

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
Fax (802) 871-3318

June 19, 2015

Mr. Roger Allbee, Administrator
Grace Cottage Hospital
PO Box 216
Townshend, VT 05353-0216

Dear Mr. Allbee:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 29, 2015**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



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



JUN 09 2015



*Account POC
6-18-15
for for Dennis*

June 5, 2015

Suzanne Leavitt, RN, MS
Assistant Division Director
Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671

Regarding Form CMS-2567 Statement of Deficiencies for Grace Cottage Hospital, Provider ID 471300

Dear Ms. Leavitt,

Enclosed please find:

- Signed form CMS-2567 received by Grace Cottage Hospital on May 26, 2015, detailing the deficiencies identified on our recent survey on April 29, 2015
- Grace Cottage Hospital's Plan of Correction to address these deficiencies (please see attachments)

If additional information is required, please contact myself at (802) 365-3648 or Dr. Christopher Schmidt, CMO at (802) 365-7140 x 193

Respectfully submitted,

Roger Allbee
CEO

Grace Cottage Hospital

Grace Cottage Family Health

Messenger Valley Pharmacy

P.O. Box 216, 185 Grafton Road, Townshend, Vermont 05353
802-365-7357 • www.gracecottage.org

JUN 09 2015

PRINTED 05/26/2015
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: 471300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2015
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NAME OF PROVIDER OR SUPPLIER GRACE COTTAGE HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 216 TOWNSHEND, VT 05353
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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C 000 INITIAL COMMENTS

C 000

An unannounced onsite recertification survey and investigation of 1 entity self-report was conducted on 4/27/15-4/29/15 by the Division of Licensing & Protection. As a result of the survey, the Critical Access Hospital was determined not to be in compliance with the Conditions of Participation for Emergency Services. The following regulatory violations were identified:

C 200 485.618 EMERGENCY SERVICES

C 200

The CAH provides emergency care necessary to meet the needs of its inpatients and outpatients.

This CONDITION is not met as evidenced by. Based on staff interview and record review the CAH failed to meet the needs of 1 of 5 ER (Emergency Room) patients reviewed, by failing to conduct an evaluation of the patient's condition to determine need for any medical stabilizing treatment, prior to transfer to another facility (Patient #24). Findings include:

1. Per record review Patient #24 was transported by ambulance to the ER (Emergency Room), on the evening of 4/23/15, underwent diagnostic testing ordered by PA #1 (Physician Assistant), the ER medical provider on duty, and, although no ER medical provider had put eyes on or evaluated the patient, s/he was then transferred by ambulance to an outside field location to await air medical transport to another facility. ER nursing notes indicated that Patient #24 had been taken directly to CT scan upon arrival at 7:26 PM, was awake, with no signs of respiratory distress and was able to follow commands. The notes further stated that the patient had exhibited signs

see Attachment (1a-f)

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

TITLE
COO

(X6) DATE
6/15/15

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 200	<p>Continued From page 1</p> <p>and symptoms of a stroke with right sided facial droop, slurred speech, left arm and leg paralysis and vital signs that included an elevated blood pressure of 151/100 PA #1's note, at 7 55 PM, stated that the ambulance had been called out at 6 52 PM for a patient with acute stroke symptoms EMS (Emergency Medical Services) then communicated to the ER that they had contacted DHART (Dartmough Hitchcock Advanced Response Team) and would bypass the ER and connect with the medical care air transport for transport of the patient to a facility that could provide higher level care PA #1's note further revealed that EMS again contacted the ER to request to bring the patient to the CAH to obtain a CT scan while they waited the approximate 25 minutes it would take for DHART to arrive Patient #24 arrived in the ER and went directly to CT scan, which had been ordered by PA #1 After the scan was done the patient was immediately taken out to the ambulance and transported back to the landing area for DHART without having been seen or examined by PA #1 or any other ER medical provider. The documentation by PA #1 included the diagnosis of 'Possible CVA' (stroke) and stated that a phone call had been placed to a medical provider at the receiving hospital to alert him/her " of the coming patient and was informed that they could not take [Patient #24] because there was not a neuro interventionist available and [Patient] might need to have the clot extracted for maximum benefit At that point [ER Physician #1] came on and I asked if [s/he] could talk with DHMC and define what we should do with the patient DHART was in the air with the patient at that point and a decision was made to fly [him/her] to Mass But according to [ER Physician #1] they were not able to accept [Patient #24] either and because of</p>	C 200		
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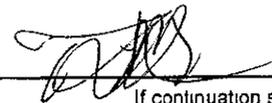
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C 200 Continued From page 2

fuel concerns [Patient #24] was taken to DHMC " Although the CAH's established Emergency Room Scope Of Services policy, identified by staff as the currently used policy, stated within it's scope of services 'The Emergency Room (ER) will provide the following services Staff competencies include, but are not limited to: Initiation of Stroke management, including administration of thrombolytics Stabilization of patients to be transferred to a higher level of care...', the patient was taken from the ER without benefit of evaluation by a medical provider to determine need for medical treatment/stabilization prior to transfer In addition, although the patient had not been evaluated by PA #1, or any other ER medical provider, there was a Patient Transfer Form, completed by PA #1, that identified the patient's condition as "stable "

C 200

During interview, on the afternoon of 4/28/15, Physician #2, [the ER Medical Director], confirmed that patient #24 had not been seen or examined by any ER medical provider when s/he presented, via EMS, for CT scan on the evening of 4/23/15 Physician #2 stated that Physician #1 had contacted Physician #2 on 4/24/15 to inform him/her of the incident Physician #2 stated that s/he had interviewed PA #1 who told Physician #2 that EMS had reportedly conducted a field assessment of Patient #24, had made the determination of possible stroke and, despite the fact that the CAH did have a Stroke Protocol in place, had contacted DHART to have the patient transported via medical air transport to a hospital that could provide higher level care EMS reportedly contacted the ER a second time to state that there would be a 25 minute waiting period for DHART arrival and requested, and



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C 200	Continued From page 3 were given approval by PA #1, to bring Patient #24 to the CAH to obtain a CT scan to "save time" The patient reportedly arrived at the CAH, went directly to CT scan, which had been ordered by PA #1 and was immediately put back on the ambulance stretcher and taken from the CAH by EMS Physician #2 stated that a limited nursing assessment had been completed, and although PA #1 had reportedly attempted to evaluate the patient after the CT scan was completed, s/he was unable to do so as the patient had already been transferred from the ER without PA #1's knowledge	C 200			
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 The facility staff failed to follow policy in regard to the administration of an emergency involuntary medication when there was a lack of evidence of imminent threat of bodily harm to the patient or others (Patient #1) Findings include 1 Per record review, Patient #1 age 84 was admitted to the CAH (Critical Access Hospital) on 4/4/15 for rehabilitation after a repair of a fractured hip Upon admission it was noted Patient #1 had a long psychiatric history (Bipolar disorder) and dementia and recently had not been compliant with prescribed medication to include Lithium The patient's attending physician who visited with the patient at the time of admission noted Patient #1 to be "quite manic". As a result, Patient #1 demonstrated challenging behaviors to include ongoing periodic refusal of medications, failure to maintain post surgical hip	C 271	see Attachment 2(a-h)		

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C 271	<p>Continued From page 4</p> <p>replacement precautions, ambulated without assistance although at risk for falls, refused physical and occupational therapy, was impulsive and often refused assistance with personal care. Although some nursing staff were able to provide provision of services to Patient #1, others were unable to establish a rapport that would facilitate administration of medications, incontinence care or assure patient safety. Per Nursing progress notes staff document Patient #1 was resistant when staff attempted to ambulate or transfer to bed and would slap at the nurses. Per interview on 4/29/15 at 9:50 AM, Nurse #1 acknowledged Patient #1 had reached to grab at a staff member's throat on 4/11/15, however was rapidly redirected by Nurse #1 without injury to staff or the patient. The patient expressed her/his frustration during this incident and acknowledging his/her resistance of care provided by certain staff.</p> <p>On the morning of 4/12/15 during nursing attempts to administer medications, once again the patient refused and "battered the cup of pills on the floor." Patient #1 also intentionally spilled 2 cups of water on his/her bed and over-bed table. Staff notified the on-call hospitalist and received an order for an involuntary medication Haldol 5 mg (psychotropic medication) IM (intramuscular) was prescribed. Per CAH policy Involuntary Procedures and Uses of Restraint last revised 1/2015 states: Definition of an emergency and validation of use "1. A significant change in the patient's condition or past behavior; 2. Resulting in the imminent threat of serious bodily harm to the patient or others." During interview, RN #1 also confirmed Patient #1 was agitated on 4/12/15 and staff had attempted to redirect and provide support. However, the patient's behavior</p>	C 271		

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C 271	Continued From page 5 had not changed significantly from admission which included on 4/12/15 to be the ongoing refusal of medication and refusal to comply with staff direction and when approached s/he would, at times, slap at staff. However, there was no indication of imminent threat of serious bodily harm to the patient or staff. In addition, staff had failed on 4/12/15 to use alternative, less restrictive interventions as directed by the General procedures for all involuntary procedures. "Such interventions may include but not be limited to the following: Crisis Prevention Intervention (CPI) de-escalation techniques, activity changes, distraction, separate the patient from the situation/offer a quiet space, remove others that are upsetting to the patient, relaxation techniques, music, sit and talk." Subsequently, Patient #1 had refused oral medication which was offered, the decision was made to administer the involuntary medication. On 4/12/15 at 0901, 3 staff members entered Patient #1's room. While in bed, Patient #1's arms were held by accompanying staff and Nurse #1 supported the patient's leg and administered the Haldol 5 mg IM. Per the Certificate of Need for Involuntary Procedures, Nurse #1 notes on 4/12/15 at 10:35 AM, after 1 hour of the involuntary medication administration, Patient #1 was calmer though still unable to follow instructions, still unable to keep herself safe with no insight into his/her illness or safety. Prior to the involuntary procedure, the CAH had not developed a behavioral plan to assist staff in the management and understanding of Patient #1's psychosocial needs.	C 271		
C 276	485.635(a)(3)(iv) PATIENT CARE POLICIES [The policies include the following]	C 276		

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C 276	<p>Continued From page 6</p> <p>Rules for the storage, handling, dispensation, and administration of drugs and biologicals. These rules must provide that there is a drug storage area that is administered in accordance with accepted professional principles, that current and accurate records are kept of the receipt and disposition of all scheduled drugs, and that outdated, mislabeled, or otherwise unusable drugs are not available for patient use. This STANDARD is not met as evidenced by:</p> <p>The facility failed to properly store and secure expired medications within the pharmacy department and failed to securely store contrast media in the radiology department from unauthorized access. Findings include:</p> <ol style="list-style-type: none"> 1. On 4/28/15 at 10 20 AM, during a tour of the Pharmacy Department accompanied by the staff pharmacist, a large quantity (100 +) of expired medications to include multi-dose and single dose vials, packaged tablets and capsules were observed overflowing in 2 boxes located in the pharmacy staff bathroom. The pharmacist stated the medications observed will eventually be picked up by a contracted pharmacy vendor for credit, however the removal was overdue. The pharmacist confirmed, although access to this location is restricted to authorized pharmacy staff, unauthorized staff do access the bathroom for housekeeping or maintenance purposes at which time continuous observation and/or supervision of such individuals could not be guaranteed. The pharmacist agreed, there was a failure to properly store expired medications. 2. Per observation, on 4/27/15 at 2.42 PM, an unlocked warming unit containing (8) 100 ml and (1) 50 ml vials of Omnipaque injectable contrast. 	C 276	<p style="text-align: center; font-size: 2em; font-family: cursive;">Attachment 3 (a)</p> <p style="text-align: right; font-family: cursive;"></p>	
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C 276	Continued From page 7 solution was unsecured in the CT room of the radiology department. The inner corridor door to the room was unlocked and accessible by a common hallway that extended to a patient waiting area. The room was not within direct sight of staff within the department. The lack of secure storage was confirmed by the director of diagnostic imaging at the time of the observation. The facility added a lock to the warming unit to secure the contrast solution after it was identified during the survey.	C 276	
C 279	485 635(a)(3)(vii) PATIENT CARE POLICIES [The policies include the following] Procedures that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practices and the orders of the practitioner responsible for the care of the patients, and that the requirement of §483.25(i) of this chapter is met with respect to inpatients receiving post CAH SNF care This STANDARD is not met as evidenced by. Based on observation and policy review, the hospital failed to assure that dietary staff consistently adhered to daily and weekly cleaning schedules to maintain sanitary food preparation and storage areas. Staff also failed to assure that all perishable foods were labeled and dated in accordance with hospital policy and accepted safe food handling practices. Findings include: Per observations during the tour of the hospital's kitchen commencing at 10:58 AM on 4/27/15, the following perishable food item was not labeled and dated in accordance with the Dietary Policy/Procedure for "Labeling and Dating",	C 279	see Attachment 4 (a-c) 

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C 279	<p>Continued From page 8 effective 8/1/07, revised 3/22/11. a piece of cooked deli-style turkey stored in the walk-in cooler was not labeled and dated. The policy/procedure stated "Date all items the day they are prepared or opened and use the guide below to determine expiration cooked turkey (and other cooked packaged meats) - 3 days "</p> <p>Per observations of the kitchen preparation and food storage areas, the following areas were noted to be soiled with a build-up of visible dirt/debris in the corner areas the walk-in freezer floor, the walls, under sink area, trash containers and flooring in the dish machine area, the floor perimeter and corner areas in the main kitchen, a stainless steel cart and a Rubbermaid cart used in the kitchen areas and the floor in the dry food storage pantry</p> <p>Per review of the daily and weekly cleaning schedules for dietary personnel, the areas cited are to be cleaned daily and deep cleaned, including "all crevices" and walls and floors weekly These observations were confirmed with the Director of Dietary Services at the conclusion of the tour on 4/27/15, at 11.40 AM</p>	C 279		
C 298	<p>485 635(d)(4) NURSING SERVICES</p> <p>A nursing care plan must be developed and kept current for each inpatient</p> <p>This STANDARD is not met as evidenced by. The facility nursing staff failed to develop a care plan to address behavioral factors that affected the provision of care and services for 1 patient with psychosocial and behavioral impairments. (Patient #1) Findings include</p> <p>1 Per record review, Patient #1 age 84 was</p>	C 298	<p><i>see Attachment 5</i></p> 	

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C 298	<p>Continued From page 9</p> <p>admitted to the CAH on 4/4/15 for rehabilitation after a repair of a fractured hip Upon admission it was noted Patient #1 had a long psychiatric history (Bipolar disorder) and dementia and recently had not been compliant with prescribed medication to include Lithium. The patient's attending physician who visited with the patient at the time of admission noted Patient #1 to be "quite manic". As a result, Patient #1 demonstrated challenging behaviors to include ongoing periodic refusal of medications, failure to maintain post surgical hip replacement precautions, ambulated without assistance although at risk for falls, refused physical and occupational therapy, was impulsive and often refused assistance with personal care Although some nursing staff were able to provide provision of services to Patient #1, others were unable to establish a rapport that would facilitate administration of medications, incontinence care or assure patient safety. Per Nursing progress notes staff document Patient #1 was resistant when staff attempted to ambulate or transfer to bed and would, at times, slap at the nurses</p> <p>Although a care plan was developed which addressed Patient #1's anxiety, there was a failure to address Patient #1's behavioral needs and management The care plan failed to address interventions to best assist both the nursing staff and the patient in approaching the patient's inability to appropriately process and comply with nursing directives due to his/her psychiatric diagnosis, dementia and cognitive impairment On going issues with non-compliance and varied interactions which were effective with managing the above-mentioned behaviors, were not incorporated in a plan that may have provided</p>	C 298		

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C 298	Continued From page 10 more effective approaches with Patient #1's challenging behaviors Per interview on the afternoon of 4/29/15, the CNO (Chief Nursing Officer) confirmed the nursing care plan for Patient #1 had failed to address behavioral factors which impacted the provision of both nursing care and rehab therapies	C 298		

GRACE COTTAGE HOSPITAL – PROVIDER # 471300 - ATTACHMENT # 1

Tag C200 485.618 Emergency Services

Plan of Correction:

- This patient was self-reported as a potential EMTALA violation (see attachment 1f)
- On 4/28/2015 all providers were re-educated by email about EMTALA. (see attachment 1a)
- On 4/29/2015 all nursing and secretaries were re-educated about EMTALA by email. (see attachment 1b)
- An RCA was held on 4/30/2015 which included GCH providers, Rescue Inc. staff, GCH nursing staff, Dartmouth Hitchcock Medical Center DHART staff, and Grace Cottage Hospital administration.
- A Powerpoint presentation was presented at the ED Committee meeting on 5/6/2015. This was also emailed to ED providers, nursing and secretaries. (see attachment 1c)
- All ED providers nursing and secretaries confirmed understanding of GCH policies on Emergency Medical Care ER Scope of Services and Transfers. (see attachment 1d for policies)
- Confirmed with Rescue Inc. Medical Director that Rescue Inc. understands EMTALA and will no longer call DHART helicopter 'scene pickups' for stroke Division 2 patients. (see attachment 1e)
- All ED providers and clinical staff will complete the Elsevier module on EMTALA by July 1, 2015.
- All 100% of ED transfers are reviewed monthly at the ED committee meeting. If there are any outliers they are discussed and addressed at this committee and reported to Quality.

*POC complete
6.18.15
S Dennis / RB*

EMTALA 4/23/2015

Plan of Correction	Plan	Person Responsible	Date to be Done	Date Completed
	Re-educate all providers about EMTALA by email	Dr. Schmidt	4/28/2015	4/28/2015
	Re-educate all nursing and secretaries about EMTALA by email	Dr. Schmidt	4/29/2015	4/29/2015
	Conduct RCA around 4/23 incident	Dr. Schmidt/Heather	4/30/2015	4/30/2015
	Have all ED providers, nursing and secretaries sign off and confirm understanding of EMTALA email	Dr. Schmidt/Jeanne	5/30/2015	5/30/2015
	Present a PowerPoint about EMTALA at ED Committee Meeting, including form completion	Dr. Schmidt	5/6/2015	5/6/2015

	Have all ED providers, nursing and secretaries sign off and confirm understanding of GCH policies on Emergency Medical Care; ER Scope of Services; and Transfers.	Dr. Schmidt	5/30/2015	5/30/2015
	Send EMTALA PowerPoint to all ED providers, nurses and secretaries & confirm their review of same	Dr Schmidt	5/30/2015	5/30/2015
	Confirm with Rescue Inc. Medical Director that Rescue Inc. understands EMTALA law	Dr. Schmidt	5/15/2015	5/10/2015
	Confirm with Rescue Inc. Medical Director that Rescue Inc. will no longer call for DHART helicopter 'scene pickups' for stroke for Division 2 patients.	Dr. Schmidt	5/15/2015	5/10/2015

	Have all ED providers and clinical staff complete the Elsevier module on EMTALA	Dr. Schmidt/Jeanne	7/1/2015	
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S. Davis / SK
6-18-15
of court

Heather Boucher

From: Christopher Schmidt
Sent: Tuesday, April 28, 2015 2:42 PM
To: Linda Rimkunos; Sarah Logan; paul donovan; buzzon@hotmail.com; Danny Ballentine; Donald J. Jackson; Karen Cusato; karencusato@yahoo.com; Kenneth Rudd; kenneth.w.rudd.ii@dartmouth.edu; kimjam@sover.net; Kimona B. Alin; Maurice Geurts; mauricevermont@gmail.com; Moss J. Linder; Richard Meyer; richski48@gmail.com; Warren R. Montgomery; wmont@comcast.net
Subject: EMTALA Responsibilities
Attachments: 20 Commandments of EMTALA.docx

All,

All of us ED providers are responsible to know and practice EMTALA requirements.

