instructed how to instill NS and cough via trach, declines suctioning trach..Assessment: Alt in resp function; trach with congested cough, chronic anxiety, cont. trach training.." Although the note stated to continue trach training, there was not documented evidence that the patient/spouse demonstrated competency with the trach care at any time during the hospitalization. A CM progress note written on 4/27/12 at 1335 as a late entry for 4/26/12 at 1615 stated "CM spoke with (spouse) who expressed concerns regarding ----'s inability to cough up mucus and that the suction equipment had not yet arrived. --- responded in the back ground "the nurse had shown me how to squirt saline into my trach and then cough it onto a napkin". She said several times, "I can't cough anything up and I can't breathe". The patient's spouse was instructed to call an ambulance and go the ED if unable to breathe. The CM spoke with the spouse a short time later to inform him that the suction equipment should be at the home within 60 minutes and the home health agency was called to have a RN visit ASAP. The spouse decided to wait for the HHA RN's visit when the	A 822	See Plan of Correction A 822 POC assigned Patient Cuming Risins 11/13/12	11/9/12	

[Handwritten Signature] 11-7-12

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

PRINTED: 10/16/2012
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 10/10/2012
NAME OF PROVIDER OR SUPPLIER CENTRAL VERMONT MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE BOX 547 BARRE, VT 05641		
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A 822	Continued From page 24 patient felt better after a few minutes had passed. Refer also to A 287	A 822	A 822 POC accepted Patricia Cummins 11/13/12	RUMS	
A1002	482.52(b)(1) PRE-ANESTHESIA EVALUATION Anesthesia services must be consistent with needs and resources. Policies on anesthesia procedures must include the delineation of pre-anesthesia and post-anesthesia responsibilities. The policies must ensure that the following are provided for each patient: Anesthesia services must be consistent with needs and resources. Policies on anesthesia procedures must include the delineation of pre-anesthesia and post-anesthesia responsibilities. The policies must ensure that the following are provided for each patient: This STANDARD is not met as evidenced by: Based on staff interview and record review, Anesthesia services failed to develop policies and procedures specific to delivery of anesthesia services consistent with the needs of the hospital and with recognized standards of anesthesia care. Findings include: Anesthesia services was unable to provide policies and procedures specific to the delineation of pre-anesthesia, intraoperative/procedural and post-anesthesia responsibilities of this service as it relates throughout the hospital. Although a policy existed within the "Completion of Medical Records" (effective 2/17/11) which addressed responsibilities of Anesthesia services to complete specific documentation in patient medical records and a second policy "Guidelines for Moderate Sedation/Analgesia" (effective 8/20/12) defined the management of sedated patients and establishing criteria for credentialed	A1002	See Plan of Correction. A 1002 POC accepted Patricia Cummins 11/13/12	11/5/12	
			See Plan of Correction.	11/5/12	

[Handwritten Signature] 11-7-12

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A1002	<p>Continued From page 25</p> <p>staff (to include Anesthesia services for monitored anesthesia care) and nursing responsibilities during moderate sedation procedures, no policies specific to Anesthesia services existed regarding the delivery of care to include: Infection Control methods; safety practices in all anesthetizing areas; protocols for supportive life functions; reporting requirements; documentation requirements and monitoring, inspection, testing of anesthesia equipment.</p> <p>Per the American Society of Anesthesiology (ASA) The Organization of Anesthesia Department; Committee of Origin: Quality Management and Department Administration (Approved by the ASA House of Delegates 10/15/2003 and last amended on 10/22/08) states: The director of the anesthesia department should be responsible for the following: "Participating in the development of, and enforcing policies and procedures relating to the functioning of anesthesia personnel and the administration of anesthesia throughout the hospital. This should include the development and maintenance of a written policy defining the perioperative care of patients that may appropriately be provided in the facility, based upon consideration of age, risk categories, proposed procedure, and facility equipment and nursing capabilities." In addition the ASA also recommends "A description of the details of the operation of the anesthesia department, including all policies and procedures applicable to personnel in the department, should be compiled in a single set of rules and regulations or in a procedure and policy manual."</p> <p>Per record review, on 10/8/12 Patient #31</p>	A1002	<p><i>A1002 POC accepted</i></p> <p><i>Patricia Cummings RN, MS</i></p> <p><i>11/13/12</i></p> <p><i>See Plan of Correction 11/5/12</i></p>	

[Signature] 11-7-12

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A1002	Continued From page 26 underwent surgery for adenoidectomy. Prior to this day surgery procedure, on 10/3/12 Patient #31 completed a "Patient Questionnaire" at his physician's office. Using this form, which was developed by Anesthesia services, the patient answers several questions which then determines if the patient would have a "face to face" pre-anesthesia assessment prior to the day of surgery. Per interview on the morning of 10/8/12, the Director, Ambulatory Nursing Services stated once completed, the "Patient Questionnaire" is faxed to Pre-Op screening staff who then provide the questionnaire to anesthesia staff for review. If the patient answers "yes" to questions in the middle column, then a pre-anesthesia visit will be scheduled prior to the day of surgery to allow a complete anesthesia assessment or to meet with the patient several days before the procedure if the patient has requested such a meeting to discuss the anesthesia process. Although Patient #31 had answered "yes" to middle column questions to include: s/he had a history of chest pain coming from his/her heart, had a heart attack, has untreated high blood pressure and has a heart murmur followed by a cardiologist, a face to face anesthesia prescreening prior to the day of surgery did not occur. The patient did receive a pre-anesthesia screening on the morning of surgery. When asked if there was a policy regarding this pre-anesthesia screening, the Vice President of Medical Affairs confirmed on 10/9/12 at 8:20 AM, no policy existed. Per interview on 10/9/12 at 2:05 PM Anesthesiologist #1 confirmed the use of the "Patient Questionnaire" allowing screening of the patient 4-6 days prior to a surgical procedure requiring anesthesia services. S/he further stated if the review is not done and a patient presents with	A1002	See Plan of Correction A1002 Poc accepted Dated Cumings R, MS 11/13/12	4/5/12	

JMM 11-7-12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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A1002	Continued From page 27 health issues that may be affected by anesthesia, then the surgery is canceled. This would create an inconvenience for the patient and disruption of operating room scheduling. Per review, the Quality Assessment completed by Anesthesiologist #2, who provided anesthesia to Patient #31 on 10/8/10, noted the patient experienced "Prolonged Hypertension" during the course of surgery.	A1002	See Plan of Correction A1002 POC accepted Patient Coming Back 11/13/12	11/13/12	

JLMA 11-7-12

A 000 Initial Comments

A full hospital survey, as authorized by the Centers for Medicare and Medicaid Services, was conducted from 10/08/12 – 10/10/12, subsequent to a complaint survey completed on 08/08/12. During the survey, the Conditions of Participation (COPs) for Quality Assurance and Performance Improvement and Discharge Planning were not met. The full survey completed on 10/10/12 included a Life Safety survey and investigation on 2 complaints. The following regulatory violations were found.

A 263 482.21 QAPI

The hospital must develop, implement and maintain an effective, ongoing, hospital wide, data-driven quality assessment and performance improvement program.

The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services, involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.

The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.

The CONDITION is not met as evidenced by: Based on staff interview and record review, the Condition of Participation; Quality Improvement and Performance Improvement Program was not met based on hospital's failure to meet the requirements for quality improvement and related nursing care and discharged planning prior to discharge of on applicable patient in the sample. Patient #1 was placed at risk upon discharge by the hospital's failure to assure that all components required for safe discharge from the hospital had been met prior to discharge. A patient who required specialized equipment subsequent to placement of a tracheotomy was discharged home without assuring that the suction machine was in the home and training was provided to the patient and spouse, prior to discharge from the hospital. The hospital completed a root cause analysis subsequent to a patient adverse event report on 5/3/12; however the hospital failed to identify all deficient practice and failed to initiate an appropriate action plan, including documentation of the plan, a system for monitoring progress of the plan and ongoing evaluation and analysis of the plan's progress by the Quality Department. Refer to TAGS A 287, A 288 and A 302

Central Vermont Medical Center Plan of Correction

- Central Vermont Medical Center formally responded to the standard level deficiencies referenced in the above text at the standard level.
- A contract was executed on 9/21/2012 for services from The James M. Jeffords Institute for Quality. Central Vermont Medical Center has contracted with the Jeffords Institute (JI) to provide consultation and oversight to the CVMC Quality Management Department. A new Director of Quality position was approved by the CEO in September 2012. This new position will report to the VP for the JI and the

CVMC VP for Quality and CNO. The new position will provide oversight and leadership of the Quality Management staff. All root cause analysis will be conducted by the Jeffords Institute Patient Safety staff until such time as the CVMC Quality Management staff are able to re-assume those functions.

- A Performance Improvement Committee (PIC) was chartered by Central Vermont Medical Center (CVMC) Senior Management and approved by the CVMC BOT on 9/26/2012. This committee will provide oversight for performance improvement and patient safety activities for the organization. The PIC is a multidisciplinary committee comprised of senior management, physicians and nurses. The committee is chaired by the CEO and reports directly to the CVMC Board level Quality Council.
- In addition, oversight will be provided by the Fletcher Allen Partners (FAP) Board Quality Committee. This committee is comprised of senior management from Central Vermont Medical Center and Fletcher Allen Health Care. Relevant performance improvement and patient safety activity will be reported to the joint FAP Quality Committee on a quarterly basis. The VP of the Jeffords Institute for Quality serves as staff to this Board level committee.
- A system for tracking root cause analysis and the related performance improvement activities was instituted effective October 2012. Going forward, root cause analysis performance improvement activities will be reported upon completion. Progress to plans will be tracked by the Quality Management staff at the 3, 6, and 12 month intervals. Beginning November 2012, root cause analysis action plans completed by the Jeffords Institute will be reported by the Jeffords Institute, Director of Patient Safety to the CVMC Performance Improvement Committee.

A 287 482.21 (c)(2) QAPI IMPROVEMENT ACTIVITIES

[Performance improvement activities must track medical errors and adverse patient events,] and analyze their causes, and....

