

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 23, 2015

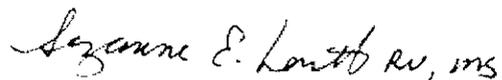
Mr. Roger Allbee, Administrator  
Grace Cottage Hospital Swing Bed Unit  
185 Grafton Road  
Townshend, VT 05353

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 10 2015



June 8, 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 47Z300

Dear Ms. Leavitt,

Enclosed please find:

- Signed form CMS-2567 received by Grace Cottage Hospital on May 29, 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

*Handwritten note:*  
Schmidt  
6-11-15  
P. Cant



VERMONT

AGENCY OF HUMAN SERVICES  
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING  
Division of Licensing and Protection

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May 29, 2015

Roger Allbee, Administrator  
Grace Cottage Hospital Swing Bed Unit  
185 Grafton Road  
Townshend, VT 05353

Provider ID #:

Dear . Allbee:

On **April 29, 2015**, the Division of Licensing and Protection conducted a complaint investigation at your facility. After a careful review of the findings, we have determined that your hospital is not in compliance with Medicare Swing Bed Requirements for Critical Access Hospitals (CAH). one deficiency was cited at the standard level. The deficiencies identified are listed on the enclosed form CMS-2567 Statement of Deficiencies.

Since the hospital was not in compliance with all Centers for Medicare & Medicaid Services (CMS) at CFR 485 (Critical Access Hospitals) regulations you must submit a Plan of Correction (POC) to this office by **June 8, 2015**. Under Federal disclosure rules a copy of the findings of this Medicare survey must be publicly disclosed within 90 days of the completion.

The POC is your allegation of compliance and must contain the following:

- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective actions will be monitored to ensure the deficient practice will not reoccur, i.e., what quality assurance program will be put into place.
- The dates corrective action will be completed.

If you have any questions concerning this letter, please contact me at (802) 871-3317.

Sincerely,

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



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

PRINTED 05/29/2015  
FORM APPROVED  
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  472300	(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 SWING BED UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 185 GRAFTON ROAD 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  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. The following Critical Access Hospital (CAH) Swing Bed Unit regulatory violations were found:	C 000		
C 361	485 645(d)(1) RESIDENTS RIGHTS  [The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter.]  (1) Resident rights (§483.10(b)(3))  "The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition;"  This STANDARD is not met as evidenced by: Based on record review and staff interview, the hospital failed to provide a written copy of Resident Rights to 10 of 10 patients sampled from the Swing Bed status admissions to the unit. The findings are as follows:  Per review of a sample of 10 patients who were admitted to the hospital's Swing Bed Status, none of the patient records had evidence of patient receipt of a written copy of the Resident Rights, and a verbal explanation of those rights as required by the Centers for Medicare and Medicaid Services (CMS) per requirements for Critical Access Hospitals (CAH) with Swing Beds. A review of the admission packet given to patients upon admission to a Swing Bed did not include a copy of Resident Rights. During	C 361		

*see Attachment #1 (a-d)*

*Doc. submitted 6-23-15 S. Davis / gpl*

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE CFO	DATE 05/29/15
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>47Z300</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/29/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRACE COTTAGE HOSPITAL SWING BED UNIT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>185 GRAFTON ROAD TOWNSHEND, VT 05353</b>		
(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	
C 361	Continued From page 1 interview on 4/28/15 at 2 20 PM, the CNO (Chief Nursing Officer) confirmed that patients were not provided a copy of the Resident Rights upon admission	C 361			
C 362	485 645(d)(1) RESIDENTS RIGHTS  [The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter ]  (1) Resident rights (§483.10(b)(4)):  "The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section; and"  §483.10(b)(8)  "The facility must comply with the requirements specified in subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. If an adult individual is incapacitated at the time of admission and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he	C 362	<i>See attachment #2 (a-h)</i>		

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NAME OF PROVIDER OR SUPPLIER  GRACE COTTAGE HOSPITAL SWING BED UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 185 GRAFTON ROAD TOWNSHEND, VT 05353		
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C 362	Continued From page 2 or she has executed an advance directive, the facility may give advance directive information to the individual's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with State law. The facility is not relieved of its obligation to provide this information to the individual once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time."  This STANDARD is not met as evidenced by: The facility staff failed to recognize and respect that 1 of 10 residents had the right to refuse treatment, to include medications or assistance with mobility and transfers (Resident #1) Findings include:  1. Per record review, Resident #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 Resident #1 had a long psychiatric history (Bipolar disorder) and dementia and recently had not been compliant with prescribed medication. The patient's attending physician who visited with the patient at the time of admission noted Patient #1 to be "quite manic." Patient #1 would often refuse assistance from nursing staff for personal care, refused medications and would not participate in physical and occupational therapy.  Per review of Swing Bed hospitalization, individual staff at times failed to acknowledge and respect the resident's rights. On 4/10/15 at 05:30	C 362			