Despite honorable goals by all involved, we had an unintentional EMTALA violation in our ED last week. This is the first one I have ever been involved in or personally seen. Here's what happened in brief summary.

Rescue responded to a probable stroke, diagnosed an acute stroke and alerted DHART for a stroke alert; DHART said they would pick up patient at the scene; Rescue had an idea to get the head CT done while waiting "to save time;" we agreed to get the CT done for them; the patient was whisked in and out of the CT scanner and back to the ambulance so quickly after being booked into the ED that our ED provider could not do an exam; then, finally, the DHMC neuro resident refused to accept the case while the patient was in the copter because we hadn't examined, treated, stabilized, etc. There is more but the patient finally did get tPA at DHMC ED.

So, by law, we were obligated to report this to CMS and they will investigate. To avoid hefty financial fines to the provider and the facility, we have to do a root cause analysis and change things immediately.

I have chatted with all involved and this is our immediate fix:

1. **Rescue has never had a stroke alert protocol agreement with DHMC and will not have one per current medical regimens.**
2. **Rescue's stroke alert protocol is with local hospitals only.**
3. **Never allow any healthcare provider to request our ED services for anything other than what EMTALA mandates.**
4. **EMTALA (Emergency Medical Treatment and Active Labor Law) is binding for every ED patient in these key ways:**
 - a. **Who is an ED patient? Every patient who comes to the ED, is logged into the ED and every person who presents anywhere on the hospital campus meaning the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings and requests emergency services, or who would appear to a reasonably prudent person to be in need of medical attention, must be**

handled under EMTALA. That 250 yard sphere does not include non-medical businesses (shops and restaurants located close to the hospital).

- b. **Medical Screening Exam**: The ED patient must be offered a medical screening examination and testing to exclude the presence of an immediate threat to life, limb or organ function.
- c. **Stabilization**: The patient must be offered stabilizing treatment for any condition diagnosed (emergent or non-emergent) as far as the facility's resources allow before any plans to discharge, transfer or admit the patient.
- d. **Transfer**: Any patient in need of transfer must be accepted at the receiving hospital after a documented doc-to-doc conversation.
- e. **The REST**: There is more that every ED provider is responsible for: Please review and know the attached 20 Commandments of EMTALA.

Thanks,
CS

The "20 Commandments" of COBRA/EMTALA

1. THOU SHALT: Log in every patient who presents, together with diagnosis and disposition;
2. THOU SHALT: Provide a medical screening examination [by physician, preferably], beyond triage, in the hospital to every person presenting to the hospital (including hospital-owned ambulances);
3. THOU SHALT NOT: delay the medical screening examination to secure verification or authorization from third party payor, nor attempt to influence the patient by drawing payor status issues to the patient's attention prior to screening;
4. THOU SHALT: Provide necessary testing, including on-call services, to exclude the presence of a life-threatening emergency medical condition;
5. THOU SHALT: Provide stabilization so that the patient is not likely to deteriorate from or during transport or discharge;
6. THOU SHALT: Provide on-call coverage schedule for all medical specialties represented on the medical staff, and maintain the list of the individuals on-call for five years;
7. THOU SHALT: Require on-call specialists respond in timely manner and provide stabilizing care and/or definitive treatment in the hospital;
8. THOU SHALT: Transfer COBRA patients for only services or care not available at your facility;
9. THOU SHALT: Treat OB patients with contractions as unstable patients under the law;
10. THOU SHALT: Obtain and document advance acceptance from the receiving hospital;
11. THOU SHALT: Provide medically appropriate vehicles, personnel, and life support equipment for all COBRA transfers;
12. THOU SHALT: Provide a physician certification with clearly stated risks and benefits of transfer for all COBRA transfers;
13. THOU SHALT: Provide medical records, labs, reports and consultation records to accompany the patient on all COBRA transfers;
14. THOU SHALT: Include the name of any on-call physician who refused to respond or failed to make a timely response in the transfer records of any COBRA patient transferred as a result of that refusal or lack of timely response;
15. THOU SHALT: Obtain written refusal of services by a patient or responsible party that refuses exam, treatment, or transfer that documents the specific risks of refusal associated with the individual case, or document the reasonable efforts by the hospital to obtain written refusal;
16. THOU SHALT: Obtain written consent to transfer from the patient or responsible party, or document the reasonable justification for not obtaining the written consent;
17. THOU SHALT: Document in the medical record sufficient specific date and information to substantiate the appropriate nature of the actions taken in the individual case;
18. THOU SHALT: Obtain discharge vital signs or vital signs at the time of transfer;
19. THOU SHALT: Post COBRA signs in all entries, waiting areas, registration and care areas;
20. THOU SHALT: Report any possible violations of COBRA by another facility within 72 hours of receipt of the patient.

Dr. G...
6-18-15
S. D...
S...

Heather Boucher

From: Christopher Schmidt
Sent: Wednesday, April 29, 2015 12:54 PM
To: ER Nurses; Carolyn Schuck; Desiree V Plumley; Cynthia Rae
Subject: FW: EMTALA Responsibilities
Attachments: 20 Commandments of EMTALA.docx

All,

All ED personnel (providers, nurses, unit secretaries) are responsible to know and practice EMTALA requirements.

Despite honorable goals by all involved, we had an unintentional EMTALA violation in our ED last week. This is the first one I have ever been involved in or personally seen. Here's what happened in brief summary.

Rescue responded to a probable stroke, diagnosed an acute stroke and alerted DHART for a stroke alert; DHART said they would pick up patient at the scene; Rescue had an idea to get the head CT done while waiting "to save time;" we agreed to get the CT done for them; the patient was whisked in and out of the CT scanner and back to the ambulance so quickly after being booked into the ED that our ED provider could not do an exam; then, finally, the DHMC neuro resident refused to accept the case stating that there was no interventional radiologist on-call; pt ended up in DHMC ED and was treated.

So, by law, we were obligated to report this to CMS and they are investigating. To avoid hefty financial fines to the provider and the facility, we have to do a root cause analysis and change things immediately.

I have chatted with all involved and this is our immediate fix:

- 1. Rescue has never had a stroke alert protocol agreement with DHMC and will not have one per current medical regimens.**
- 2. Rescue's stroke alert protocol is with local hospitals only.**
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- 4. EMTALA (Emergency Medical Treatment and Active Labor Law) is binding for every ED patient in these key ways:**
 - a. Who is an ED patient? Every patient who comes to the ED, is logged into the ED and every person who presents anywhere on the hospital campus meaning the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings and requests emergency services, or who would appear to a reasonably prudent person to be in need of medical attention, must be handled under EMTALA. That 250 yard sphere does not include non-medical businesses (shops and restaurants located close to the hospital).**

- b. Medical Screening Exam: The ED patient must be offered a medical screening examination and testing to exclude the presence of an immediate threat to life, limb or organ function.**
- c. Stabilization: The patient must be offered stabilizing treatment for any condition diagnosed (emergent or non-emergent) as far as the facility's resources allow before any plans to discharge, transfer or admit the patient.**
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CS

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19. THOU SHALL: Post COBRA signs in all entries, waiting areas, registration and care areas;
20. THOU SHALL: Report any possible violations of COBRA by another facility within 72 hours of receipt of the patient.

9/18/15
S. Demas
15/10/15

Emergency Medical Treatment and Labor Act (EMTALA)

The University of New Mexico
Office of University Counsel
Vicki J. Hunt, JD, MPH
Associate University Counsel

Emergency Medical Treatment and Labor Act ("EMTALA")

- Applies to Medicare participating hospitals with emergency departments
- Purpose to prevent hospitals from rejecting, refusing to treat, or transferring individuals to other hospitals based on lack of ability to pay or insurance status (i.e. Medicare or Medicaid)
- Regulates when and how individual may be (1) refused treatment, or (2) transferred from one hospital to another when they have "emergency medical condition" that is not "stabilized"

When do Hospital's obligations under EMTALA arise?

- Two prongs to trigger EMTALA:
Individual "comes to the hospital's emergency department"; and
Requests examination or treatment for a "medical condition"

What are Hospital's obligations under EMTALA?

- Two duties arise if EMTALA is triggered:
Duty of hospital to provide "appropriate medical screening examination" (MSE) "within capability of hospital's ED"; and
If patient determined to have "emergency medical condition," duty to provide "necessary stabilizing treatment" or provide "appropriate transfer" to another hospital

Who “Comes to ED?”

- “Comes to Hospital’s ED” means when individual presents to hospital’s “dedicated emergency department” or elsewhere on hospital property (i.e. driveway, parking lot, sidewalks, or other departments or facilities that are “part of” the hospital, or are within 250 yards of hospital’s main buildings, except for non-medical businesses or medical entities with separate Medicare identity)

Who “Comes to ED?”

- “Comes to Hospital’s ED”
Individual has “come to hospital’s ED” if:
 - in hospital “owned/operated” ambulance on or off hospital property
 - in non-hospital “owned/operated” ambulance on hospital property
 - in non-hospital “owned/operated” ambulance that arrives on hospital property after hospital in “diversionary status” denies access

Who Has Not “Come to ED?”

- “Comes to Hospital’s ED” does not apply
If individual is
 - in hospital “owned/operated” ambulance directed to another hospital by community-wide EMS protocol
 - in non-hospital “owned/operated” ambulance not on hospital property, even if en route calls made to hospital (*until* arrives on hospital property)

Definition of ED:

- “Dedicated Emergency Department” means any department or facility of hospital that
 - (1) is licensed by State as ED;
 - (2) held out to public as providing treatment for emergency medical conditions; or
 - (3) 1/3 of visits in preceding calendar year for treatment of emergency conditions on urgent basis without scheduled appointments

Definition of Request for Exam:

- "Request for examination or treatment of medical condition" means a request made by the individual or on individual's behalf or, in absence of a request, one will be considered to exist if prudent layperson observer would believe, based on individual's appearance or behavior, that individual needs examination or treatment for medical condition

Note: "Medical condition" does not need to be "emergency medical condition"; hospital obligated to conduct "appropriate" MSE to determine if emergency exists and, if so, to provide further exam and treatment of problem.

Definition of MSE:

- "Appropriate Medical Screening Examination" (MSE) means examination of patient "within capability of hospital's ED, including ancillary services routinely available to the ED," by physician or other "qualified medical person" (as set forth in hospital's bylaws, rules or regulations) to determine if patient has an emergency medical condition.

Definition of Capability:

- "Capability" to provide appropriate MSE means the ability of hospital personnel to provide level of care required (within training/scope of professional licenses) to conduct screening examination adequate to determine existence of an Emergency Medical Condition; includes "ancillary services" routinely available to hospital such as consultant services available to main hospital ED).

Definition of Emergency Med Condition:

- "Emergency Medical Condition" means a medical condition manifested by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
 - placing health of individual (or of pregnant woman and unborn child) in jeopardy;
 - serious impairment to bodily functions; or
 - serious dysfunction of any bodily organ or limb

Pregnancy & Labor Emergencies:

- An Emergency Medical Condition of a pregnant woman with contractions means there is inadequate time to effect safe transfer before delivery, or transfer may pose threat to health or safety of woman or unborn child.

Psychiatric Emergencies:

- “Emergency psychiatric condition” is when an individual presenting to a hospital ED or hospital psychiatric department or unit expresses suicidal or homicidal thoughts or gestures, attempt or at risk, altered orientation or other assaultive behavior that indicates a danger to self or others.

Definition of Stabilization:

- “Necessary stabilizing treatment” of an Emergency Medical Condition means further medical examination and treatment as required to *stabilize* it, within capabilities of staff and facilities available.
- To “stabilize” an Emergency Medical Condition means to provide such medical treatment of it necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during transfer of the patient (for pregnant woman, delivery of child and placenta).

Stabilizing Psychiatric Emergencies:

- “Stabilized emergency psychiatric condition for transfer” means when individual is protected and prevented from injuring or harming self or others.
- “Stabilized emergency psychiatric condition for discharge” means when individual is no longer threat or danger to self or others.

Appropriate Transfers:

- "Appropriate transfer" means transfer of an individual from one hospital that lacks the "specialized capabilities" or "capacity" to render "necessary stabilizing treatment" of an Emergency Medical Condition to a hospital with the "specialized capabilities" and "capacity" to render "necessary stabilizing treatment" of it (must meet 4 requirements)

Transferring Requirements:

- "Appropriate transfer" – 4 requirements:
 - (1) Transferring hospital provides treatment of individual's Emergency Medical Condition within its capabilities and capacity that minimizes risks to individual's health; AND
 - (2) Receiving hospital accepts transfer and has capabilities and capacity to treat individual's Emergency Medical Condition; AND

Transferring Requirements:

- (3) Transferring Hospital sends to Receiving Hospital copies of all records related to patient's Emergent Medical Condition at time of transfer. AND provides written consent from patient or patient's representative OR certification from physician and name and address of any Transferring Hospital on-call physician who refused or failed to provide necessary stabilizing treatment of patient's Emergency Medical Condition; AND

Transferring Requirements:

- (4) Transfer effectuated via qualified personnel and transportation equipment.

Unstabilized Transfers:

- "Appropriate transfer" of patient with Emergency Medical Condition that has not been "stabilized" can only be made if the above 4 requirements are met AND, Individual (or legally responsible person) requests transfer in writing, after being informed of Transferring Hospital's obligations and risks of transfer, and acknowledging reasons for request and awareness of risks and benefits of transfer; OR

Unstabilized Transfers:

Certification signed by physician at Transferring Hospital that medical benefits of transfer to Receiving Hospital for treatment outweigh risks of transfer (must contain summary of risks and benefits upon which certificate based);

OR

Unstabilized Transfers:

If physician not physically present in Transferring Hospital ED, a certificate signed by "qualified medical person" after consulting with physician who agrees and subsequently countersigns certification.

Who Has Specialized Capabilities?

"Specialized capabilities" means that there is physical space, equipment, supplies and specialized services that the hospital provides (i.e. surgery, psychiatry, obstetrics, intensive care, pediatrics, trauma). "Capabilities" of staff means the level of care that the personnel of the hospital can provide within the training and scope of their professional licenses, including coverage available from hospital's on-call roster, equipment.

Who Has Capacity?

- "Capacity" to render care is not merely reflected by the number of persons occupying a specialized unit, the number of staff on duty, or the amount of equipment on the hospital's premises, but also includes whatever a hospital customarily does to accommodate patients in excess of its occupancy limits. Thus, if a hospital customarily accommodates patients in excess of its occupancy limits by whatever means (i.e. moving patients to other units, calling in additional staff, borrowing equipment from other facilities) it has demonstrated the ability to provide services to patients in excess of its occupancy limits.

No Delays Accepted in Conducting MSE or Treatment of Emergencies:

Delays in conducting MSE or providing treatment of an Emergency Medical Condition is *prohibited* for purposes of routine registration, questions regarding payment source or insurance status, seeking authorizations from third-party payers, obtaining individual's medical history from health plan or PCP, obtaining parental consent for minors, etc. These activities are permissible if *simultaneously* conducted and *do not delay* the MSE or treatment of Emergency Medical Condition.

EMTALA *does not* apply:

1. If MSE reveals no Emergency Medical Condition.
2. If individual with Emergency Medical Condition leaves the ED before treatment *unless* individual leaves at "suggestion" of hospital personnel or the hospital is operating beyond capacity and did not attempt to provide "appropriate transfer" of individual to another hospital.

EMTALA *does not* apply:

3. If individual refuses treatment for Emergency Medical Condition after informed of risks/benefits of further examination and treatment.
4. If Emergency Medical Condition of patient is "stabilized" before transfer or discharge.
5. If individual with "unstabilized" EMC refuses transfer to another hospital.

EMTALA *does not* apply:

6. If patient who comes to ED is admitted to hospital for inpatient services, whether or not patient has an Emergency Medical Condition (inpatients subject to standards and protections of Medicare Conditions of Participation).
7. If patient is "boarded" in ED awaiting inpatient bed if "good faith" intent to admit to hospital (even if improves and discharged before bed available).

Other EMTALA Obligations:

- Adopt and enforce policies and procedures to comply with requirements of EMTALA;
- Post signs in ED specifying rights of individuals with Emergency Medical Conditions and women in labor who come to ED for health care services;
- Maintain central log of individuals who come to ED seeking treatment and indicate disposition (refused treatment; denied treatment; were treated, admitted, stabilized, and/or transferred or were discharged;

Other EMTALA Obligations:

- Maintain list of on-call providers who are available to provide further evaluation and treatment necessary to stabilize an individual's Emergency Medical Condition.
- Maintain medical and other records related to individuals transferred to and from hospital for period of 5 years from date of transfer.

Other EMATALA Obligations:

- A recipient hospital that suspects receiving an improperly transferred individual (transfer of "unstable" patient with Emergency Medical Condition who was not provided "appropriate transfer") must report violation within 72 hours of incident to Centers for Medicare and Medicaid (CMS) or the State Agency, or may

Other EMATALA Obligations:

- A recipient hospital that suspects receiving an improperly transferred individual (transfer of

Summary - EMTALA *does* apply:

- To an individual who "comes to hospital's ED" and "requests examination or treatment of medical condition"
- To other individuals (i.e. visitors, employees) in hospital or on hospital "campus" (i.e. within 250 yards of main hospital building, excluding non-medical businesses or other medical entities with separate Medicare identities) if request examination or treatment or would appear to reasonably prudent person to be in need of medical attention (i.e. slip-and-fall accident resulting in injury, collapse due to illness, etc.)

Summary - EMTALA *does* apply:

- To transfers of individuals from a hospital that lacks "specialized capabilities" or "capacity" to render "necessary stabilizing treatment" of Emergency Medical Condition to a hospital with "specialized capabilities" or "capacity" to render "necessary stabilizing treatment" of Emergency Medical Condition.

Summary - EMTALA *does* apply:

- To acceptance by hospital with "specialized capabilities" or "capacity" to render "necessary stabilizing treatment" of an Emergency Medical Condition of an individual referred from another hospital that lacks "specialized capabilities" or "capacity" to render "necessary stabilizing treatment" of an Emergency Medical Condition

SUBJECT: Emergency Room Scope of Services	REFERENCE #2.0014
DEPARTMENT: Administrative/Nursing	PAGE: 1 OF: 4
APPROVED BY: Quality Improvement Committee	EFFECTIVE: 08-01-2007
REVISED BY: Jeanne Fortier, VP Patient Care Services	REVISED: 12-2010

PURPOSE:

To define medical management and emergency care for all patients that present to the Emergency Room for treatment.