This STANDARD is not met as evidences by: Based on staff interview and record review, the hospital's QAPI committee failed to develop and document data for a corrective action plan in response to an adverse patient event reviewed during a Root Cause Analysis (RCA) for 1 applicable patient in the total sample of 11 patient records reviewed. (Patient #1). Findings include:

Per review of the medical record for Patient #1 and interview with hospital staff from Discharge Planning, Nursing Services, Respiratory Therapy and Quality Improvement on 8/7/12 and 8/8/12, the hospital's QAPI response to an adverse patient event failed to completely identify causes which contributed to the event during the RCA (ROOT CAUSE ANALYSIS) process. The QAPI response failed to show evidence of follow up with corrective action plans and failed to include written data of the audits being completed by responsible department staff (Nursing and Respiratory Therapy). The QAPI response failed to address the lack of patient teaching and care planning regarding the self-care for newly placed tracheostomy.

A regulatory complaint regarding the incomplete discharge planning was investigated after Patient #1 died within hours of discharge from the hospital's medical surgical unit on 4/26/12. The patient had received emergent placement of a tracheostomy after experiencing respiratory failure. The patient was hospitalized at CVMC during the period of 3/21/12–4/26/12, excluding a 5 day hospitalization at another hospital from 4/18/12 – 4/23/12. The hospital course included inpatient status in the ICU for almost 1 month. In addition to respiratory failure, diagnoses included multiple co-morbidities contributing to the patient's acute medical condition. The patient was discharged home from the hospital with no evidence of adequate training to assure competency for self-care of the new tracheotomy post discharge. CMs (case managers); RTs (respiratory therapists) and RNs (registered nurses) failed to assure that necessary medical supplies, including a suction machine, were available in the home prior to the patient's arrival home. The patient was discharged at 12:35PM on 4/26/12 and the suction machine arrived at the home at 5:28 PM, later that same day, per interview with Director of Cardiopulmonary Services on 8/7/12 at 3PM. He confirmed the respiratory therapist working with the patient on 4/26/12 spoke with the CM and it was then discovered that no arrangements had yet been made to order a suction machine for delivery to the home that day. Per review of the Discharge Instructions Sheet signed by the Registered Nurse (RN) discharged the patient home on 4/26/12, the form was incomplete and had nothing written in the section for home medical supplies. Page 2 of the form revealed the section of the form for patient education was blank, as well as the area for other instructions. During interview on 8/8/12 at 3:17PM, the CM responsible for the discharge plan confirmed that no one was aware the patient needed suctioning equipment at home until the day of discharge. A discharge note by the CM dated 4/26/12 at 1402 stated "respiratory therapy is working on obtaining the suction equipment she will need in the home". This note was written 1 and ½ hours after the patient's discharge from the hospital.

Per review of a CM late entry progress note for 4/26/12 at 1615 (written at 1335 on 4/27/12), "CM spoke with spouse was expressed concerns regarding -----(patient's) inability to cough up mucus and the suction equipment had not yet arrived.----- (patient responded in the back ground that "I can't cough anything up and I can't breath". The CM gave instructions to the spouse and said if the patient could not breathe to return to the Emergency Department via ambulance. Although the spouse called back a short time later and said that ----- (patient) felt better, this was a potentially dangerous situation for the patient.

During the hospital's RCA, staff failed to identify all of the issues that contributed to this event. During interview on 8/8/12 at 4:19PM, the Medical Director for Quality Improvement stated that s/he felt they met the priority of the RCA by determining who is responsible for respiratory equipment at discharge. A checklist was designed to assure all necessary referrals/equipment was in place for future discharges home. Although the Director of Cardiopulmonary Services (DCPS) developed and audit form to review all discharges for evidence of appropriate discharge services and provided education to staff, he failed to assure written data was completed to show evidence of compliance, adherence to the PI plan and evaluation of needed changes to the interventions in the plan. The DCPS also confirmed that respiratory therapist are responsible for patient teaching on trash self-care, a responsibility shared with nursing staff, and that his staff failed to document adequate evidence of teaching/patient/spouse competency for trash self-care prior to discharge home from the hospital. At approximately 9PM on 4/26/12, in the presence of the Home Health RN, the patient collapsed on the bedroom floor and EMS was

called to transport to the Emergency Department, where the patient expired. The hospital QA response was not sufficient to assure that a similar situation with potentially life threatening consequences for a patient would not occur again. There was no nursing action plan as result of the RCA, per interview with the RN Director of Critical Care Services on 8/8/12 at 8:20AM. S/he stated that s/he was not aware of any QA plans for nurses re: discharge process, patient education and patient care planning. The Director of Quality Assurance, interviewed on 8/8/12 at 3:30 PM also confirmed that she was not aware of any quality response plan for corrective action regarding this patient's care and discharge process from the nursing department. She stated that the usual process for a RCA has been to utilize tracking tool to monitor what the corrective plan is, where staff are in the process, communication with work groups to assure that process is on-going and evaluation of actions to maintain compliance. The Director stated that she was on leave of absence during the RCA for this patient. The hospital failed to assure that trained staff was available to carry on QA activities during the Director's absence. In addition, the Director stated that the RCA was not brought to the hospital wide Quality Council meetings for review May and July, 2012. During interview on 8/8/12 at 4:20PM, the staff member conducting the RCA stated that a committee was devised to determine who was responsible when a patient with a tracheotomy was being discharged home, including what each discipline was responsible for. A checklist document was devised which has not yet been implemented. There have been no follow up meetings or evidence of follow up contact with committee members since the RCA meeting by the responsible Quality staff. The Director of QA, who was also present for the interview, confirmed that the hospital's quality assurance staff had not followed the department's procedural processes for this case.

Central Vermont Medical Center Plan of Correction

- A contract was executed on 9/21/2012 for services from The James M. Jeffords Institute for Quality. Central Vermont Medical Center has contracted with the Jeffords Institute (JI) to provide consultation and oversight to the CVMC Quality Management Department. A new Director of Quality position was approved by the CEO in September 2012. This new position will report to the VP for the JI and the CVMC VP for Quality and CNO and provide leadership and oversight of the Quality Management staff. All root cause analysis will be conducted by the Jeffords Institute Patient Safety staff until such time as the CVMC Quality Management staff are able to re-assume those functions.
- The Performance Improvement Committee (PIC) was chartered by Central Vermont Medical Center (CVMC) Senior Management and approved by the CVMC BOT on 9/26/2012. This committee will provide oversight for performance improvement and patient safety activities for the organization. The PIC is a multidisciplinary committee comprised of senior management, physicians and nurses. The committee is chaired by the CEO and reports directly to the CVMC Board level Quality Council.
- In addition, oversight will be provided by the Fletcher Allen Partners (FAP) Board Quality Committee. This committee is comprised of senior management from Central Vermont Medical Center and Fletcher Allen Health Care. Relevant performance improvement and patient safety activity will be reported to the joint FAP Quality

Committee on a quarterly basis. The VP of the Jeffords Institute for Quality serves as staff to this Board level committee.

- A system for tracking root cause analysis and the related performance improvement activities was instituted effective October 2012. Going forward, root cause analysis performance improvement activities will be reported upon completion. Progress to plan will be tracked by the Quality Management staff at the 3, 6, and 12 month intervals. Beginning November 2012, root cause analysis action plans completed by the Jeffords Institute will be reported by the Jeffords Institute, Director of Patient Safety to the CVMC Performance Improvement Committee.
- The Discharge Planning Improvement Committee (DPIC) was established on 8/28/12. The multidisciplinary committee comprised of Nursing, Rehabilitation Services, Respiratory Therapy and Care Management performed an extensive review of the existing discharge process, documentation tools and policies. Based upon the review, the discharge process, tools and related policies were redesigned to include a multidisciplinary discharge assessment and planning process. The redesign includes a standardized process and documentation tools. The redesign consisted of small tests of change beginning with the medical/surgical unit and was spread to relevant services. The discharge process redesign rollout and education will be completed as of 11/9/12.
- The Discharge Planning and Patient Discharge (A309) policy was revised by the Discharge Planning Improvement Committee on 8/31/12 to reflect the updated Medical Surgical discharge process. The Discharge Planning and Patient Discharge policy articulates each relevant discipline's accountabilities related to discharge planning and the discharge process. The policy was reviewed and approved by the Discharge Planning and Improvement Committee and subsequently approved by the Senior Leadership Team on 9/11/12. The referenced policy was updated to reflect process improvements for each service line and was finalized and approved by the Chief Operating Officer on 11/2/12.
- The discharge checklist was developed on 8/31/12 by the Discharge Planning Improvement Committee (DPIC). The checklist supports the Discharge Planning and Patient Discharge process. All members of the treatment team as appropriate 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 assure that appropriate services have been addressed prior to the patient's discharge.
- The Discharge Planning and Patient Discharge (A309) policy and accompanying Discharge Checklist was reviewed with the appropriate staff by relevant leadership

and the Vice President of Medical Affairs as the redesign was being tested beginning in September 2012 with completion on 11/7/2012. Education on the revised process, policy and checklist was communicated through appropriate staff meetings and via electronic communication.