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NAME OF PROVIDER OR SUPPLIER  GRACE COTTAGE HOSPITAL SWING BED UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 185 GRAFTON ROAD TOWNSHEND, VT 05353		
(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	
C 362	Continued From page 3 Resident #1 refused to get out of bed to have his/her bed changed after an episode of incontinence. The Nursing progress note states " we made pt get up with us by picking her/him up with her/his strong objections and slapping at us and put her/him on BSC (bed side commode) tried to talk her/him into putting legs up in bed, and finally told pt that after a count of 5 if s/he did not get her/his legs up we would do it for her/him " On 4/14/15 at 2330 Resident #1 was found sitting up in a chair in his/her room napping When approached by 2 nurses to assist Resident #1 to bed, the Resident refused. Despite the resident's objections and refusal and upon the insistent of Nurse #1, Resident #1 was forced to go to bed. Resident #1 complained to staff and asked not to be "man-handled" Per interview on 4/28/15 at 8 30 AM Nurse #1 confirmed his/her involvement with Resident #1 on 4/14/15, justifying his/her actions as a result of directions from the resident's attending physician who had informed staff to make Resident #1 do what is needed for her/his care and if s/he will not comply with requests then staff are to physically assist the resident Resident #1 was not determined to be incapacitated and was able to make health decisions of his/her choice.	C 362			
C 395	485 645(d)(6) COMPREHENSIVE CARE PLANS  [The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter  Comprehensive assessment, comprehensive care plan, and discharge planning (§483 20(b), (k), and (l), except that the CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under	C 395			

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NAME OF PROVIDER OR SUPPLIER  <b>GRACE COTTAGE HOSPITAL SWING BED UNIT</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>185 GRAFTON ROAD TOWNSHEND, VT 05353</b>	
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C 395	Continued From page 4 §483 20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in §413 343(b) ]  Comprehensive care plans (§483 20(k)(1))  "The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following-  (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25, and  (ii) Any services that would otherwise be required under §483 25 but are not provided due to the resident's exercise of rights under §483 10, including the right to refuse treatment under §483 10(b)(4) "  This STANDARD is not met as evidenced by The facility failed to develop a comprehensive care plan to address the psychosocial and behavioral health needs of 1 of 10 sampled residents to promote his/her highest level of well being. The findings are as follows  1. Per review of the comprehensive assessment, there was a failure of the multidisciplinary team to address the psychosocial and behavioral health needs for Resident #1. Per record review, Resident #1 age 84 was admitted to the CAH (Critical Access Hospital) on 4/4/15 for	C 395	<p style="font-size: 2em; text-align: center;"><i>see attachment # 2 (a-h)</i></p> <p style="text-align: right;"><i>[Signature]</i></p>
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C 395	<p>Continued From page 5</p> <p>rehabilitation after a repair of a fractured hip. Upon admission it was noted Resident #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.</p> <p>Per review of the comprehensive care plan, although Resident #1's anxiety was partially addressed, there was minimal input from all disciplines to address how to appropriately approach, redirect, react and manage nursing staff interactions with Resident #1 which would also help support the resident's mental and psychosocial well-being. Per interview on the afternoon of 4/29/15, the CNO (Chief Nursing Officer) confirmed the comprehensive care plan for Patient #1 had failed to address behavioral factors which impacted the provision of both nursing care and rehab therapies.</p>	C 395		

Plan of Correction Outstanding Work Items TRACKING SPREADSHEET - SWING BED

TAG NUMBER	ISSUE	PLAN OF CORRECTION	RESPONSIBLE PARTY	TARGET COMPLETION DATE	COMPLETED
C361	Failure to provide a copy of resident rights to 10 patients upon admission and provide a verbal explanation of those rights.	Initiate the inclusion of the 'Additional Bill of Rights for Swing Patients' in the patient admission information packet. The unit secretary's patient packet checklist will also be updated to include this document.	Jeanne	6/1/2015	Yes
C362	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
C362	Failure to use alternative, less restrictive interventions as directed by the general procedures for all involuntary procedures.	Nurse education including resident rights and the patient's right to refuse, identifying and responding strategies to patient behavioral issues (distraction, redirection, offering a quiet space etc.).	Amy	7/31/15	
C362	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

*for review  
5/23/15  
S. Bryner*

For unit 15  
 5/24/15  
 S. Davis

C362	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
C362	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
C395	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
C395	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	
C395	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

C395	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
C395	Failure to develop care plan for mental health patient.	Nurse education regarding delirium, confusion, capacity and behavioral emergencies.	Amy/Dr. Schmidt	7/31/15	

5/21/15  
 Amy  
 Schmidt

GRACE COTTAGE HOSPITAL – PROVIDER # 47Z300 - ATTACHMENT # 1

Tag C 361  
Plan of Correction

Every patient (acute, swing I, swing II) that gets admitted into Grace Cottage Hospital is given our "Bill of Rights and Responsibilities for Hospitalized Patients" (attachment 1a). As of June 1<sup>st</sup>, we began giving a second document entitled "Additional Bill of Rights for Swing Patients" (attachment 1b) to all Swing patients. This document has been added to the Unit Secretary's New Admission Worksheet (attachment 1c). The unit secretaries are responsible for ensuring that all admission paperwork and consents are given to patients and completed in a timely fashion. The patients continue to sign the "Acknowledgement of Receipt of Information" (attachment 1d), which now also lists the "Additional Bill of Rights for Swing Patients". When patients sign the Acknowledgement of Receipt of Information, they acknowledge that they have received, discussed and have had the opportunity to ask questions about the documents listed on it (attachment 1d). The unit secretary is also responsible to scan into the patient's EMR the signed acknowledgement and admission consent. Once a week, the head unit secretary will continue to spot check admission charts to make sure that information has been distributed and required forms have been signed, scanned and are present in the record.

BC  
6-28-11  
S. DeWitt

GRACE COTTAGE HOSPITAL – PROVIDER # 47Z300 - ATTACHMENT # 1

Tag C 362  
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 1<sup>st</sup> 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 31<sup>st</sup>. Attendance will be taken and recorded. Any staff member who did not attend will be followed up with by the Rehabilitation Director.

