



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

January 17, 2013

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

Provider ID #: 470001

Dear Ms. Tarr-Tartaglia:

The Division of Licensing and Protection completed a revisit survey at your facility on **December 10, 2012**. The purpose of the survey was to determine if your facility met the conditions of participation for Acute Care Hospitals found in 42 CFR Part 482.

Following the revisit survey, your facility submitted a Plan of Corrections (POC) which was found to be acceptable on **January 16, 2013**.

Sincerely,

A handwritten signature in cursive script that reads "Pamela M. Cota RN".

Pamela M. Cota, RN
Licensing Chief

Enclosure



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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470001 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | PROJECTION DATE SURVEY COMPLETED R 12/10/2012 |
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| NAME OF PROVIDER OR SUPPLIER CENTRAL VERMONT MEDICAL CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE BOX 547 BARRE, VT 05641 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) CDMPLETION DATE |
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| {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 complaint 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 of 2 complaints. The following regulatory violations were found. On 12/10/12 a follow-up survey was completed subsequent to the previous full survey conducted from 10/08/12 - 10/10/12. The following regulatory violations were identified.. | {A 000} | | |
| {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 coverings and masks in a manner that covered all areas appropriately during surgical procedures. | {A 291} | See Plan of Correction | 11/9/12 |

| | | |
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  | TITLE CEO | (X6) DATE 1-7-13 |
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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.

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

PRINTED: 12/13/2012
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 R 12/10/2012 | |
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| {A 291} | <p>Continued From page 1</p> <p>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.</p> <p>Refer to Tag A-0749</p> <p>During a follow up survey on 12/10/12 and based on observations and staff interviews, the hospital failed to ensure performance improvement actions, previously implemented for infection control deficient practice were sustained. Findings include:</p> <p>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 sterile technique was adhered to by perioperative staff in</p> | {A 291} | See Plan of Correction | 11/9/12 |

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| {A 291} | <p>Continued From page 2 accordance with standards of practice. Findings include:</p> <p>While observing operating room # 4 on 12/10/12 at 10:55 A.M., accompanied by the Director of Ambulatory Nursing Services (DANS)and another Surveyor, a surgeon broke sterile technique during a tonsillectomy for Patient # 5. After sanitizing his/her hands, the surgeon touched a headlamp light source box and the headlamp device with ungloved hands. The surgeon then turned to the scrub tech who assisted the surgeon to gown and glove. The surgeon then proceeded with the tonsillectomy without rescrubbing or sanitizing his/her hands. A circulating Registered Nurse (RN), an anesthesiologist and a scrub technician were present in the operating room and failed to bring the break in technique to the surgeon's attention or stop the procedure. Immediately after making the observation, the DANS stated that the surgeon should have sanitized his/her hands after touching the light source and headlamp prior to gowning and gloving. The DANS also stated that neither the light source box nor the headlamp was sterile. In a 1:05 P.M. interview on 12/10/12 with the scrub technician and the RN, the Scrub Technician confirmed the break in sterile technique, stating " I missed that". Both the RN and the scrub technician stated that the surgeon should have been notified of the break in technique prior to beginning the procedure. A hospital policy entitled " Maintaining a sterile field", section D, 2, states " Do not be afraid to call attention to a break in technique on the part of the surgeon or any other member of the operating room team". Per review of the operative note dictated by the above surgeon on 12/10/12</p> | {A 291} | See Plan of Correction | 11/9/12 |

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| {A 291} | Continued From page 3 at 11:29 A.M., the surgeon stated " a break in sterile technique was done where the headlight was put on after scrub but before the gloves were put on". 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 12/10/12, improvement actions associated with this plan to correct this deficient practice and breach of infection control policy had not been sustained. | {A 291} | | | |
| {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 medical staff, or by Federal or State law if applicable, to require written patient consent. This STANDARD is not met as evidenced by: Based on staff interview and record review during a follow-up survey conducted on 12/10/12 the hospital failed to assure that a properly executed anesthesia consent form was obtained for 1 of 4 patients in the applicable sample undergoing a surgical procedure (Patient # 11) Findings include: Per record review on 12/10/12 at 10:25 A.M., Patient # 11 underwent a Myringotomy on 12/10/12. The anesthesia consent form was not signed, dated or timed by a physician as required. This was confirmed by the Director of Ambulatory Nursing Services at 10:30 A.M. on 12/10/12. | {A 466} | See Plan of Correction | 11/9/12 | |
| {A 749} | 482.42(a)(1) INFECTION CONTROL OFFICER RESPONSIBILITIES | {A 749} | See Plan of Correction | 11/9/12 | |

