

Division of Licensing and Protection

103 South Main Street

Waterbury VT 05671-2306

<http://www.dail.vermont.gov>

Voice/TTY (802) 871-3317

To Report Adult Abuse: (800) 564-1612

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September 30, 2015

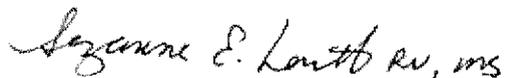
Joseph Woodin, Administrator
Gifford Medical Center
44 South Main Street
Randolph, VT 05060

Dear Mr. Woodin:

The Division of Licensing and Protection completed a survey at your facility on **August 26, 2015**. The purpose of the survey was to determine if your facility met the conditions of participation for Critical Access Hospitals found in 42 CFR Part 485.

Following the survey, your facility submitted a Plan of Corrections (POC) which was found to be acceptable on **September 30, 2015**.

Sincerely,



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

Enclosure



PRINTED: 09/04/2015
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/26/2015
NAME OF PROVIDER OR SUPPLIER GIFFORD MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 44 SOUTH MAIN STREET RANDOLPH, VT 05060		
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C 000	INITIAL COMMENTS An unannounced on-site survey was conducted by the Vermont Division of Licensing and Protection from 8/24/15 - 8/26/15 to investigate a facility mandated self-report and a regulatory complaint. The following regulatory violations are related to both reports.	C 000	Self-report and regulatory complaint - CORRECTIVE ACTION PLAN		
C 253	485.631(a)(3) STAFFING The staff is sufficient to provide the services essential to the operation of the CAH. This STANDARD is not met as evidenced by: Based on staff interview and record reviews, the hospital failed to assure sufficient staff coverage was available at all times in the Emergency Department (ED) to meet the needs of patients demonstrating psychotic or other behavioral health symptoms. (Patients #5 and #6). Findings include: 1. Patient #6 eloped from the ED on 7/19/15 at 0915 hours and there was insufficient staff on duty at the time to respond in a manner that left adequate coverage in the ED and other qualified staff to respond to the emergent situation. Per staff interview and schedule review for 7/19/15, 2 RNs (Registered Nurses) and 1 physician were on duty in the ED when a patient diagnosed with Schizophrenia and Post Traumatic Stress Disorder, experiencing a mental health crisis and awaiting involuntary psychiatric hospital admission, eloped from the ED. At the time the patient exited the ED and the hospital, one RN was available to respond to the patient and attempt to get them safely back into the ED. The patient stated that the RN yelled loudly and pointed at them to return to the	C 253	An assessment of the ED staffing plan began in May/June 2015. After the assessment Gifford began hiring for sitters. As of this report date, staff has been hired for these positions and have begun the orientation process. The ED staffing plan will be reassessed by October 30, 2015 and adjusted per that assessment. 9/25/2015 Ammendment: ED staffing is reviewed daily at various times throughout the day. Decisions to call in additional staff are made between the clinical nurse and clinical leadership (Supervisor, Manager, or VP) based on unit volume and acuity. C253 POC accepted 9/30/15 mibclm RN/pme		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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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C 253	<p>Continued From page 1</p> <p>hospital and after they had turned and headed back, the RN grabbed them roughly and pushed them back into the hospital. The patient claimed that the RN then pushed them to the floor and fell on them, causing pain. During interviews on the afternoon of 8/25/15, the CNO and the ED Nurse Manager confirmed that the RN may have felt stressed that no one was available to help him/her with the situation; a Code Grey (emergency call for help) had been called but response time had been slow, per the ED Nurse Manager. The RN had been trained on how to care for patients with aggressive behaviors and mental health diagnoses; however, hospital policies/procedures were not implemented in this case. The CNO verified that they recognized the need for increased availability of staff to help in emergency situations, and to act as 'sitters' for violent or disruptive patients, and had begun the hiring process in June, 2015. As of the date of the incident and the date of survey (8/25/15), the orientation process had not yet started and was planned for September, 2015.</p> <p>2. After being found wandering in the woods for 24 hours, Patient #5 was brought to the ED on 7/13/15 at 0907 in an agitated and delusional state. Per ED Nursing Documentation Record, Patient #5 was described to have "flight of ideas" but remained cooperative and was assigned a 1:1 LNA (Licensed Nursing Assistant) for close monitoring. During the rest of the day and evening Patient #5 could be redirected but remained delusional. While remaining in the ED for further medical clearance and to be screened for a possible psychiatric hospitalization, Patient #5 became increasingly more agitated. At 0430 on 7/14/15 Patient #5 began yelling and threatening staff, eloped from the ED, left the</p>	C 253		