*Planned  
6-24-15  
S. Diaz/SL*

GRACE COTTAGE HOSPITAL – PROVIDER # 47Z300 - ATTACHMENT # 1

Tag C 395  
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.

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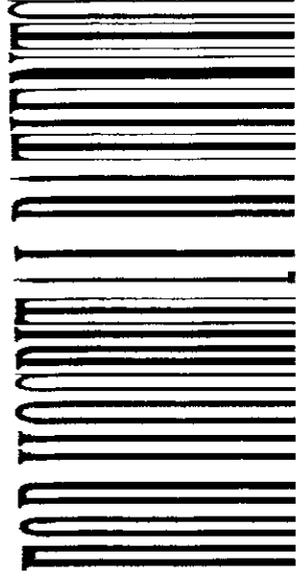
Compliance with the initiation and individualization of appropriate care plans for our patients will be monitored by the on duty charge nurse within 24 hours of a patient's admission, utilizing the "Nursing New Admission Check List" (attachment 2g). The checklist will be reviewed weekly by the nurse 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.

*Revised  
6-24-15  
S. Davis RSE*

Attachment 1a



**BILL OF RIGHTS & RESPONSIBILITIES**



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**BILL OF RIGHTS & RESPONSIBILITIES  
FOR HOSPITAL PATIENTS**

Grace Cottage Hospital  
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Updated 09/2011  
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**CARLOS G. OTIS HEALTH CARE CENTER, INC.  
GRACE COTTAGE HOSPITAL**

**BILL OF RIGHTS FOR HOSPITAL PATIENTS**

In accordance with Vermont law (18 V.S.A. 42), Grace Cottage Hospital acknowledges its obligations to honor the following rights granted to hospital patients:

- Considerate and respectful care and recognition of personal dignity .
- To have an attending physician responsible for coordinating care, and to know the name of that physician and any other person responsible for procedures or treatment.
- Except in emergencies, to be informed by his/her physician of complete and current information concerning his/her diagnosis, treatment, any known prognosis, medically significant risks, and medically significant alternatives in terms the patient can reasonably be expected to understand, and to make an informed consent to, or informed refusal of, treatment or procedures.
  - If the patient consents, if the patient is incompetent or unable to understand, or if it is not medically advisable to give such information to the patient, the information may also be received by the patient's agent as designated in his/her advance directive, immediate family members, reciprocal beneficiary, civil union partner or guardian, who may make medical decisions on behalf of the patient as authorized by law.
  - If the patient, or an authorized person on behalf of the patient, refuses treatment, he/she shall be informed of the medical consequences of that action.
- Privacy
  - Case discussion, examination, treatment are to be discreetly conducted.
  - Those not directly involved in the patient's care are present only with patient's permission.
  - If the patient requests, a person of his/her own sex is present during examination by a health care professional of the opposite sex.

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- The patient is not to remain disrobed any longer than is required for accomplishing the medical purpose involved.
- The patient may wear appropriate personal clothing and religious or other symbolic items if they do not interfere with diagnostic procedures or treatment.
- To have access to information regarding Advance Directives, to formulate an Advance Directive, and to have the Hospital staff implement your Advance Directive in compliance with Hospital policies and procedures.
- Confidentiality - Only individuals directly involved with the patient care, or those monitoring the quality or effectiveness of that care, shall have access to the patient's medical records. Others may have access only with legal authority or the patient's written authorization.
- Reasonable responses to reasonable requests for services within the capacity of the hospital, including without exception:
  - Transfer to another room, if physically possible, if unreasonably disturbed by another person in that room or place
  - Transfer to another facility only after receiving complete information concerning need for, and alternatives to, such transfer and acceptance by the receiving facility.
  - To receive professional assessment of pain and professional pain management.
  - To be informed in writing of the availability of hospice services and the eligibility criteria for those services.
- To know the identity and professional status of individuals providing service to him/her, and the existence of any professional relationship among those individuals and/or between those individuals and any other health care or educational institutions involved in his/her care
- To refuse to participate in clinical training programs
- To refuse to participate in human experimentation or in projects gathering data for research
- Continuity of care and information from attending physician of any continuing health care needs after discharge
- An itemized, detailed and understandable explanation of charges, regardless of source of payment
- Information about what hospital rules and regulations apply to him/her as a patient
- Whenever possible, 24 hours per day visitation for patients who are children by their guardians or parents, or for patients who are terminally ill by their

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guardians, agents, reciprocal beneficiaries, civil union partners or immediate family members

- An interpreter for a patient who does not speak or understand English, or who is hearing impaired, if the language barrier or impairment presents a continuing problem to patient understanding of the provided care and treatment

*This organization has a process for addressing complaints by or on behalf of patients. If you have a complaint regarding your care or treatment or other associated issue, you are encouraged to notify any of the following hospital representatives at 802-365-7357:*

*Roger Allbee, Interim CEO, ext. 108*

*Jeanne Fortier, COO/CNO, ext. 116*

*Jessica Emerson, Director of Social Services, ext. 150*

*Elaine Swift, Director of Quality/Compliance, ext.157*

*You may lodge a complaint directly with one of the following state agencies, regardless of whether you have notified a hospital representative of your concerns:*

*Department of Disabilities, Aging and Independent Living,  
Division of Licensing and Protection*