- Under the direction of the Director of Cardiopulmonary Services, Respiratory Therapy created written instructions for patient and family tracheostomy care. The Director of Cardiopulmonary Services educated Respiratory staff on the use of the written instructions and the Discharge Planning and Patient Discharge policy during staff meetings in September. The patient and family tracheostomy care instructions were implemented in September 2012. An audit tool was developed to evaluate the Respiratory Therapists' documentation of patient teaching, including identification of the teaching materials provided to the patient and family. The audits will be ongoing with feedback to the Respiratory Therapy staff by the Director of Cardiopulmonary Services. Audit results will be shared at the Discharge Planning Improvement Committee meetings.
- Nursing staff was required by the Nursing Directors to review and acknowledge understanding of the Nursing Assessment and Documentation (N107) policy and the Multidisciplinary Assessment and Planning (A210) policy. This was completed on 11/2/12.
- A web based competency was developed by the lead Nurse Educator and the Director of Critical Care, to support the Discharge Planning and Patient Discharge policy and accompanying Discharge Checklist. Nursing staff will have completed the competency by 11/9/12.
- In order to assure appropriate patient education documentation at discharge, the expectations outlined in Patient and Family Education Discharge (A301) policy were reinforced by the Nursing Directors with nursing staff. This was completed on 11/2/12.
- Compliance with the Discharge Planning and Patient Discharge (A309) policy will be monitored by the Manager of Quality Management. A random sample of discharge checklists will be reviewed for completion as specified by the referenced policy. Performance feedback will be reported to the Nursing Directors, Discharge Planning Improvement Committee and the Performance Improvement Committee.
- Compliance with the Patient and Family Education Discharge (A301) policy will be monitored by the Nursing Directors or designee. Feedback for identified performance improvement opportunities will be given to the appropriate Nursing Director for follow up and action. Performance data will be shared at the Performance Improvement Committee by the Chief Nursing Officer.

A 288 482.21(c)(2) QAPI FEEDBACK AND LEARNING

[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 through the hospital.

This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to assure that it's performance improvement plans were implemented and failed to assure that mechanisms to include feedback and learning extended throughout the hospital regarding patient care for one applicable patient in the sample. (Patient #1). Findings include:

Per interview on 8/8/12 at 4:30PM, the QA staff member who was responsible for conducting a RCA (on 5/3/12) after an adverse patient event confirmed that s/he had not had follow up meetings with the subcommittee to evaluate and monitor the quality improvement process. Although nursing staff was involved in the discharge of the patient on 4/26/12, no performance activities were put into place as a result of the findings of the RCA meeting. The Medical Director also confirmed that during the RCA they did not acknowledge the lack of patient/significant other education prior to discharge to assure safe management of the patient's tracheotomy. The RN Director of Critical Services confirmed during interview on 8/8/12 at 3:45PM that he was not aware of any corrective actions put into place for re-education for nursing staff regarding RN teaching of tracheotomy care in preparation for discharge home for the patient/significant other. He also confirmed that there was no care plan for patient/significant other education for tracheotomy at home.

Although the Respiratory Department did initiate some corrective action plans, they were not fully operationalized and there was no evidence of monitoring and assessment of the ongoing corrective action plan by the department director. This was confirmed during the interview with the Directors of Cardiopulmonary Services on 8/8/12 at 3PM. The director also confirmed that he was not document the chart audits/results data that he was completing as part of the corrective action.

During interview on 8/8/12 at 4PM, the Director of Quality Assurance confirmed that the hospital's improvement plan after the RCA was lacking in follow through and analysis of the needed corrective actions necessary to assure safe patient care and planning related to discharges home with a newly placed tracheotomy requiring self-care.

Central Vermont Medical Center Plan of Correction

- A contract was executed on 9/21/2012 for services from The James M. Jeffords Institute for Quality. Central Vermont Medical Center has contracted with the Jeffords Institute (JI) to provide consultation and oversight to the CVMC Quality Management Department. A new Director of Quality position was approved by the CEO in September 2012. This new position will report to the VP for the JI and the CVMC VP for Quality and CNO and provide leadership and oversight of the Quality

Management staff. All root cause analysis will be conducted by the Jeffords Institute Patient Safety staff until such time as the CVMC Quality Management staff are able to re-assume those functions.

- The Performance Improvement Committee (PIC) was chartered by Central Vermont Medical Center (CVMC) Senior Management and approved by the CVMC BOT on 9/26/2012. This committee will provide oversight for performance improvement and patient safety activities for the organization. The PIC is a multidisciplinary committee comprised of senior management, physicians and nurses. The committee is chaired by the CEO and reports directly to the CVMC Board level Quality Council.
- In addition, oversight will be provided by the Fletcher Allen Partners (FAP) Board Quality Committee. This committee is comprised of senior management from Central Vermont Medical Center and Fletcher Allen Health Care. Relevant performance improvement and patient safety activity will be reported to the joint FAP Quality Committee on a quarterly basis. The VP of the Jeffords Institute for Quality serves as staff to this Board level committee.
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Discharge Planning and Improvement Committee and subsequently approved by the Senior Leadership Team on 9/11/12. The referenced policy was updated to reflect process improvements for each service line and was finalized and approved by the Chief Operating Officer on 11/2/12.

- The discharge checklist was developed on 8/31/12 by the Discharge Planning Improvement Committee (DPIC). The checklist supports the Discharge Planning and Patient Discharge process. All members of the treatment team as appropriate 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 assure that appropriate services have been addressed prior to the patient's discharge.
- The Discharge Planning and Patient Discharge (A309) policy and accompanying Discharge Checklist was reviewed with the appropriate staff by relevant leadership and the Vice President of Medical Affairs as the redesign was being tested in each beginning in September 2012 with completion on 11/7/2012. Education on the revised process, policy and checklist was communicated through appropriate staff meetings and via electronic communication.
- Under the direction of the Director of Cardiopulmonary Services, Respiratory Therapy created written instructions for patient and family tracheostomy care. The Director of Cardiopulmonary Services educated Respiratory staff on the use of the written instructions and the Discharge Planning and Patient Discharge policy during staff meetings in September. The patient and family tracheostomy care instructions were implemented in September 2012. An audit tool was developed to evaluate the Respiratory Therapists' documentation of patient teaching, including identification of the teaching materials provided to the patient and family. The audits will be ongoing with feedback to the Respiratory Therapy staff by the Director of Cardiopulmonary Services. Audit results will be shared at the Discharge Planning Improvement Committee meetings.
- Nursing staff was required by the Nursing Directors to review and acknowledge understanding of the Nursing Assessment and Documentation (N107) policy and the Multidisciplinary Assessment and Planning (A210) policy. This was completed on 11/2/12.
- A web based competency was developed by the lead Nurse Educator and the Director of Critical Care, to support the Discharge Planning and Patient Discharge policy and accompanying Discharge Checklist. Nursing staff will have completed the competency by 11/9/12.
- In order to assure appropriate patient education documentation at discharge, the expectations outlined in Patient and Family Education Discharge (A301) policy were reinforced by the Nursing Directors with nursing staff. This was completed on 11/2/12.

- Compliance with the Discharge Planning and Patient Discharge (A309) policy will be monitored by the Manager of Quality Management. A random sample of discharge checklists will be reviewed for completion as specified by the referenced policy. Performance feedback will be reported to the Nursing Directors, Discharge Planning Improvement Committee and the Performance Improvement Committee.
- Compliance with the Patient and Family Education Discharge (A301) policy will be monitored by the Nursing Directors or designee. Feedback for identified performance improvement opportunities will be given to the appropriate Nursing Director for follow up and action. Performance data will be shared at the Performance Improvement Committee by the Chief Nursing Officer.

A291 482.21(c)(3) QAPI SUSTAINED IMPROVEMENT

The hospital must take action aimed at performance improvement and, after implementing these actions; the hospital must measure its success, and track performance to ensure that improvements are sustained.

This standard was not met as evidenced by: Based upon observation, staff interview and record review, the hospital failed to ensure performance improvement actions, previously implemented for infection control deficient practice was sustained. Findings include:

A deficient practice was identified during a complaint survey on 7/31/12, related to failure of all OR (operating room) staff to wear head coverings and masks in a manner that covered all areas appropriately during surgical procedures. During interview, on 7/31/12 at 4:00 PM the Infection control Nurse stated that per hospital policy and standard of care, PPE (Personal Protective Equipment), including head covers that completely covered all hair and facial masks, completely covering nose and mouth, should be worn by anyone entering an OR in which an active case was in progress. However, during a tour of the perioperative areas on 10/9/12 at 11:20 AM with the VP of Medical Affairs and the Director of Ambulatory Nursing Services, in OR #3 the scrub nurse, the circulating nurse and the anesthesiologist were all observed wearing PPE (head coverings) that failed to completely cover their hair and jewelry while actively involved in a surgical procedure. Although the Director for Ambulatory Nursing Services confirmed frequent auditing/surveillance of staff in the operating rooms had been conducted, the deficient practice has not been corrected as of 10/9/12. Improvement actions associated with this plan to correct this deficient practice and breach of infection control policy had not been sustained

Central Vermont Medical Center Plan of Correction

- A memo from the Infection Prevention staff was sent on 10/29/12 to all staff reinforcing the expectations outlined in the following Central Vermont Medical Center policies: Hand Hygiene (IC-17), OSHA Blood Borne Exposure Control Plan (PPE) (IC 18) and Isolation Precautions (IC-108). Reinforced in this memo was the expectation to wear appropriate head covers while in the Operating Room. Noted was the expectation that

hair and jewelry must be covered when in the semi-restricted and restricted areas of the operating room. In addition, the referenced memo was sent from the Vice President of Medical Affairs on 10/29/12 to all medical staff reinforcing the expectations outlined above.

- On 10/25/12 the Vice President of Medical Affairs reviewed the expectations regarding the appropriate use of head covers while in restricted areas at the Department of Surgery Meeting.
- At a staff meeting on 11/1/12, the Director of Ambulatory Nursing Services reinforced the expectations outlined in the Infection Prevention memo. Specifically, reviewing the expectations outlined in the Central Vermont Medical Center Policies: Hand Hygiene (IC-17), OSHA Blood Borne Exposure Control Plan (PPE) (IC 18) and Isolation Precautions (IC-108). Noted was the expectation that hair and jewelry must be covered when in the semi-restricted and restricted areas of the Operating Room.
- Use of proper Operating Room head covering will be monitored by the Director of Ambulatory Nursing Services and by Infection Prevention staff. Feedback regarding compliance will be given to the Vice President of Medical Affairs and the Chief Nursing Officer. Data will be reported to the Performance Improvement Committee by the Infection Prevention staff.

A 302 482.21(d)(3) QA PI PROJECT DOCUMENTATION

[The hospital must document what quality improvement projects are being conducted the reasons for conducting these projects, and] the measurable progress achieved on these projects.

