

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

103 South Main Street, Ladd Hall

Waterbury VT 05671-2306

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

Voice/TTY (802) 871-3317

To Report Adult Abuse: (800) 564-1612

Fax (802) 871-3318

January 9, 2014

Kevin Donovan, Administrator
Mt Ascutney Hospital
289 County Road
Windsor, VT 05089-9000

Dear Mr. Donovan:

The Division of Licensing and Protection completed a survey at your facility on **December 11, 2013**. The purpose of the survey was to determine if your facility met the conditions of participation for Critical Access Hospitals found in 42 CFR Part 485.

Following the survey, your facility submitted a Plan of Corrections (POC) which was found to be acceptable on **January 9, 2014**.

Sincerely,



Frances L. Keeler, RN, MSN, DBA
Assistant Division Director
Director State Survey Agency

FK:jl

Enclosure

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

PRINTED: 12/30/2013
RECEIVED FORM APPROVED
Division of OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ JAN - 9 14 B. WING _____ Licensing and Protection	(X3) DATE SURVEY COMPLETED 12/11/2013
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NAME OF PROVIDER OR SUPPLIER MT ASCUTNEY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 289 COUNTY ROAD WINDSOR, VT 05089
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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 on-site recertification survey was conducted by the Division of Licensing and Protection on 12/9-12/11/13. There were regulatory findings cited.	C 000		
C 271	485.635(a)(1) PATIENT CARE POLICIES The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law. This STANDARD is not met as evidenced by: Based on record review and confirmed through staff interview the facility failed to assure the use of restraints was applied in accordance with their Policy and Procedure for 1 patient. (Patient #25). Findings include: Per review the facility's policy, last revised in July 2013 and titled Restraints, stated that physical restraint "may only be used..... A. To treat a specific medical condition. B. To provide care and services necessary for the individual to achieve the highest practicable level of well being. C. To prevent self-injury or injury to others. D. When lesser restrictive measures have been ineffective." The policy also stated, "VI. Nursing Responsibilities:....ED...A. Assessment of specific problems, for which a restraint is considered will be made upon admission and whenever use of a restraint is initiated. Upon administration of use of a restraint the specific problem will be documented in the patient/resident record. The patient's plan of care must include.....evidence that less restrictive means of restraint were attempted, but ineffective...B. A nurse may initiate use of a physical restraint...but must obtain a	C 271	1. Restraint Policy was reviewed and revised to more effectively reach, maintain and ensure compliance with the standard of care. Policy was reviewed and revised on January 2, 2014 by the nursing leadership team, and January 3, 2014 by the quality department and plan of correction team. Policy will be presented to the Medical Staff Executive Committee on January 9, 2014 and sent to the Board of Trustees on February 3, 2014 for approval. 2. Standards of care related to restraint use will be reinforced and education provided to the medical staff by the Chief Medical Officer, Dr. Catherine Schneider, at the Medical Executive meeting on January 9, 2014, and through memo to Section Chiefs with the expectation that each Section Chief reinforce the standards with the medical staff for whom they are responsible. 3. Standards of care related to restraint use will be reinforced and education provided to the nursing staff on all inpatient units and the emergency department through the coordinated effort of the quality coach and the ED Manager. Attendance will be documented. Education will include, at a minimum, policy review with emphasis on when and why restraints are initiated. Documenting evidence that less restrictive measures have been attempted and proved to be ineffective prior	By 2/3/14 By 1/16/14 By 2/14/14 in the ED and by 2/28/14 for inpatient units.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kenn W. Dorn</i>	TITLE CEO	(X6) DATE 1/6/14
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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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C 271	<p>Continued From page 1</p> <p>Physician Order within (1) hour. The order must include the type of restraint to be used, the reason for use, and time frame....D. A physician or other licensed independent practitioner, must see and evaluate the need for restraint within (1) hour after the initiation of this intervention."</p> <p>Per record review Patient #25, who presented to the ED on 9/30/13 with suicidal ideation, agitation and alcohol intoxication; had soft wrist restraints applied without indication for use of the restraints, without a physician order and without evidence that less restrictive measures had been attempted and proven ineffective prior to initiation of the restrains. A nursing note, dated 9/30/13 at 11:00 PM, stated; "restraint check, pt able to move (his/her) hands...", indicating that restraints had been applied to each of the patient's hands at some point following arrival in the ED at 5:51 PM. Follow up nursing notes at 11:27 PM and 11:38 PM, respectively, stated; "Left dept. to CT scan....soft restraints removed", and "returns from CT scan, Will keep soft restraints off as long as pt remains cooperative." A provider note, dated 10/1/13 at 12:40 AM - an hour and 40 minutes after the 11:00 PM nursing note, indicated a re-evaluation of the patient had been conducted and stated the patient had become aggressive, leaving [his/her] room....was escorted back to her room....continued to be aggressive verbally escalating.....attempted to exit [his/her] exam room again, and was held up by.....In [his/her] attempt to resist, it appears the patient may have slipped....struck [his/her] head on the base of the stretcher in the room and then the floor....was assisted back onto the cot, and restrained for [his/her] safety....." Although the record indicates there was one to one constant observation of the patient, and despite the</p>	C 271	<p>to restraints intervention, obtaining physician orders and utilizing the restraint templates (please see Attachment 1) in our EMR, how and when to file a Quantros/Incident Report, the importance of on-going assessment and documentation. Please see attached revised Restraint Policy (Attachment 2), having an anticipated approval date of February 3, 2014.</p> <p>4. Quality monitoring to ensure deficiency does not recur. Quality monitoring will be implemented as follows: effective January 3, 2014 each application of a restraint or administration of a chemical restraint will require nursing to initiate a Quantros/incident report entitled Restraint/Seclusion Incident. This will trigger the nurse manager of the unit to complete a quality checklist (please see Attachment 3) to monitor each component of the restraint policy has been met. Follow-up corrective action will be implemented as needed. The nurse manager will submit the completed quality audit to the Director of Risk Management. All audit forms, hospital wide, will be reviewed, trended and evaluated at the Clinical Incident Prevention Committee on a quarterly basis. Follow-up corrective action will be implemented as needed. Reports will be given annually to the Quality Improvement Committee and subsequently to the Board of Trustees. Quality monitoring will be completed on an ongoing basis.</p>	To be completed on an on-going basis.	