POPULATION SERVED:

The patient population includes neonates, pediatrics, adolescences, adults, and geriatrics. Any patient presenting to the Emergency Room with a need or request for medical services is triaged, evaluated, treated and stabilized to the best of our abilities and available resources.

SCOPE OF SERVICES:

The Emergency Room (ER) will provide the following services:

- 24 hours a day on-call Physician, Physician Assistant, and/or Nurse Practitioner for ER coverage
- An on-call Physician available to provide on-site ER consultation and back-up as requested by any on-duty Physician Assistant or Nurse Practitioner
- 24 hours a day ER qualified Registered Nurse
- Staff competencies include, but are not limited to:
 - Advanced Cardiac Life Support (ACLS)
 - Pediatric Cardiac Life Support (PALS)
 - Automated and/or Manual External Defibrillation
 - External pacing
 - Initiation of advanced airway management, including Rapid Sequence Intubation
 - Peripheral IV line placement
 - IV therapy
 - Blood transfusions
 - Medication administration
 - Oxygen therapy
 - Initiation of Stroke management, including administration of thrombolytics
 - Initiation of Acute Coronary Syndrome management, including administration of thrombolytics

SUBJECT: Emergency Room Scope of Services	REFERENCE #2.0014
DEPARTMENT: Administrative/Nursing	PAGE: 2 OF: 4
APPROVED BY: Quality Improvement Committee	EFFECTIVE: 08-01-2007
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- Trauma evaluation and stabilization
- Disease process management
- Evaluation and initial management of fluid and electrolyte imbalance
- Cervical immobilization
- Thoracentesis
- Chest Tube placement
- Fracture, dislocation, strain, or sprain management
- Conscious Sedation
- Wound repair
- Stabilization of patients to be transferred to a higher level of care.

Emergency Room Staff:

- Staffing includes a Physician, Physician's Assistant, or Nurse Practitioner on call 24 hours a day and available to evaluate, diagnose, and treat the patient within 30 minutes of being notified of the patient's arrival. If the on-call physician is unable to fulfill his/her shift, that person must call the Chief of Staff for a suitable replacement. A back-up physician is on call and available within thirty (30) minutes of being called when mid-level practitioners are covering.
- A Registered Nurse is on site 24 hours per day to perform the initial assessment of the patient, triage appropriately, and notify the health care provider. Additional nursing staff are moved from the Inpatient Care Unit to assist in the Emergency Room when necessary, as determined by the ER RN. The Inpatient Unit Charge Nurse calls in additional replacement staff as he/she deems necessary.
- EMS personnel are able to assist in a GCH's Emergency Room patient's care if that patient was under EMS's care before being brought into the GCH ER by EMS, or if the ER patient is going to be transferred from GCH ER, by EMS, to a higher level of care facility.
- Ancillary Services such as Laboratory, Radiology, and Dietary are available during their normal working hours. On off hours, Laboratory services are provided by physicians and mid level practitioners, Radiology services are provided by on call personnel. Light meals and snacks are provided during off hours by nursing per physicians' orders and patients' needs.

SUBJECT: Emergency Room Scope of Services	REFERENCE #2.0014
DEPARTMENT: Administrative/Nursing	PAGE: 3 OF: 4
APPROVED BY: Quality Improvement Committee	EFFECTIVE: 08-01-2007
REVISED BY: Jeanne Fortier, VP Patient Care Services	REVISED: 12-2010

- Crisis Response workers are available on a consulting basis for patients with mental health issues when appropriate disposition of the patient is in question. Crisis Response workers will recommend and assist with the patient's disposition plan; however, the GCH provider is ultimately responsible for the care and disposition of the patient.

Physician Orders:

A Physician, Physician Assistant, or Nurse Practitioner provides written orders for all treatment and interventions related to patient care. Approved pre-printed protocols are available for Acute Coronary Syndrome and its associated medications. Patient care provided by mid-level practitioners is reviewed by the covering physician who then co-signs such patient charts in accordance with the GCH Medical Staff By-Laws.

Demand Beyond Capacity:

The Emergency Room has three stretcher equipped treatment areas and one recliner equipped infusion area. In the event of multiple victims from an accident or a disaster, the GCH Emergency Operations Plan is activated and available inpatient rooms and the inpatient rehabilitation area may be used as needed. These patients are triaged and are prioritized according to triage assessment for their care. It may be necessary to divert disaster scene and accident victims to other area hospitals based on the ER's ability to handle a large volume of patients in need of care. (Refer to the hospital's Emergency Operations Plan.)

Discharge or Transfer:

- Patients are dispositioned to home, to GCH inpatient or observation status, or transferred to a higher level of care per physician order according to appropriate standards of care.
- All ER patients and/or their caregiver receive written and verbal discharge instructions and are assessed for the ability to understand and carry out the instructions.

EMTALA

If it is determined by the physician through medical screening examination and evaluation that the patient needs to be transferred to another health care facility for a higher level of care and treatment, it is the physician that makes the arrangements with the receiving hospital and decides

SUBJECT: Emergency Room Scope of Services	REFERENCE #2.0014
DEPARTMENT: Administrative/Nursing	PAGE: 4 OF: 4
APPROVED BY: Quality Improvement Committee	EFFECTIVE: 08-01-2007
REVISED BY: Jeanne Fortier, VP Patient Care Services	REVISED: 12-2010

on the mode of transportation and the clinical skills necessary for the safe transfer of the patient. If an Emergency Room patient or family/legal representative requests a transfer to another facility, the GCH health care provider makes the arrangements. All Federal EMTALA requirements are met and documented for all Emergency Room transfers.

Supplies and Emergency Equipment:

Equipment and supplies are stocked to provide quality patient care. Replacement items can be found in the Supply Room or in the Purchasing Department. A Crash Cart with a monitor/defibrillator and other emergency resuscitation equipment/supplies is located in the main Emergency Room. Emergency carts and supplies are checked daily and monthly in accordance with approved ER policy. Pharmaceuticals are stored in the Pyxis automated dispensing machine located in the main ER. Additional pharmaceuticals are available for ER use in the Inpatient Care Unit Pyxis and refrigerator located in the locked medication storage room. Nursing and Pharmacy are responsible for replacing used or outdated medications per Pharmacy and Nursing policies.

Continuous Quality Improvement:

The GCH Emergency Room monitors the care it renders in accordance with its approved QI plan and actively participates in performance improvement activities.

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**VERMONT ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS
STANDARD PROCEDURES FOR INTERHOSPITAL PATIENT TRANSFERS**

I. Preamble

The coordination of policies and procedures for the interhospital transfer of patients is an issue of importance to Vermont patients, medical staffs and the families of the sick and injured. Recognizing that professionals trained in patient management are best qualified to develop standard patient transfer procedures, Vermont hospitals and other bordering hospitals, through the Vermont Association of Hospitals and Health Systems (VAHHS), have volunteered to work together to formalize and update the standard procedures for the transfer of patients that will best meet the needs of patients and their families, and allow Vermont hospitals to offer the highest quality care in the most appropriate facility. These policies and procedures are intended to meet the requirements of the federal Emergency Medical Treatment and Active Labor Act (EMTALA), 42 USC Section 1395dd, and shall be coordinated with any Agreement regarding the provision of Disaster Aid Services, if adopted subsequent to the above date.

II. Scope and Applicability.

The Standard Procedures set forth herein have been adopted by the Board of Trustees of VAHHS by resolution dated March 10, 1999. Hospitals servicing Vermont patients, if desirable, shall become Participating Institutions by each separately adopting the Standard Procedures set forth herein and utilizing them for the transfer and receipts of all patients. The Standard Procedures shall be reviewed and updated periodically by the Board of Trustees of VAHHS.

III. Definitions of Terms used in Standard Procedures.

A. A Participating Institution is a hospital which provides medical services to Vermont Patients and who has adopted the Standard Procedures for the transfer and receipt of transfer of patients.

B. A "Patient" is an individual who is seeking or receiving medical care. For decision making purposes, the word "patient" includes the patient's legal representative, if the patient is a minor or is incompetent or is otherwise incapacitated.

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C. An Emergency Medical Condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

1. placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or
2. serious impairment to bodily functions, or
3. serious dysfunction of any bodily organ or part.
4. With respect to a pregnant woman who is having contractions, the term includes situations where:
 - a. there is inadequate time to effect a safe transfer to another hospital before delivery, or
 - b. the transfer may pose a threat to the health or safety of the woman or the unborn child.

D. For the purposes of establishing the priority of transfer, the severity of a patient's medical condition shall be as follows:

1. "Emergency" – An emergency is a situation requiring immediate intervention to assist a person with potentially disabling or life threatening conditions and includes an "emergency medical condition" as described in Section C above.
2. "Urgent" – Urgent refers to a degree of severity of an illness or injury that is less severe than immediately life threatening (emergency) but requiring care more quickly than elective; a pressing necessity to treat a condition or illness to avoid a serious risk of harm.
3. "Elective" – Elective refers to any procedure or service that can be deferred without significant risk to the patient and scheduled at a later date and time.

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E. A Transfer Liaison is a staff position (or hospital department) designated by each Participating Institution and held by individuals who may be contacted to facilitate communications regarding patient transfers. The position should include responsibilities for reviewing and monitoring transfer communications and procedures at a Participating Institution.

IV: Responsibilities of Transferring Institution.

A Participating Institution transferring a patient shall effect the transfer of a patient only upon compliance with the following conditions:

A. Indications for Transfer. The transfer of a patient to another institution shall be undertaken only in situations in which either:

1. the patient requests transfer to another facility;
2. the transfer is necessary in order for the patient to obtain the most appropriate medical care; or
3. the transfer is an elective and planned in advance with the cooperation and agreement of the medical staffs and administrative representatives from the Transferring Institution and the Receiving Institution with regard to treatment and discharge plans.

B. The Transferring Institution shall identify:

1. the severity of the patient's medical condition at the time of transfer – whether emergent, urgent or elective;
2. the level of care needed by the patient; and
3. whether inpatient or outpatient care is sought by transfer.

C. Communication with/Confirmation by Receiving Institution.

1. The Transferring Institution shall transfer a patient only upon confirmation from the Receiving Institution that:

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a. it has available space and qualified personnel for treatment of the patient; and

b. the Receiving Institution has agreed to accept the transfer of the patient and to provide appropriate medical treatment.

2. If the physician at the Transferring Institution is uncertain as to the appropriate physician or department to contact, communications with the Receiving Institution shall be initiated by contacting the Receiving Institution's emergency department, unless another designated contact is known.

3. If a physician at the Transferring Institution has communicated directly with a physician at the Receiving Institution to arrange a transfer, it is the responsibility of the physician at the Receiving Institution to initiate all appropriate internal communications.

D. Patient's Rights. A patient shall not be transferred to another institution unless the patient has received complete information and explanation concerning the needs, benefits, risks and alternatives to the transfer. It is recognized that a patient has the right to refuse examination, treatment or transfer to another medical facility.

V. Documentation – Medical Records.

The Transferring Institution shall at the time of a transfer provide to the Receiving Institution copies of all medical records related to the patient's medical condition, of examination and treatment of the transferred patient at the Transferring Institution. Such records shall accompany the patient and should include a Patient Transfer Form, in the form attached hereto as Appendix B-1, or Appendix B-2, if the transfer is to or from the Veterans Administration Center, and, at a minimum, the following information:

1. patient's name, address, hospital number, age, and name, address and telephone number of next of kin;
2. history of injury or illness;
3. condition on admission and preliminary diagnosis;

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4. noted observations of symptoms and vital signs, as available prehospital, during stay in emergency department, and at time of transfer;
5. treatment rendered to patient, including medications;
6. laboratory and x-ray findings, including films;
7. fluids given by type and volume;
8. informed written consent of patient to transfer;
9. any additional information which is necessary for the maintenance of the patient during transit or for treatment upon arrival at the Receiving Institution.
10. name, address and phone number of physician referring the patient;
11. name of physician at the Receiving Institution to whom the patient is to be transferred;
12. name of physician at the Receiving Institution who has been contacted about the patient; and
13. as mandated by law, the name and address of any on-call physician who refused or failed to appear within a reasonable time to provide necessary stabilizing treatment to a patient in an emergency medical condition.

A. Patient Payment Information. If known prior to transfer, the Transferring Institution shall provide to the Receiving Institution information regarding the status of the Patient's insurance coverage or other payment coverage, such as eligibility for Medicaid or Medicare. No attempt to obtain payment information shall be made if a patient is, and continues to be, experiencing an emergency medical condition.

B. Patient Personal Belongings. The Transferring Institution shall be responsible during the transfer of a patient for the handling of the patient's personal belongings.

C. Patient Transport. The Transferring Institution shall effect the transfer of patients

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only through accompanying qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.

D. Emergency Transfers.

1. Before a patient with an emergency medical condition is transferred, the Transferring Institution shall provide an appropriate medical screening examination and provide medical treatment to the patient within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child.
2. The Transferring Institution shall provide to the Receiving Institution, at the time of the transfer, the following written evidence:
 - a. that the transferred patient has requested or has consented to a transfer from the Transferring Institution, after having been fully informed of:
 - (1) the need for the transfer including the anticipated benefits,
 - (2) the Transferring Institution's legal obligations under the law as set forth in this Section D,
 - (3) the risks involved in the transfer and
 - (4) the alternatives to the transfer; and
 - b. that (unless the transfer is requested against medical advice) a physician has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time of the transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at the Receiving Institution outweigh the increased risks to the patient's medical condition from effecting the transfer; or
 - c. that, in the event that a physician is not readily available in the

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emergency department at the time the patient is transferred, a qualified medical person as identified in the Transferring Institution's Bylaws, Rules and Regulations has signed the certification described in Subsection (b) after consulting a physician who has made the determination required in Subsection (b), and who will subsequently countersign the certification.

d. The certification described in Subsections (b) and (c) shall include a summary of the specific risks and benefits upon which the certification is based.

e. In each instance in which an emergency transfer decision involves a woman in labor, any consideration or explanation of the risks, benefits and alternatives regarding the transfer shall consider both the individual and the unborn child.

E. Communications to Patients about Financial Responsibility.

Unless the transfer involves a patient experiencing an emergency medical condition, the Transferring Institution may provide information to the patient regarding the financial responsibility he or she may incur as a result of the transfer.

VI. Responsibilities of Receiving Hospital.

Unless a transfer is made as a result of a request for Disaster Aid Services and is covered by a separate agreement adopted after the effective date of the Standard Procedures, a Participating Institution who receives patients in transfer shall to the best of its ability comply with the following provisions:

A. Time Guidelines for Response to Transfer Inquiry:

A Receiving Institution shall respond to a transfer inquiry by a Transferring Institution pursuant to the following time period guidelines:

1. Emergency – as soon as possible, but not more than twenty minutes;
2. Urgent – within a maximum of one hour; or
3. Elective – within a maximum of one working day (twenty-four hours

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during a Monday through Friday time period, or if on a weekend or holiday, by the end of the next day).

B. Prioritization of Transfers.

Patient transfer shall be accorded the following priorities by Receiving Institutions:

1. Priority One = Emergency patients; the transfer shall be effected immediately.
2. Priority Two = Urgent patients; the transfer shall be effected within a maximum of twenty-four hours from the time transfer is requested or as agreed upon by physicians from the Transferring and Receiving Institutions.
3. Priority Three = Elective patients; the transfer shall be effected as agreed upon between physician and administration representatives of the Transferring and Receiving Institutions.

C. Tertiary Care Receiving Institutions.

A Receiving Institution providing tertiary care shall accept all transfers of emergency patients so long as it has the capacity to treat the patients. If it does not, it shall provide assistance as set forth in Section F below.

D. Transfer Acceptance. Each Participating Institution shall develop procedures to accept transfers and shall communicate these procedures to those other Participating Institutions from whom it regularly receives transfers.

E. Physician Communications. If directly contacted by the Transferring Institution, it is the responsibility of the physician at a Receiving Institution to initiate all appropriate internal communications.

F. Diversion Procedures.

1. Each Participating Institution shall develop a diversion plan in the event that it is unable to receive patients for transfer or admission.
2. If a Participating Institution is contacted to receive a patient in transfer and

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is unable to accept and receive the patient, to the extent of its reasonable capabilities, it shall work with the Transferring Institution to identify an appropriate Transferring Institution in communicating with potential Receiving Institutions. Nonetheless, the final responsibility for effecting the transfer remains with the Transferring Institution.

G. Post Transfer Communication:

1. Periodic reports shall be made by the Receiving Institution to the Transferring Institution on the transferred patient's status. At a minimum, these periodic reports may include (a) a communication on the patient's disposition, department to department, immediately following the transfer, and (b) the sending of a copy of the patient's discharge summary to the Referring/Attending Physician.
2. The Receiving Physician should communicate with the Referring/Attending Physician on the transferred patient's disposition in a timely manner.

VII. Confidentiality of Patient Information.

Confidentiality of the patient's medical records and information shall be maintained by all Participating Institutions in accordance with applicable state and federal laws. Only medical personnel, or individuals under the supervision of medical personnel, directly treating the patient or directly involved in the transfer procedures, or those individuals monitoring the quality or effectiveness of the treatment, shall have access to the patient's medical records.

VIII. Discharge Planning.

- A. Discharge Planning shall be a collaborative process and a shared responsibility of Transferring and Receiving Institutions. Both Institutions shall work together with the patient to arrange appropriate continuation of medical care, which will include consideration of a return transfer to the Transferring Institution following completion of the requested care at the Receiving Institution.
- B. With the exception of emergency transfers, the Transferring Institution and the Receiving Institution shall, in advance of transfer, clarify the purpose of the transfer and consider whether a return transfer is anticipated.

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IX. Capacity and Services of Participating Institutions.

Each institution is responsible for providing notice to the Participating Institutions in the event that there is a substantial change in its basic capabilities and services. It is understood that the defined capability of a Participating Institution does not assure its availability for the receipt of transfer patients.

X. Quality Assurance Transfer Review.

A. In-house Review.

Each Participating Institution shall establish quality assurance review procedures to monitor the appropriateness of patient transfers and the quality of care delivered during patient transfer procedures.

B. Statewide Patient Transfer Review Committee.

VAHHS shall create an ad hoc statewide Patient Transfer Review Committee including, at a minimum, the Transfer Liaisons from each Participating Institution. This Committee shall meet at least once a year to review the implementation of these Standard Procedures and to evaluate generally any issues regarding the quality of care rendered during inter-hospital patient transfers. The Committee shall be a peer review committee under 26 V.S.A. §144i and may collect data and make recommendations for the improvement of patient care during transfer. If patient medical records are necessary for this review process, all information which would identify the patient or the physician shall be deleted consistent with State law.

C. Continuing Education.

Participating Hospitals shall cooperate to develop in-service educational programs to address problems relating to patient transfers and to enhance the delivery of medical care during transfer procedures.

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XI. List of Participating Hospitals.