This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to assure that a quality improvement project initiated after an adverse patient event was properly documented and that measurable progress was achieved regarding the care of one applicable patient in sample. (Patient #1). Findings include:

Per interviews on (8/7/12 and 8/8/12) with the QA staff assigned to conduct a RCA after an adverse event, there were no transcribed notes from the RCA; no documentation of a corrective action plan for nursing staff re: patient care planning and teaching in preparation for discharge, no documentation of respiratory department QA audit process and no evidence of written follow up and/or committee meetings to measure progress in the corrective action plan. The hospital completed a root cause analysis subsequent to a patient adverse event report on 5/3/12; however the hospital failed to identify all deficient practice and failed to initiate an appropriate action plan, including documentation of the plan, a system for monitoring progress of the plan and evaluation of the plan's progress by the Quality Department.

Central Vermont Medical Center of Correction

- A contract was executed on 9/21/2012 for services from The James M. Jeffords Institute for Quality. Central Vermont Medical Center has contracted with the Jeffords Institute (JI) to provide consultation and oversight to the CVMC Quality Management Department. A new Director of Quality position was approved by the CEO in September 2012. This new position will report to the VP for the JI and the CVMC VP for Quality and CNO. The new position will provide oversight and leadership of the Quality Management staff. All root cause analysis will be conducted by the Jeffords Institute Patient Safety staff until such time as the CVMC Quality Management staff are able to re-assume those functions.
- A Performance Improvement Committee (PIC) was chartered by Central Vermont Medical Center (CVMC) Senior Management and approved by the CVMC BOT on 9/26/2012. This committee will provide oversight for performance improvement and patient safety activities for the organization. The PIC is a multidisciplinary committee comprised of senior management, physicians and nurses. The committee is chaired by the CEO and reports directly to the CVMC Board level Quality Council.
- In addition, oversight will be provided by the Fletcher Allen Partners (FAP) Board Quality Committee. This committee is comprised of senior management from Central Vermont Medical Center and Fletcher Allen Health Care. Relevant performance improvement and patient safety activity will be reported to the joint FAP Quality Committee on a quarterly basis. The VP of the Jeffords Institute for Quality serves as staff to this Board level committee.
- A system for tracking root cause analysis and the related performance improvement activities was instituted effective October 2012. Going forward, root cause analysis performance improvement activities will be reported upon completion. Progress to plan will be tracked by the Quality Management staff at the 3, 6, and 12 month intervals. Beginning November 2012, root cause analysis action plans completed by the Jeffords Institute will be reported by the Jeffords Institute, Director of Patient Safety to the CVMC Performance Improvement Committee.

A 395 482.23 (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 staff interview and record review, the hospital failed to assure that RNs evaluated, assessed and implemented a plan to provide appropriate tracheotomy self care training to Patient #1 and his/her significant other prior to discharge from the hospital to the home setting. Findings include:

Per record reviews on 8/7/12 and 8/8/12, Patient #1 had a tracheotomy placed during a hospital stay and RNs failed to document adequate teaching of self care for the patient/spouse in preparation for discharge from the hospital to home on 4/26/12. Review of nursing notes from

4/23/12-4/23/12 reveals incomplete documentation regarding the skill level of the patient in completing their own trash care. There was no evidence of training in suctioning the tracheotomy if it should become blocked by thick secretions. The patient expressed anxiety regarding responsibility for his/her own care during a meeting with the psychiatrist on 4/25/12. The progress note stated "she looks forward to going home but states she is afraid because if there is a medical complication, she will not have immediate help". There was no evidence that the patient was given any written educational materials regarding tracheotomy care upon discharge on 4/26/12. There was no evidence of any assessment of the patient's capabilities for self trash care. Per review of the discharge Instructions Sheet, signed by the patient and the RN on 4/26/12 at 12:35PM, the section regarding patient education was blank. This was confirmed during the interview with the RN Director of Critical Care Services on 8/8/12 at 3:45PM. Refer also to A 396

Central Vermont Medical Center Plan of Correction

- The Discharge Planning Improvement Committee (DPIC) was established on 8/28/12. The multidisciplinary committee comprised of Nursing, Rehabilitation Services, Respiratory Therapy and Care Management performed an extensive review of the existing discharge process, documentation tools and policies. Based upon the review, the discharge process, tools and related policies were redesigned to include a multidisciplinary discharge assessment and planning process. The redesigned process includes a standardized process and documentation tools. The redesign consisted of small tests of change beginning with the medical/surgical unit and was spread to relevant services. The discharge process redesign rollout and education will be completed as of 11/9/12.
- The Discharge Planning and Patient Discharge (A309) policy was revised by the Discharge Planning Improvement Committee on 8/31/12 to reflect the updated Medical Surgical discharge process. The Discharge Planning and Patient Discharge policy articulates each relevant discipline's accountabilities related to discharge planning and the discharge process. The policy was reviewed and approved by the Discharge Planning and Improvement Committee and subsequently approved by the Senior Leadership Team on 9/11/12. The referenced policy was updated to reflect process improvements for each service line and was finalized and approved by the Chief Operating Officer on 11/2/12.
- The discharge checklist was developed on 8/31/12 by the Discharge Planning Improvement Committee (DPIC). The checklist supports the Discharge Planning and Patient Discharge process. All members of the treatment team as appropriate 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 assure that appropriate services have been addressed prior to the patient's discharge.

- The Discharge Planning and Patient Discharge (A309) policy and accompanying Discharge Checklist was reviewed with the appropriate staff by relevant leadership and the Vice President of Medical Affairs as the redesign was being tested beginning in September 2012 with completion on 11/7/2012. Education on the revised process, policy and checklist was communicated through appropriate staff meetings and via electronic communication.
- Under the direction of the Director of Cardiopulmonary Services, Respiratory Therapy created written instructions for patient and family tracheostomy care. The Director of Cardiopulmonary Services educated Respiratory staff on the use of the written instructions and the Discharge Planning and Patient Discharge policy during staff meetings in September. The patient and family tracheostomy care instructions were implemented in September 2012. An audit tool was developed to evaluate the Respiratory Therapists' documentation of patient teaching, including identification of the teaching materials provided to the patient and family. The audits will be ongoing with feedback to the Respiratory Therapy staff by the Director of Cardiopulmonary Services. Audit results will be shared at the Discharge Planning Improvement Committee meetings.
- Nursing staff was required by the Nursing Directors to review and acknowledge understanding of the Nursing Assessment and Documentation (N107) policy and the Multidisciplinary Assessment and Planning (A210) policy. This was completed on 11/2/12.
- A web based competency was developed by the lead Nurse Educator and the Director of Critical Care, to support the Discharge Planning and Patient Discharge policy and accompanying Discharge Checklist. Nursing staff will have completed the competency by 11/9/12.
- In order to assure appropriate patient education documentation at discharge, the expectations outlined in Patient and Family Education Discharge (A301) policy were reinforced by the Nursing Directors with nursing staff. This was completed on 11/2/12.
- Compliance with the Discharge Planning and Patient Discharge (A309) policy will be monitored by the Manager of Quality Management. A random sample of discharge checklists will be reviewed for completion as specified by the referenced policy. Performance feedback will be reported to the Nursing Directors, Discharge Planning Improvement Committee and the Performance Improvement Committee.
- Compliance with the Patient and Family Education Discharge (A301) policy will be monitored by the Nursing Directors or designee. Feedback for identified performance improvement opportunities will be given to the appropriate Nursing Director for follow up and action. Performance data will be shared at the Performance Improvement Committee by the Chief Nursing Officer.

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.

This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to assure that RNs developed and kept current a nursing care plan for one patient/significant other regarding training of tracheotomy care in preparation for discharge home. (Patient #1). Findings include:

Per record review on 8/7/12, there was no nursing care plan developed to address Patient #1's needs regarding education for him/her and the spouse for total care/self care at home for a newly placed tracheotomy during an extended hospital stay. Review of the 'teach back checklist' notes (4/18//12) o 8/8/12 revealed that the patient was instructed only briefly regarding instillation of NS (normal saline solution) into the trachea to loosen mucus. There was no evidence of training regarding how to suction the trachea for removal of excessive mucus if needed. Although a RN documented that a booklet with training materials was given to patient while s/he was critically ill in the ICU, there was no evidence of follow through and return demonstration for all necessary trach care to be carried out by the patient/spouse after discharge home on 4/26/12. The discharge instructions sheet given to the patient by the RN at discharge documented no educational materials regarding trach care in the education section of the sheet. This was confirmed with the Director of Critical Care Services on 8/8/12 at 3:45 PM. Refer also to A395

Central Vermont Medical Center Plan of Correction

- Nursing staff was required by the Nursing Directors to review and acknowledge understanding of the Nursing Assessment and Documentation (N107) policy and the Multidisciplinary Assessment and Planning (A210) policy. This was completed on 11/2/12.
- A web based competency was developed by the lead Nurse Educator and the Director of Critical Care, to support the Discharge Planning and Patient Discharge policy and accompanying Discharge Checklist. Nursing staff will have completed the competency by 11/9/12.
- In order to assure appropriate patient education documentation at discharge, the expectations outlined in Patient and Family Education Discharge (A301) policy were reinforced by the Nursing Directors with nursing staff. This was completed on 11/2/12.
- Compliance with the Discharge Planning and Patient Discharge (A309) policy will be monitored by the Manager of Quality Management. A random sample of discharge

checklists will be reviewed for completion as specified by the referenced policy. Performance feedback will be given to the Nursing Directors, Discharge Planning Improvement Committee and the Performance Improvement Committee.

- Compliance with the Patient and Family Education Discharge (A301) policy will be monitored by the Nursing Directors or designee. Feedback for identified performance improvement opportunities will be reported to the appropriate Nursing Director for follow up and action. Performance data will be shared at the Performance Improvement Committee by the Chief Nursing Officer.

A466 482.24 (c)(2)(v) CONTENT OF THE RECORD-INFORMED CONSENT

[All records must document the following as appropriate:]

Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by Federal or State law if applicable to require written patient consent.