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C 271	Continued From page 2 physician note at 12:40 AM on 10/1/13, there was no indication of when or why restraint use was initiated, no evidence that less restrictive measures had been attempted and found to be ineffective prior to use of restraints and no physician order for the restraints. ED nurse #1 confirmed, during interview at on 12/3/13, that there was no evidence of when or why the restraints had been initiated, no evidence that less restrictive measures had been attempted and proven to be ineffective prior to the restraint intervention and no physician orders for use of the restraints. This was also confirmed by the Director of Patient Care Services during interview on the afternoon of 12/4/13.	C 271			
C 276	485.635(a)(3)(iv) PATIENT CARE POLICIES [The policies include the following:] 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: Based on observation and staff interview the facility failed to assure the safe and secure storage of all drugs in the ED (Emergency Department). Findings include:	C 276	1. Effective January 3, 2014 all drugs and biologicals found in the dental box in the emergency department will be either discontinued related to documented lack of use in the last three years, or placed in the Pyxis in the emergency department. Department Head of Pharmacy Services will build order sets in our EMR so that the drugs can be ordered through CPOE. 2. Medications are monitored hospital wide with accountability through the Pyxis system as follows: count of medications and expiration dates are monitored on a weekly basis through a computer-generated report. Soon to expire Medications are manually removed from the Pyxis on a monthly basis. Results of quality monitoring are included in the quarterly pharmacy QA and are reported through the Pharmacy and Therapeutics Committee to the Medical Executive Committee, and annually	1/3/14	To be completed on an on-going basis.

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C 276	Continued From page 3 Per observation, during tour of the ED, at 11:41 AM on 12/11/13, an unlocked Dental kit box, containing 30 vials of marcaine (a local anesthetic) 0.5% and benzogel, containing 20% benzocaine (pain reliever) was found stored in an unlocked cabinet in the trauma room. During interview, at the time of the observation, RN#1 confirmed the drugs were stored in an unsecured manner and stated there was no process or policy to assure accountability of the drugs. The Director of Pharmacy stated, during interview at 10:00 AM on 12/12/13, that the drugs ' should be locked ' . S/he indicated that nursing was responsible for locking the box, and further stated that the drugs within the box were ' non formulary, non traditional meds."	C 276	to the Quality Improvement Committee and the Board of Trustees.		
C 278	485.635(a)(3)(vi) PATIENT CARE POLICIES [The policies include the following:] a system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to assure an ongoing infection control process in the ED (Emergency Department) for cleaning and disinfection of commodes used by patients. Findings include: Per observation, during tour of the ED at 11:41 AM on 12/11/13, one commode, used by patients, was stored in the dirty utility room and one was stored in one of two bathrooms utilized by patients. RN #1 stated, during interview at the	C 278	1. Effective December 9, 2013, and thereafter, emergency room nursing staff will clean the commodes utilizing a facility improved disinfection process and indicate that the process has been completed by placing a sanitary strip around the commode seat. 2. Effective January 3, 2014, housekeeping staff will monitor the presence of strips placed on the commode seats on a daily basis and document the results of their monitoring on a form placed on the door of the utility room. Lack of sanitary strips will be noted on the form. The nurse manager will audit the form, trend any variances, take action as needed to correct variances, and report monthly to the ED Committee, and annually through the Quality Improvement Committee to the Board of Trustees.	12/9/13 Quality monitoring will be completed on an ongoing basis.	