The following institutions have adopted the Standard Procedures for Interhospital Patient Transfers, dated March 10, 1999, and agree to utilize them for the transfer and receipt of all patients:

- Brattleboro Memorial Hospital
- Brattleboro Retreat
- Central Vermont Hospital
- Copley Hospital
- Fletcher Allen Health Care
- Gifford Memorial Hospital
- Grace Cottage Hospital
- Mary Hitchcock Memorial Hospital
- Mt. Ascutney Hospital and Health Center
- North Country Hospital
- Northeastern Vermont Regional Hospital
- Northwestern Medical Center
- Porter Hospital
- Rutland Regional Medical Center
- Southwestern Vermont Medical Center
- Springfield Hospital
- Veteran's Administration Center

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POLICY:

It is the policy of GCH that individuals who have “come to the emergency department” (as defined by EMTALA regulations) for examination and treatment of a medical condition, decisions about care, discharge or transfer shall be made only after a timely and appropriate medical screening exam by an appropriate caregiver. Discharge or transfer decisions shall be based solely on the patient’s medical needs as determined by the medical screening exam and the capacity of GCH to meet those needs, and shall never be based on financial considerations. Under no circumstances shall a medical screening exam or treatment (including transfer, as appropriate) for an emergency medical condition be refused, unreasonably delayed, or inappropriately limited in scope. Signs of the type and content required by EMTALA regulations shall be posed as required.

PURPOSE:

To define the emergency medical care responsibilities of GCH under applicable Medicare Conditions of Participation and the Emergency Medical Treatment and Active Labor Act (EMTALA) and associated federal regulations.

DEFINITIONS:

- **Capacity** - The ability of the hospital to accommodate the individual requesting examination. Capacity encompasses such things as:
 - Numbers and availability of qualified staff, beds and equipment, and
 - The hospital’s past practices of accommodating additional patients in excess of its occupancy limits.

- **“Comes to the emergency department”** - An individual on hospital property requesting examination or treatment, or having such request made on his/her behalf. Hospital property includes:
 - The entire hospital campus; and
 - Other areas not contiguous to the main buildings but located within 250 yards of the main buildings; and
 - Parking lots, sidewalks, driveways; and
 - Any other areas or departments of the facility determined by the Center for Medicare & Medicaid Services (CMS), on an individual case basis, to be part of the campus.

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- **Emergency medical condition** - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:

 - Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
 - Serious impairment to bodily functions; or
 - Serious dysfunction of any bodily organ or part; or
 - With respect to a pregnant woman who is having contractions:
 - There is inadequate time to effect a safe transfer to another hospital before delivery; or
 - Transfer may pose a threat to the health or safety of the woman or the unborn child.

- **Labor** - The process of childbirth beginning with the latent or early phase of labor and continuing through delivery of the placenta. A woman experiencing contractions is in true labor unless a provider certifies that, after a reasonable time of observation, the woman is in false labor.

- **Stabilize** - To provide such medical treatment for the emergency medical condition necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to occur during a transfer of the individual from the facility. **Note:** In the case of a pregnant woman in labor, the woman is stabilized only when she has delivered the infant and placenta.

- **Transfer** - The movement (including discharge) of an individual from a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital. **Note:** EMTALA regulations specifically exclude from this definition an individual who leaves the facility without the permission of such employed, affiliated or associated person or the movement of an individual who has been declared dead. (For patients who wish to leave without or against medical advice, GCH caregivers should consider whether the patient has the mental capacity to make an informed decision to leave, and then should act accordingly.)

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PROCEDURE:

• **Medical Screening Exam**

- Any individual who comes to the emergency department (see definition above), and a request is made by or on behalf of that individual for examination or treatment of a medical condition, shall have an appropriate medical screening exam within the capability of the hospital's emergency room.
- Medical screening exams shall not be delayed to determine the patient's insurance status or method of payment. Routine registration procedures may include requests for positive identification, but a patient's inability or refusal to provide such identification shall not preclude or delay a medical screening exam and appropriate treatment for an emergency medical condition.
- The purpose of the medical screening exam is to determine whether or not an emergency medical condition exists.
- The medical screening exam is not equivalent to triage, which is a process to determine priority of medical needs as opposed to determining the presence or absence of an emergency medical condition.
- The medical screening exam shall include the use of ancillary services routinely available to the emergency room.
- Medical screening exams shall be performed by:
 - Physicians with training or experience in emergency care; or
 - Nurse practitioners or physician assistants with training or experience in emergency care who are credentialed as allied health professional members of the GCH medical staff and who practice within their individual scopes of practice. There will always be a physician on second call when an advanced practice nurse or physician's assistant is on first call.
- The ER on-call physician, advanced practice nurse or physician's assistant will be immediately available by telephone or beeper/pager and available on site within thirty (30) minutes.

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- If the medical screening exam results in a determination that the patient does not have an emergency medical condition (as defined above), the transfer provisions of this policy do not apply.

- **Treatment**

- A patient with an emergency medical condition shall receive timely and appropriate treatment within the capacity of GCH.
- **Informed Consent/Informed Refusal of Examination or Treatment.** It is recognized that a patient has the right to consent to, or to refuse, examination or treatment. If there is a refusal of examination or treatment by or on behalf of the patient, the medical record must contain a description of the examination and/or treatment that was refused. Reasonable steps shall be taken to secure the patient's written informed refusal (or that of the authorized representative acting on the patient's behalf) on the GCH "Against Medical Advice" form. The written document shall indicate that the person has been informed by the physician, advanced practice nurse or physician's assistant of the risks and benefits of accepting or refusing the proposed examination and/or treatment.

- **Transfer of Patients with an Emergency Medical Condition**

- **Stabilized Patient.** In the event that definitive treatment of an emergency medical condition cannot be provided by GCH due to unavailability of beds or services, the patient shall receive sufficient medical treatment, within the capacity of GCH, to stabilize the patient prior to transfer to an appropriate facility. The transfer protocol in Section IV.D (below) shall be followed. If a physician is not physically present in the ER at the time an individual is transferred, the advanced practice nurse or physician's assistant has signed the certification described after consultation with a physician who has made the determination required for the certification. The certification must contain a summary of the risks and benefits upon which it is based. The physician shall subsequent co-sign the certification.
- **Unstabilized Patient.** Transfer of an unstabilized patient is acceptable only in the following circumstances:
 - The patient, or the patient's authorized representative, requests the transfer in spite of medical advice to the contrary and has been informed of the hospital's obligations and of the risks of transfer. The Patient Transfer Form

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(or the VA Inter-Facility Transfer Form, as applicable) shall be used to document this information. (Attachments I and II)

OR

- A physician has signed a certification that based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based. (Attachments I and II)

AND

- The transfer process meets the appropriateness standards as delineated in EMTALA regulations (See Section IV.D below.)
- **Informed Consent/Informed Refusal.** It is recognized that a patient has the right to consent to, or to refuse transfer.
 - The patient, or the authorized representative of a patient who lacks the capacity to understand or to make his/her decisions, shall be informed by the physician, advanced practice nurse or physician's assistant of:
 - The obligation of GCH to provide a medical screening exam and stabilizing treatment within its capacity, and
 - The need, benefits, risks and alternatives to examination, treatment and transfer.
 - **Written Consent/Refusal.** The patient, or the authorized representative of a patient who lacks the capacity to make his/her own decisions, shall be requested to sign the appropriately completed "Transfer Consent" portion of the Patient Transfer Form. (Attachment I) If the patient is being transferred to a VA Hospital, the Department of Veterans Affairs Inter-Facility Transfer Form shall be used. (Attachment II)
 - Reasonable steps should be taken to secure the patient's written informed refusal of transfer (or that of the authorized representative acting on the patient's behalf). The written document (see relevant portions of the Patient

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Transfer Form) shall indicate that the person has been informed of the risks and benefits of the transfer and the refusal. The individual's reasons for refusal shall be included on the document. The medical record must contain a description of the proposed transfer.

- **Transfer Process.** Appropriate transfer under EMTALA requires that:
 - GCH has provided medical treatment within its capacity to minimize the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child.
 - The receiving facility has confirmed that it has available space and qualified personnel for treatment of the patient and has agreed to accept transfer of the patient and to provide appropriate medical treatment.
 - GCH has sent to the receiving hospital copies of all medical records related to the patient's emergency medical condition, examination and treatment that are available at the time of transfer, including but not limited to:
 - Patient's name, address, hospital number, age;
 - Next of kin name, address, telephone number;
 - Available history;
 - Condition on admission and preliminary diagnosis;
 - Observations of signs or symptoms, including vital signs, as available, prehospital, in emergency room, at time of transfer;
 - Treatment rendered, including medications and type and volume of fluids;
 - Laboratory, x-ray findings and other available diagnostic studies;
 - Written informed consent to transfer;
 - Any additional information pertinent to the patient during transfer or for treatment upon arrival at the receiving hospital;
 - Name, address and phone number of referring physician;
 - Name of physician at receiving hospital to whom the patient is to be transferred;
 - Name of physician at receiving hospital who has been contacted about the patient;
 - As mandated by law, the name and address of any on-call physicians who refused or failed to appear within a reasonable time to provide

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necessary stabilizing treatment to the patient in an emergency medical condition.

- Copies of other records not available at the time of transfer (e.g., test results, historical records) must be sent as soon as practicable after transfer.
- The transfer is carried out by qualified personnel and equipment as required for the patient, including necessary and appropriate life support measures during the transfer.
- **Maintenance of On-Call Lists and Transfer Records**
 - Physician on-call lists and logs of all patients transferred to and from GCH shall be maintained for five years.
- **No adverse action may be taken against:**
 - A physician, advanced practice professional or physician’s assistant who refuses to transfer an unstabilized patient with an emergency medical condition whose treatment is within the capacity of the hospital, or
 - An employee who reports a violation of a requirement of this section.
- **Signage**
 - As required by CMS, GCH will conspicuously post signs in appropriate locations (ER, public entrances, registration areas, and treatment waiting areas).
 - The wording on the signs shall be as required by CMS (Attachment III).
 - The signs shall be clearly visible from a distance of 20 feet or from a patient’s likely viewing point and posted in a manner likely to be seen. Conflicting signs that may raise confusion by references to payment, advanced authorization, co-payment, etc. shall not be posted.

Attachment 1e

RR 6/18/15
S. D. Davis / S. D.

Heather Boucher

From: Christopher Schmidt
Sent: Monday, May 11, 2015 7:35 AM
To: Suozzi, James C
Subject: RE: RCA goals

Perfect – thanks Jim.
CS

From: Suozzi, James C [mailto:JSuozzi@Cheshire-Med.COM]
Sent: Sunday, May 10, 2015 7:57 AM
To: Christopher Schmidt
Cc: Rescue Inc. Captain; Mark Considine
Subject: RE: RCA goals

Hi Chris:

We discussed this case at clinical practice. Here is some follow-up that will be happening at Rescue.

- Review with all staff our current Field Alert plans for Trauma, STEMI, Stroke and Sepsis. Updated guidelines are attached.
- All staff to review EMTALA guidelines, including what you provided below. In particular, when a patient is being transferred from a hospital, they will need (1) Name of destination (2) Name of accepting provider. They should not be taking any transfers without this information.

Please let me know should you need anything further.

Jim

James C. Suozzi, DO, NRP, FACEP
EMS Medical Director
Rescue Inc.
Brattleboro, VT

Medical Advisor
Vermont EMS District 13

bypassencrypt

From: Christopher Schmidt [mailto:CSchmidt@gracecottage.org]
Sent: Thursday, April 30, 2015 2:19 PM
To: Suozzi, James C
Subject: RE: RCA goals

Jim,
Super! This helps a lot!
Perhaps this can help (sent to our ED folks).
Also, nice prepared EMTALA slide shows online for free.

All,

All ED personnel (providers, nurses, unit secretaries) are responsible to know and practice EMTALA requirements.

1. Never allow any healthcare provider to request our ED services for anything other than what EMTALA mandates.

2. EMTALA (Emergency Medical Treatment and Active Labor Law) is binding for every ED patient in these key ways:
 - a. Who is an ED patient? Every patient who comes to the ED, is logged into the ED and every person who presents anywhere on the hospital campus meaning the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings and requests emergency services, or who would appear to a reasonably prudent person to be in need of medical attention, must be handled under EMTALA. That 250 yard sphere does not include non-medical businesses (shops and restaurants located close to the hospital).
 - b. Medical Screening Exam: The ED patient must be offered a medical screening examination and testing to exclude the presence of an immediate threat to life, limb or organ function.
 - c. Stabilization: The patient must be offered stabilizing treatment for any condition diagnosed (emergent or non-emergent) as far as the facility's resources allow before any plans to discharge, transfer or admit the patient.
 - d. Transfer: Any patient in need of transfer must be accepted at the receiving hospital after a documented doc-to-doc conversation.
 - e. The REST: There is more that every ED provider is responsible for: Please review and know the attached 20 Commandments of EMTALA.

Thanks,
CS

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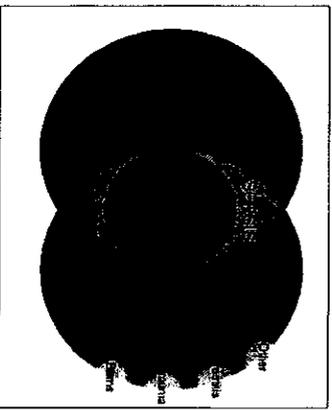
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FIELD ALERTS FOR PREEMPTIVE HOSPITAL NOTIFICATION

Attachment 1e
for memo
6.18.15
S. Davis

TRAUMA	STEMI	STROKE	SEPSIS
<p>Vital Signs and Mentation</p> <p>Criteria:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Glasgow Coma Scale < 13 <input type="checkbox"/> SBP (mmHg) < 90 mm Hg <input type="checkbox"/> Respiratory Rate < 10 or > 29 bpm, or need for ventilatory support (< 20 in infant aged < 1 year) <p>Anatomical</p> <ul style="list-style-type: none"> <input type="checkbox"/> All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee <input type="checkbox"/> Chest wall instability or deformity (e.g. flail chest) <input type="checkbox"/> Two or more proximal long-bone fractures <input type="checkbox"/> Crushed, degloved, mangled, or pulseless extremity <input type="checkbox"/> Amputation proximal to wrist or ankle <input type="checkbox"/> Pelvic fractures <input type="checkbox"/> Open or depressed skull fracture <input type="checkbox"/> Paralysis <p>Mechanism</p> <ul style="list-style-type: none"> <input type="checkbox"/> Falls -Adults: > 20 feet (one story is equal to 10 feet) -Children: > 10 feet or 2-3 times the height of the child <input type="checkbox"/> High-risk auto crash -Intrusion, including roof: > 12 inches occupant site; > 18 inches any site <input type="checkbox"/> Ejection - (partial or complete) from automobile -Death in same passenger compartment <input type="checkbox"/> Auto vs. pedestrian/bicyclist thrown, run over, or with significant (> 20 mph) impact <input type="checkbox"/> Motorcycle crash > 20 mph <input type="checkbox"/> Recreational Vehicle (ATV) collision <p>TRANSMIT TRAUMA ALERT ASAP</p>	<p>History and Presentation</p> <ul style="list-style-type: none"> <input type="checkbox"/> Duration of continuous pain <input type="checkbox"/> EKG findings <p>Inclusion Criteria:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Symptoms compatible with ACS (chest pain, diaphoresis, dyspnea, etc) <input type="checkbox"/> 12-lead ECG showing ST-segment elevation (STE) at least 1 mm in two or more anatomically contiguous leads <input type="checkbox"/> Age < 35 years (contact receiving hospital for consult) <p>Exclusion Criteria:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Symptoms NOT suggestive of ACS (e.g.: asymptomatic patient) <input type="checkbox"/> If unsure if patient is appropriate for Cardiac Alert, discuss with receiving hospital IMD <p>TRANSMIT STEMI ALERT ASAP</p>	<p>History and Presentation</p> <ul style="list-style-type: none"> <input type="checkbox"/> Patient age > 18 <input type="checkbox"/> Last Time Known Well <input type="checkbox"/> Blood Glucose <input type="checkbox"/> Severe Headache <input type="checkbox"/> Seizure <input type="checkbox"/> Head Trauma at Onset <input type="checkbox"/> Level of Consciousness (AVPU) <p>Inclusion Criteria:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Time Last Known Well <3 hours AND <input type="checkbox"/> At least one of the Cincinnati Stroke Scale items marked yes. <input type="checkbox"/> YES <input type="checkbox"/> NO Facial Droop (have patient show teeth or smile) <input type="checkbox"/> YES <input type="checkbox"/> NO Arm Drift (have patient close their eyes and hold both arms out straight for 10 seconds) <input type="checkbox"/> YES <input type="checkbox"/> NO Abnormal Speech (have the patient say "you can't teach an old dog new tricks") <p>TRANSMIT STROKE ALERT ASAP</p>	<p>History and Presentation</p> <ul style="list-style-type: none"> <input type="checkbox"/> Patient 18 years or older <input type="checkbox"/> Suspected or documented infection (and) <input type="checkbox"/> At least two of the following criteria: <ul style="list-style-type: none"> <input type="checkbox"/> Temperature greater than 38° C (100.4° F) or lower than 36° C (96.8° F) <input type="checkbox"/> Pulse greater than 90 <input type="checkbox"/> Respiratory rate > 20 or mechanically ventilated <input type="checkbox"/> SBP less than 90 <input type="checkbox"/> mm Hg (or) MAP < 65 mm Hg <input type="checkbox"/> ET/CO₂ <25 mmHg <input type="checkbox"/> New onset altered level of responsiveness <p>Caution</p> <p>Goal Directed Therapy – Fluid Resuscitation to maintain MAP > 65 mm Hg</p> <ul style="list-style-type: none"> <input type="checkbox"/> Notify receiving hospital of Sepsis alert <input type="checkbox"/> Transport patient to local ED <p>TRANSMIT SEPSIS ALERT ASAP</p>



Attachment 1f

POC complete
6-18-15
S. Desai 157

Department of Health & Human Services
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2325
Boston, MA 02203



Northeast Division of Survey & Certification

May 19, 2015

Mr. Roger Allbee, Administrator, President & CEO
Grace Cottage Hospital
Po Box 216
Townshend, VT 05353-0216

**RE: CMS Certification Number: 471300
Survey ID: 79TH11, 04/30/2015**

Dear Mr. Allbee:

To participate in the Medicare program, a hospital must meet the requirements established under Title XVIII of the Social Security Act (the Act) and the regulations established by the Secretary of Health and Human Services under the authority contained in §1861(e) of the Act. Further, §1866(b) of the Act authorizes the Secretary to terminate the Medicare provider agreement of a hospital that fails to meet these provisions.

This office authorized the Division Of Licensing And Protection to conduct a survey of Grace Cottage Hospital on April 30, 2015. As a result of that survey, it was determined that your facility violated 42 C.F.R. §489.24, "Responsibilities of Medicare Participating Hospitals in Emergency Cases" and/or the related provisions at 42 C.F.R. §489.20. The deficiencies identified are cited in the enclosed Statement of Deficiencies and Plan of Correction.