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| {A 749} | <p>Continued From page 4</p> <p>The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.</p> <p>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 sterile technique was adhered to by perioperative staff in accordance with standards of practice. Findings include:</p> <p>While observing operating room # 4 on 12/10/12 at 10:55 A.M., accompanied by the Director of Ambulatory Nursing Services (DANS) and another Surveyor, a surgeon broke sterile technique during a tonsillectomy for Patient # 5. After sanitizing his/her hands, the surgeon touched a headlamp light source box and the headlamp device with ungloved hands. The surgeon then turned to the scrub tech who assisted the surgeon to gown and glove. The surgeon then proceeded with the tonsillectomy without rescrubbing or sanitizing his/her hands after making contact with unsterile surgical equipment. A Registered Nurse (RN) whose role was as the circulating nurse, an anesthesiologist and a scrub technician were present in the operating room and failed to bring the break in technique to the surgeon's attention or stop the procedure. Immediately after making the observation, the DANS stated that the surgeon should have sanitized his/her hands after touching the light source and headlamp prior to</p> | {A 749} | <i>See Plan of Correction</i> | 11/9/12 |
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| {A 749} | Continued From page 5 gowning and gloving. The DANS also confirmed that neither the light source box nor the headlamp was sterile. Per Interview on 12/10/12 at 1:05 PM the Scrub Technician confirmed the break in sterile technique, stating "I missed that". The RN who was the circulating nurse during the surgical procedure and present during interview agreed with the scrub technician that the surgeon should have been notified of the break in technique prior to beginning the surgical procedure. A hospital policy entitled "Maintaining a sterile field", section D, 2. revised 4/12/12 states "Do not be afraid to call attention to a break in technique on the part of the surgeon or any other member of the operating room team". Per review of the operative note dictated by the above mentioned surgeon on 12/10/12 at 11:29 A.M., the surgeon stated " a break in sterile technique was done where the headlight was put on after scrub but before the gloves were put on". Per interview with the hospital Infection Control Nurse and the Vice President of Medical affairs on 12/10/12 at 11:20 A.M., the Infection Control Nurse confirmed the aforementioned breach in sterile technique. | {A 749} | See Plan of Correction | 11/9/12 | |

Central Vermont Medical Center
Plan of Correction
January 7th, 2013

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.

On 12/10/12 a follow-up survey was completed subsequent to the previous full survey conducted from 10/08/12 – 10/10/12. The following regulatory violations were identified.

A291

482.21(2)(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 evidence 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 coverings and masks in a manner that covered all areas appropriately during surgical procedures. During interview, on 07/31/12 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 per operative area on 10/09/12 at 11:20 AM with the VP of Medical Affairs, 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 of 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.

Refer to Tag A-0749

During a follow up survey on 12/10/12 and based on observations and staff interviews, the hospital failed to ensure performance improvement actions, previously implemented for infection control deficient practice were sustained.

Findings include:

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 sterile technique was adhered to by perioperative staff in accordance with standards of practice. Findings include:

While observing operating room #4 on 12/10/12 at 10:55 A.M., accompanied by the Director of Ambulatory Nursing Services (DANS) and another Surveyor, a surgeon broke sterile technique during a tonsillectomy for Patient #5. After sanitizing his/her hands, the surgeon touched a head lamp light source box and the headlamp device with ungloved hands. The surgeon then turned to the scrub tech who assisted the surgeon

to gown and glove. The surgeon then proceeded with the tonsillectomy without rescrubbing or sanitizing his/her hands. A circulating Registered Nurse (RN), an anesthesiologist and a scrub technician were present in the operating room and failed to bring the break in technique to the surgeon's attention or stop the procedure. Immediately after making the observation, the DANS stated that the surgeon should have sanitized his/her hands after touching the light source and the headlamp prior to gowning and gloving. The DANS also stated that neither the light source box nor the headlamp was sterile. In a 1:05 P.M. interview on 12/10/12 with the scrub technician and the RN, the Scrub Technician confirmed the break in sterile techniques, stating "I missed that". Both the RN and the scrub technician stated that the surgeon should have been notified of the break in technique prior to beginning the procedure. A hospital policy entitled "Maintaining a sterile field", section D, 2, states "Do not be afraid to call attention to a break in technique on the part of the surgeon or any other member of the operating room team". Per review of the operative note dictated by the above surgeon on 12/10/12 at 11:29 A.M., the surgeon stated "a break in sterile technique was done where the headlight was put on after scrub but before the gloves were put on". 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 12/10/12; 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