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C 253	Continued From page 2 CAH grounds and was later found and removed from inside a private residence located in the neighborhood near the CAH campus by police. At the time of the elopement, the ED was staffed with the RN night nursing supervisor, a second nurse and ED physician. The Randolph police department returned Patient #5 to the ED at 0510 and continued to remain with the patient. Three police officers remained with Patient #5 while s/he is screened by staff from the Clara Martin Center for an Emergency Evaluation (EE) for involuntary psychiatric hospitalization. At 09:30 the police leave the ED returning to the staff ratio of 2 nurses and a physician. At 09:35 Patient #5's behavior begins to escalate, pushing staff in ED, and then exiting the ED into the Radiology Department. Although a Code Gray was called (emergency assistance from hospital staff during a behavioral emergency) during the second elopement, the ED Nurse Manager stated on 8/25/15 at 1:00 PM, response was slow at the time of the Code Gray, and that, due to insufficient numbers of available staff, an appropriate and safe restraint hold was not attempted while Patient #5 was present in the Radiology Department. Eventually the patient left the Radiology Department and exited the hospital. Police were again called for reinforcement and Patient #5 was returned to the ED a second time. Patient #5 had unsuccessfully attempted a third elopement shortly after being returned to the ED, restraints and emergency medications were administered. The police were again stationed at the patient's bedside for a period of time until medication became effective. During the emergent incidents on 7/14/15, (which placed staff, patients and the general public at risk), the available staff on duty proved to be insufficient to meet the essential needs for all	C 253			

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C 253	Continued From page 3 patients.	C 253			
C 271	485.635(a)(1) PATIENT CARE POLICIES The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law. This STANDARD is not met as evidenced by: Based on record review and staff interview, the CAH failed to assure that care and services were provided in accordance with currently established written policies and procedures regarding care provision for patients at risk of violence towards self or others, and/or for the use of restraints for 3 of 8 patients in the total sample. The hospital also failed to develop written policies/procedures regarding the assurance of Patient Rights, and for Medical and Nursing staff, for the use of chemical restraints. (Patients #5, #6 and #8). Findings include: 1. After being found wandering in the woods for 24 hours, Patient #5 was brought to the ED on 7/13/15 at 0907 in an agitated and delusional state. Over the course of 24 hours the patient's behaviors continued to escalate with delusional and agitated rantings, elopements and physical threats of violence toward ED staff. On 7/14/15 at 0950 after attempting to elope for the third time and with increased combativeness, the patient was administered emergency medications to include Haldol 5 mg. (antipsychotic) and Ativan 2 mg (an anti-anxiety agent) IM (intramuscularly) and 4 point restraints were applied. Per review of the Restraint Observation Flow Chart, Patient #5 remained restrained until 11:15 when s/he was observed sleeping and the restraints were removed. Per review of policy Restraints and Seclusion for Behavioral Health Patients effective	C 271	1. Policy review/revision: The following policies are currently under review/revision: NUR-114 Management of Patients at Risk to Themselves or Others; NUR-199 Restraints and Seclusion for Behavioral Health Patients; and NUR-200 Restraints for Non-Behavioral Health Reasons. -- Completion by 10/1/2015 2. A patient rights policy has been developed (CAH-218 Inpatient Rights and Responsibilities). -- Completed 8/26/2015 Education & Monitoring: ED staff and Med/Surg staff will review the policies discussed above and complete a competency through Policy Manager. -- Completion for regular/part-time staff by 10/30/2015; completion for per diem staff by 10/30/2015 or their next shift. 3. Nursing staff on ED and Med/Surg will receive verbal de-escalation training -- trainings are scheduled for 9/25/2015 and 10/16/2015. Additional trainings will be planned. Staff will participate in the training by 12/31/2015 4. Training on patient rights will be incorporated with an annual nursing competency for ED and Med/Surg staff. -- Effective 1/1/2016 9/25/2015 Ammendment: The Director of Quality Management, or designee, will monitor completion of the corrective action plan activities. C271 POC accepted 9/30/15 miboltonRD/pmc		