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C 278	Continued From page 4 time of tour, that, although the commodes looked clean, s/he was unsure if they had been cleaned or not as there was no process to confirm it. S/he stated the bathrooms, utilized by patients, are cleaned by housekeeping, and a piece of paper is placed across the seat to identify that cleaning has occurred. S/he further stated that commodes, which are brought to patients for use in their rooms, are cleaned by nursing staff after the patient is discharged and usually stored in each of the patient bathrooms for future use, however, there is no process for identifying whether or not the commodes have been cleaned.	C 278			
C 295	485.635(d)(1) NURSING SERVICES A registered nurse must provide (or assign to other personnel) the nursing care of each patient, including patients at a SNF level of care in a swing-bed CAH. The care must be provided in accordance with the patient's needs and the specialized qualifications and competence of the staff available. This STANDARD is not met as evidenced by: Based on record review and confirmed through staff interview nursing failed to conduct ongoing assessments, in accordance with standards of nursing practice, of the needs of one patient for whom the initial assessment revealed elevated BP (blood pressure) and for whom a change in clinical condition had occurred. (Patient #25). Findings include: Per record review Patient #25, who presented to the ED on 9/30/13 with suicidal ideation, agitation and alcohol intoxication, and whose BP (blood pressure) was elevated, at 176/98, at 6:04 PM,	C 295	1. On January 3, 2014, the team, including the quality department, nurse manager of the ED, and the Director of Patient Care services reviewed and revised the hospital policy entitled "Patient Assessment Hospital-Wide" (see Attachment 4) . The policy was changed to specify that reassessments are done and documented in the emergency department every 15 minutes for unstable patients, and at least every hour for stable patients. Education will be completed and documented by the nurse manager for emergency department nursing staff prior to February 14, 2014. 2. Quality monitoring will occur as follows: nurse manager will randomly audit 10 charts per month to include both adult and pediatric patients to ensure that unstable patients are reassessed every 15 minutes and stable patients at least every hour. Follow-up actions will be taken as necessary. Reports will be provided to the ED Committee on a monthly basis. Outcomes will be tracked and trended and reported in the emergency department	By 2/14/14	Quality monitoring will be completed on an ongoing basis.

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C 295	Continued From page 5 did not have a reassessment of the BP until more than 5 hours later at 11:21 PM. In addition, although a provider note indicated the patient sustained a head injury as the result of a fall in the ED at approximately 10:00 PM and suffered a subdural hematoma, and although the patient was not discharged until 9:01 AM on 10/1/13, there was no evidence that ongoing assessments of the patient's neurological status or VS occurred after 1:24 AM on 10/1/13. The Director of Patient Care Services confirmed there was no evidence of ongoing reassessments of the patient's clinical status, during interview on the afternoon of 12/11/13. S/he further stated that the facility's policies and procedures did not address the frequency of reassessments and that nursing staff are expected to use the standards reflected in the Lippincott Manual of Nursing Practice.	C 295	annual report to the Quality Council and through the Quality Council to the Board of Trustees.		
C 302	Lippincott Manual of Nursing Practice 485.638(a)(2) RECORDS SYSTEMS The records are legible, complete, accurately documented, readily accessible, and systematically organized. This STANDARD is not met as evidenced by: Based on record review and confirmed through staff interview the facility failed to assure that documentation was complete for 1 patient's record. (Patient #25). Findings include: Per record review Patient #25, who presented to the ED on 9/30/13 with suicidal ideation, agitation and alcohol intoxication, lacked documentation to	C 302	1. The Restraint Policy was reviewed and revised to include the expectation that restraint templates found in the EMR will be used for documentation with the application of restraints hospital wide. Please see attached templates (attachment 1) which include the time the restraints were applied, indication for use of restraints, less restrictive measures employed and determined to be effective prior to initiation of restraints, and physician orders. Education regarding use of EMR templates will be provided to nursing staff hospital wide through the coordination of the Quality Coach.	2/14/14	

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C 302	<p>Continued From page 6</p> <p>justify the use of soft wrist restraints. A nursing note, dated 9/30/13 at 11:00 PM, stated; "restraint check, pt able to move (his/her) hands...", indicating that restraints had been applied to each of the patient's hands at some point following arrival in the ED at 5:51 PM. Follow up nursing notes at 11:27 PM and 11:38 PM, respectively, stated; "Left dept. to CT scan.....soft restraints removed", and "returns from CT scan, Will keep soft restraints off as long as pt remains cooperative." Despite this information there was no documentation regarding; the time the restraints were applied, indication for the use of restraints, less restrictive measures employed and determined to be ineffective prior to initiation of the restraints and no physician order for the intervention. In addition, although the patient's BP was elevated, at 176/98, at 6:04 PM and although a provider note indicated the patient sustained a head injury as the result of a fall in the ED at approximately 10:00 PM and suffered a subdural hematoma, there was no documentation that a subsequent BP was checked until 12:29 AM on 10/1/13, and although the patient was not discharged until 9:01 AM on 10/1/13, there was no documentation of further VS or neurological assessments after 1:24 AM on 10/1/13.</p> <p>The Director of Patient Care Services confirmed the lack of complete documentation in Patient #25's record, during interview on the afternoon of 12/11/13.</p>	C 302	<p>2. Quality monitoring to ensure deficiencies do not recur will be implemented as follows: effective January 3, 2014, each application of a restraint will require nursing to initiate a Quantros/Incident Report entitled Restraint/ Seclusion Incident. This will trigger the nurse manager of the unit to complete a quality checklist (please see attachment 3) to monitor each component of the restraint policy has been met. Follow-up corrective action will be implemented as needed. The nurse manager will submit the completed quality audit to the Director of Risk Management. All audit forms, hospital wide, will be reviewed, trended and evaluated at the Clinical Incident Prevention Committee on a quarterly basis. Follow-up corrective action will be implemented as needed. Reports will be given annually to the Quality Improvement Committee and subsequently to the Board of Trustees.</p> <p>3. The policy entitled "Patient Assessment Hospital-Wide" was reviewed and revised on January 3, 2014, to include the expectation that reassessments for emergency department patients will occur every 15 minutes for unstable patients and every hour for stable patients.</p> <p>4. Quality monitoring will occur as follows: nurse manager will randomly audit 10 charts per month to include both adult and pediatric patients to ensure that unstable patients are reassessed every 15 minutes and stable patients at least every hour. Follow-up actions will be taken as necessary. Reports will be provided to the ED committee month on a monthly basis. Outcomes will be tracked and trended and reported in the Emergency Department Annual Report to the Quality Council and through the Quality Council to the Board of Trustees. Please be advised that our records indicate that the emergency room patient cited in this deficiency was admitted on September 30, 2013 at 17:24 PM and discharged on October 1, 2013 at 1:35 AM.</p>	<p>Quality monitoring will be completed on an ongoing basis.</p> <p>Quality monitoring will be completed on an ongoing basis.</p>	