The Division Of Licensing And Protection found that, prior to the survey, you discovered the violation and implemented corrective action that has been effective over the longer term. Therefore, we are not proceeding with a termination of your Medicare provider agreement with the Secretary of Health and Human Services.

As the requirements for participation in the Medicaid program under 42 C.F.R. §440.10(a)(3)(iii) include meeting Medicare requirements, we are notifying the appropriate State officials concerning your hospital's past violation of the requirements of 42 C.F.R. §489.24. In addition, we are notifying the Regional Office for the Office of Civil Rights, which may take action under the Hill-Burton Subpart G Community Service regulations at 42 C.F.R. §124.603(b)(1).

If you have any questions concerning this notice, please contact Charles Marino at 617-565-1328.

Sincerely,



J. William Roberson
Associate Regional Administrator
Northeast Division, Survey & Certification

Enclosure: Form CMS-2567, Statement of Deficiencies

cc: OIG
 OCR/FO
 QIO

Tag C271

Plan of Correction

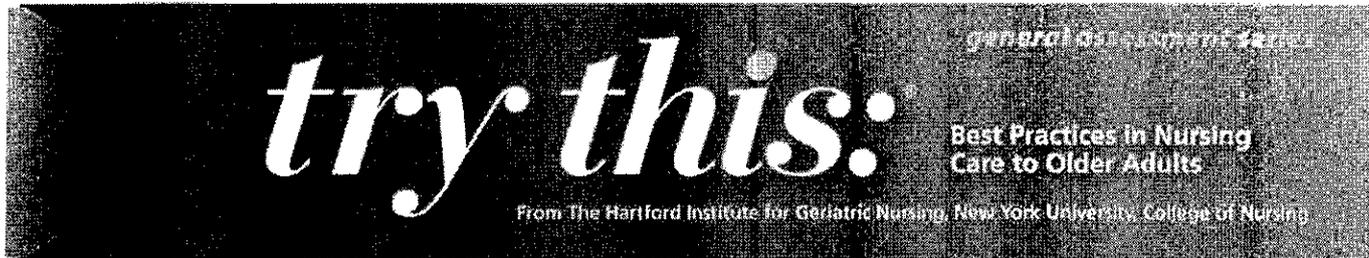
Nursing – A Delirium Knowledge pretest (attachment 2a) has been given to all nurses to assess their understanding of delirium and acute confusion; and their knowledge base on how to address these issues. The pretest was handed out to all RNs, LPNs and LNAs with an expected return date of no later than 6/5/15. The GCH Nurse Educator is collecting and tracking return of the tests. The educator, with the assistance of one of our charge nurses, will review and analyze the test results to develop an educational program tailored to meet identified staff knowledge deficits. In addition to education on managing delirium, this education will include how to recognize limited capacity; utilize our new guidelines; and a review of patient/resident rights, including the right to refuse treatment (attachment 2d, 2f). We are currently in the process of working with our Electronic Medical Record (EMR) vendor to have the Confusion Assessment Method tool (attachment 2b) placed in the system so it will be readily available to all nurses. Nursing staff will also be educated on interventions that could be utilized with this patient population, including but not limited to: de-escalation, alternative activities, distraction, relaxation techniques etc. This education will be mandatory for all Nursing staff and attendance will be taken and recorded. The Nurse Educator will be responsible to follow up with any staff that do not attend a scheduled session. This educational effort will be completed later than July 31, 2015.

Prior to the L & P visit in April, the Nurse Educator had identified deficiencies with nursing care planning and had educational sessions scheduled for 5/4 and 5/7 /15 which were held. Twenty out of our 29 RNs and 4 out of 6 LPNs attended on those 2 dates (attachment 2h). As of June 1st all other staff have been educated via e-mail and received follow-up from the nurse educator. At our request our EMR vendor modified and renamed some of our previously available care plans to provide more care plan options for patients with behavioral issues. These now include: Altered Mood plan of care, Anxiety plan of care, Confusion plan of care, Risk for Injury plan of care and Diversional Activity Deficit plan of care (attachment 2e). Nursing was notified by email on 5/21/15 that the new care plans listed above were now available for use in our EMR. Additionally all care plans can and will be modified by nursing to reflect the individual patient's needs. A reminder reference sheet on how to customize care plans has been placed in the charge nurse reference binder and also e-mailed to all RNs.

Compliance with the initiation and individualization of appropriate care plans for our patients will be monitored by the on duty charge nurse within 24 hours of a patient's admission, utilizing the "Nursing New Admission Check List" (attachment 2g). The checklist will be reviewed weekly by the nurse manager/designee for completeness. Any missing information will be addressed. Nursing is directed by an electronic task that drops daily to review all patient care plans daily and update as needed. At the weekly interdisciplinary team care plan meetings all care plans will be reviewed by the CNO/designee with feedback to the on duty charge nurse to add, update or complete specific plans.

Providers – Providers will be re-educated on capacity (attachment 2d) and behavioral emergencies (attachment 2c) at provider meetings which will take place on 6/3/15 and 6/11/15. Attendance will be taken at the meeting and followed up by email. The providers who do not attend the meetings will review the material electronically and have the opportunity to speak with the CMO or ED Director if they have questions.

Rehab – The GCH Rehabilitation staff will be educated by the CMO or designee regarding the use of the capacity assessment and behavioral emergency algorithm by July 31st. Attendance will be taken and recorded. Any staff member who did not attend will be followed up with by the Rehabilitation Director.



Issue Number 13, Revised 2012

Editor-in-Chief: Sherry A. Greenberg, PhD(c) MSN, GNP-BC
New York University College of Nursing

The Confusion Assessment Method (CAM)

By: Christine M. Waszynski, MSN, APRN, BC, Hartford Hospital

WHY: Delirium is present in 10%-31% of older medical inpatients upon hospital admission and 11%-42% of older adults develop delirium during hospitalization (Siddiqi, House, & Holmes, 2006; Tullmann, Fletcher, & Foreman, 2012). Delirium is associated with negative consequences including prolonged hospitalization, functional decline, increased use of chemical and physical restraints, prolonged delirium post hospitalization, and increased mortality. Delirium may also have lasting negative effects including the development of dementia within two years (Ehlenbach et al., 2010) and the need for long term nursing home care (Inouye, 2006). Predisposing risk factors for delirium include older age, dementia, severe illness, multiple comorbidities, alcoholism, vision impairment, hearing impairment, and a history of delirium. Precipitating risk factors include acute illness, surgery, pain, dehydration, sepsis, electrolyte disturbance, urinary retention, fecal impaction, and exposure to high risk medications. Delirium is often unrecognized and undocumented by clinicians. Early recognition and treatment can improve outcomes. Therefore, patients should be assessed frequently using a standardized tool to facilitate prompt identification and management of delirium and underlying etiology.

BEST TOOL: The Confusion Assessment Method (CAM) is a standardized evidence-based tool that enables non-psychiatrically trained clinicians to identify and recognize delirium quickly and accurately in both clinical and research settings. The CAM includes four features found to have the greatest ability to distinguish delirium from other types of cognitive impairment. There is also a CAM-ICU version for use with non-verbal mechanically ventilated patients (See *Try This*.[■] CAM-ICU).

VALIDITY AND RELIABILITY: Both the CAM and the CAM-ICU have demonstrated sensitivity of 94-100%, specificity of 89-95% and high inter-rater reliability (Wei, Fearing, Eliezer, Sternberg, & Inouye, 2008). Several studies have been done to validate clinical usefulness.

STRENGTHS AND LIMITATIONS: The CAM can be incorporated into routine assessment and has been translated into several languages. The CAM was designed and validated to be scored based on observations made during brief but formal cognitive testing, such as brief mental status evaluations. Training to administer and score the tool is necessary to obtain valid results. The tool identifies the presence or absence of delirium but does not assess the severity of the condition, making it less useful to detect clinical improvement or deterioration.

FOLLOW-UP: The presence of delirium warrants prompt intervention to identify and treat underlying causes and provide supportive care. Vigilant efforts need to continue across the healthcare continuum to preserve and restore baseline mental status.

MORE ON THE TOPIC:

Best practice information on care of older adults: www.ConsultGeriRN.org.

The Hospital Elder Life Program (HELP), Yale University School of Medicine. Home Page: www.hospitalelderlifeprogram.org/

CAM Disclaimer: www.hospitalelderlifeprogram.org/private/cam-disclaimer.

Useful websites for clinicians including the CAM Training Manual:

www.hospitalelderlifeprogram.org/pdf/TheConfusionAssessmentMethodTrainingManual.pdf

Cole, M.G., Ciampi, A., Belzile, E., & Zhong, L. (2009). Persistent delirium in older hospital patients: A systematic review of frequency and prognosis. *Age and Ageing*, 38(1), 19-26.

Ehlenbach, W.J., Hough, C.L., Crane, P.K., Haneuse, S.J.P.A., Carson, S.S., Randall Curtis, J., & Larson, E.B. (2010). Association between acute care and critical illness hospitalization and cognitive function in older adults. *JAMA*, 303(8), 763-770.

Inouye, S.K. (2006). Delirium in older persons. *NEJM*, 354, 1157-65.

Inouye, S., van Dyck, C., Alessi, C., Balkin, S., Siegel, A., & Horwitz, R. (1990). Clarifying confusion: The confusion assessment method. *Annals of Internal Medicine*, 113(12), 941-948.

Maldonado, J.R. (2008). Delirium in the acute care setting: Characteristics, diagnosis and treatment. *Critical Care Clinics*, 24(4), 657-722.

Rice, K.L., Bennett, M., Gomez, M., Theall, K.P., Knight, M., & Foreman, M.D. (2011, Nov/Dec). Nurses' recognition of delirium in the hospitalized older adult. *Clinical Nurse Specialist*, 25(6), 299-311.

Siddiqi, N., House, A.O., & Holmes, J.D. (2006). Occurrence and outcome of delirium in medical in-patients: A systematic literature review. *Age and Ageing*, 35(4), 350-364.

Tullmann, D.F., Fletcher, K., & Foreman, M.D. (2012). Delirium. In M. Boltz, E. Capezuti, T.T. Fulmer, & D. Zwicker (Eds.), A. O'Meara (Managing Ed.), *Evidence-based geriatric nursing protocols for best practice* (4th ed., pp 186-199). NY: Springer Publishing Company, LLC.

Vasilevskis, E.E., Morandi, A., Boehm, L., Pandharipande, P.P., Girard, T.D., Jackson, J.C., Thompson, J.L., Shintani, A., Gordon, S.M., Pun, B.T., & Ely, E.W. (2011). Delirium and sedation recognition using validated instruments: Reliability of bedside intensive care unit nursing assessments from 2007 to 2010. *JAGS*, 59(Supplement s2), S249-S255.

Wei, L.A., Fearing, M.A., Eliezer, J., Sternberg, E.J., & Inouye, S.K. (2008). The confusion assessment method (CAM): A systematic review of current usage. *JAGS*, 56(5), 823-830.

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The Confusion Assessment Method Instrument:

1. **[Acute Onset]** Is there evidence of an acute change in mental status from the patient's baseline?
- 2A. **[Inattention]** Did the patient have difficulty focusing attention, for example, being easily distractible, or having difficulty keeping track of what was being said?
- 2B. **(If present or abnormal)** Did this behavior fluctuate during the interview, that is, tend to come and go or increase and decrease in severity?
3. **[Disorganized thinking]** Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?
4. **[Altered level of consciousness]** Overall, how would you rate this patient's level of consciousness? (Alert [normal]; Vigilant [hyperalert, overly sensitive to environmental stimuli, startled very easily], Lethargic [drowsy, easily aroused]; Stupor [difficult to arouse]; Coma; [unarousable]; Uncertain)
5. **[Disorientation]** Was the patient disoriented at any time during the interview, such as thinking that he or she was somewhere other than the hospital, using the wrong bed, or misjudging the time of day?
6. **[Memory impairment]** Did the patient demonstrate any memory problems during the interview, such as inability to remember events in the hospital or difficulty remembering instructions?
7. **[Perceptual disturbances]** Did the patient have any evidence of perceptual disturbances, for example, hallucinations, illusions or misinterpretations (such as thinking something was moving when it was not)?
- 8A. **[Psychomotor agitation]** At any time during the interview did the patient have an unusually increased level of motor activity such as restlessness, picking at bedclothes, tapping fingers or making frequent sudden changes of position?
- 8B. **[Psychomotor retardation]** At any time during the interview did the patient have an unusually decreased level of motor activity such as sluggishness, staring into space, staying in one position for a long time or moving very slowly?
9. **[Altered sleep-wake cycle]** Did the patient have evidence of disturbance of the sleep-wake cycle, such as excessive daytime sleepiness with insomnia at night?

The Confusion Assessment Method (CAM) Diagnostic Algorithm

Feature 1: Acute Onset or Fluctuating Course

This feature is usually obtained from a family member or nurse and is shown by positive responses to the following questions: Is there evidence of an acute change in mental status from the patient's baseline? Did the (abnormal) behavior fluctuate during the day, that is, tend to come and go, or increase and decrease in severity?

Feature 2: Inattention

This feature is shown by a positive response to the following question: Did the patient have difficulty focusing attention, for example, being easily distractible, or having difficulty keeping track of what was being said?

Feature 3: Disorganized thinking

This feature is shown by a positive response to the following question: Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

Feature 4: Altered Level of consciousness

This feature is shown by any answer other than "alert" to the following question: Overall, how would you rate this patient's level of consciousness? (alert [normal]), vigilant [hyperalert], lethargic [drowsy, easily aroused], stupor [difficult to arouse], or coma [unarousable])

The diagnosis of delirium by CAM requires the presence of features 1 and 2 and either 3 or 4.

© 2003 Sharon K. Inouye, MD, MPH

Inouye, S., van Dyck, C., Alessi, C., Balkin, S., Siegel, A. & Horwitz, R. (1990). Clarifying confusion: The confusion assessment method. *Annals of Internal Medicine*, 113(12), 941-948.

try this:

Practical Geriatric Nursing
Best Practices in Nursing
Care in Older Adults

A series provided by The Hartford Institute for Geriatric Nursing,
New York University, College of Nursing

EMAIL: hartford.ign@nyu.edu HARTFORD INSTITUTE WEBSITE: www.hartfordign.org
CLINICAL NURSING WEBSITE: www.ConsultGerIRN.org

Develop
older
gts

CONFUSION ASSESSMENT METHOD (CAM) SHORTENED VERSION WORKSHEET

EVALUATOR:

DATE:

I. ACUTE ONSET AND FLUCTUATING COURSE

a) Is there evidence of an acute change in mental status from the patient's baseline?

No _____

Yes _____

b) Did the (abnormal) behavior fluctuate during the day, that is tend to come and go or increase and decrease in severity?

No _____

Yes _____

II. INATTENTION

Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?

No _____

Yes _____

III. DISORGANIZED THINKING

Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

No _____

Yes _____

IV. ALTERED LEVEL OF CONSCIOUSNESS

Overall, how would you rate the patient's level of consciousness?

-- Alert (normal)

-- Vigilant (hyperalert)

-- Lethargic (drowsy, easily aroused)

-- Stupor (difficult to arouse)

-- Coma (unarousable)

Do any checks appear in this box?

No _____

Yes _____

If all items in Box 1 are checked and at least one item in Box 2 is checked a diagnosis of delirium is suggested.

Adapted from Inouye SK et al. Clarifying Confusion: The Confusion Assessment Method. A New Method for Detection of Delirium. Ann Intern Med. 1990; 113:941-8.

ACE Unit - mobility walking frequency

Geriatrics
CAM

Inclusion criteria: Age >70, no transfers from other units, no observation patients, no CMO, no end-stage dementia, only ED admissions

criteria

CMA for walking
Diet and activity program
Quiet zone time

Identify Risk for Delirium

- Screen for history dementia
- Document changes in mental status, ADLs
- Identify any abrupt changes from baseline (Family observations, inattentiveness, all LOC)
- Six known risk factors: cognitive impairment, sleep deprivation, immobility, visual impairment and dehydration.

Monitor cognitive function

- Establish baseline cognitive function
- Monitor for changes in mental status

Perform cognitive assessment (CAM) every 12 hours

Positive CAM

Negative CAM

Ongoing monitoring, assessment, and evaluation

Manage symptoms of delirium

All Patients

Patients with severe agitation

Nonpharmacologic treatment

- Continue delirium management techniques
- Reorient patient, encourage family involvement
- Use Constant Companions
- Avoid use of physical restraints and Foley catheters
- Use nonpharmacologic approaches for agitation: music, massage, relaxation techniques
- Use eyeglasses, hearing aids, interpreters
- Maintain patient's mobility and self-care ability
- Normalize sleep-wake cycles, discourage naps, aim for uninterrupted period of sleep at night
- At night+ have patient sleep in quiet room with low level ng

Pharmacologic management

- Reserve this approach for patients with severe agitation at risk for interruption of essential medical care (e.g. IV lines) or for patients who pose safety hazard to themselves or staff
- Start low doses and adjust until effect achieved
- Maintain effective dose for 2-3 days

Identify and address predisposing and precipitating factors

Physiological Stability: O2 saturation, blood work, hydration, hearing, vision, nutrition pain

Consultation and Referral (Geriatrics, psychiatry interdisciplinary team)

Pharmacological Awareness

Provide supportive care and prevent complications

Behavioral Strategies ?

Environmental (lighting, noise, sleep)

Therapeutic Communications / Emotional support

Prevent symptoms of delirium

Behavioral Emergencies

Behavioral emergencies threaten the safety of patients and others. The key purpose in intervening is to prevent harm to the patient and others. Leaving a behavioral emergency patient alone is considered the worst treatment as it results in the worst patient outcomes. Gaining physical control over an out-of-control, violent patient is difficult in the least and can be dangerous to providers.

Acute medical complications in behavioral emergencies include: self-induced trauma, cardiac arrhythmias, cardiac arrest, aggravation of pulmonary diseases such as COPD and asthma, hyperpyrexia, hypo-glycemia, hypo/hypertension, positional or restraint asphyxia and death.

Behavioral emergencies are caused by five sets of disorders.

1. Acute medical disorders (viral encephalopathy, delirium, drug side effects, sepsis, hyperpyrexia, brain tumor, etc.)
2. Substance intoxications (alcohol, cocaine, PCP, antihistamines, hallucinogens, etc.)
3. Acute psychiatric disorders (mania, schizophrenia, suicidal or homicidal ideation, etc.)
4. Antisocial behavior (criminal behavior, delinquency)
5. Cognitive disorders that limit understanding (immaturity, intellectual disability, dementia, post-stroke changes, traumatic brain injury).

Known risk factors that can be red flags for violence are substance abuse, withdrawal syndromes, mob mentality and if a violent act has already occurred.

Behavioral emergencies range in severity. Experts detail a range of 6 levels in the following increasing order of severity. A seventh extreme level is known as excited delirium. These levels provide clues on how severe the behavioral disturbance is at the time of initiating care.