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C 271	<p>Continued From page 4</p> <p>05/06/2014 stated "7. If restraints or seclusion are discontinued prior to the expiration of the original order, a new order must be provided by the physician and the initial requirements for the emergency procedure restarted if the patient meets the clinical criteria for involuntary procedure". However, staff failed to obtain a new order for the restraints when they were reapplied at 1600 through 1700 HR on 7/14/15. The ED Nurse Manager confirmed on the morning of 8/26/15 staff's failure to obtain an order for the reapplication of restraints, as per CAH policy.</p> <p>2. On 7/19/15 at 0220 HR (hours) Patient #7 arrived in the ED via ambulance heavily intoxicated. As a result of the acute alcohol intoxication, Patient #7 required intubation with an endotracheal tube to assist with maintaining an airway. After receiving treatment in the ED, Patient # 7 was admitted to the Special Care Unit (SCU) at 0615 HR. Soft restraints had been applied for medical immobilization to prevent Patient #7 from attempting to remove the endotracheal tube, intravenous catheter and nasal gastric (NG) tube. The History & Physical note written by the admitting hospitalist stated the patient was eventually extubated and his/her NG tube removed and "at this time in 4 point restraints secondary to his/her altered mental status.....the patient is awake, alert but does not understand how s/he got here and has become quite belligerent...". Patient #7 was assessed for alcohol withdrawal and was administered medication for agitation. Per review of nursing progress notes for 7/19/15 from 1046 HR through 1550 HR Patient #7 was observed by staff to be sleeping, however restraints were not removed. During this time period there was no indication the patient was demonstrating a risk to</p>	C 271		

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C 271	<p>Continued From page 5</p> <p>himself/herself or others and least restrictive measures had not been initiated to include the progressive removal of the 4 point restraints as per CAH policy. Per interview on 8/26/15 at 11:40 AM, the Nurse Manager for Medical/Surgical and Transitional Units confirmed the nurse should have removed Patient #7's restraints after the patient's behaviors became calm and was sleeping for a significant period of time.</p> <p>3. Per review of the medical record record on 8/24/15, Patient #6 was administered involuntary emergency medication when the patient exhibited assaultive and threatening behaviors while in the ED on 7/19/15. The patient was being held involuntarily in the ED due to self-harming behavior, while waiting for placement at a psychiatric facility. Per the provider notes from 3:30 AM on 7/19/15, 'the patient was intent on harming self and had stopped taking medication days ago. The patient became agitated (shouting and throwing items, striking out) and delusional and a risk to him/her self and others'. The provider note of 9:40 AM stated that the patient "was extremely agitated and attempting to physically assault staff, Haldol and Benadryl ordered". The Haldol 10 mg. and Benadryl 50 mg. were administered by Intramuscular Injection (I.M.) at 10:10 AM by the RN, per physician orders.</p> <p>The hospital's policy "Restraints and Seclusion for Behavioral Health Patients", under Procedure #4 stated "The physician's order will include the following:</p> <ul style="list-style-type: none"> - Date and time of the order - Type of restraint or seclusion - Duration of order - Level of nursing observation - Clinical criteria for discontinuation of procedure 	C 271			

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C 271	Continued From page 6 The policy further stated under "Ill Staff Competency and Training: D. Physicians and other licensed independent practitioners authorized for ordering restraints for behavioralreasons.....and/or involuntary medications will have a working knowledge of the policies regarding these treatment interventions." Based on a review of the documentation including the orders for the chemical restraints, there was no reason given in the orders for the involuntary medications, as required. Additionally, the RN who administered the medication failed to document the patient's response to and the effect of the medication in the medical record. During interview on 8/25/15 at 3:15 PM, the Medical Director of the Hospital Division (who oversees the ED) confirmed that the hospital's Policies/Procedures regarding restraints did not include written directives regarding the procedures for ordering and administration of chemical restraints (emergency involuntary medication). Refer also to C 273.	C 271			
C 273	485.635(a)(3)(i) PATIENT CARE POLICIES [The policies include the following:] (i) A description of the services the CAH furnishes, including those furnished through agreement or arrangement.	C 273			