- The surgeon that was observed breaking sterile technique was given direct feedback and the Central Vermont Medical Center policy: Maintaining a Sterile Field (N-OR-724) was reinforced with the individual during the day of survey by the Vice President of Medical Affairs. A tip sheet created by the Infection Preventionist that outlines Principles of Aseptic Technique in an Operating Room was provided as part of the reinforcement. Note: as part of routine post-operative follow-up, the index patient in question has had no signs or symptoms of infection.
- A memo from the Vice President of Medical Affairs was sent on January 3, 2013 to the Perioperative staff and Physicians in the Department of Surgery and Anesthesia reinforcing the expectations outlined in Central Vermont Medical Center policy: Maintaining a Sterile Field (N-OR-724). Reinforced in the memo is each team member's role and responsibility in identifying any break in sterile technique.
- The expectations of the policy related to Central Vermont Medical Center policy: Maintaining a Sterile Field (N-OR-724) will be reinforced at the Department of Surgery meeting scheduled January 24, 2013 by the Vice President of Medical Affairs.
- At a staff meeting on 12/13/12 the Director of Ambulatory Nursing Services reinforced the expectations outlined in Central Vermont Medical Center policy: Maintaining a Sterile Field (N-OR-724). Specifically, that it was each team member's responsibility to identify a break in sterile technique so that the issue can be corrected.
- Maintaining proper sterile technique and infection prevention practices will be monitored by the Director of Ambulatory Nursing Services and by Infection Prevention staff. Monthly feedback regarding compliance will be given to the Vice President of Medical Affairs and Chief Nursing Officer as appropriate.

- Monthly performance data collection will begin January 7, 2013 and be reported at the February 13, 2013 Performance Improvement Committee (PIC) by Infection Prevention staff and at subsequent PIC meetings. Ongoing monitoring of proper infection prevention methods (e.g. hair/jewelry covered and hand hygiene) will continue and also be reported at PIC.

Adm PIC accepted 1/16/13 BHOWEN/PIC

A 466

482.24©(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 medical staff, or the Federal or State law if applicable, to require written patient consent.

This STANDARD is not met as evidenced by: Based on staff interview and record review during a follow-up survey conducted on 12/10/12 the hospital failed to assure that a properly executed anesthesia consent form was obtained for 1 of 4 patients in the applicable sample undergoing a surgical procedure (Patient #11) Findings include:

Per record review on 12/10/12 at 10:25 A.M., Patient #11 underwent a Myringotomy on 12/10/12. The anesthesia consent form was not signed, dated or timed by a physician as required. This was confirmed by the Director of Ambulatory Nursing Services at 10:30 A.M. on 12/10/12.

Central Vermont Medical Center Plan of Correction

- At a staff meeting on December 13, 2012 the Director of Ambulatory Nursing Services reinforced the expectation that all items on the Preoperative Checklist, including the anesthesia consent form need to be completed prior to the patient progressing into the surgical suite.
- The new Anesthesia Consent Form was put in place December 17, 2012. Presentation of the new consent form went to the Department of Anesthesia prior to the December 17, 2012 form rollout.
- A memo from the Vice President of Medical Affairs was sent January 3, 2013 to the Department of Anesthesia providers on the expectations outlined in the Informed Consent Policy (A104). Specifically highlighted were the expectations that that the signed consent must be complete and present on the chart prior to the patient proceeding into the surgical suite.
- The expectations of the related to Central Vermont Medical Center policy: Informed Consent (A104) will be reinforced at the Department of Surgery meeting scheduled January 24, 2013 by the Vice President of Medical Affairs.
- Ensuring completion of anesthesia consents will be monitored by the Director of Ambulatory Nursing Services. Monthly feedback regarding compliance will be given to the Vice President of Medical Affairs and Chief Nursing Officer as appropriate. Non-compliance will be addressed by the Vice President of Medical Affairs, Chief Nursing Officer and Chief of Anesthesia.
- Monthly performance data collection will continue and be reported at the February 13, 2013 Performance Improvement Committee (PIC) by the Director of Ambulatory Nursing Services and at

subsequent PIC meetings. Ongoing monthly monitoring for assessment of anesthesia consents being signed, dated, timed and that nursing reviewed as part of the pre-op checklist will continue and also be reported at PIC.