This standard is not met as evidenced by: based upon the interview and record review, the hospital failed to assure that properly executed anesthesia consent from was obtained from 2 patients in the applicable sample undergoing a surgical procedure (Patients #13 and #27).

Findings include:

- 1. Per record review and confirmed with the charge Nurse on 10/8/12 at 4:50 PM, there was no signed anesthesia consent for Patient #13 who received anesthesia for a surgical procedure on 10/15/12.
Per record review and confirmed with the VP, Quality and Nursing/Chief Nursing Officer (CNO) on 10/9/12 at 1:15 PM, the Anesthesia Record for patient #13 states "anesthesia pre-op, patient medicated and not consentable" and was electronically signed by the Anesthesiologist on 10/15/12.*
- 2. Per record review on 10/10/12, there was no signed anesthesia consent for Patient #27, who received spinal anesthesia for a surgical procedure 10/2/12. This was confirmed by both the Director of Peri-Operative Services and the VP, Quality and Nursing/Chief Nursing Officer (CNO) during separate interviews on the afternoon of 10/10/12. In addition, per staff interview and confirmed with the VP, Quality and Nursing/Chief Nursing Officer (CNO) on 10/10/12 at 1:15 PM, the facility policy titled Informed Consent with an effective date 8/16/12 states that Surgical or Invasive Procedure consent should be obtained for General or Spinal anesthesia and Conscious Sedation.*

Central Vermont Medical Center Plan of Correction

- The Central Vermont Medical Center Informed Consent policy (A104) was updated by the Vice President of Medical Affairs in collaboration with the Chief of Anesthesia and the Anesthesia Quality Chair to include specific language regarding patients that are unable to give informed consent. Clarifying language was added regarding accountability

for obtaining consent for General, Regional (Spinal or Epidural) and Monitored Anesthesia Care.

- On 10/31/12, The Vice President of Medical Affairs communicated the final version of Informed Consent Policy (A104) to the Chief of Anesthesia and the Anesthesia Quality Chair. On 11/5/2012, The Chief of Anesthesia and the Anesthesia Quality Chair communicated the expectations outlined in the Informed Consent (A104) policy to the Department of Anesthesia.
- Effective 10/22/12 the anesthesia consent form was added to the pre-operative checklist process in the Pre-op Holding area by the Director of Ambulatory Nursing Services. Items on the Pre-operative checklist will need to be completed prior to the patient progressing into the surgical suite. The nursing staff was educated to this process revision by the Director of Ambulatory Nursing Services at the 11/1/12 staff meeting.
- Monitoring for completeness of anesthesia consents will be performed under the direction of the Director of Ambulatory Nursing Services. Performance feedback will be reported to the Vice President of Medical Affairs and the Performance Improvement Committee.

A749 482.42(a)(1) INFECTION CONTROL OFFICER RESPONSIBILITIES

The infection control officer or officers must develop a system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel.

This standards was not met as evidenced by: Based on observations, staff interview and record review the hospital failed to assure that infection control measures were implemented in an ongoing and consistent manner to assure terminal cleaning in all operating rooms was conducted; appropriate use of PPE (personal Protective Equipment) by all peri-operative staff was worn in accordance with standards of practice and compliance was maintained by staff regarding the use of PPE when contact precautions are initiated. Findings include:

1. *During a tour of the perioperative area on 10/9/12 AM with the VP of Medical Affairs and the Director of Ambulatory Nursing Services, in Operating Suite #3 the scrub nurse, circulating nurse and the anesthesiologist were all observed wearing PPE (head coverings) that failed to completely cover their hair and jewelry while actively involved in a surgical procedure. Per AORN (Association of PeriOperative Registered Nurses) Journal January 2012 Vol. 95 No1 "Implementing AORN Recommended Practices for Surgical Attire," Perioperative nurses should not wear jewelry such as earrings, necklaces.... that cannot be contained within surgical attire because of the risk of contaminating the surgical attire. AORN further states "All personnel should cover their head and facial hair when in the semi restricted and restricted areas. Head covering should cover the facial hair, sideburns and the nape of the neck. Perioperative nurses can help minimize the risk of surgical site infections by covering head and facial hair....." AORN further states "Skull caps are not recommended because they do not completely cover the side hair above and in front of the ears and the hair on the nape of the neck." The Director of Ambulatory Nursing Services confirmed at the time of the observation, staff were not meeting standards of practice and*

were not in compliance with the hospital Infection Prevention and Control Guidelines for surgical Services last reviewed 1/13/12 which state, per VII., Environmental Control D.-2 "hair coverings will be donned prior to entering the OR suite and will cover and contain all hair". This violation of hospital policy and standards of practice was also confirmed the morning of 10/10/12 with the Manager of Infection Prevention and Control.

2. While touring operating room Suite #2 and #4 on 10/9/12 at 11:25 AM and 2:00 PM with the Director of Ambulatory Nursing Services powder-like dust was observed on the ventilation faceplates covering w/out take air vents located on the lower walls of each of the operating rooms. The director acknowledged housekeeping staff assigned to perform terminal cleaning each night in each of the OR Suites would be responsible for cleaning the ventilation faceplates. Per review of the hospital's policy Infection prevention and Control Guidelines for Surgical Services, V. Housekeeping : "Housekeeping will clean the department according to established department policy and is responsible for floors, walls, cabinets, chairs and certain equipment this terminal cleaning will include v. Ventilation faceplates". The policy further states: "Surgical procedure rooms and scrub/utility sinks will be terminally cleaned daily, regardless of whether they are used that day. A clean surgical environment will reduce the number of microbial flora present. This means that these rooms should be terminally cleaned once during each 24 hour period during the regular work week". Per interview on the morning of 10/10/12, the Manager for Infection Prevention and Control noted although Environmental Patient Safety Inspections did inspect the Operating suited, the ventilation faceplates had not been part of their observations.
3. Per observations on 10/8/12, between 2:25 PM and 2:30 PM, hospital staff failed to adhere to orders for 'Contact precautions' when entering and leaving the room of a patient with a suspected infection. Per record review on the afternoon of 10/9/12, on 10/6/12 at 10:27 AM Patient #5, who was hospitalized for treatment for cellulitis [a severe inflammation of dermal and subcutaneous layers of the skin], was placed on 'Contact Precautions' [Contact Precautions are methods used to prevent transmission of infectious agents which are spread by direct/indirect contact with a patient or a patient's environment]. Per review of patient #5's medical record, physician progress notes dictated on 10/7/12 at 3:44 PM regarding Patient #5's cellulitis stated, "MRSA is likely". [Methacillin Resistant Staphylococcus Aureus (MSRA) is a bacterium in infections that has developed a resistance to multiple antibiotics]. Per observation of Resident #5 on 10/18/12 at 2:25 PM, the facilities' Contact Precautions sheet was present on the wall in the hallway, outside the patient's room. "Perform hand hygiene between all patient contact and before entering and leaving the room. Wear gloves when entering room and for all patient contact." The precautions also list "wear a gown whenever anticipating clothing will have direct contact with the patient or potentially contaminated environment surfaces or items in the patient's room."

Per observation on 10/8/12 at 2:25 PM, a physician entered Patient #5's room with gloves on, but no gown, sat down on a chair across from Patient #5, and performed a procedure on the patient's left wrist. Per review, the Physician's progress note, dictated on 10/8/12 at 2:52 PM regarding the procedure on Patient 35 stated, "I did express a small amount of purulence [containing or discharging pus] at one site....I sent this for culture".

Per observation at 2:30 PM on 10/8/12, after the physician had left the patient's room, a Social Worker entered the room without performing hand hygiene and without donning gloves or a gown. The Social Worker sat down in a chair across from the patient, and after speaking with the patient exited the room without performing hand hygiene.

Per interview on 10/9/12 at 3:09 PM both the Physician and the Social Worker confirmed that on 10/8/12 between approximately 2:25 PM and 2:35 PM they had each visited with the patient. In addition, they were aware the patient was on Contact Precautions and that the Contact Precautions sign was posted on the wall outside the patient's room prior to entering.

The Physician confirmed during an interview on 10/9/12 at 3:09 PM that s/he had only used gloves when touching the patient and obtaining the culture and stated, "Normally I would gown up". The Physician also confirmed that the lab results from the culture s/he took would not be available until the next day. During this same interview, on 10/9/12 at 3:09 PM the social Worker confirmed that s/he did not perform hand hygiene or don gloves and gown up before entering the patient's room (per the posted Contact precautions), that s/he had sat down in a chair next to the patient and could not recall if s/he had performed hand hygiene after exiting the patient's room. Per observation by this surveyor on 10/8/12 at approximately 2:40 PM hand washing and/or sanitizing of the hands was not completed by the Social Worker after exiting the patient's room.

Per interview with the Infection Control Nurse on 10/8/12 at 2:35 PM, s/he confirmed that s/he was present during the observations on 10/8/12, and that neither the Physician nor the Social Worker properly followed the facility's CDC-based Contact Precautions sheet that was posted outside the patient's room. The Infection Control Nurse state that the facility's Contact Precautions are taken from recommendations from the Centers for Disease Control (CDC) guidelines for 'Preventing Transmission of Infectious Agents in Healthcare Settings'.

Central Vermont Medical Center Plan of Correction

- Infection Prevention conducted an employee poll on 10/12/12 to solicit input for ways to improve staff compliance with utilization of appropriate PPE. Based upon feedback received, signage has been lowered to be more visible and yellow colored "precaution" magnetic signs have been ordered to allow for more prominent visibility of this visual aide.
- A memo from the Infection Prevention staff was sent on 10/29/12 to all staff reinforcing the expectations outlined in the following Central Vermont Medical Center policies: Hand Hygiene (IC-17), OSHA Blood Borne Exposure Control Plan (PPE) (IC 18) and Isolation Precautions (IC-108). Reinforced in this memo was the expectation to wear appropriate head covering while in the Operating Room for staff that have reason to enter the area. Noted was the expectation that hair and jewelry must be covered when in the semi-restricted and restricted areas of the Operating Room. The referenced memo was also sent

from the Vice President of Medical Affairs on 10/29/12 to all medical staff reinforcing the expectations outlined above.