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C 273	<p>Continued From page 7</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the CAH failed to operationalize policies and procedures for ordering and administration of chemical restraints for 1 applicable patient of the total sample of 8, as part of it's policy titled "Restraints and Seclusion for Behavioral Health Patients". The CAH also failed to adhere to Emergency Department Medical Staff Rules regarding written clinical guidelines, policies and procedures for the ED. (Patient #6). Findings include:</p> <p>Per review of the medical record record on 8/24/15, Patient #6 was administered involuntary emergency medication when the patient exhibited assaultive and threatening behaviors while in the ED on 7/19/15.</p> <p>Although the hospital refers to chemical restraints in it's policy/procedure regarding restraints, they failed to develop protocols for the ordering and administration of emergency involuntary medications for physicians and nursing staff.</p> <p>Per the provider notes from 3:30 AM on 7/19/15, 'the patient was intent on harming self and had stopped taking medication days ago. The patient became agitated (shouting and throwing items, striking out) and delusional and a risk to him/her self and others'. The provider note of 9:40 AM stated that the patient "was extremely agitated and attempting to physically assault staff, Haldol and Benadryl ordered". The Haldol 10 mg. and Benadryl 50 mg. were administered by Intramuscular Injection (I.M.) at 10:10 AM by the RN, per physician orders.</p> <p>The hospital's policy "Restraints and Seclusion for Behavioral Health Patients", under Procedure: #4 stated "The physician's order will include the following:</p>	C 273	<p>1. As mentioned above NUR-199 Restraints and Seclusion for Behavioral Health Patients; and NUR-200 Restraints for Non-Behavioral Health Reasons will be reviewed/revise by 10/1/2015. See below.</p> <p>2. Order sets for behavioral restraints and medical restraints have been revised. Nursing documentation has been revised -- Completed 9/15/2015. See below</p> <p>3. Nurse managers will conduct chart review for all patients with use of restraints. Restraint review will be a standing agenda item at nursing leadership meetings. Findings from chart review will be discussed and reflected in minutes of that meeting. See below</p> <p>Education and Monitoring:</p> <p>1. As previously stated, staff will complete a competency through Policy Manager by 10/30/2015 for regular/part-time staff. Per diem staff will complete the competency by 10/30/2015 or their next shift.</p> <p>2. Staff on ED and Med/Surg staff will be trained on the revised order sets. -- completion for Regular/part-time staff by 10/30/2015 and per diem staff by 10/30/2015 or their next shift.</p> <p>3. QM will review restraint log and minutes from nursing leadership meeting x 6 months to ensure 100% compliance with restraint review.</p> <p>9/25/2015 Ammendment: ED/Hospitalist providers will review policies on restraints (NUR-199 and NUR-200) and will be educated on the revised order sets for restraints. Review of policies and order sets will be completed by 11/15/2015 for regular/part-time staff and per diem provider by 11/15/2015 or their next shift.</p> <p>Written clinical guidelines for the ED will be reviewed and revised to include use of restraints and involuntary medications. Clinical guidelines will be completed by 10/15/2015. Regular/part-time providers will be educated on these guidelines by 11/15/2015 and per diem providers by 11/15/2015 or by their next shift.</p> <p>The Director of Quality Management, or designee, will monitor completion of these corrective action plan activities.</p> <p>C273 POC accepted 9/30/15 MBoit/nrn/PML</p>

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C 273	Continued From page 8 - Date and time of the order - Type of restraint or seclusion - Duration of order - Level of nursing observation - Clinical criteria for discontinuation of procedure The policy further stated under III Staff Competency and Training: D. Physicians and other licensed independent practitioners authorized for ordering restraints for behavioralreasons.....and/or involuntary medications will have a working knowledge of the policies regarding these treatment interventions. Based on a review of the documentation including the orders, there was no reason given in the orders for the involuntary medications, as required. There were no specific written policies and procedures and clinical guidelines to manage these treatment services, as stated in the Emergency Department Medical Staff Rules, at #3. Rules/Responsibilities for the Emergency Department Committee, per review on 8/25/15. Rule #3 stated "Provide written clinical guidelines, policies and procedures for the Emergency Department." The lack of clinical guidelines and P/P were confirmed during interview with the Medical Director of the Hospital Division on 8/25/15 at 3:15 PM. Refer also to C 271.	C 273			
C 294	485.635(d), (d)(1) NURSING SERVICES §485.635(d) Standard: Nursing Services Nursing services must meet the needs of patients. (1) A registered nurse must provide (or assign to other personnel) the nursing care of each patient, including patients at a SNF level of care in a	C 294			