*103 South Main Street, Ladd Hall, Waterbury VT 05671-2306*

*Toll Free (in Vermont) 800-564-1612 or 802-871-3326*

*Or*

*Board of Health and Board of Medical Practice*

*Vermont Department of Health*

*PO Box 70, Burlington, VT 05402-0070*

*Toll-free (in Vermont) 800-745-7371 or 802-674-4220*

### **RESPONSIBILITIES OF HOSPITAL PATIENTS**

**To assist us in providing the quality of care and services you expect and deserve, you as a patient at Grace Cottage Hospital, or the person who may make medical decisions on your behalf as authorized by law, have certain responsibilities. You are responsible to:**

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- Provide complete and accurate information, including your full name, address, home telephone number, date of birth, insurance carrier and coverage, employer, and when necessary, your Social Security number.
- Provide the Hospital or your doctor with a copy of your advance directive if you have one.
- Provide complete and accurate information about your health and medical history, including present condition, past illnesses, hospital stays, medications (including vitamins, herbals and other drugs), and any other matters that pertain to your health, including perceived safety risks.
- Ask questions about your treatment, diagnosis and/or prognosis and when you do not understand instructions or information being given to you.
- Report unexpected changes in your condition to your doctor or nurse.
- Tell your doctor if you believe that you cannot follow through with the plan for your care, treatment or follow-up services. Accept responsibility for your actions if you should refuse or choose not to follow care, treatment and/or services plans.
- Actively participate in your pain management plan. Alert us when you are in pain and assist your doctor and nurse in assessing your level of pain and the effectiveness of pain relief interventions.
- Leave valuables at home and only bring necessary items for your hospital stay. Never bring a weapon, alcohol or non-authorized drug/medication into the Hospital.
- Use only the medications prescribed for you in the amount specified.
- Treat all Hospital staff, other patients and visitors with courtesy and respect. Abide by all Hospital rules and safety regulations, including the no smoking policy. Be mindful of noise levels, privacy and number of visitors.
- Fulfill your financial obligations for care and treatment in a timely manner. Be honest with us about your financial needs so that we may connect you to resources that can assist you with these obligations.
- Talk to a member of the staff if you are dissatisfied with the care or services you have received.

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## ADDITIONAL BILL OF RIGHTS FOR SWING PATIENTS

As a Swing patient, you have certain rights and responsibilities specific to your level of care. We have outlined them as follows:

1. Grace Cottage Hospital will inform you or your representative about your rights at the time you are admitted by issuing you or your representative this document. You will be asked to sign a form acknowledging that you received this information.
2. We will ask you or your representative to sign a consent for treatment form accepting the responsibility of payment for your care.
3. We will gladly give you or your representative information regarding your billing records upon request by yourself or your representative.
4. If you or your representative want information concerning Medicaid or help in filling out Medicaid forms, a representative of the business office or Social Services will be glad to assist you.
5. Your physician will tell you or your representative about your medical condition and will document that this was done.
6. You may participate in planning your medical treatment, planning for discharge, and may refuse to take part in experimental research.
7. You may be transferred or discharged for medical reasons, for your own welfare, or the welfare of other patients. We must inform you and document all such action.
8. You will be treated with consideration and respect, in full recognition of your personal dignity and individuality. You have the right to privacy and confidentiality in your treatment and in the care of your personal needs.
9. You have the right to receive the care you need. You will not be subject to mental, verbal, or physical abuse. You will not be subject to chemical or physical restraints unless ordered by your physician for a specified and limited period of time, in order to protect you or others.
10. You will not be required to perform any work for the hospital unless it is part of your therapeutic plan.
11. Your personal medical records are confidential. You have the right to approve or refuse their release to people or organizations outside the hospital, except when you are transferred to another facility or when information is requested by a third party payor (an insurance company).
12. You may choose your own friends. You may send and receive mail unopened, unless your physician thinks this is not medically advisable. Your physician must document any restrictions.
13. You may attend the social and religious groups of your choice, unless your physician thinks this is not medically advisable. Your physician must document any restrictions.

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14. You may have your own clothes and possessions as space permits.
15. Married couples or your reciprocal beneficiary may share the same room, unless your physician thinks this is not medically advisable and document this opinion. We assure you privacy when your spouse visits or at your request.
16. You have the right to receive information on alternatives for your care and treatment.
17. To the extent permitted by law, you have the right to refuse care or treatment, and to be informed of the consequences of that action. In the event of your refusal, the hospital shall be relieved of any further responsibility.
18. You have the right to choose your own attending physician who is responsible for coordinating your care.
19. If you have pain, you have the right to a professional assessment and management of pain.
20. Whenever possible, guardians or parents have the right to stay with their minor children 24 hours per day. Whenever possible, agents, guardians, reciprocal beneficiaries or immediate family members have the right to stay with terminally ill patient's 24 hours per day.
21. You are encouraged to exercise your rights as a patient and as a citizen or resident of the United States. You may voice grievances and recommend changes to the staff or to outside representatives without reprisal or interference.
22. We will provide notice and explanation if we need to relocate you within our facility.