Restraint Orders and Documentation Available to MAH

Restraint Monitoring/Discontinue - Non-Violent - WORST, DO NOT USE

Sign Form on: 12/31/2013 1739 EST

Monitoring
Education
Discontinue
Vital Signs

Restraint Initiation Date/Time
12/31/2013 0900

Restraint Discontinue Date/Time

The initiate Date/Time pre-populates from the Initiation Form completed earlier

The Restraint Initiation Date/Time indicates the beginning of an episode of restraints.

The Restraint Discontinue Date/Time indicates the end of an episode of restraints.

An episode is defined as the duration of time that restraints remain in place beginning with the initiation from the original order until all restraints are discontinued without intent to reapply.

Discontinue

Once the Restraint Discontinuation time is entered then the appropriate Total Restraint Time box which was inactive or dithered or grayed out will become active and the total time will be populated.

Medical Surgical Total Restraint Time (Minutes)

Medical Surgical Total Restraint Time (Hours)

Criteria Met for Restraint Discontinue

Cognitive status improved and no longer interferes with medical care
 Medical devices, tubes, and dressings removed
 Other:

Restraint Debriefing Documentation

Restraint Debriefing - WORST, DO NOT USE

*Performed on: 12/31/2013 1739 EST

By: Strohle, Patti

Debriefing

Restraint Debriefing

Debriefing Type

Physical restraint
 Seclusion

Debriefing Participants

Patient Family member Sibling Involved caregiver(s)
 Spouse Friend Significant other Other:
 Daughter Parent Son

Patient Interview

Why Do You Think You Were Restrained/Secluded?

How Safe Did You Feel While Restrained/Secluded?

Very safe
 Safe
 Somewhat safe
 Not safe

How Did Staff Try to Help You Before Using Restraint/Seclusion?

Gave medication for comfort Remained at bedside
 Limited visitors/contacts Suggested diversional activity
 Offered medication Suggested time in quiet room
 Offered no help Talked
 Provided comfort measures Other:

What Could You Have Done Differently to Stay Out of Restraint/Seclusion?

Patient Perception of Care During Restraint/Seclusion Episode

	Yes	No	Comment
Did You Suffer Mental Trauma While Restrained?			
Did You Suffer Physical Trauma While Restrained?			
Were Release Criteria Explained to You?			
Were You Given Comfort Medications While Restrained?			
Have You Had Previous Restraint/Seclusion Episodes?			
Was Your Privacy Protected During Restraint/Seclusion?			
Do You Still Need to Discuss Restraint/Seclusion?			

Times will auto populate based on documentation in the Initiate and Discontinuation forms

Medical Restraint Initiation Time 12/31/2013 0900 **Medical Restraint DC Time** 12/31/2013 1400

Behavioral Restraint Initiation Time 12/31/2013 0800 **Behavioral Restraint DC Time** 12/31/2013 1300

Restraint Orders and Documentation Available to MAH

Restraint Monitoring / Discontinuation Documentation

Restraint Monitoring/Discontinue - Non-Viole WORST, DO NOT USE

*Performed on: 12/31/2013 1739 EST

Monitoring

Education
Discontinue
Vital Signs

Restraint Monitoring

Extremity/Torso Restraint Type	
Left Upper Extremity	<MultiAlpha>
Right Upper Extremity	<MultiAlpha>
Left Lower Extremity	<MultiAlpha>
Right Lower Extremity	<MultiAlpha>
Torso	<MultiAlpha>

Type of Full Body Restraint	
<input type="checkbox"/>	Enclosed bed
<input type="checkbox"/>	Physical hold
<input type="checkbox"/>	Seclusion
<input type="checkbox"/>	Side rails full
<input type="checkbox"/>	Side rails full with pads

Restraining Activity	
Left Upper Extremity	<Alpha>
Right Upper Extremity	<Alpha>
Left Lower Extremity	<Alpha>
Right Lower Extremity	<Alpha>
Torso	<Alpha>
Systemic	<Alpha>
Full Body	<Alpha>

Reason Not in Restraints (for Temporary Release)	
<input type="checkbox"/>	Sleeping/Restful
<input type="checkbox"/>	Sitter/Caregiver/Staff at bedside
<input type="checkbox"/>	Receiving care/treatment
<input type="checkbox"/>	Other:

Circulation/Skin	
<input type="checkbox"/>	Pulses intact
<input type="checkbox"/>	Skin intact
<input type="checkbox"/>	Broken
<input type="checkbox"/>	Cyanotic
<input type="checkbox"/>	Reddened
<input type="checkbox"/>	Other:

Range of Motion/Positioning	
<input type="checkbox"/>	Active range of motion
<input type="checkbox"/>	Passive range of motion
<input type="checkbox"/>	Repositioned
<input type="checkbox"/>	Other:

Nutrition/Hydration	
<input type="checkbox"/>	Offered
<input type="checkbox"/>	Offer declined
<input type="checkbox"/>	IV fluid
<input type="checkbox"/>	NPO
<input type="checkbox"/>	Tube feeding
<input type="checkbox"/>	Other:

Hygiene/Elimination	
<input type="checkbox"/>	Offered
<input type="checkbox"/>	Offer declined
<input type="checkbox"/>	Diaper change
<input type="checkbox"/>	Incontinent
<input type="checkbox"/>	Urinary Catheter
<input type="checkbox"/>	Other:

Respirations

<input type="checkbox"/>	Unlabored	<input type="checkbox"/>	Retracting
<input type="checkbox"/>	Quiet	<input type="checkbox"/>	See saw
<input type="checkbox"/>	Agonal	<input type="checkbox"/>	Shallow
<input type="checkbox"/>	Diaphragmatic	<input type="checkbox"/>	Snoring
<input type="checkbox"/>	Dyspnea	<input type="checkbox"/>	Stridor
<input type="checkbox"/>	Gasping	<input type="checkbox"/>	Tachypnea
<input type="checkbox"/>	Grunting	<input type="checkbox"/>	Tripod position
<input type="checkbox"/>	Hyperpnea	<input type="checkbox"/>	Use of accessory muscles
<input type="checkbox"/>	Labored	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Nasal flaring		
<input type="checkbox"/>	Nocturnal		
<input type="checkbox"/>	Orthopnea		
<input type="checkbox"/>	Paroxysmal nocturnal dysp		
<input type="checkbox"/>	Pursed lips		

Respiratory Pattern Description

<input type="checkbox"/>	Regular
<input type="checkbox"/>	Irregular
<input type="checkbox"/>	Apnea
<input type="checkbox"/>	Cheyne Stokes
<input type="checkbox"/>	Kussmaul
<input type="checkbox"/>	Prolonged expiratory phase
<input type="checkbox"/>	Other:

Patient Safety

<input type="checkbox"/>	Adequate room lighting	<input type="checkbox"/>	Be
<input type="checkbox"/>	Bed in low position	<input type="checkbox"/>	Ch
<input type="checkbox"/>	Call device within reach	<input type="checkbox"/>	Mc
<input type="checkbox"/>	Encourage handrail/safety bar use	<input type="checkbox"/>	Mc
<input type="checkbox"/>	Encourage personal mobility support item use	<input type="checkbox"/>	Nig
<input type="checkbox"/>	Encourage sensory support item use	<input type="checkbox"/>	Pe
<input type="checkbox"/>	ID band check	<input type="checkbox"/>	Se
<input type="checkbox"/>	Non-slip footwear	<input type="checkbox"/>	Se
<input type="checkbox"/>	Personal items within reach	<input type="checkbox"/>	Su
<input type="checkbox"/>	Traffic path in room free of clutter	<input type="checkbox"/>	DT
<input type="checkbox"/>	Wheels locked		
<input type="checkbox"/>	Side Rails up X 4		
<input type="checkbox"/>	Side Rails up X 3		
<input type="checkbox"/>	Side Rails up X 2		

Affect/Behavior While in Restraints

<input type="checkbox"/>	Appropriate	<input type="checkbox"/>	Hostile
<input type="checkbox"/>	Calm	<input type="checkbox"/>	Impulsive
<input type="checkbox"/>	Cooperative	<input type="checkbox"/>	Inappropriate
<input type="checkbox"/>	Agitated	<input type="checkbox"/>	Restless
<input type="checkbox"/>	Anxious	<input type="checkbox"/>	Uncooperative
<input type="checkbox"/>	Appears depressed	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Combative		
<input type="checkbox"/>	Crying		
<input type="checkbox"/>	Fearful		
<input type="checkbox"/>	Flat		

Restraint Discontinuation Readiness Attempts

<input type="checkbox"/>	Comfort measures
<input type="checkbox"/>	Diversional activities
<input type="checkbox"/>	Enhanced observation
<input type="checkbox"/>	Environmental changes
<input type="checkbox"/>	Family/Visitors at bedside
<input type="checkbox"/>	Frequent toileting
<input type="checkbox"/>	Negotiation
<input type="checkbox"/>	Reality orientation
<input type="checkbox"/>	Verbal limit setting
<input type="checkbox"/>	Other:

Evaluation of Status While in Restraints

<input type="checkbox"/>	No evidence of injury related to restraint
<input type="checkbox"/>	Restraints properly applied
<input type="checkbox"/>	Other:

Restraint Orders and Documentation Available to MAH

Restraint Initiation - Non-Violent/Non-Self De - WORST, DO NOT USE

*Performed on: 12/31/2013 1739 EST

Episode Start
Initiation
Education
Vital Signs

In each piece of restraint documentation the Vital Sign fields will be available to document on