- a. Refusal to cooperate; intense staring
- b. The above *plus* motor restlessness and purposeless movements
- c. The above *plus* emotional lability and loud speech
- d. The above *plus* irritability and intimidating behavior
- e. The above *plus* aggression toward property or demeaning, hostile verbal behavior
- f. The above *plus* direct threats or assault
- g. Excited delirium characterized by extreme mental and physiological excitement, exceptional agitation and hyperactivity, overheating, profuse sweating, excessive tearing of the eyes, hostility, superhuman strength, aggression, acute paranoia, endurance without apparent fatigue, bizarre actions, partially clothed or nakedness, incoherent speech, loud yelling or screaming, grunting, animal-like vocalizations, disorientation, hallucinations, foaming at the mouth, drooling, and immunity to pain.

The response to any behavioral emergency should be orderly. Preparation is always the pillar of success when it comes to behavioral emergencies. The best approach to any behavioral emergency is to try to reduce tension and deescalate the situation or crisis as rapidly as possible. Even if a patient is considered to be imminently violent, the order that steps should be taken are as follows:

Behavioral Emergency Treatment: Orderly Progression – Not all Steps May be Necessary

- 1. Stop, Reassess, Deescalate, Prepare**
- 2. Ensure Scene Safety First.** Notify provider ASAP. Provider should consult with DPOA/kin ASAP. Notify security/response team of possible intervention. Remove any agitated on-lookers or associates. If needed, move patient to safer environment and away from potential weapons.
- 3. When situation is safe, identify yourself and approach the patient calmly.**
- 4. Be considerate, kind, caring, attentive, concerned.** Talk softly. Encourage the patient to talk. Ask the patient if he/she has any weapons or has plans to be violent. Don't proceed if the patient refuses to be calm or cooperate. Do not threaten or humiliate the patient.
- 5. Attempt to discover if the patient has a physical need that may be addressed** (pain, thirst, hunger, cold, hot, wet, nicotine or drug withdrawal, etc.).
- 6. When possible and safe to do so, inquire, examine and test for any reversible or treatable cause** of the behavioral change, (hypoxia, hypoglycemia, hypotension, fever, overdose, drug side effects, drug or alcohol withdrawal, etc.).
- 7. If not done, perform a focused history with particular attention to:**
 - Onset, progression and duration for this behavior.
 - Previous history of violence.
 - Any illicit drug or alcohol intoxication.
 - Any medication or drug side effects or overdose.
 - Any psychological or psychiatric history.
 - Any history of trauma to the patient.
- 8. If not done, perform a focused exam with testing with particular attention to:**
 - Level of severity of the behavioral emergency.
 - Body language changes: posture, facial expressions, hand motions, clenched fists, restlessness.
 - Speech changes: hostility, anger, yelling, abusive, threats.
 - Medical changes Seek for hypoxia, hypoglycemia, hypotension, fever, overdose, drug side effects, drug or alcohol withdrawal, arrhythmia, trauma).
- 9. Look for a “quick cure”** like an acute drug withdrawal or contacting the DPOA or next of kin.
- 10. Offer voluntary medication:** Example: oral lorazepam, 1 mg, sublingual/po.
- 11. Provide a show of force by security/response team if the patient’s behavior escalates.**
- 12. If the patient is 18 years old or over and considered to be imminently or actively violent, inject emergency medication, under force if necessary:** IM/IV lorazepam 1 - 2mg with IM/IV haloperidol lactate 2 - 5 mg together in the same syringe. May also add Benadryl 25 - 50 mg IM/IV as a third medicine.
 - If the patient is small, frail, elderly or has significant systemic diseases, use half doses.
 - May repeat doses if needed at least 15-30 minutes after the first doses.
 - IN (intranasal) midazolam 2.5mg - 5mg may be used as the initial sedative dose followed by lorazepam with haloperidol.
 - IM (not IV) Geodon 10 – 20 mg can be used in place of Haldol.
 - Never use narcotics, valium or any other drugs in behavioral emergencies.
- 13. If medications fail, use physical restraints.**
 - Be sure there is adequate help. Utilize security/response team whenever possible.
 - Prepare padded restraints or wide cravats.
 - At the pre-arranged signal, approach from the sides and grasp the patient's extremities and apply the restraints.
 - Maintain verbal contact with the patient and explain what will happen next.
 - Check circulation in extremities every 5 minutes.
 - Do not place patient in prone position.
 - Secure airway and ensure adequate ventilation and circulation.
 - Place rhythm and oximetry monitoring on patient and administer oxygen.
- 14. Re-examine patient and treat any injuries or illnesses.**

PK Unit
6-18-15
S. DeWitt

GCH Capacity Assessment for Patient _____ Date _____ Time _____

Step 1: Capacity Testing Questions & Answers: Compiled by _____ Witness _____

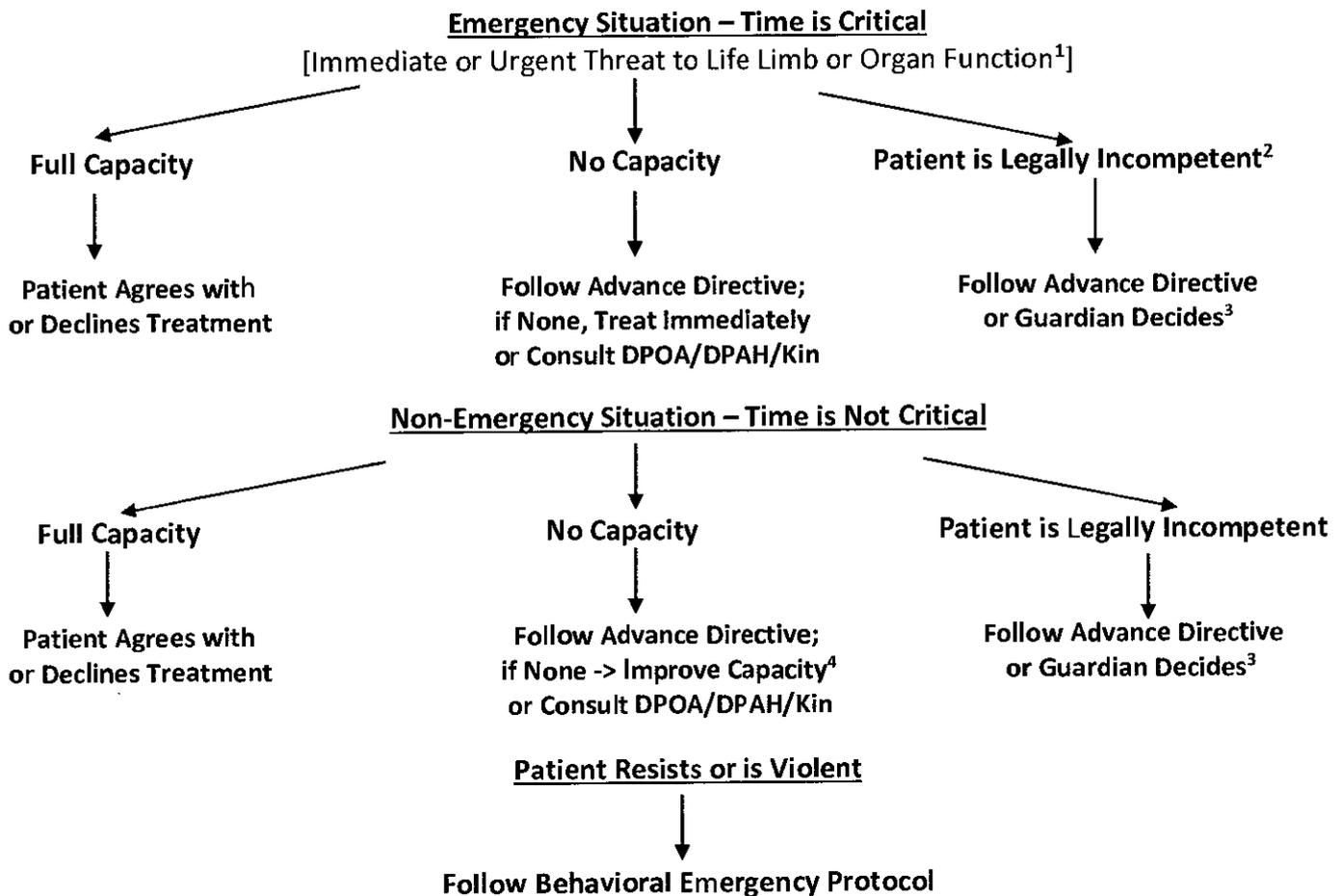
1. Understanding the Current Medical Condition(s)
 - Can you tell me what your medical problems are? _____
 - Why have you been brought to the hospital? _____
 - What is your understanding of why you are _____ or have _____ or can't _____?
2. Understanding the Natural Course of the Medical Condition(s)
 - What do you understand will happen to you over time with this illness, condition or injury? _____
 - In what ways might you become sick or get worse? _____
3. Understanding the Proposed Treatment Intervention(s)
 - What are the tests or treatments that your provider recommends? _____
4. Understanding the Benefits and Potential Risks of Accepting an Intervention(s)
 - What can happen to you if you have the test or treatment? _____
 - What are the pros & cons to this test or treatment? _____
5. Understanding the Consequences of Refusing Proposed Intervention(s)
 - Can you explain what can happen to you if you don't have this test or treatment? _____
6. Understanding Viable Alternatives, if applicable to patient's situation.
 - What other options have been presented to you other than medication, etc? _____
 - Your doctor suggested other avenues for treatment of your condition; can you indicate what they are? _____
7. Understanding the Benefits and Potential Risks of Viable Alternatives, if applicable to patient's situation.
 - Can you explain the pros and cons of this alternative treatment? _____
 - Would you reconsider your options if the intervention you selected appears to fail? _____
 - How would you decide when the best time to reconsider your options would be? _____

Step 2: Capacity Assessment Compiled by _____ Witness _____

- Patient **Exhibits** the Ability to Make a Choice After Disclosure of Essential Information (options, benefits, risks)
- Patient **Fails to Exhibit** the Ability to Make a Choice After Disclosure of Essential Information (ditto)
- Patient **Exhibits** the Ability to Understand Relevant Information
- Patient **Fails to Exhibit** the Ability to Understand Relevant Information
- Patient **Exhibits** the Ability to Appreciate the Situation & Its Likely Consequences
- Patient **Fails to Exhibit** the Ability to Appreciate the Situation & Its Likely Consequences
- Patient **Exhibits** the Ability to Manipulate Information Rationally
- Patient **Fails to Exhibit** the Ability to Manipulate Information Rationally

Conclusion: If patient exhibits all 4 items above, he/she **has** decision-making capacity. If patient fails to exhibit even one of these, he/she **does not have** decision-making capacity.

Capacity & Competence Treatment Algorithm



¹ "a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs."

²**Competence/Incompetence** are court/legal determinations. Examples include minors (age < 18 under the authority of parents, guardians, state custody or the dept of corrections) and those with congenital or acquired developmental or intellectual disabilities who have court appointed guardians or durable powers of attorney for health care (DPAH). Minors who are legally able to provide their own consent are those who: **a)** are or have been married; **b)** are in active military duty; **c)** have become emancipated by court order; **d)** are seeking treatment for any type of sexual abuse; **e)** are seeking abortions and contraceptive care and possibly all levels of pregnancy care; **f)** are ≥ 12 years of age who are seeking outpatient (not inpatient) treatment for STD's, drug dependence and alcoholism; **g)** are ≥ 14 years of age and can provide written consent for inpatient treatment for mental health disorders. Minors who happen to be parents can provide consent for their own children.

It is legally acceptable to examine a minor to determine if he/she is experiencing an emergency. A total hands-off approach until the guardian is contacted is not necessary and may be dangerous if an emergent condition is missed.

³If you suspect the guardian of a minor is incapacitated, making irrational decisions or the guardian's decision is consistent with child abuse or neglect, call **Family Services at 802-257- 2888 (normal operation hours) or 802-649-5285 (after hours)**. If you suspect the guardian/DPAH of an adult is incapacitated, making irrational decisions or the guardian's/DPAH's decision is consistent with adult abuse or neglect, call the **Police if it is an emergency or report it to Adult Protective Services at 1800-564-1612, (fax 1802-241-2358), for investigation**. If the guardian or DPAH is not available, treat the emergency while trying to contact him/her. Call **VT State Guardian Office at 800-642-3100**. Document your reasoning to treat.

⁴Ideas: hydration, nutrition, sleep, oxygen administration, comfort measures, presence of DPOA, kin, friend or another nurse, anxiolytic meds, reduction of medications.

Attachment 2e
DOC visit
6-18-15
S. Dennis 152

How to Customize Plans of Care:

Choose the +Add to Phase button then choose Add Outcome/Intervention

+ Add to Phase ▾ | Comments | Start: 5/6/2015 01:57 EDT

Neurolo

Add Order...

Add Outcome / Intervention...

Last updated on: 5/20/2015 11:18 EDT by: Andrew Semegram RN

5/20/2015 11:18 EDT by: Morris, Christine - ...

A search box will then appear (use broad terms to perform search – see below). Choose the appropriate items to add to the plan of care.

Search Mode: Keyword

behavior Search Search within: All

Clinical Category:

- Affect/Behavior - Appropriate or Calm
- Affect/Behavior - Appropriate or Calm or Cooperative
- Assess for aggressive/homicidal behavior - Done
- Demonstrate appropriate motor behavior. - Met
- Demonstrate Behaviors or Lifestyle Changes to Promote Healing - Met
- Demonstr decreased aggressive/threatening behavior - Met
- Engage in Appropriate Behaviors to Prevent or Reduce Frequency of Bleeding Episodes - Met
- Monitor for behavior changes, reorient as needed - Done
- Observe bonding behaviors every shift - Done
- Pain Associated Behavior Reduced, Unable to Self Report - Met
- Parents will demonstrate appropriate behaviors to meet the needs of newborn before D/C - Met
- Promote bonding as evidence by verbal and non-verbal behavior - Met
[Document In Plan]
- Pt. demonstrates less bizarre behavior - Met
- Pt.'s behavior will not become aggressive - Met

OK Cancel

Altered Mood Plan of Care (Planned Pending)

	\$		Component	Status	Details
<p>4 Outcomes</p>					
<input checked="" type="checkbox"/>			Patient report less depression on scale 1-10 daily - Met		By Discharge
<input checked="" type="checkbox"/>			Patient will move through the stages of grieving. - Met		By Discharge
<p>4 Interventions</p>					
<input checked="" type="checkbox"/>			Monitor sleep patterns - Done		During Phase
<input checked="" type="checkbox"/>			Encourage adequate nutritional intake - Done		During Phase
<input checked="" type="checkbox"/>			Convey acceptance of feelings - Done		During Phase
<input checked="" type="checkbox"/>			Assess for suicidal ideations - Done		During Phase
<input checked="" type="checkbox"/>			Provide opportunities for Pt. to succeed - Done		During Phase
<input checked="" type="checkbox"/>			Make frequent contact w/ patient early - Done		During Phase
<input checked="" type="checkbox"/>			Assist patient with ADL's as needed - Done		During Phase
<input checked="" type="checkbox"/>			Administer meds as ordered and monitor - Done		During Phase
<input checked="" type="checkbox"/>			Provide constant structured environment - Done		During Phase
<input checked="" type="checkbox"/>			Eval patient tolerance for interaction/groups - Done		During Phase
<input checked="" type="checkbox"/>			Implement Risk for Injury plan of care if needed. - Done		During Phase
<input checked="" type="checkbox"/>			Encourage patient to discuss situation - Done		During Phase
<input checked="" type="checkbox"/>			Facilitate the grieving processes - Done		During Phase
<input checked="" type="checkbox"/>			Consult to Pastoral Care		During Phase
<input checked="" type="checkbox"/>			Consult to Social Services		During Phase
<input checked="" type="checkbox"/>			Conduct Geriatric Depression Scale Exam. - Done		During Phase
<input checked="" type="checkbox"/>			Review Care Plan (Review Plan of Care)		Qshift - 12 hour, Review Altered Mood Plan of C

	\$		Component	Status	Details
--	----	--	-----------	--------	---------

Anxiety Plan of Care (Planned Pending)

4 Outcomes

- Demonstrate improved concentration and accuracy of...
- Demonstrate return of basic problem-solving skills. - ...
- Demonstrate some ability to reassure self. - Met
- Identify and verbalize symptoms of anxiety. - Met
- Identify, verbalize and demonstrate anxiety control tec...

4 Interventions

- Accept client's defenses, do not confront, argue or de...
- Assess for the presence of depression. - Done
- Avoid stimulants: caffeine, nicotine, theophylline, terb...
- Explain all activities and procedures using simple term...
- Explore coping skills previously used by client to reliev...
- Help client identify precipitants of anxiety. - Done
- Intervene when possible to remove sources of anxiety...
- Involve significant other in information giving, proble...
- Rule out withdrawal from alcohol, sedatives or tobacc...
- Review Care Plan (Review Plan of Care)
- Consult to Mental Health
- Administer anxiolytics as ordered. - Done

By Phase End
 During Phase
 Qshift - 12 hour, Review Anxiety Plan of Car
 During Phase

Confusion Plan of Care (Planned Pending)

	\$	%	Component	Status	Details
Outcomes					
<input checked="" type="checkbox"/>			Demonstrate restoration of cognitive status to baseline...		By Phase End
<input checked="" type="checkbox"/>			Maintain functional capacity. - Met		By Phase End
<input checked="" type="checkbox"/>			Obtain adequate amounts of sleep. - Met		By Phase End
<input checked="" type="checkbox"/>			Demonstrate use of techniques to help with memory l...		By Phase End
<input checked="" type="checkbox"/>			Assist the client in developing reminders, (e.g. calenda...		By Phase End
Interventions					
<input checked="" type="checkbox"/>			If possible, determine and treat underlying cause of co...		During Phase
<input checked="" type="checkbox"/>			Maintain a normal sleep-wake cycle. - Done		During Phase
<input checked="" type="checkbox"/>			Place patient in a room near the nurses station - Done		During Phase
<input checked="" type="checkbox"/>			Maintain fall precautions - Done		During Phase
<input checked="" type="checkbox"/>			Review Care Plan (Review Plan of Care)		Qshift - 12 hour, Review Confusion (Acute) Plan of C
<input checked="" type="checkbox"/>			Establish a calm environment. - Done		During Phase
<input checked="" type="checkbox"/>			Determine if memory loss onset is gradual or sudden. ...		During Phase
<input checked="" type="checkbox"/>			Neuro checks qshift, as ordered, or prn - Done		During Phase
<input checked="" type="checkbox"/>			Monitor pulse oximetry - Done		During Phase
<input checked="" type="checkbox"/>			Ensure pt is in safe environment by removing potentia...		During Phase
<input checked="" type="checkbox"/>			Use brief simple wording-closed questions when able ...		During Phase
<input checked="" type="checkbox"/>			Encourage family to stay with patient - Done		During Phase
<input checked="" type="checkbox"/>			Determine amount and pattern of alcohol intake. - Do...		During Phase
<input checked="" type="checkbox"/>			Re-orient patient with each contact - Done		During Phase
<input checked="" type="checkbox"/>			Administer medications as ordered - Done		During Phase

Risk for Injury Plan of Care (Planned Pending)