As a patient you have the responsibility:

- To be considerate of other patients by respecting their privacy and limiting visitors;
- To observe safety regulations, including the non-smoking policy;
- To supply accurate information to appropriate personnel;
- To ask questions if medical instruction is not clear;
- To participate in and follow the treatment plan recommended by your physician. This includes cooperation with other health-care personnel who are implementing physician orders.
- To be respectful to staff

## RESOLVING ANY QUESTIONS

Grace Cottage Hospital takes all complaints seriously. Complaints are viewed as an opportunity to learn from our patients' experiences and make systemic improvements. Patients, visitors and family members can submit complaints in a number of ways:

- Verbal and/or written to any member of the GCH staff
- Verbal and/or written to any member of the Quality Management
- Department, Board of Trustees or administrative staff
- Written, using the contact form on the Hospital website at <http://gracecottage.org/contact-us/>

If you are not satisfied with the response you receive from the department manager, you may contact the Quality Management Department directly at (802) 365-3707. If you feel the need to speak with someone outside of Grace Cottage Hospital, you can contact the following state agencies:

Department of Disabilities, Aging, and Independent Living (DAIL)  
Vermont Division of Licensing and Protection  
103 South Main Street, Ladd Hall  
Waterbury, VT 05671-2306 (802) 871-3326  
(800) 564-1612  
Vermont Board of Health and Board of Medical Practice

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Vermont Board of Health (802) 863-7280  
Vermont Board of Medical Practices (802) 657-4220  
All Boards can be written to at: Vermont Department of Health P.O. Box 70  
Burlington, VT 05401-0070

Vermont Board of Nursing  
81 River Street  
Montpelier, VT 05609-1104  
(802) 828-2396

Disability Rights Vermont  
141 Main Street, Suite 7  
Montpelier, VT 05602  
(802) 299-1355  
(800) 834-7890

Vermont Health Care Ombudsman  
P.O. Box 1367  
Burlington, VT 05401  
(800) 917-7787

For Medicare Patients Contact:  
Livanta (the quality improvement organization for Vermont) at:  
9090 Junction Drive, Suite 10  
Annapolis Junction, MD 20701  
Helpline Phone Number (complaints and appeals):  
(866) 815-5440 (toll-free)  
TDD: (866) 868-2289  
Fax: (844) 420-6671  
Medicare Hotline: 800-633-4227

We will begin to investigate your problems within five working days and will work to resolve it as soon as possible. You may also write the Hospital Chief Executive Officer. All correspondence will receive prompt personal attention.

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6-24-11  
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Attachment 1d



Name of Patient: \_\_\_\_\_

Room: \_\_\_\_\_

**Acknowledgement of Receipt of Information**

I acknowledge that a Grace Cottage Hospital representative has provided me with information concerning the following policies, procedures and/or informational brochures:

- Important Message from Medicare*
- Patient's Bill of Rights and Responsibilities*
- Swing Patient's Additional Rights (For Swing I and II)*
- Joint Notice of Privacy Practices*
- Admission Agreement (For Swing II Only)*

I also acknowledge that I have had the opportunity to ask questions about these policies, and that my questions have been answered to my satisfaction.

*Please indicate your interest in our pastoral care program:*

I would like:

- A chaplain to visit me.
- A chaplain to let my pastor know I am here.
- I do not wish any pastoral assistance at this time.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date/Time

*If the patient has been determined by the court to be incompetent, or if the patient's physician has documented that the patient is incapable of understanding his/her rights and responsibilities, this acknowledgement may be signed on behalf of the patient by his/her authorized representative (health care agent, guardian, next of kin):*

\_\_\_\_\_  
Print Name of Authorized Representative

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date/Time

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# try this:

Best Practices in Nursing  
Care to Older Adults

From The Hartford Institute for Geriatric Nursing, New York University, College of Nursing

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*.<sup>■</sup> 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.ConsultCeriRN.org](http://www.ConsultCeriRN.org).

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

CAM Disclaimer: [www.hospitalelderlifeprogram.org/private/cam-disclaimer](http://www.hospitalelderlifeprogram.org/private/cam-disclaimer).

Useful websites for clinicians including the CAM Training Manual:

[www.hospitalelderlifeprogram.org/pdf/TheConfusionAssessmentMethodTrainingManual.pdf](http://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 inpatients: A systematic literature review. *Age and Aging*, 35(4), 350-364.

Tullmann, D.P., Fletcher, K., & Foreman, M.D. (2012). Delirium. In M. Boltz, E. Caperuti, 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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5-25-15  
JSA

## 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:**

How to Assess if Nursing  
Care is Older Adults

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

EMAIL: [hartford.ign@nyu.edu](mailto:hartford.ign@nyu.edu) HARTFORD: 212.875.5600 WWW: [www.hartfordign.org](http://www.hartfordign.org)  
GERIATRIC NURSING WEB SITE: [www.ConsultGerIRN.org](http://www.ConsultGerIRN.org)

Develop  
older  
GAS

**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 \_\_\_\_\_

**BOX 1**

**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 \_\_\_\_\_

**BOX 2**

**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.

Accept  
Proctor  
#

ACE Unit - Geriatrics  
C Am

ACE Unit - mobility walking frequency

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  
Dietary 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 light