Vital Signs

Oral DegC

Rectal DegC

Intravascular DegC

Peripheral Pulse Rate bpm

Systolic/Diastolic BP mmHg / mmHg

SpO2 %

O2 Flow Rate L/min

FiO2 %

Head Circumference cm

Tympanic DegC

Axillary DegC

Temporal DegC

Apical Heart Rate bpm

Respiratory Rate br/min

Mean Arterial Pressure

O2 Therapy

<input type="checkbox"/> Aerosol mask	<input type="checkbox"/> Face mask	<input type="checkbox"/> Humidification
<input type="checkbox"/> Artificial nose	<input type="checkbox"/> Face shield	<input type="checkbox"/> Jet
<input type="checkbox"/> All-Purpose nebulizer	<input type="checkbox"/> Face tent	<input type="checkbox"/> Mist tent
<input type="checkbox"/> BiPAP	<input type="checkbox"/> Hi-flow nasal cannula	<input type="checkbox"/> Nasal cannula
<input type="checkbox"/> Blow-By	<input type="checkbox"/> High-Flow nebulizer	<input type="checkbox"/> Nonrebreather mask
<input type="checkbox"/> CPAP	<input type="checkbox"/> Hood	<input type="checkbox"/> Oscillator
<input type="checkbox"/> DC (Dual Control)	<input type="checkbox"/> Hood (Pedi Only)	<input type="checkbox"/> Oxy mask

Restraint Continuation Documentation

Restraint Continue - Non-Violent/Non-Self De - WORST, DO NOT USE

*Performed on: 12/31/2013 1739 EST

By: Strohla, Patti

Continue Restraint

Clinical Reasons to Continue Restraints

This documentation required only when new order received to "continue" restraints.

Current Restraint Order

No active restraint orders.

Another reminder that we still have no active restraint order...

Reason/Behavior Necessitating the Use of Restraints

- Behavior interfering with medical care, devices, tubes/drains or dressings
- Medically approved head trauma protocol
- Medically approved mechanical ventilation protocol
- Other medically approved protocol

Behavior Description

Restraint Alternatives Attempted

- Assistive devices easily available
- Comfort measures
- Device protection
- Diversional activities
- Enhanced observation
- Environmental changes
- Presence of family/visitors
- Reality orientation
- Regular ambulation
- Sitter at bedside
- Toileting needs addressed
- Other:

Restraint Orders and Documentation Available to MAH

Restraint Initiation - Non-Violent/Non-Self De WQRST, DO NOT USE

*Performed on: 12/31/2013 1739 EST

Episode Start

Initiation

Education

Vital Signs

Medical Surgical Restraint Initiation

Extremity/Torso Restraints		Type of Full Body Restraint	Restraint Type Chemical
Left Upper Extremity	<MultiAlpha>	<input type="radio"/> Enclosed bed <input type="radio"/> Physical hold <input type="radio"/> Seclusion <input type="radio"/> Side rails full <input type="radio"/> Side rails full with pads	<input type="radio"/> Yes <input type="radio"/> No
Right Upper Extremity	<MultiAlpha>		
Left Lower Extremity	<MultiAlpha>		
Right Lower Extremity	<MultiAlpha>		
Torso	<MultiAlpha>		

Reason/Behavior Necessitating Restraints

Behavior interfering with medical care, devices, tubes/drains or dressings
 Medically approved head trauma protocol
 Medically approved mechanical ventilation protocol
 Other medically approved protocol

Behavior Description

Restraint Alternatives Attempted

Assistive devices easily available Presence of family/visitors
 Comfort measures Reality orientation
 Device protection Regular ambulation
 Diversional activities Sitter at bedside
 Enhanced observation Toileting needs addressed
 Environmental changes Other:

Restraint Initiation - Non-Violent/Non-Self De WQRST, DO NOT USE

*Performed on: 12/31/2013 1739 EST

Episode Start

Initiation

Education

Vital Signs

Patient Education

Responsible Learner(s)

No Data Available

Home Caregiver Present for Session

Yes
 No

Barriers To Learning

None evident Hearing deficit
 Acuity of illness Language barrier
 Cognitive deficits Literacy
 Cultural barrier Memory problems
 Desire/Motivation Religious
 Difficulty concentrating Vision impairment
 Emotional state Other:
 Financial concerns

Teaching Method

Demonstration Printed materials Video/Educational TV
 Explanation Teach back Web-Based

Response of "Home Independently" to "Discharge To, Anticipated" indicates that patient is the Responsible Caregiver.

Document Learning Evaluation for Responsible Learner(s)

Verbalizes understanding	Demonstrates	Needs further teaching	Needs practice/supervision	Comment

Policy Regarding Use of Restraints

Reason for Use of Restraint

Restraint Release Criteria

Education Referral Made To

Behavioral Health Practitioner Occupational Therapy Social Work
 Diabetes Educator Physical Therapy Speech Pathology
 Dietitian Physician Specialist Other:
 Home Health Primary Care Physician
 Hospice Respiratory Therapy
 Nurse Specialist School district

Additional Learner(s) Present

Spouse Father
 Daughter Mother
 Family member Sibling
 Friend Significant other
 Grandfather Son
 Grandmother Other:

Documentation of the following responses to "Barriers to Learning" will create an order for a Morse Fall Risk assessment if not done within last 24 hours: Cognitive deficit, Difficulty concentrating, Hearing deficit if age greater than 65 years, Memory problems.