- On 10/25/12 the Vice President of Medical Affairs reviewed the expectations regarding the appropriate use of head covering while in restricted areas at the Department of Surgery Meeting.
- At a staff meeting on 11/1/12, the Director of Ambulatory Nursing Services reinforced the expectations outlined in the Infection Prevention memo. Specifically, reviewing the expectations outlined in the Central Vermont Medical Center Policies: Hand Hygiene (IC-17), OSHA Blood Borne Exposure Control Plan (PPE) (IC 18) and Isolation Precautions (IC-108). Noted was the expectation that hair and jewelry must be covered when in the semi-restricted and restricted areas of the Operating Room.
- Use of proper Operating Room head covering will be monitored by the Director of Ambulatory Nursing Services and by Infection Prevention staff. Feedback regarding compliance will be given to the Vice President of Medical Affairs and the Chief Nursing Officer as appropriate. Data will be reported to the Performance Improvement Committee by Infection Prevention staff.
- Proper use of PPE and appropriate hand hygiene will be monitored by the Infection Prevention staff. Data will be reported to the Performance Improvement Committee by Infection Prevention staff.
- An “OR Daily General Cleanliness Checklist” was developed by the Director of Building Services on 11/1/12. This checklist includes verification that wall vents are clean and free of dust. The “Checklist” is utilized by housekeeping staff each morning prior to surgery to ensure the room is ready for use. If a room is not ready for use, the housekeeping staff will alert the OR CNC and appropriate follow-up actions will be taken and documented prior to OR use.
- The Building Services staff has been educated on the OR Daily General Cleanliness Checklist and process by the Director of Housekeeping and their designee on 11/1/12. The Operating Room staff has been educated regarding the “Checklist” by the Director of Nursing Ambulatory Services at the 11/1/12 staff meeting.
- The Environment of Care team will monitor vents in the Operating Room as part of the Environmental Safety Rounds conducted every 6 months. Performance feedback will be given to the Director of Housekeeping and the Vice President of Support Services.
- The Building Services Housekeeping Supervisor will conduct weekly inspections to ensure daily checks and overall cleanliness meets the required standards. Performance

feedback will be given to the Director of Housekeeping and the Vice President of Support Services.

A 799 482.23 DISCHARGE PLANNING

The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing.

This CONDITION is not met as evidenced by: Based on staff interview and record review, the Condition of Participation: Discharge Planning was not met due to the hospital's failure to assure that a comprehensive and accurate discharge plan was devised and implemented prior to discharge of one applicable patient in the sample. Patient #1 was placed at risk of harm/adverse outcome upon discharge by the hospital's failure to assure that all components required for safe discharge from the hospital had been met prior to discharge. A patient who required specialized equipment subsequent to placement of a tracheostomy was discharged home without assurance that the suction machine was in the home and training provided to the patient and spouse, prior to discharge from the hospital.

Refer to TAGS A 808, A 810, A 820 and A 822.

Central Vermont Medical Center of Correction

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

A 808 482.23(b)(3) POST HOSPITAL SERVICES

The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services.

This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to assure that discharge planners identified all of the discharge services/equipment needs required post discharge for one applicable patient in the sample. (Patient #1). Findings include:

Per record review and confirmed by staff interview on 8/7/12 and 8/8/12, hospital failed to assure that all necessary components of the discharge plan for Patient #1 were completed and/or arranged prior to discharge home on 4/26/12. Hospital staff providing care and services to the patient, including respiratory therapists, RNs and CM all failed to assure that the patient's needs regarding trach care, including necessary equipment and demonstration of competency to complete care was completed prior to discharging the patient home on 4/26/12. Per interview on 8/7/12 at 2:58 PM, the DCPC stated that the respiratory therapist for 4/26/12 had obtained physician order for home suction equipment at approximate 2:45PM, more 2 hours after the patient was discharged from the hospital. He stated that he spoke with the medical equipment driver who said that he arrived at the home with the suction machine at 5:28PM. He confirmed that when the CM called to patient's home at 3:30PM, the CM was told that the patient was

*short of breath. He stated that the CM called the respiratory department who instructed her to have the patient call 911.
Refer to A 287, A 395, A 810 and A 822*

Central Vermont Medical Center of Correction

- The Discharge Planning Improvement Committee (DPIC) was established on 8/28/12. The multidisciplinary committee comprised of Nursing, Rehabilitation Services, Respiratory Therapy and Care Management performed an extensive review of the existing discharge process, documentation tools and policies. Based upon the review, the discharge process, tools and related policies were redesigned to include a multidisciplinary discharge assessment and planning process. The redesign includes a standardized process and documentation tools. The redesign consisted of small tests of change beginning with the medical/surgical unit and was spread to relevant services. The discharge process redesign rollout and education will be completed as of 11/9/12.
- The Discharge Planning and Patient Discharge (A309) policy was revised by the Discharge Planning Improvement Committee on 8/31/12 to reflect the updated Medical Surgical discharge process. The Discharge Planning and Patient Discharge policy articulates each relevant discipline's accountabilities related to discharge planning and the discharge process. The policy was reviewed and approved by the Discharge Planning and Improvement Committee and subsequently approved by the Senior Leadership Team on 9/11/12. The referenced policy was updated to reflect process improvements for each service line and was finalized and approved by the Chief Operating Officer on 11/2/12.
- The discharge checklist was developed on 8/31/12 by the Discharge Planning Improvement Committee (DPIC). The checklist supports the Discharge Planning and Patient Discharge process. All members of the treatment team as appropriate 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 assure that appropriate services have been addressed prior to the patient's discharge.
- The Discharge Planning and Patient Discharge (A309) policy and accompanying Discharge Checklist was reviewed with the appropriate staff by relevant leadership and the Vice President of Medical Affairs as the redesign was being tested beginning in September 2012 with completion on 11/7/2012. Education on the revised process, policy and checklist was communicated through appropriate staff meetings and via electronic communication.
- Under the direction of the Director of Cardiopulmonary Services, Respiratory Therapy created written instructions for patient and family tracheostomy care. The

Director of Cardiopulmonary Services educated Respiratory staff on the use of the written instructions and the Discharge Planning and Patient Discharge policy during staff meetings in September. The patient and family tracheostomy care instructions were implemented in September 2012. An audit tool was developed to evaluate the Respiratory Therapists' documentation of patient teaching, including identification of the teaching materials provided to the patient and family. The audits will be ongoing with feedback to the Respiratory Therapy staff by the Director of Cardiopulmonary Services. Audit results will be shared at the Discharge Planning Improvement Committee meetings.

- Nursing staff was required by the Nursing Directors to review and acknowledge understanding of the Nursing Assessment and Documentation (N107) policy and the Multidisciplinary Assessment and Planning (A210) policy. This was completed on 11/2/12.
- A web based competency was developed by the lead Nurse Educator and the Director of Critical Care, to support the Discharge Planning and Patient Discharge policy and accompanying Discharge Checklist. Nursing staff will have completed the competency by 11/9/12.
- In order to assure appropriate patient education documentation at discharge, the expectations outlined in Patient and Family Education Discharge (A301) policy were reinforced by the Nursing Directors with nursing staff. This was completed on 11/2/12.
- Compliance with the Discharge Planning and Patient Discharge (A309) policy will be monitored by the Manager of Quality Management. A random sample of discharge checklists will be reviewed for completion as specified by the referenced policy. Performance feedback will be reported to the Nursing Directors, Discharge Planning Improvement Committee and the Performance Improvement Committee.
- Compliance with the Patient and Family Education Discharge (A301) policy will be monitored by the Nursing Directors or designee. Feedback for identified performance improvement opportunities will be given to the appropriate Nursing Director for follow up and action. Performance data will be shared at the Performance Improvement Committee by the Chief Nursing Officer.

A 810 482.23 (b)(5) TIMELY DISCHARGE PLANNING EVALUATIONS

The hospital personnel must complete the evaluation on timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge.

This STANDARD is not met as evidenced by: Bases on staff interview and record review, hospital personnel failed to complete a timely evaluation for all the post hospital needs and

services prior to discharge for one applicable patient in the sample. (Patients #1). Findings include:

Per record reviews and information received from an anonymous complaint, hospital discharge planners failed to assure that all of the necessary post hospital needs for Patient #1, who had a newly placed tracheotomy, were made prior to discharge from the hospital. The failure to assure that a suction machine had been delivered to the home prior to the patient's arrival home from the hospital, placed the patient at risk of significant harm from a failure to have necessary equipment available and evidence of competency to use all the equipment properly. A failure to communicate all of the needs of the patient/spouse by hospital staff including respiratory therapists, staff RNs and CM (case manager) and obtain all necessary physician orders and equipment needed prior to discharge placed that patient at risk of significant harm. The hospital's policy "Discharge Planning", procedure, #8, states "Specific steps in discharge planning undertaken by each discipline must include: (a) an evaluation of need; (b) education and instruction of patient and family regarding the patient's needs, and (c) providing for continuing care following discharge to meet ongoing needs." During interview on 8/8/12 at 2:45PM, the Director of Discharge Planning confirmed the lack of appropriate discharge planning for the patient and stated that s/he had instituted audits of discharge instruction sheets for accuracy and completeness of documentation in meeting patient needs. Refer also to A 820

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- The Discharge Planning Improvement Committee (DPIC) was established on 8/28/12. The multidisciplinary committee comprised of Nursing, Rehabilitation Services, Respiratory Therapy and Care Management performed an extensive review of the existing discharge process, documentation tools and policies. Based upon the review, the discharge process, tools and related policies were redesigned to include a multidisciplinary discharge assessment and planning process. The redesign includes a standardized process and documentation tools. The redesign consisted of small tests of change beginning with the medical/surgical unit and was spread to relevant services. The discharge process redesign rollout and education will be completed as of 11/9/12.
- The Discharge Planning and Patient Discharge (A309) policy was revised by the Discharge Planning Improvement Committee on 8/31/12 to reflect the updated Medical Surgical discharge process. The Discharge Planning and Patient Discharge policy articulates each relevant discipline's accountabilities related to discharge planning and the discharge process. The policy was reviewed and approved by the Discharge Planning and Improvement Committee and subsequently approved by the Senior Leadership Team on 9/11/12. The referenced policy was updated to reflect process improvements for each service line and was finalized and approved by the Chief Operating Officer on 11/2/12.