A466 POC accepted 1/16/13 BHOWERN|PMC

A749

482.42(a)(1) INFECTION CONTROL OFFICER RESPONSIBILITIES

The Infection control officer or officers must develop a system of 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 sterile technique was adhered to by perioperative staff in accordance with standards of practice.

Findings include:

While observing operating room #4 on 12/10/12 at 10:55 A.M., accompanied by the Director of Ambulatory Nursing Services (DANS) and another Surveyor, a surgeon broke sterile technique during a tonsillectomy for Patient #5. After sanitizing his/her hands, the surgeon touched a headlamp light box and the headlamp device with ungloved hands. The surgeon then turned to the scrub tech who assisted the surgeon to gown and glove. The surgeon then proceeded with the tonsillectomy without rescrubbing or sanitizing his/her hands after making contact with unsterile surgical equipment. A Registered Nurse (RN) whose role was as the circulating nurse, an anesthesiologist and a scrub technician were present in the operating room and failed to bring the break in technique to the surgeon's attention or stop the procedure. Immediately after making the observations, the DANS stated that the surgeon should have sanitized his/her hands after touching the light source and headlamp prior to gowning and gloving. The DANS also confirmed that neither the light source box nor the headlamp was sterile. Per Interview on 12/10/12 at 1:05 PM the Scrub Technician confirmed the break in sterile techniques, stated "I missed that". The RN who was the circulating nurse during the surgical procedure and present during interview agreed with the scrub technician that the surgeon should have been notified of the break in technique prior to beginning the surgical procedure. A hospital policy entitled "Maintaining a sterile field", section D, 2. revised 4/12/12 states "Do not be afraid to call attention to a break in technique on the part of the surgeon or any other member of the operating room team". Per review of the operative note dictated by the above mentioned surgeon on 12/10/12 at 11:29 A.M., the surgeon stated "a break in sterile technique was done where the headlight was put on after scrub but before the gloves were put on". Per interview with the hospital Infection Control Nurse and the Vice President of Medical Affairs on 12/10/12 at 11:20 A.M., the Infection Control Nurse confirmed the aforementioned breach in sterile technique.

Central Vermont Medical Center Plan of Correction

- The surgeon that was observed breaking sterile technique was given direct feedback and the Central Vermont Medical Center policy: Maintaining a Sterile Field (N-OR-724) was reinforced with the individual during the day of survey by the Vice President of Medical Affairs. A tip sheet created by the Infection Preventionist that outlines Principles of Aseptic Technique in an Operating Room was provided as part of the reinforcement. Note: as part of routine post-operative follow-up, the index patient in question has had no signs or symptoms of infection.

- A memo from the Vice President of Medical Affairs was sent on January 3, 2013 to the Perioperative staff and Physicians in the Department of Surgery and Anesthesia reinforcing the expectations outlined in Central Vermont Medical Center policy: Maintaining a Sterile Field (N-OR-724). Reinforced in the memo is each team member's role and responsibility in identifying any break in sterile technique.
- The expectations of the policy related to Central Vermont Medical Center policy: Maintaining a Sterile Field (N-OR-724) will be reinforced at the Department of Surgery meeting scheduled January 24, 2013 by the Vice President of Medical Affairs.
- At a staff meeting on 12/13/12 the Director of Ambulatory Nursing Services reinforced the expectations outlined in Central Vermont Medical Center policy: Maintaining a Sterile Field (N-OR-724). Specifically, that it was each team member's responsibility to identify a break in sterile technique so that the issue can be corrected.
- Maintaining proper sterile technique and infection prevention practices will be monitored by the Director of Ambulatory Nursing Services and by Infection Prevention staff. Monthly feedback regarding compliance will be given to the Vice President of Medical Affairs and Chief Nursing Officer as appropriate.
- Monthly performance data collection will begin January 7, 2013 and be reported at the February 13, 2013 Performance Improvement Committee (PIC) by Infection Prevention staff and at subsequent PIC meetings. Ongoing monitoring of proper infection prevention methods (e.g. hair/jewelry covered and hand hygiene) will continue and also be reported at PIC.

A749 POC accepted 1/16/13 BHOWERN/PMC