Fields are specific to restraint use and the Education Navigator section will be available on all components of the restraint documentation

Restraint Orders and Documentation Available to MAH

Restraint Documentation Available in Ad Hoc Charting on PowerForms

Ad Hoc Charting - WQRST, DO NOT USE

- Admission/Transfer/Discharge
- Activities of Daily Living
- Assessments
- Behavioral Health
- Basic Care
- ED Forms
- Nursing Procedures
- Occupational Therapy
- OB Assessments and Treatments
- Patient Education
- Physical Therapy
- POC Lab & Diagnostic Testing
- Restraints**
- Other Treatments and Evals
- All Items

- Restraint Continue Violent/Self Destructive 18 Years and Older
- Restraint Continue Non-Violent/Non-Self Destructive
- Restraint Debriefing
- Restraint Initiate Violent/Self Destructive 18 Years and Older
- Restraint Initiate Non-Violent/Non-Self Destructive
- Restraint Monitoring/Discontinue Violent/Self Destructive
- Restraint Monitoring/Discontinue Non-Violent/Non-Self Destructive

In the Ad Hoc Restraint Folder there seven (7) PowerForms available...

The first six (6) are *Initiate, Continue and Monitoring / Discontinue* forms for both Behavioral Restraints (labeled as Violent / Self Destructive) and Medically Necessary Restraints (labeled as Non-Violent / Non-Self Destructive).

The seventh PowerForm is for documentation of a *Post Restraint Debriefing*.

Ad Hoc is an alternative to documenting directly via iView. Both methods allow for documentation of the same clinical elements.

Screenshots of portions of these PowerForms are provided below...

Restraint Initiation Documentation

Restraint Initiation - Non-Violent/Non-Self De WQRST, DO NOT USE

*Performed on: 12/31/2013 1739 EST

Episode Start

Initiation

Education

Vital Signs

Medical Surgical Restraint Episode Start

Current Restraint Order

No active restraint orders.

When we have an active order to restrain a patient, it will appear here... after first protecting our patients and ourselves we should ensure we get an order ASAP detailing the restraint details and parameters

Restraint Initiation Date/Time

12/31/2013 1739 EST

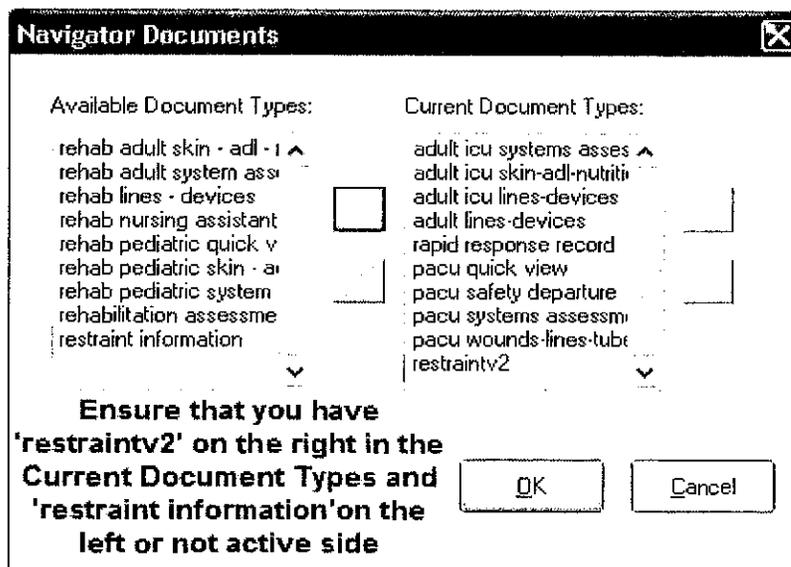
Completing this field will carry it through all our documentation through to the final calculation of total minutes restrained.

The Restraint Initiation Date/Time indicates the beginning of an episode of restraints, and is a contributing value for calculating the length of an episode of restraints.

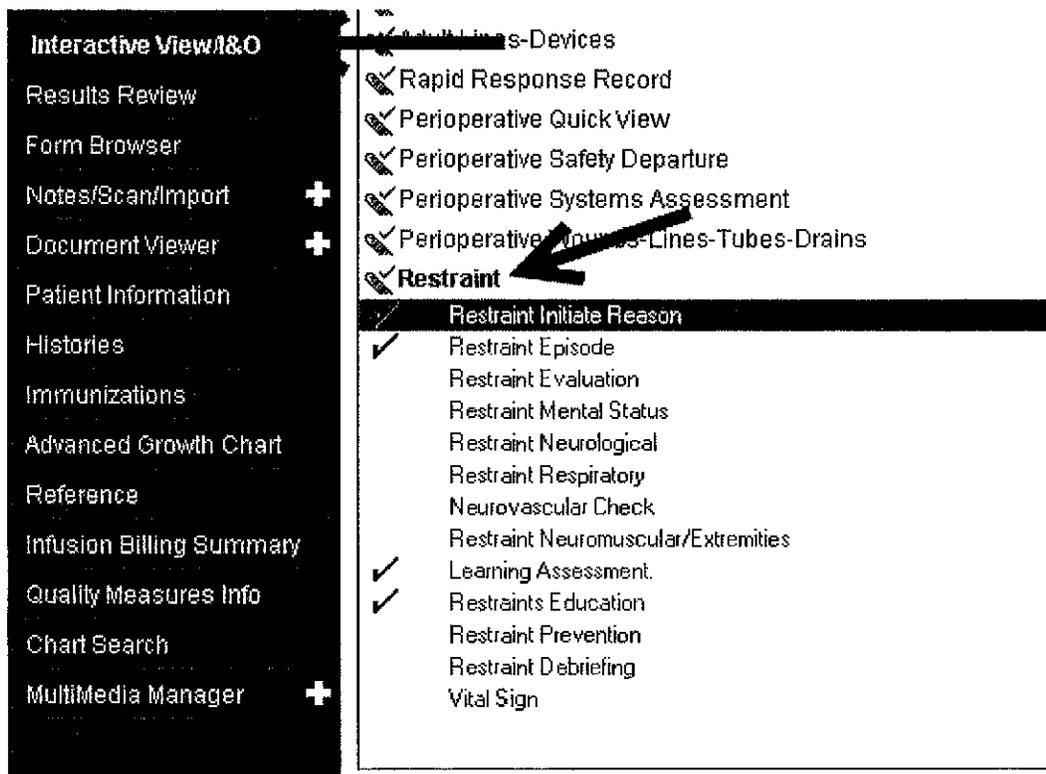
An episode is defined as the duration of time that restraints remain in place beginning with the initiation from the original order until all restraints are discontinued without intent to reapply.