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 gain

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 delirium

# Attachment 2c

## 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:

Picanto  
6-24-15  
S.2in/10

## **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.**

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? \_\_\_\_\_

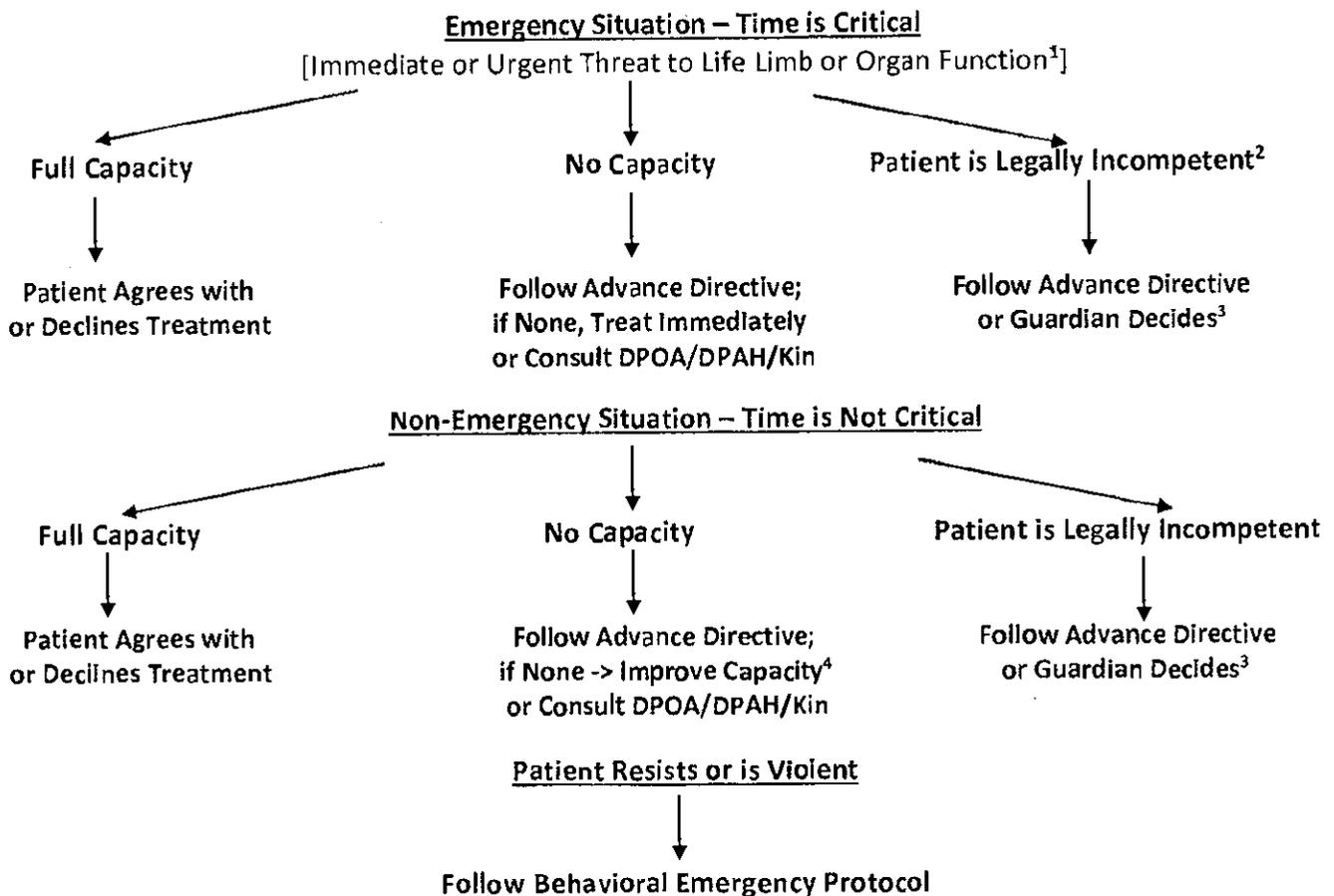
Step 2: Capacity Assessment Compiled by \_\_\_\_\_ Witness \_\_\_\_\_

- 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.

*Revised  
6-25-15  
S. D. [Signature]*

## Capacity & Competence Treatment Algorithm



<sup>1</sup> "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."

<sup>2</sup>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.

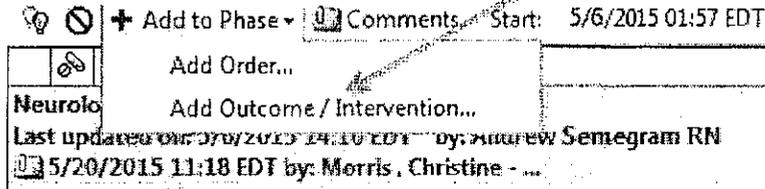
It is legally acceptable to examine a minor to determine if he/she is experiencing an emergency. A total hands-off approach until the guardian is contacted is not necessary and may be dangerous if an emergent condition is missed.

<sup>3</sup>If 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.