- The discharge checklist was developed on 8/31/12 by the Discharge Planning Improvement Committee (DPIC). The checklist supports the Discharge Planning and Patient Discharge process. All members of the treatment team as appropriate 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 assure that appropriate services have been addressed prior to the patient's discharge.
- The Discharge Planning and Patient Discharge (A309) policy and accompanying Discharge Checklist was reviewed with the appropriate staff by relevant leadership and the Vice President of Medical Affairs as the redesign was being tested beginning in September 2012 with completion on 11/7/2012. Education on the revised process, policy and checklist was communicated through appropriate staff meetings and via electronic communication.
- Under the direction of the Director of Cardiopulmonary Services, Respiratory Therapy created written instructions for patient and family tracheostomy care. The Director of Cardiopulmonary Services educated Respiratory staff on the use of the written instructions and the Discharge Planning and Patient Discharge policy during staff meetings in September. The patient and family tracheostomy care instructions were implemented in September 2012. An audit tool was developed to evaluate the Respiratory Therapists' documentation of patient teaching, including identification of the teaching materials provided to the patient and family. The audits will be ongoing with feedback to the Respiratory Therapy staff by the Director of Cardiopulmonary Services. Audit results will be shared at the Discharge Planning Improvement Committee meetings.
- Nursing staff was required by the Nursing Directors to review and acknowledge understanding of the Nursing Assessment and Documentation (N107) policy and the Multidisciplinary Assessment and Planning (A210) policy. This was completed on 11/2/12.
- A web based competency was developed by the lead Nurse Educator and the Director of Critical Care, to support the Discharge Planning and Patient Discharge policy and accompanying Discharge Checklist. Nursing staff will have completed the competency by 11/9/12.
- In order to assure appropriate patient education documentation at discharge, the expectations outlined in Patient and Family Education Discharge (A301) policy were reinforced by the Nursing Directors with nursing staff. This was completed on 11/2/12.
- Compliance with the Discharge Planning and Patient Discharge (A309) policy will be monitored by the Manager of Quality Management. A random sample of discharge checklists will be reviewed for completion as specified by the referenced policy.

Performance feedback will be reported to the Nursing Directors, Discharge Planning Improvement Committee and the Performance Improvement Committee.

- Compliance with the Patient and Family Education Discharge (A301) policy will be monitored by the Nursing Directors or designee. Feedback for identified performance improvement opportunities will be given to the appropriate Nursing Director for follow up and action. Performance data will be shared at the Performance Improvement Committee by the Chief Nursing Officer.

A 820 782.43(c)(3) IMPLEMENTATION OF A DISCHARGE PLAN

The hospital must arrange for the initial implementation of the patient's discharge plan.

This STANDARD is not met as evidences by: Based on staff interview and record review, the hospital failed to assure that initial implementation of the discharge plan regarding a physician ordered referral for one applicable patient in the sample was implemented upon discharge. (Patient #1), Findings include:

Per review of the Discharge Instructions Sheet Dated 4/26/12 for Patient #1 on 8/7/12 and confirmed during interview with the Director of Discharge Planning on 8/8/12 at 3:10 PM, there was no evidence that a mental health referral documented on the section "referral for continuing health care or services at home" was ever implemented prior to discharge. During interview the Director of the department stated that there was no formal process to assure that this referral was picked up by anyone responsible for the discharge process. A consulting psychiatrist's progress note dated 4/25/12 stated "Make referral to WCMH" (a local mental health service) "as well as VNA" (Visiting Nurses Association). At 3:40 PM, the director also confirmed that if the Discharge Instruction Sheet stated WCMH referral was indicated, the CM would be responsible for calling WCMH. There was no way to determine during the review if this has been completed based on the information obtained from staff and the record reviews. Refer also to A 810.

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- The Discharge Planning Improvement Committee (DPIC) was established on 8/28/12. The multidisciplinary committee comprised of Nursing, Rehabilitation Services, Respiratory Therapy and Care Management performed an extensive review of the existing discharge process, documentation tools and policies. Based upon the review, the discharge process, tools and related policies were redesigned to include a multidisciplinary discharge assessment and planning process. The redesign includes a standardized process and documentation tools. The redesign consisted of small tests of change beginning with the medical/surgical unit and was spread to relevant services. The discharge process redesign rollout and education will be completed as of 11/9/12.

- The Discharge Planning and Patient Discharge (A309) policy was revised by the Discharge Planning Improvement Committee on 8/31/12 to reflect the updated Medical Surgical discharge process. The Discharge Planning and Patient Discharge policy articulates each relevant discipline's accountabilities related to discharge planning and the discharge process. The policy was reviewed and approved by the Discharge Planning and Improvement Committee and subsequently approved by the Senior Leadership Team on 9/11/12. The referenced policy was updated to reflect process improvements for each service line and was finalized and approved by the Chief Operating Officer on 11/2/12.
- The discharge checklist was developed on 8/31/12 by the Discharge Planning Improvement Committee (DPIC). The checklist supports the Discharge Planning and Patient Discharge process. All members of the treatment team as appropriate 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 assure that appropriate services have been addressed prior to the patient's discharge.
- The Discharge Planning and Patient Discharge (A309) policy and accompanying Discharge Checklist was reviewed with the appropriate staff by relevant leadership and the Vice President of Medical Affairs as the redesign was being tested beginning in September 2012 with completion on 11/7/2012. Education on the revised process, policy and checklist was communicated through relevant staff meetings and via electronic communication.
- Under the direction of the Director of Cardiopulmonary Services, Respiratory Therapy created written instructions for patient and family tracheostomy care. The Director of Cardiopulmonary Services educated Respiratory staff on the use of the written instructions and the Discharge Planning and Patient Discharge policy during staff meetings in September. The patient and family tracheostomy care instructions were implemented in September 2012. An audit tool was developed to evaluate the Respiratory Therapists' documentation of patient teaching, including identification of the teaching materials provided to the patient and family. The audits will be ongoing with feedback to the Respiratory Therapy staff by the Director of Cardiopulmonary Services. Audit results will be shared at the Discharge Planning Improvement Committee meetings.
- Nursing staff was required by the Nursing Directors to review and acknowledge understanding of the Nursing Assessment and Documentation (N107) policy and the Multidisciplinary Assessment and Planning (A210) policy. This was completed on 11/2/12.
- A web based competency was developed by the lead Nurse Educator and the Director of Critical Care, to support the Discharge Planning and Patient Discharge policy and

accompanying Discharge Checklist. Nursing staff will have completed the competency by 11/9/12.

- In order to assure appropriate patient education documentation at discharge, the expectations outlined in Patient and Family Education Discharge (A301) policy were reinforced by the Nursing Directors with nursing staff. This was completed on 11/2/12.
- Compliance with the Discharge Planning and Patient Discharge (A309) policy will be monitored by the Manager of Quality Management. A random sample of discharge checklists will be reviewed for completion as specified by the referenced policy. Performance feedback will be reported to the Nursing Directors, Discharge Planning Improvement Committee and the Performance Improvement Committee.
- Compliance with the Patient and Family Education Discharge (A301) policy will be monitored by the Nursing Directors or designee. Feedback for identified performance improvement opportunities will be reported to the appropriate Nursing Director for follow up and action. Performance data will be shared at the Performance Improvement Committee by the Chief Nursing Officer.
- On 10/31/12 The Vice President of Medical Affairs communicated to the inpatient medical staff a reminder to be sure when recommending a consult or referral, the physician must write an order for care management to coordinate the specific request and make the necessary follow-up arrangements.

A 822 482.43(c)(5) PREPARATION FOR DISCHARGE

As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care.

This STANDARD is not met as evidenced by: Based on staff interviews and record reviews, the hospital failed to assure that the patient/spouse were counseled on all aspects of post discharge treatments/care to be done at home prior to discharge from the hospital for one applicable patient. (Patient #1) Findings include:

Based on record review and confirmed by staff interviews on 8/7/12 and 8/8/12, CVMC staff failed to assure that Patient #1 and her spouse received appropriate education and training in the care of a newly placed tracheotomy prior to discharge home on 4/26/12. Staff also failed to provide evidence of written instructions regarding safe care of the tracheotomy upon discharge home. The discharge instructions sheet dated 4/26/12, signed by the RN and the patient, was left blank for the section entitled 'patient education.' Per review the hospital's policy titled "Patient & Family Education" states: "It is the policy of CVMC to assure that patients and/or their family, significant other, or caregiver are provided with appropriate...2) training to learn skills and behaviors that promote recovery and improved function, and 3) referrals to assist with care as needed. Staff will work to ensure that patients and others involved in their care have the necessary information including written instructions to assist in the recovery process...after

discharge. All disciplines involved in the care of a patient are responsible for providing appropriate explanations and teaching based on the ongoing assessment of those needs.”