	\$		Component	Status	Details
			Outcomes		
			Remain free from injury. - Met		By Phase End
			Interventions		
			Administer medications as ordered per detoxification ...		During Phase
			Observe client frequently. - Done		During Phase
			Follow CIWA protocol as ordered - Done		During Phase
			Monitor for signs and symptoms of withdrawal per de...		During Phase
			Report signs and symptoms not relieved by ordered m...		During Phase
			Ensure pt is in safe environment by removing potentia...		During Phase
			Implement Risk for Injury plan of care if needed. - Done		During Phase
			Review Care Plan (Review Plan of Care)		Qshift - 12 hour, Review Risk for Injury Plan of Ca

	\$	↕	Component	Status	Details
--	----	---	-----------	--------	---------

Diversional Activity Deficit Plan of Care (Planned Pending)

4 Outcomes
 Pt to participate w/ planning/utilizing activities - Met
 By Phase End

4 Interventions
 Review Care Plan (Review Plan of Care)
 Qshift - 12 hour

Offer diversional activities - Done
 During Phase

Provide diversional activities - Done
 During Phase

Assess for physical signs of anxiety - Done
 During Phase

Provide emotional support - Done
 During Phase

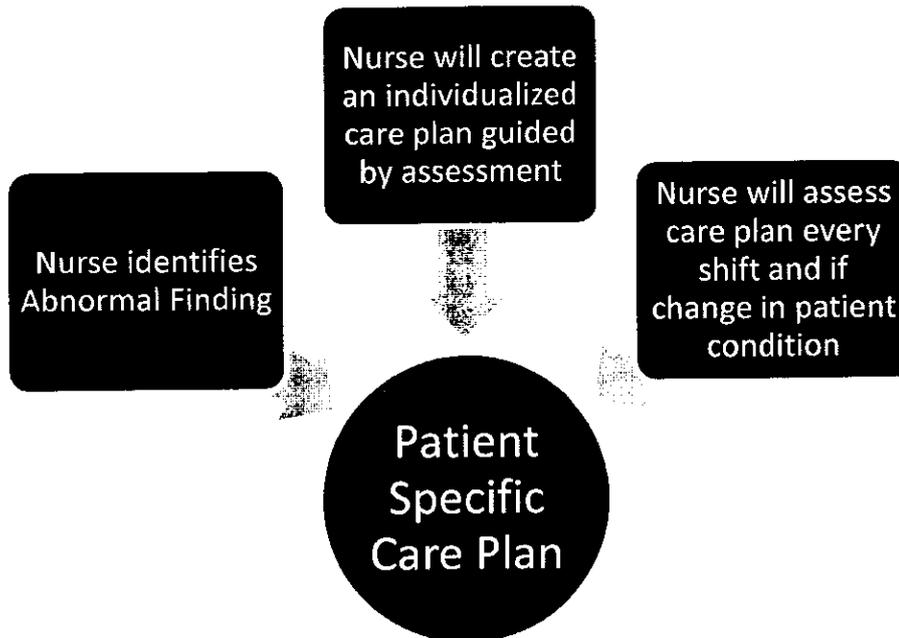
Inform pt./family/SO of community resources availabl...
 During Phase

Allow and encourage patient to verbalize feelings - Do...
 During Phase

Identify the patient's areas of interest.
 During Phase

Daily room visits.
 During Phase

Pravda
6-18-15
S. Deir

Overview:**Objectives:**

1. After this class the nurse will recognize clinical data needed to identify patient care needs.
2. After this class the nurse will be able to choose appropriate nursing diagnoses to meet patient care needs.
3. After this class the nurse will demonstrate how to use the available resources to develop a patient specific care plan.
4. After this class the nurse will verbalize documentation requirements.

Name: _____ Case Scenario #: ____ Date: _____

S: Subjective Data – collection of health assessment
through communication.

O: Objective Data – collection of health assessment
through observation, physical assessment, lab results,
vital signs and other measurements.

A: Assessment

1. What concerns do I have for this patient?
2. What are, if any, potential risks for this patient?
3. What should be monitored and for how long?
4. Do I need more information and if so what and
how will you obtain it?

P: Plan of Care – response to concerns or risks

Nursing Diagnosis (LIST 3)		
Nursing Diagnosis #1	Nursing Diagnosis #2	Nursing Diagnosis #3

EXPECTED OUTCOMES FOR EACH Nursing Diagnosis		
First Nursing Diagnosis	Second Nursing Diagnosis	Third Nursing Diagnosis

INTERVENTIONS FOR EACH Nursing Diagnosis		
First Nursing Diagnosis	Second Nursing Diagnosis	Third Nursing Diagnosis

Attachment 2h
S. Train
6-14-15
BOK counts

March 20, 2015 Correction Action Plan

Care Plan Education Statistics

AS of June 1, 2015

Number of RN's on staff:	29
Number of RN's attended:	20
Number of RN's on LOA or excused:	3
Number of RN's unexcused:	6
% of RN's attended:	76.9%

Number of LPN's on staff:	6
Number of LPN's attended:	4
Number of LPN's on LOA or excused:	2
Number of LPN's unexcused :	0
% of LPN's attended:	66.6%

GRACE COTTAGE HOSPITAL – PROVIDER # 471300 - ATTACHMENT # 3

Tag C276 485.635(a)(3) Patient Care Policies

#1 Pharmacy

Plan of Correction.

Maintenance will install new cabinetry in the back room of the pharmacy that is behind the second locked door. The cabinets will have locks installed on them so that this medication cannot be confused with the medications that are in the current inventory. The doors will be labeled "Expired Medications". This will be completed by June 15th.

The current schedule of the reverse distributor coming quarterly will be maintained as the cabinets will be sufficiently large enough to store the medications. The current schedule is on track as they come within the first 2 weeks of March, June, September, and December based on our request. Their last date here was March 12 and they are scheduled for June 4th.

#2 Diagnostic Imaging

While Licensing and Protection was onsite the contrast warming unit was identified that it should have a lock on it. A lock was installed by maintenance the same day.

A policy will be written and discussed with all Diagnostic Imaging staff with regards to keeping the contrast warming unit locked. This will occur by June 15, 2015. (attachment 3a)

The Director will spot check for continued compliance.

SUBJECT: Utilization Of Contrast Media in Imaging	REFERENCE #6.0020
DEPARTMENT: Imaging Department	PAGE: 1 OF: 3
APPROVED BY: Medical Staff	EFFECTIVE: 08-01-2007
REVISED BY: Angie Clark	REVISED: 01-10-2013

POLICY:

Patient safety will be maintained through the identification and management of risk factors prior to the administration of contrast media.

Contrast Media can be defined as a diagnostic substance that alters the x-ray absorption by body tissues or organs into which they are introduced, thus providing contrast in density between the tissue or organs being examined and the surrounding tissue. Image enhancement can discriminate disease from normal tissue. All intravenous contrast agents will be stored in a locked cabinet.

1. All patients receiving IV contrast will have a screening performed for contraindications, history of reaction, and clinical risk factors for a contrast reaction. This screening process will be completed by the Radiologic Technologist. No IV contrast media will be administered until the screening form is completed.
2. All patients receiving contrast will sign an informed consent after reviewing all potential risks and screening has been performed. No IV contrast media will be administered if there are identified risks until approved by the Radiologist.
 - A. Risk factors for IV contrast media requiring preapproval by a Radiologist include:
 - Pregnancy
 - Contrast Allergy
 - Paraproteinemia syndromes (multiple myeloma or sickle cell disease) or pheochromocytoma
 - Sickle Cell Disease
 - eGFR must be greater than 45 and/or serum Creatinine must be less than 1.7
3. The technologist will review the screening form before contrast is administered. All outpatients will have an IV placed by the CT technologist. No more than 3 attempts are to be made before obtaining a nurse to insert access. All other patients must have an IV or heparin lock in place prior to transport to radiology if the patient is to have IV contrast.
4. Any patient over age 60 years of age — eGFR /serum Creatinine must be drawn within the last 30 days

eGFR:

 - 60 = inject according to normal protocol.

SUBJECT: Utilization Of Contrast Media in Imaging	REFERENCE #6.0020
DEPARTMENT: Imaging Department	PAGE: 2 OF: 3
APPROVED BY: Medical Staff	EFFECTIVE: 08-01-2007
REVISED BY: Angie Clark	REVISED: 01-10-2013

- 30-59 = Technologist alerts Radiologist about decreased eGFR. Radiologist weighs risks and benefits of IV contrast for the individual patient. If contrast is injected, hydration is encouraged to decrease the risk of renal injury.
- < 29 = Technologist alerts Radiologist. Utilization of Iodinated contrast is contraindicated unless ordered as medically necessary by the ordering physician. Contrast is not injected without Radiologist approval.
- Contrast will not be injected through central venous lines, PICC lines, or small-bore peripheral sites (due to risk of catheter breakage).
- Contrast media administered to high risk patients will have an MD/RN present to treat for possible complication.
- Serum Creatinine mg/dl 1.7 or less – inject according to normal protocol

5. Ordering Physician Information:

- A. If a test requires IV contrast to make a certain diagnosis (i.e. Chest CT to rule out PE) and the test is cancelled due to contraindication of contrast, then the ordering physician will be notified immediately about the cancellation of the exam so that an alternate test can be ordered if necessary. If the physician requests an alternate test, the Technologist will obtain a new physician order before performing the alternate test.
- B. If an ordering physician demands that an exam be done emergently when the patient's eGFR /serum Creatinine results are abnormal based on the established criteria, the Radiologist must be consulted.
- C. If a contrast study is requested, all patients over age 60 or with risk factor must have an eGFR /serum Creatinine within the normal range within the last 30 days. Medical Staff at Grace Cottage Hospital approve reflex testing to ensure patients obtain this screening blood test prior to undergoing imaging and contrast administration.

6. Metformin (glucophage or combinations including: Riomet, Glumetza, Fortamet, Metaglip, Glucovance, Janumet, Actoplus Met, Prandimet, Kombiglyze) procedure:

- A. May be taken day of scheduled Radiologic exam
- B. A baseline (within 30 days) serum Creatinine/eGFR must be drawn. The ordering physician is responsible for obtaining these laboratory tests. The Radiologist will be notified by technologist prior to contrast injection as in #4 above.
- C. All patients that routinely take Metformin medications and receive Intravenous iodinated contrast will be instructed to discontinue this medication for 48 hours after the exam and for the need for follow-up serum Creatinine/eGFR levels. This

SUBJECT: Utilization Of Contrast Media in Imaging	REFERENCE #6.0020
DEPARTMENT: Imaging Department	PAGE: 3 OF: 3
APPROVED BY: Medical Staff	EFFECTIVE: 08-01-2007
REVISED BY: Angie Clark	REVISED: 01-10-2013

information will be given in writing to outpatients by the technologist and also faxed to the patient's PCP. Similar written instructions will be given to the Charge Nurse for Inpatients and Emergency Department patients.

1. Outpatients and Emergency Department patients are referred to their primary care provider for an evaluation of their renal function prior to resuming Metformin therapy.
 2. For Inpatients, the unit Charge Nurse is responsible for obtaining an order for serum Creatinine/eGFR levels 48 hours post imaging, and for checking with the patient's PCP or attending MD before resuming the patient's Metformin therapy.
7. Technologist will describe examination and possible side effects to patient before IV injection.
 8. The technologist will closely monitor the injection to evaluate for extravasations. In the event of extravasation or any reaction to contrast media, the contrast and scan should be immediately stopped and the Radiologist or appropriate/available in-house provider notified. The ordering physician should be notified as well (non-urgently).

REFERENCES

1. Solomon R: Nephrology forum: Contrast-medium-induced acute renal failure. *Kidney Int* 53:230 -242, 1998
2. Andrew E, Berg KJ. Nephrotoxic effects of X-ray contrast media. *J Toxicol Clin Toxicol* 2004;42: 325-32.
3. Laroche D, Aimone-Gastin I, Dubois F, Huet H, Gerard P, Vergnaud MC, et al. Mechanisms of severe, immediate reactions to iodinated contrast material. *Radiology* 1998;209: 183-90.
4. Greenberger PA, Patterson R. The prevention of immediate generalized reactions to radiocontrast media in high-risk patients. *J Allergy Clin Immunol* 1991;87: 867-72.
5. American College of Radiology. Patient selection and preparation strategies. In: *Manual on contrast media*.
6. Morcos SK, Thomsen HIS, Webb JA. Prevention of generalized reactions to contrast media: a consensus report and guidelines. *Eur Radio!* 2001;11: 1720-8

Tag C279 485.635(a)(3)(vii) Patient Care Policies

Dietary

Food item not labeled:

All employees were spoken to, by the Dietary Manager, at a staff meeting on 4/27/2015 after the inspection regarding the importance that everything is labeled and dated properly.

As of 6/2/2015, we have purchased a Fresh Date 2 label maker by Med Vantage that will have items programmed into the machine. The machine is programmed to print the product name, date prepared on and the use by date. It also allows us to print labels that have "Received on", "opened on", "pulled to thaw", and "Use First" replacing the old procedure of writing on the saran wrap with a sharpie. (Attachment 4b)

Cleaning:

The dietary staff were also re-educated at the meeting on 4/27/2015 about cleaning list and cleaning duties. They were re-educated that if the Dietary Manager is out of the department or on vacation, the cleaning lists need to be followed.

The 'heavy duty' individual employee cleaning lists have been changed from weekly to bi-weekly. During discussion with all employees, it was made clear that they will do their weekly cleaning on the weekends that they work. This schedule will allow for better time utilization. The bi-weekly individualized cleaning list will be checked on Monday mornings by the dietary manager or designee, to ensure that the lists are completed and the areas will also be visually checked. If not cleaned, they will need to complete it before the end of the day on Monday and it will be rechecked at the end of the day by the Dietary Manager or designee. After 3 times, failing to complete the cleaning, the employee will get a written warning. A new daily cleaning list will be developed by 6/5/2015 which will be split into 3 shifts instead of 2. Many tasks of the bi-weekly cleaning will be incorporated into the daily cleaning lists. These will be checked daily by the Dietary Manager or Registered Dietitian to ensure that the cleaning is completed. (Attachment 4a)

The handout (attachment 4C) was given to dietary staff for their reference on June 3, 2015.

*BC revised
6.18.15
S. L. H. / S. M. H.*

SUBJECT: Cleaning and Sanitation of Dining and Food Service Areas	Reference #
DEPARTMENT: Food Service Department	PAGE: 1 OF: 1
APPROVED BY:	EFFECTIVE: 6/2/2015
Authored by :Denise M. Choleva	REVISED:

Policy:

The food service staff will maintain the cleanliness and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule.

Procedure:

1. The food service manager will record all cleaning and sanitation tasks needed for the department. (Daily and Bi-Weekly)
2. Tasks shall be designated to be the responsibility of specific positions in the department for the daily cleaning. Employees will each have individual Bi-Weekly cleaning lists that they will be responsible for.
3. All staff will be trained on the frequency of cleaning necessary.
4. A cleaning schedule will be posted for all cleaning tasks, and staff will initial the tasks as completed.
5. Staff will be held accountable for cleaning assignments.

Approved
S. Denis 6/18/15

SUBJECT: Labeling and Dating Policy	Reference #
DEPARTMENT: Food Service	PAGE: 1 OF: 1
	EFFECTIVE: 6/2/2015
APPROVED BY:	REVISED:
Authored by: Denise M. Choleva	

Policy:

The food service staff will use the FreshDate 2 labeling machine to print labels for all items in the kitchen

Procedure:

1. The Fresh Date 2 Label machine is preprogrammed with all menu items, salad bar items, meats/cheeses, and desserts
2. When a product is opened, the employee will find that product on the machine and print a label for it. The machine will automatically print the item name, date it was opened and the date that it is good until. The label will be placed on the product and checked regularly to make sure the item is not out of date. If out of date the item will be discarded.
3. Any leftover items will also have a label printed and placed on the container it is being stored in. These labels will also have the product name, date prepared and use by date.
4. When orders arrive, received on stickers will be placed on the cases, or product to be sure that FIFO rules are being met.



DM Reference Shelf



Attachment 4c

Dr. Davis
6-18-15
S. Davis

Food Storage Guidelines

by | Susan Davis Allen, MS, RD, CDE

Professional Standards of Practice serve as the basis for quality dietetic practice for dietary management. The standards that follow provide guidelines for dietary managers to use in the proper storage of food.

Answers to CE Review Questions

CDM, CFPPs who answer the CE Review Questions on page 29 of this issue can check their responses against the answer key found on page 38. This "self check" allows you to confirm your understanding of the test questions.

You may ask yourself, "Why do we need a standard for food storage?" Do you track the cost of food that is discarded each week because of improper storage? Can you be sure that in the event of a disaster, your food storage practices would be adequate?

With the increase in healthcare costs, your ability to control costs may come down to your ability to control the shelf stability of both raw and cooked foods. Besides reducing waste, properly stored food maintains its nutritional quality and decreases the risk of food-borne illness. In addition, with the threat of terrorist and natural disasters, properly storing water and other appropriate emergency supplies is becoming increasingly important.

STANDARD 1:

The certified dietary manager (CDM) shall ensure that standards for refrigerated, frozen, and dry foods are put into practice.

Criteria for Refrigerator Storage

- 1.1 Refrigerator storage temperature meets FDA or state standards (usually a maximum of 35°-41°F) and is recorded once each shift.
- 1.2 Refrigerators are used for short-term storage (usually a maximum of 7 days).
- 1.3 Food storage procedures are followed to diminish environmental and cross-contamination. (Example: All foods are covered and raw meat items are stored below cooked items.)
- 1.4 Refrigerator storage areas meet FDA or state standards (e.g. 6 inches off the floor, clean, slatted shelving).
- 1.5 Ready-to-eat refrigerated foods are labeled according to FDA or state standards (e.g. the date or day by which the food should be consumed, sold, or discarded).
- 1.6 Refrigerated ready-to-eat food that is not labeled is discarded.
- 1.7 A refrigerated food storage time-line chart is in place and followed. (See sample.)
- 1.8 Staff receives training on the proper refrigerator storage time and temperature.
- 1.9 All discarded refrigerated food is recorded with food item, amount, date, and reason.
- 1.10 Blast chillers, if available, are used to quickly cool foods to safe refrigeration temperatures.
- 1.11 Refrigeration unit is cleaned and inspected on a regular basis.
- 1.12 Only food purchased from approved vendors is refrigerated.
- 1.13 Refrigerated food stock rotation follows the FIFO (first in, first out) principle.