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C 294	Continued From page 9 swing-bed CAH. The care must be provided in accordance with the patient's needs and the specialized qualifications and competence of the staff available. This STANDARD is not met as evidenced by: Based on staff interview and record review, the CAH failed to assure that RNs in all areas of the hospital were appropriately trained to provide care in accordance with the patients' needs related to care provided in the Emergency Department for 1 applicable patient in the sample (Patient #6). Findings include: 1. Per review of Patient #6's medical record, as well as hospital investigative information, the patient did not receive nursing care in the Emergency Department (ED) in consideration of his/her medical and psychological needs. Based on a review of a patient complaint regarding care provided by one RN in the ED on 7/19/15, the RN failed to consider the patient's mental health needs when attempting to return the patient to the ED after the patient had eloped. The patient was experiencing a psychiatric crisis, including self-harming behaviors, and was brought to the ED by law enforcement. The patient was aggressive and was acting out physically and verbally. The patient was being held emergently in the ED while waiting for a psychiatric facility bed. The RN failed to follow the hospital's policy/procedure titled "Management of Patients at Risk to Themselves or Others" which stated "DO NOT ATTEMPT TO personally RESTRAIN A PERSON", referring to a person who commits an act of aggression or assault. The RN physically restrained Patient #6 alone, in violation of this policy, resulting in rough handling and mental trauma, as described by the patient during	C 294	1. As mentioned above ED and Med/Surg staff will review the following policies relating to patient needs: NUR-114 Management of Patients at Risk to Themselves or Others; CAH-213 Inpatient Rights and Responsibilities. See below 2. As stated above, nursing staff on ED and Med/Surg will receive verbal de-escalation training. See below 3. A plan of care will be documented for all patients experiencing a psychiatric crisis, including self-harming behaviors who are pending admission to a psychiatric facility. See below Education and Monitoring: 1. As previously stated, staff will complete a competency through Policy Manager by 10/30/2015 for regular/part-time staff. Per diem staff will complete the competency by 10/30/2015 or their next shift. 2. Verbal de-escalation trainings are scheduled for 9/25/2015 and 10/16/2015. Additional trainings will be planned. Staff will participate in the training by 12/31/2015. 3. QM will review records of patients experiencing a psychiatric crisis, including self-harming behaviors who are pending admission to a psychiatric facility x 6 months to ensure 100% compliance with documented use of a plan of care. 9/25/2015 Ammendment: ED/Hospitalist providers will participate in de-escalation training. Training will be completed by 12/31/2015 for regular/part-time providers and 12/31/2015 or by their next shift for per diem providers. As previously stated, ED/Hospitalist providers will review policies on restraints (NUR-199 and NUR-200) and will be educated on the revised order sets for restraints. Review of policies and order sets will be completed by 11/15/2015 for regular/part-time staff and per diem provider by 11/15/2015 or their next shift. The Director of Quality Management, or designee, will monitor compliance with this plan		

C294 POC accepted 9/30/15 mBoltonRN/PML

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: 471301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/26/2015
NAME OF PROVIDER OR SUPPLIER GIFFORD MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 44 SOUTH MAIN STREET RANDOLPH, VT 05060		
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C 294	<p>Continued From page 10</p> <p>interview with the surveyor.</p> <p>The policy directed staff dealing with a person at risk to: "#4. Assume a non-confrontational manner... #5. Maintain a safe amount of physical space until assistance has arrived." The policy also directed staff to use a calm, quiet voice and to give concrete explanations of everything being done. This did not happen in this case, as confirmed with the CNO and the ED Nurse Manager during interview on 8/25/15 at 1:30 PM. The RN's actions (captured via closed circuit camera at the entrance to the hospital), confirmed the patient restraint process and lack of appropriate nursing care, thus failing to meet the patient's needs.</p> <p>2. Per record review and confirmed by ED Nurse Manager interview on 8/24/15 at 3:15 PM, another RN was called to the ED from the Medical Surgical Unit to administer emergency involuntary medication (Haldol and Benadryl) to Patient #6. The RN documented administration of the medication at 10:10 AM on 7/19/15. There was no further documentation in the ED notes regarding the effect of the medication and assessment of the patient at the time of administration and following administration. The next note in the ED documentation was not until 10:45 AM and referred to other issues. The ED Nurse Manager and the Medical Director of Hospital Services also confirmed that there were no written policies/procedures to direct Nurses and providers regarding the use of chemical restraints. Refer also to C 271.</p> <p>3. Per record review and staff interviews, the care plan for Patient #6 failed to address the patient's needs regarding psychiatric disturbances and history of Post Traumatic Stress Disorder</p>	C 294		