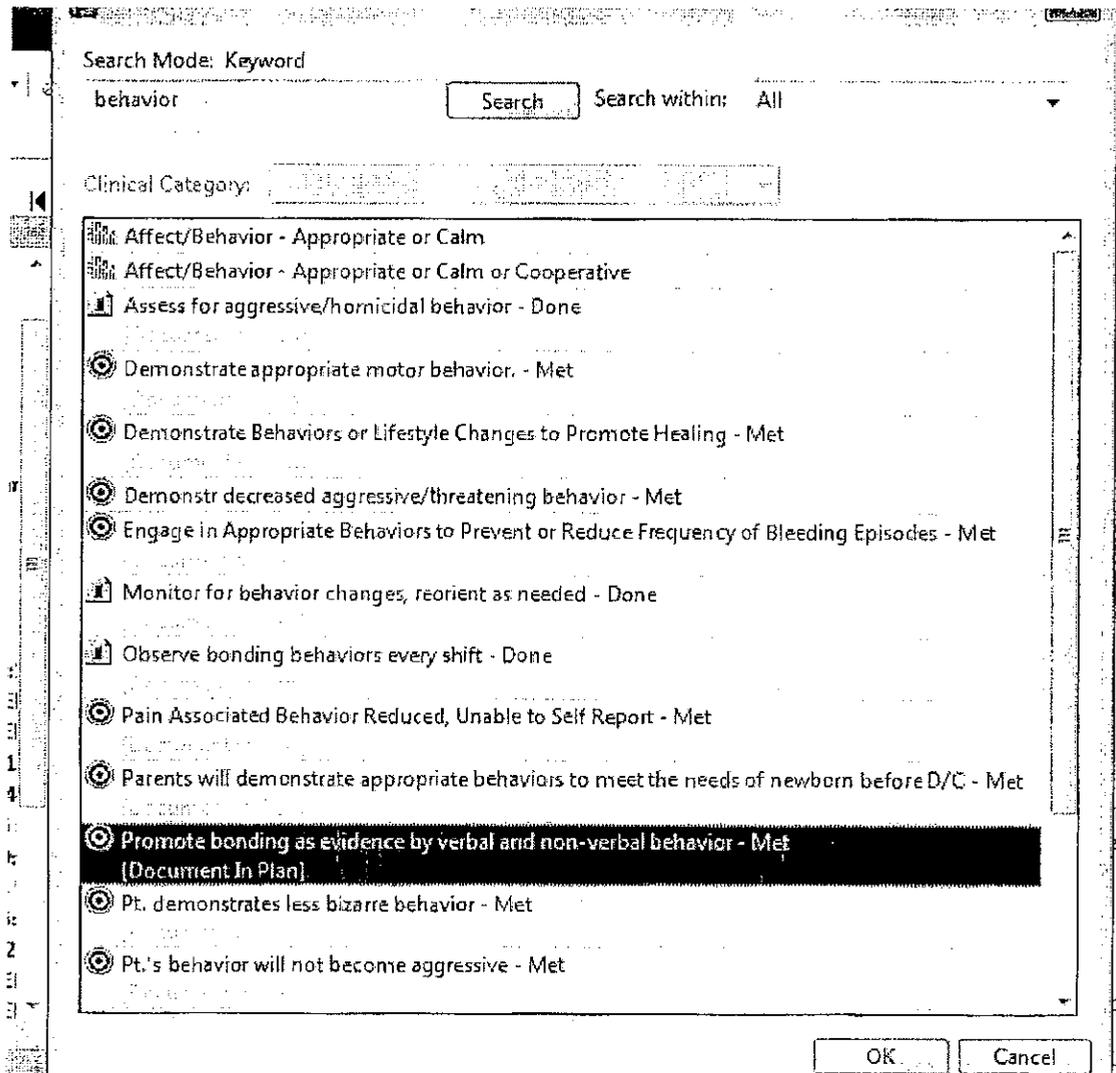
<sup>4</sup>Ideas: hydration, nutrition, sleep, oxygen administration, comfort measures, presence of DPOA, kin, friend or another nurse, anxiolytic meds, reduction of medications.

## How to Customize Plans of Care:

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



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.



Rec'd  
6-24-16  
S.D.M.



**Anxiety Plan of Care (Planned Pending)**

	\$	▼	Component	Status	Details
▼ Outcomes					
<input checked="" type="checkbox"/>			Demonstrate improved concentration and accuracy of...		By Phase End
<input checked="" type="checkbox"/>			Demonstrate return of basic problem-solving skills. - ...		By Phase End
<input checked="" type="checkbox"/>			Demonstrate some ability to reassure self. - Met		By Phase End
<input checked="" type="checkbox"/>			Identify and verbalize symptoms of anxiety. - Met		By Phase End
<input checked="" type="checkbox"/>			Identify, verbalize and demonstrate anxiety control tec...		By Phase End
▼ Interventions					
<input checked="" type="checkbox"/>			Accept client's defenses, do not confront, argue or de...		During Phase
<input checked="" type="checkbox"/>			Assess for the presence of depression. - Done		During Phase
<input checked="" type="checkbox"/>			Avoid stimulants: caffeine, nicotine, theophylline, terb...		During Phase
<input checked="" type="checkbox"/>			Explain all activities and procedures using simple term...		During Phase
<input checked="" type="checkbox"/>			Explore coping skills previously used by client to reliev...		During Phase
<input checked="" type="checkbox"/>			Help client identify precipitants of anxiety. - Done		During Phase
<input checked="" type="checkbox"/>			Intervene when possible to remove sources of anxiety;...		During Phase
<input checked="" type="checkbox"/>			Involve significant other in information giving, proble...		During Phase
<input checked="" type="checkbox"/>			Rule out withdrawal from alcohol, sedatives or tobacc...		During Phase
<input checked="" type="checkbox"/>			Review Care Plan (Review Plan of Care)		Qshift - 12 hour, Review Anxiety Plan of Car
<input checked="" type="checkbox"/>			Consult to Mental Health		
<input checked="" type="checkbox"/>			Administer anxiolytics as ordered. - Done		During Phase