(Continued on page 26)

Dairy Products	Refrigerator ¹ @ 36-40°F	Freezer ² @ 0°F
Fluid milk	5-7 days after sell-by date	1-3 months
Nonfat dry milk (NFDN)	5-6 months	10-12 months
Reconstituted NFDN	3-5 days	Freezes
Buttermilk	1-2 weeks	Freezes poorly
Cheese Spread, opened	2 weeks	Freezes poorly
Condensed milk, opened	3-5 days	1 month
Evaporated milk, opened	3-5 days	Freezes poorly
Whipping cream	10 days	2 months
Whipped cream	< 1 day	1 month
Cream cheese	2 weeks	Freezes poorly
Cream-half and half	3-4 days	4 months
Margarine	4-5 months	12 months
Butter	1-3 months	6-9 months
Pudding	Package date; 2 days after opening	Freezes poorly
Sour cream	7-21 days	Freezes poorly
Yogurt	1 week after sell-by date	1-2 months
Dough		
Tube cans of rolls, biscuits, pizza dough, etc.	Use-by date	Freezes poorly
Ready-to-bake pie crust	Use-by date	2 months
Cookie dough	Use-by date unopened or opened	2 months
Fish		
Lean fish (cod, flounder, sole, haddock)	1-2 days	6 months
Fatty fish (bluefish, mackerel, salmon)	1-2 days	2-3 months
Cooked fish	3-4 days	4-6 months
Smoked fish	14 days or date on vacuum package	2 months in vacuum package
Shellfish		
Shrimp, scallops, crayfish, shucked clams, mussels and oysters	1-2 days	3-6 months
Live clams, mussels, crab, and oysters	2-3 days	2-3 months
Live lobster	1-2 days	2-3 months
Cooked shellfish	3-4 days	3 months
Processed Meats		
Hot dogs, opened package	1 week	1-2 months
Hot dogs, unopened package	2 weeks	1-2 months
Luncheon meats, opened package	3-5 days	1-2 months
Luncheon meats, unopened package	2 weeks	1-2 months
Bacon	7 days	1 month
Sausage, raw	1-2 days	1-2 months
Smoked breakfast links, patties	7 days	1-2 months
Hard sausage	2-3 weeks	1-2 months
Summer sausage—labeled "keep refrigerated"—Opened	3 weeks	1-2 months
Summer sausage—labeled "keep refrigerated"—Unopened	3 months	1-2 months

1. Table adapted from Chili/Cold Storage Chart, USDA Food Safety and Inspection Service (www.foodsafety.gov), Nov. 10, 2004.

2. Table adapted from "Recommended Food Storage Times, Cold & Dry, Refrigerated & Frozen Foods," University of Kentucky, Cooperative Extension Service, College of Agriculture, Issued May 1998, (www.ca.uky.edu/agcollege/fcs/factshts/FN-SS3.085.PDF, July, 2007).

DM Reference Shelf (Continued)

1.14 Personnel look for and follow "Use by" dates. (For example: "Use by" dates mean that a product cannot be used after that date, even if it appears and smells good. Products can be safely frozen before the "use by" date. Follow guidelines on the Freezer Storage Chart.)

Criteria for Freezer Storage

- 2.1 Freezer storage temperature meets FDA or state standards (usually a minimum of -10°-0°F) and is recorded once each shift.
- 2.2 Freezers are used for long-term storage and not used for cooling foods. (Usually a maximum of 12 months.)
- 2.3 Freezer storage areas are designed and maintained to promote proper air circulation.
- 2.4 A freezer food storage timeline chart is in place and followed. (See sample.)
- 2.5 Frozen food stock rotation follows the FIFO principle.
- 2.6 Staff receives training on the proper freezer storage time and temperature.
- 2.7 All discarded frozen food is recorded with food item, amount, date, and reason.
- 2.8 Freezers are cleaned and inspected on a regular basis.
- 2.9 Only food purchased from approved vendors is frozen.

Criteria for Dry Food Storage

- 3.1 Dry food storage temperature meets FDA or state standards (usually a maximum of 50°-70°F).
- 3.2 Dry food storage areas are kept dry, clean, and are well lighted and ventilated.
- 3.3 Dry food storage has a two-foot ceiling clearance to avoid high temperatures at ceiling.

	Refrigerator ¹ @ 36-40°F	Freezer ² @ 0°F
Ham, Corned Beef		
Corned beef, in pouch with pickling juices	5-7 days	Drained, 1 month
Ham, canned—labeled "keep refrigerated"—Opened	3-5 days	1-2 months
Ham, canned—labeled "keep refrigerated"—Unopened	6-9 months	Freezes poorly
Ham, fully cooked vacuum-sealed at plant, undated, unopened	2 weeks	1-2 months
Ham, fully cooked vacuum-sealed at plant, dated, unopened	Use-by date on package	1-2 months
Ham, fully cooked, whole	7 days	1-2 months
Ham, fully cooked, half	3-5 days	1-2 months
Ham, fully cooked, slices	3-4 days	1-2 months
Fresh Beef, Veal, Lamb, Pork		
Hamburger and stew meat	1-2 days	3-4 months
Steaks	3-5 days	6-12 months
Chops	3-5 days	4-6 months
Roasts	3-5 days	6-12 months
Pre-stuffed, uncooked chops or chicken breast stuffed with dressing	1 day	Freezes poorly
Soups or stews with meat	3-4 days	2-3 months
Meat Leftovers		
Cooked meat and meat casseroles	3-4 days	2-3 months
Gravy and meat broth	1-2 days	2-3 months
Poultry		
Raw chicken or turkey, whole	1-2 days	1 year
Raw chicken or turkey, pieces	1-2 days	9 months
Cooked poultry casseroles	3-4 days	4-6 months
Fried chicken	3-4 days	4 months
Pieces covered with broth or gravy	1-2 days	6 months
Eggs		
Fresh, in shell	3-5 weeks	Freezes poorly
Raw yolks, whites	2-4 days	1 year
Hardcooked	Up to 7 days	Freezes poorly
Liquid pasteurized eggs, egg substitutes—Opened	3 days	Freezes poorly
Liquid pasteurized eggs, egg substitutes—Unopened	10 days	1 year
Fruit Beverages		
Juices in cartons, fruit drinks, punch—Opened	7-10 days	8-12 months
Juices in cartons, fruit drinks, punch—Unopened	3 weeks	8-12 months

1. Table adapted from Chill/Cold Storage Chart, USDA Food Safety and Inspection Service (www.foodsafety.gov), Nov. 10, 2004.

2. Table adapted from "Recommended Food Storage Times, Cold & Dry, Refrigerated & Frozen Foods," University of Kentucky, Cooperative Extension Service, College of Agriculture, issued May 1998, (www.ca.uky.edu/agcollege/fcs/factshts/FN-SSB.DB5.PDF), July, 2007).

Check Out DMA's Other Professional Practice Standards

To view other Practice Standards, visit www.DMAonline.org, click on Resources & News, then click on Practice Standards, or call DMA at (800) 323-1908.

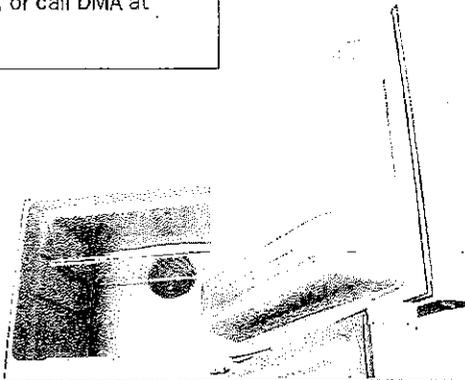


FIGURE 1: Storage Guidelines for Additional and Opened

Fresh Fruits	Refrigerator ¹ @ 36-40 °F	Freezer ² @ 0 °F
Apples	1 month	8-12 months
Apricots	3-5 days	8-12 months
Avocados	5 days	8-12 months
Berries, cherries	2-3 days	8-12 months
Cranberries	1 week	8-12 months
Grapes	5 days	10-12 months
Mangos	Ripen at room temperature	8-12 months
Nectarines	5 days	8-12 months
Peaches	2-3 days	8-12 months
Pears	5 days	8-12 months
Oranges	2 weeks	4-6 months
Pineapples	5-7 days	4-6 months
Plums	5 days	8-12 months
Watermelon	3-5 days	6-8 months
Canned fruit, opened	2-4 days	2-3 months
Fresh Vegetables		
Beets	2 weeks	8-12 months
Bok choy, broccoli, brussels sprouts	3-5 days	8-12 months
Cabbage, carrots	1 week	8-12 months
Cauliflower, celery, cucumbers, green beans	1 week	8-12 months
Corn	1-2 days	8-12 months
Greens (e.g. collard)	3-5 days	8-12 months
Lettuce and salad greens	3-5 days	Freezes poorly
Mushrooms	1-2 days	8-12 months
Green onions	3-5 days	Freezes poorly
Peppers	1 week	8-12 months
Squash, hard	Store in a cool, dry place	8-12 months
Tomatoes	1 week	8-12 months
Zucchini, summer squash	3-5 days	8-12 months
Canned vegetables, opened	1-4 days	2-3 months

3.4 A dry food storage timeline chart is in place and followed. (See sample.)

3.5 Dry food stock rotation follows the FIFO principle.

3.6 Working containers holding dry food or ingredients that are removed from their original packages are identified with the common name of the food, unless the food is easily recognizable, such as dry pasta.

3.7 All discarded dry food is recorded with food item, amount, date, and reason.

3.8 Staff receives training on the proper dry food storage time and temperature.

3.9 Storage area is kept clean, secure, and is inspected regularly.

3.10 Only food purchased from approved vendors is stored in dry storage.

3.11 There are separate storage compartments for chemical storage.

3.12 Personnel look for and follow "best before" dates. They also honor "store in a cool dry place" or "keep in the refrigerator once opened." (Note: "Best before" dates mean personnel must look for additional instructions on the label; "best before" dates also mean the item is no longer at its best quality but may still be safe to eat.)

Assessment

3.1 Storage temperatures are tracked and data is used for continuous improvement and/or corrective action.

3.2 Refrigerators are monitored daily for proper food labeling.

3.3 Discarded food record is checked weekly and cost is tracked.

3.4 Data from discarded food record is used for cost control planning purposes

(Continued on page 28)

DM Reference Shelf (Continued)

- 3.5 Inspection forms for all food storage are used for continuous quality improvement purposes.
- 3.6 Training records are evaluated to make sure all cooking staff has received training in the proper storage of dry foods; training records are maintained in the dietary department.

STANDARD 2:

The certified dietary manager shall ensure that standards for water storage and emergency supplies are put

into practice. (Note: This information is taken from recommendations of FEMA — Federal Emergency Management Agency.)

Criteria

- 1.1 A minimum of a three-day supply of drinking water is stored in appropriate containers. Appropriate containers are clean, sanitized, plastic containers that are food quality.
- 1.2 Water supplies are labeled and replaced every six months.

- 1.3 Emergency food supplies equivalent to three days are stored in appropriate storage areas.
- 1.4 Emergency foods are properly labeled and replaced every six months.
- 1.5 A three-day menu using common emergency foods is available and made up of foods from the following list:
- Canned condensed meat and vegetable soups
 - Canned fruits, fruit juices, and vegetables
 - Ready-to-eat cereals and uncooked instant cereals (stored in metal containers)
 - Peanut butter
 - Jelly
 - Hard candy and canned nuts
- 1.6 Staff receives training on the proper emergency food and water storage time procedures.



Recommended Maximum Storage Times—Dry Foods

Food Product	Shelf Storage
Baking powder or soda	18 months
Barley	2 years
Bread crumbs	6 months
Cereal, read to eat—Unopened	6-12 months
Cereal, ready to eat—Opened	2-3 months
Chocolate, baking	6-12 months
Commeal and hominy grits	12 months
Cornstarch	18 months
Flour, bleached	6-8 months
Flour, whole wheat	6-8 months
Honey and syrup	1 year
Noodles, egg	6 months
Noodles, plain	1-2 years
Olive oil	6 months
Pasta	2 years
Rice	2 years
Rice, brown or wild	6 months
Sugar, granulated	2 years +
Sugar, powdered	18 months
Yeast, dry	Expiration date
Canned foods and juices with high acid content (tomatoes, grapefruit, apple products, mixed fruit, berries, pickles, sauerkraut, and vinegar-based products)	1 year
Canned foods with low acid content, including meat and poultry products, vegetable soups (except tomato), spaghetti products, potatoes, corn, carrots, beans, beets, peas, pumpkin	2-5 years

Assessment

- 1.1 Rotation of emergency food and water supplies are recorded and used for continuous improvement and/or corrective action.
- 1.2 Training records are evaluated to make sure all cooking staff has received training in the proper storage of dry foods; training records are maintained in the dietary department.

Summing it Up

These standards are designed to help you store foods safely and ensure that your clients are receiving wholesome foods. It may be useful to post these guidelines in your kitchen where they can be consulted frequently—near your refrigerator, freezer, and food storage areas.

Susan Davis Allen, MS, RD, CHE wrote this Standard in 2005. It was updated in July 2010 by Becky Rude, MS, RD, CDM, CFPP. Allen is an advisor to the Certifying Board for Dietary Managers. Rude serves as chair of that board. Both have authored many publications for DMA and other professional groups.

Tag C298 485.635(d)(4) Nursing Services

Plan of Correction

Nursing – A Delirium Knowledge pretest (attachment 2a) has been given to all nurses to assess their understanding of delirium and acute confusion; and their knowledge base on how to address these issues. The pretest was handed out to all RNs, LPNs and LNAs with an expected return date of no later than 6/5/15. The GCH Nurse Educator is collecting and tracking return of the tests. The educator, with the assistance of one of our charge nurses, will review and analyze the test results to develop an educational program tailored to meet identified staff knowledge deficits. In addition to education on managing delirium, this education will include how to recognize limited capacity; utilize our new guidelines; and a review of patient/resident rights, including the right to refuse treatment (attachment 2d, 2f). We are currently in the process of working with our Electronic Medical Record (EMR) vendor to have the Confusion Assessment Method tool (attachment 2b) placed in the system so it will be readily available to all nurses. Nursing staff will also be educated on interventions that could be utilized with this patient population, including but not limited to: de-escalation, alternative activities, distraction, relaxation techniques etc. This education will be mandatory for all Nursing staff and attendance will be taken and recorded. The Nurse Educator will be responsible to follow up with any staff that do not attend a scheduled session. This educational effort will be completed later than July 31, 2015.

Prior to the L & P visit in April, the Nurse Educator had identified deficiencies with nursing care planning and had educational sessions scheduled for 5/4 and 5/7 /15 which were held. Twenty out of our 29 RNs and 4 out of 6 LPNs attended on those 2 dates (attachment 2h). As of June 1st all other staff have been educated via e-mail and received follow-up from the nurse educator. At our request our EMR vendor modified and renamed some of our previously available care plans to provide more care plan options for patients with behavioral issues. These now include: Altered Mood plan of care, Anxiety plan of care, Confusion plan of care, Risk for Injury plan of care and Diversional Activity Deficit plan of care (attachment 2e). Nursing was notified by email on 5/21/15 that the new care plans listed above were now available for use in our EMR. Additionally all care plans can and will be modified by nursing to reflect the individual patient's needs. A reminder reference sheet on how to customize care plans has been placed in the charge nurse reference binder and also e-mailed to all RNs.

Compliance with the initiation and individualization of appropriate care plans for our patients will be monitored by the on duty charge nurse within 24 hours of a patient's admission, utilizing the "Nursing New Admission Check List" (attachment 2g). The checklist will be reviewed weekly by the nurse manager/designee for completeness. Any missing information will be addressed. Nursing is directed by an electronic task that drops daily to review all patient care plans daily and update as needed. At the weekly interdisciplinary team care plan meetings all care plans will be reviewed by the CNO/designee with feedback to the on duty charge nurse to add, update or complete specific plans.

Plan of Correction Outstanding Work Items TRACKING SPREADSHEET - 471300

TAG NUMBER	ISSUE	PLAN OF CORRECTION	RESPONSIBLE PARTY	TARGET COMPLETION DATE	COMPLETED
C200	EMTALA		All	See EMTALA POC spreadsheet	
C271	Failure to understand patient capacity.	A delirium knowledge pretest given to all nurses to assess their understanding of delirium and acute confusion.	Amy	6/5/15	Yes - 6/5/15
C271	Failure to use alternative, less restrictive interventions as directed by the general procedures for all involuntary procedures.	Nurse education included strategies on how to identify and respond to patient behavioral issues (distraction, redirection, offering a quiet space).	Amy	7/31/15	
C271	Failure to develop nursing care plans.	Nurse educator had identified deficiencies with nursing care planning and held educational sessions.	Amy	5/4/15 and 5/7/15	Yes - 5/4/15
C271	Failure to develop nursing care plans.	Nursing was notified by email that new care plans are available for use in our EMR.	Amy	5/21/15	Yes - 5/21/15
C271	Failure to develop care plan for mental health patient.	Revise/add nursing care plans to EMR for nursing staff use: Altered Mood plan of care; Anxiety plan of care; Confusion plan of care; Risk for Injury plan of care and Diversional Activity Deficit plan of care.	Amy	5/21/15	5/21/2015
C276	Failure to properly store and secure expired medication within the pharmacy.	Maintenance will install a new cabinet in the back room of the pharmacy that is behind a second locked door. The door will be labeled "Expired Medications".	Margaret	6/15/15	
C276	Improper storage of contrast solution. The warming unit for contrast should have a lock.	A lock was installed on the warming unit by maintenance.	Angie/Scott	4/27/15	Yes - 4/27/15

C276	Failure to have a policy stating that the contrast warming unit must be locked.	Write a policy with regards to keeping the contrast warming unit locked and discuss this policy with all Diagnostic Imaging staff.	Angie	6/15/15	Yes - 6/4/15
C279	Failure to assure that all perishable foods are labeled and dated in accordance with hospital policy and accepted safe food handling practices.	Educate dietary staff about labeling and dating all food properly.	Denise	4/27/15	Yes - 4/27/15
C279	Failure to assure that all perishable foods are labeled and dated in accordance with hospital policy and accepted safe food handling practices.	Purchase a Fresh Date 2 label maker by Med Vantage. The items will be programmed into the machine and will print "Received On", "Opened On", "Pulled to Thaw" and "Use First" stickers to be adhered to each item with dates written on the sticker by dietary staff.	Denise	6/2/15	Yes - 6/2/15
C279	Failure to assure that dietary staff consistently adhered to daily and weekly cleaning schedules to maintain sanitary food preparation and storage areas.	Educate dietary staff about the dietary cleaning list and cleaning duties.	Denise	4/27/15	Yes - 4/27/15
C298	Failure to understand patient capacity.	A delirium knowledge pretest given to all nurses to assess their understanding of delirium and acute confusion and develop educational program for nursing staff.	Amy	Pretest - 6/5/15 Education - 6/30/15	Pretest - Yes - 6/5/15
C298	Failure to use alternative, less restrictive interventions as directed by the general procedures for all involuntary procedures.	Nurse education which will include strategies on how to identify and respond to patient behavioral issues (distraction, redirection, offering a quiet space).	Amy	7/31/15	

C298	Failure to develop nursing care plans.	Nurse educator had identified deficiencies with nursing care planning and held educational sessions.	Amy	5/4/15 and 5/7/15	Yes - 5/4/15 and 5/7/15
C298	Failure to develop nursing care plans.	Nursing was notified by email that their are new care plans available for use in our EMR.	Amy	5/21/15	5/21/2015
C298	Failure to develop care plan for mental health patient.	Nurse education regarding delirium, confusion, capacity and behavioral emergencies.	Amy/Dr. Schmidt	7/31/15	