Based on review of the medical record and interviews on the afternoons of 8/7/12 and 8/8/12, the CM was not aware of the need for patient/spouse teaching regarding suctioning and overall care of the tracheotomy until the respiratory therapist asked her questions concerning what post discharge service would be providing a suction machine for the home, and had it ordered by the physician. A nursing progress note dated 4/25/12 at 2234 hours stated “Help...help, I am so anxious I can’t breathe...” (patient words). PT instructed how to instill NS and cough via trach, declines suctioning trach...Assessment: Alt in resp function; trach training...” Although the note stated to continue trach training, there was not documented evidence that the patient/spouse demonstrated competency with the trach care at any time during the hospitalization. A CM progress note written on 4/27/12 at 1335 as a late entry for 4/26/12 at 1615 stated “CM spoke with (spouse) who expressed concerns regarding ----’s inability to cough up mucus and the suction equipment had not yet arrived. ---- responded in the back ground “the nurse had shown me how to squirt saline into my trach and then cough it onto a napkin”. She said several times, “I can’t cough anything up and I can’t breathe”. The patient’s spouse was instructed to call an ambulance and got to the ED if unable to breathe. The CM spoke with the spouse a short time later to inform him that the suction equipment should be at the home within 60 minutes and the home health agency was called to have a RN visit ASAP. The spouse decided to wait for the HHA RN’s visit when the patient felt better after a few minutes had passed. Refer also to A 287

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- The Discharge Planning Improvement Committee (DPIC) was established on 8/28/12. The multidisciplinary committee comprised of Nursing, Rehabilitation Services, Respiratory Therapy and Care Management performed an extensive review of the existing discharge process, documentation tools and policies. Based upon the review, the discharge process, tools and related policies were redesigned to include a multidisciplinary discharge assessment and planning process. The redesign includes a standardized process and documentation tools. The redesign consisted of small tests of change beginning with the medical/surgical unit and was spread to relevant services. The discharge process redesign rollout and education will be completed as of 11/9/12.
- The Discharge Planning and Patient Discharge (A309) policy was revised by the Discharge Planning Improvement Committee on 8/31/12 to reflect the updated Medical Surgical discharge process. The Discharge Planning and Patient Discharge policy articulates each relevant discipline’s accountabilities related to discharge planning and the discharge process. The policy was reviewed and approved by the Discharge Planning and Improvement Committee and subsequently approved by the Senior Leadership Team on 9/11/12. The referenced policy was updated to reflect

process improvements for each service line and was finalized and approved by the Chief Operating Officer on 11/2/12.

- The discharge checklist was developed on 8/31/12 by the Discharge Planning Improvement Committee (DPIC). The checklist supports the Discharge Planning and Patient Discharge process. All members of the treatment team as appropriate 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 assure that appropriate services have been addressed prior to the patient's discharge.
- The Discharge Planning and Patient Discharge (A309) policy and accompanying Discharge Checklist was reviewed with the appropriate staff by relevant leadership and the Vice President of Medical Affairs as the redesign was being tested in each beginning in September 2012 with completion on 11/7/2012. Education on the revised process, policy and checklist was communicated through appropriate staff meetings and via electronic communication.
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- Nursing staff was required by the Nursing Directors to review and acknowledge understanding of the Nursing Assessment and Documentation (N107) policy and the Multidisciplinary Assessment and Planning (A210) policy. This was completed on 11/2/12.
- A web based competency was developed by the lead Nurse Educator and the Director of Critical Care, to support the Discharge Planning and Patient Discharge policy and accompanying Discharge Checklist. Nursing staff will have completed the competency by 11/9/12.
- In order to assure appropriate patient education documentation at discharge, the expectations outlined in Patient and Family Education Discharge (A301) policy were reinforced by the Nursing Directors with nursing staff. This was completed on 11/2/12.

- Compliance with the Discharge Planning and Patient Discharge (A309) policy will be monitored by the Manager of Quality Management. A random sample of discharge checklists will be reviewed for completion as specified by the referenced policy. Performance feedback will be reported to the Nursing Directors, Discharge Planning Improvement Committee and the Performance Improvement Committee.
- Compliance with the Patient and Family Education Discharge (A301) policy will be monitored by the Nursing Directors or designee. Feedback for identified performance improvement opportunities will be given to the appropriate Nursing Director for follow up and action. Performance data will be shared at the Performance Improvement Committee by the Chief Nursing Officer.

A1002 482.52(b)(1) PREANESTHESIA EVALUATION

Anesthesia Services must be consistent with needs and resources. Policies on anesthesia procedures must include the delineation of pre-anesthesia and post-anesthesia responsibilities. The policies must ensure that the following are provided for each patient: Anesthesia services must be consistent with needs and resources. Policies on anesthesia services must include the delineation of pre-anesthesia and post-anesthesia responsibilities. The policies must ensure that the following are provided for each patient.

This standard was not met as evidenced by: Based on staff interviews and record review, Anesthesia services failed to develop policies and procedures specific to delivery of anesthesia services consistent with the needs of the hospital and with recognized standards of anesthesia care Findings include:

Anesthesia services was unable to provide policies and procedures specific to the delimitation of pre-anesthesia, intraoperative /procedural and post-anesthesia responsibilities of this service as it related throughout the hospital. Although a policy existed within the "Completion of Medical Records" (effective 2/17/11) which addressed responsibilities of Anesthesia services to complete specific documentation in patient records and a second policy "Guidelines for Moderate Sedation/Analgesia" (effective 8/20/12) defined the management of sedated patients and establishing criteria for credentialed staff (to include Anesthesia services for monitored anesthesia care) and nursing responsibilities during moderate sedation procedures, no policies specific to Anesthesia services existed regarding the delivery of care to include: Infection Control methods; safety practices in all anesthetizing areas; protocols for supportive life functions; reporting requirements; documentation requirements and monitoring, inspections testing of anesthesia equipment.

Per the American Society of Anesthesiology (ASA) The Organization of anesthesia Department, Committee of Origin; Quality Management and Department Administration (approved by the ASA House of Delegates 10/15/2003 and last amended on 10/22/08) states: The director of the anesthesia department should be responsible for the following: "Participating in the development of, and enforcing policies and procedures relating to the functioning of anesthesia personnel and the administration of anesthesia throughout the hospital. This should include the development and maintenance of a written policy defining the perioperative care of patients that

may appropriately be provided in the facility, based upon consideration of age, risk categories, proposed procedure, and facility equipment and nursing capabilities". In addition the ASA also recommends: "a description of the details of the operation of the anesthesia department, including all policies and procedures applicable to personnel in the department, should be compiled in a single set of rules and regulations or in a procedure and policy manual."

Per record review, on 10/8/12, Patient #31 underwent surgery for adenoidectomy. Prior to this day surgery procedure, on 10/3/12 Patient #31 completed a "Patient Questionnaire" at his physician's office. Using this form, which was developed by Anesthesia services, the patient answers several questions which determine if the patient would have a "face to face" pre-anesthesia assessment prior to the day of surgery. Per interview on the morning of 10/8/12, the Director, Ambulatory Nursing Services stated once completed, the "Patient Questionnaire" is faxed to Pre-Op screening staff that then provide the questionnaire to anesthesia staff for review. If the patient answers "yes" to questions in the middle column, then a pre-anesthesia visit will be scheduled prior to the day of surgery to allow a complete anesthesia assessment or to meet with the patient several days before the procedure if the patient has requested such a meeting to discuss the anesthesia process. Although Patient #31 had answered "yes" to middle column questions to include: she had a history of chest pain coming from his/her heart, had a heart attack, has untreated high blood pressure and has heart murmur followed by a cardiologist, a face to face anesthesia prescreening did not occur. The patient did receive a pre-anesthesia screening on the morning of surgery. When asked if there was a policy regarding the pre-anesthesia screening, the Vice President of Medical Affairs confirmed on 10/9/12 at 8:20 AM, no policy existed. Per interview on 10/9/12 at 2:05 Pm, Anesthesiologist #1 confirmed the use of the "Patient Questionnaire" allowed screening of the patient 4-6 days prior to a surgical procedure requiring anesthesia services. S/he further stated if the review is not done and a patient presents with health issues that may be affected by anesthesia then the surgery is cancelled. This would create an inconvenience for the patient and disruption of operating room scheduling. Per review, the Quality Assessment completed by Anesthesiologist #2, who provided anesthesia to Patient # 31 on 10/8/12, noted the patient experienced "Prolonged Hypertension" during the course of surgery.

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- A policy entitled Pre-anesthesia Evaluation was drafted and finalized on 10/31/12 by the Vice President of Medical Affairs in collaboration with the Chief of Anesthesia and the Anesthesia Quality Assurance Chair. This policy articulates a requirement that a pre-anesthesia evaluation be completed and documented by an individual qualified to administer anesthesia within 48 hours prior to an inpatient or outpatient surgery or procedure requiring anesthesia services.

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- In addition, the policy entitled Pre-Anesthesia Evaluation outlines the updated process for the Pre-Anesthesia Screening Form (PAF). The PAF is completed by the patient in a surgeon's office when the surgical procedure is scheduled. This tool is part of an assessment for patients who may need to be seen by an anesthesiologist for a pre-operative evaluation prior to the day of surgery.
- A policy entitled Post Anesthesia Assessment was drafted and finalized on 10/31/12 by the Vice President of Medical Affairs in collaboration with the Chief of Anesthesia and the Anesthesia Quality Assurance Chair. This policy articulates the requirement that a post-anesthesia evaluation must be performed for each patient who receives general, regional or monitored anesthesia.
- The expectations outlined in the Pre Anesthesia Assessment policy and Post Anesthesia Assessment policy was communicated by the Chief of Anesthesia and the Anesthesia Quality Assurance Chair to the Department of Anesthesia on 11/5/12.
- Effective 10/22/12 the Pre- Anesthesia Assessment was added to the Pre-operative checklist by the Director of Ambulatory Nursing Services. The Pre-Anesthesia Assessment will need to be completed prior to the patient progressing into the surgical suite. The surgical nursing staff were educated to this process revision by the Director of Ambulatory Nursing Services at the 11/1/12 staff meeting
- Audits for complete pre and post anesthesia assessments will be performed under the direction of the Director of Ambulatory Nursing Services. The pre-anesthesia assessment documentation will be obtained prior to the patient going to the operating room or for post anesthesia assessments – prior to discharge. Performance feedback will be given to the Vice President of Medical Affairs and reported to the Performance Improvement Committee
- The Department of Anesthesia utilizes ASA guidelines to assure the standard of care is in compliance with national guidelines. CVMC infection control guidelines and policies are utilized by the Department of Anesthesia and Surgical Services to maintain infection prevention standards.