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C 294	Continued From page 11 (PTSD).	C 294		
C 336	485.641(b) QUALITY ASSURANCE The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that -- This STANDARD is not met as evidenced by: Based on interview and record review, the CAH failed to assure that a complete and effective investigation of alleged patient abuse was conducted for 1 applicable patient, (Patient #6); the hospital also failed to assure consistent ongoing monitoring for the use of restraints for 1 of 8 patients in the total sample. (Patient #1) Findings include: 1. Per record review and confirmed during interviews with hospital staff, the Quality Assurance (QA) staff investigation of Patient #6's allegation of abuse failed to include interview of all known witnesses to the patient's statement of alleged abuse and possible mistreatment. During interviews on 8/25/15 and 8/26/15, the ED Nurse Manager and the CNO confirmed that there were 2 staff present in Patient #6's room in the ED when the patient alleged that a RN who provided care on the morning of 7/19/15 had abused him/her during the process of physically restraining him/her. Another staff person who had witnessed part of the restraint process was also not interviewed related to the allegations. The CNO confirmed that there was no QA member assigned to oversee the process and assure that	C 336	A written process has been created for managing internal investigations. The process is as follows: 1. The clinical manager notifies QM of an event warranting an internal investigation. 2. The clinical manager will make a list of all staff involved in the patient's care or witness to the event and begin gathering facts associated with the event. 3. A written statement will be obtained or an interview will be conducted with all staff involved or witness to the event. 4. The investigation team consisting of the clinical manager, VP of the Division, a representative from Quality Management, and others, as needed to review the event, including statements/interviews. 5. A representative from Quality Management will assemble all documentation from the investigation and follow-up on any actionable items identified by the investigation team. Completed 9/15/2015 This process has been added to QM-101 Incident/Adverse Event Reporting. Managers will be assigned a competency in Policy Manager to be completed by 11/1/2015. 9/25/2015 Ammendment: The Director of Quality Management will monitor compliance with the plan above. C336 POC accepted 9/30/15 MBohler RN/PML	

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C 336	<p>Continued From page 12</p> <p>all investigations into allegations of patient abuse were conducted in a thorough manner and were completed.</p> <p>2. The Nurse Manager for Medical/Surgical and Transitional Units confirmed on 8/26/14 at 11:40 AM that although s/he has a process for reviewing all restraint use on the patient care units, a review had not been conducted for the use of restraints and the failure to discontinue the restraints when appropriately indicated for Patient #7. Per record review, Patient #7 was treated in the ED for acute alcohol intoxication on 7/19/15 at 02:20. The patient required intubation with an endotracheal tube to assist with maintaining an airway and was admitted to the Special Care Unit (SCU) at 0615. Soft restraints had been applied for medical immobilization to prevent Patient #7 from attempting to remove the endotracheal tube, intravenous catheter and nasal gastric tube (NG). The History & Physical note written by the admitting hospitalist stated that patient was eventually extubated and his/her NG tube removed and at the time in 4 point restraints secondary to his/her altered mental status...."the patient is awake, alert but does not understand how s/he got here and has become quite belligerent...". Per review of nursing progress notes for 7/19/15 from 10:46 through 15:50 Patient #7 was observed by staff to be sleeping, however restraints were not removed. During this period there was no indication the patient was demonstrating a risk to himself/herself or others and least restrictive measures had not been initiated to include the progressive removal of the 4 point restraints, as per CAH policy. The Nurse Manager had also confirmed if s/he had audited the restraint use for Patient #7 it would have been noted a discontinuation of restraints should have</p>	C 336		

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C 336	Continued From page 13 resulted. At the time of Patient #7's hospitalization, the Nurse Manager stated s/he was on vacation and this specific case was not brought to the Manager's attention using the present screening process to identify opportunities for improvement.	C 336			