**Confusion Plan of Care (Planned Pending)**

	Component	Status	Details
<p>4 Outcomes</p>			
<input type="checkbox"/>	<p> Demonstrate restoration of cognitive status to baseline...</p>		By Phase End
<input type="checkbox"/>	<p> Maintain functional capacity. - Met</p>		By Phase End
<input type="checkbox"/>	<p> Obtain adequate amounts of sleep. - Met</p>		By Phase End
<input type="checkbox"/>	<p> Demonstrate use of techniques to help with memory l...</p>		By Phase End
<input type="checkbox"/>	<p> Assist the client in developing reminders, (e.g. calenda...</p>		By Phase End
<p>4 Interventions</p>			
<input type="checkbox"/>	<p> If possible, determine and treat underlying cause of co...</p>		During Phase
<input type="checkbox"/>	<p> Maintain a normal sleep-wake cycle. - Done</p>		During Phase
<input type="checkbox"/>	<p> Place patient in a room near the nurses station - Done</p>		During Phase
<input type="checkbox"/>	<p> Maintain fall precautions - Done</p>		During Phase
<input type="checkbox"/>	<p> Review Care Plan (Review Plan of Care)</p>		Qshift - 12 hour, Review Confusion (Acute) Plan of C
<input type="checkbox"/>	<p> Establish a calm environment. - Done</p>		During Phase
<input type="checkbox"/>	<p> Determine if memory loss onset is gradual or sudden. ...</p>		During Phase
<input type="checkbox"/>	<p> Neuro checks qshift, as ordered, or prn - Done</p>		During Phase
<input type="checkbox"/>	<p> Monitor pulse oximetry - Done</p>		During Phase
<input type="checkbox"/>	<p> Ensure pt is in safe environment by removing potentia...</p>		During Phase
<input type="checkbox"/>	<p> Use brief simple wording-closed questions when able ...</p>		During Phase
<input type="checkbox"/>	<p> Encourage family to stay with patient - Done</p>		During Phase
<input type="checkbox"/>	<p> Determine amount and pattern of alcohol intake. - Do...</p>		During Phase
<input type="checkbox"/>	<p> Re-orient patient with each contact - Done</p>		During Phase
<input type="checkbox"/>	<p> Administer medications as ordered - Done</p>		During Phase

**Risk for Injury Plan of Care (Planned Pending)**

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

Add to Phase **Start:** Now **Duration:** None

Component	Status	Details
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**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**

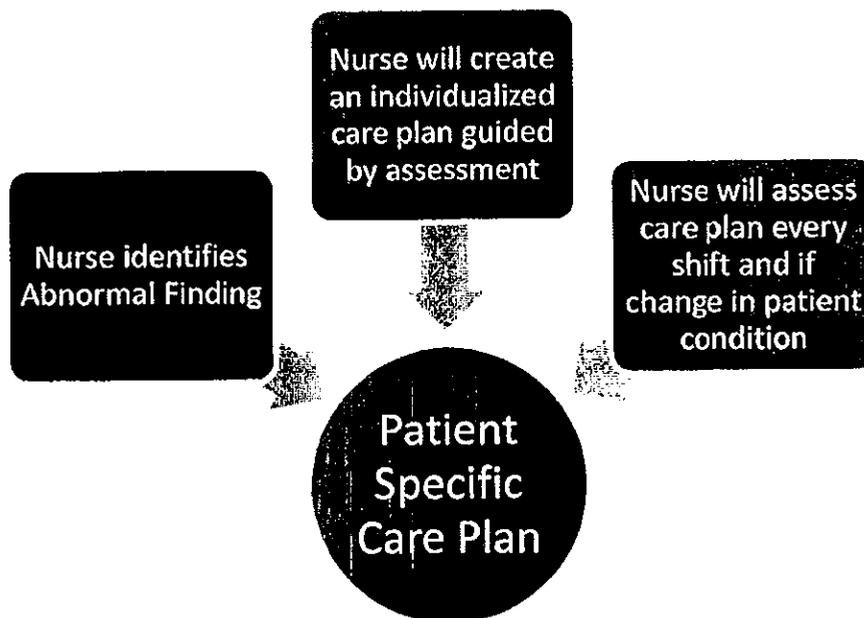
Provide emotional support - Done **During Phase**

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**

**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

# Care Plan Worksheet - SOAP note | 2015

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



# Attachment 2h

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%

Beant  
6-24-15  
S. D. M. (S)

## GRACE COTTAGE HOSPITAL – PROVIDER # 47Z300 - ATTACHMENT # 1

## Tag C 362

## 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 by 80% of nursing by July 17, 2015 and the remaining 20% of nurses no 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 1<sup>st</sup> 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.

*1306-24-15  
S. M. [Signature]*

## GRACE COTTAGE HOSPITAL – PROVIDER # 47Z300 - ATTACHMENT # 1

Tag C 395  
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 by 80% of nursing by July 17, 2015 and the remaining 20% of nurses no 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 1<sup>st</sup> 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.

*Print  
6-24-15  
S. B. B.*

Plan of Correction Outstanding Work Items TRACKING SPREADSHEET - SWING BED					
TAG NUMBER	ISSUE	PLAN OF CORRECTION	RESPONSIBLE PARTY	TARGET COMPLETION DATE	COMPLETED
C361	Failure to provide a copy of resident rights to 10 patients upon admission and provide a verbal explanation of those rights.	Initiate the inclusion of the 'Additional Bill of Rights for Swing Patients' in the patient admission information packet. The unit secretary's patient packet checklist will also be updated to include this document.	Jeanne	6/1/2015	Yes
C362	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
C362	Failure to use alternative, less restrictive interventions as directed by the general procedures for all involuntary procedures.	Nurse education including resident rights and the patient's right to refuse, identifying and responding strategies to patient behavioral issues (distraction, redirection, offering a quiet space etc.).	Amy	80% of nursing to be completed by July 17, 2015, remaining 20% by July 31, 2015	
C362	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

*Beant  
6-24-15  
S. Smith*

C362	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
C362	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
C395	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
C395	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	80% of nursing to be completed by July 17, 2015, remaining 20% by July 31, 2015	
C395	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

*Revised  
6-24-15  
S.M.R.*

C395	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
C395	Failure to develop care plan for mental health patient.	Nurse education regarding delirium, confusion, capacity and behavioral emergencies.	Amy/Dr. Schmidt	80% of nursing to be completed by July 17, 2015, remaining 20% by July 31, 2015	

*Pro into  
6-24-15  
S. Dim R*