Restraint Orders and Documentation Available to MAH

2. Upon selecting Navigator Bands a dialogue box will open



3. You will then need to close the patient's chart for the changes to take effect.....
4. When you reopen the chart, you will have a 'Restraint Band' available in iView so you can do direct documentation against all the pertinent elements of restraints without having to use multiple PowerForms



Restraint Orders and Documentation Available to MAH

Available Restraint Orders

Find: Contains Type:

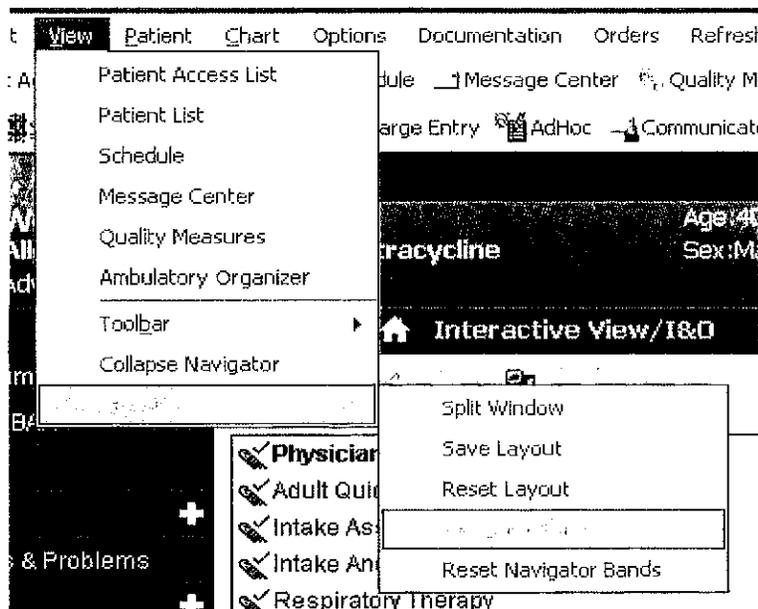
Search within:

Restraint Continue Non-Violent.
 Restraint Continue Non-Violent/Non-Self Destructive
 Restraint Continue Violent 9-17 Years.
 Restraint Continue Violent 18 Years and Older.
 Restraint Continue Violent 8 Years and Younger.
 Restraint Discontinue - Medical
 Restraint Evaluate Need to Continue After 24 Hours
 Restraint Initiate Non-Violent.
 Restraint Initiate Non-Violent/Non-Self Destructive
 Restraint Initiate Violent 18 Years and Older.
 Restraint Initiate Violent 8 Years and Younger.
 Restraint Initiate Violent 9-17 Years.
 Restraint Initiation - Invasive Device
 Restraint Initiation - Medical
 Restraint Monitoring - Invasive Device

Restraint Documentation Available through iView

There is a navigator band available in iView for direct charting of Restraints.... To ensure you have the most current Restraint Band or to add this to your iView display do the following:

1. From the top of a patient's chart click View → Layout → Navigator Bands



MT. ASCUTNEY HOSPITAL AND HEALTH CENTER

RESTRAINTS

{Formerly entitled, "Physical Restraints"}

Initiated by: Nursing Leadership

Dept.: Safety/All Inpatient Areas

Approved by Dept. Head/Committee: P&P Committee, Medical Executive Committee, Board of Trustees

Lead Author: P&P Committee

Expert Reviewer: Jill Lord, RN, MS, Director of Patient Care Services/CNO

Date Effective: 8/85

Date Reviewed: 4/05, 3/06, 5/06, 3/07, 10/07, 1/08, 10/08, 12/09, 4/11, 12/12, 1/14

Date Revised: 4/05, 3/06, 5/06, 10/07, 1/08, 12/09, 4/11, 1/14

Page 1 of 9

Philosophy

Definitions

Use of Restraints

Education

Correct Application of Restraints

Nursing Responsibilities

Reassessment

OR/Recovery Room

Reporting of Death Associated to Use of Restraint or Seclusion

Forms that are used, at a minimum, in the EMR include *All forms can be printed if the EMR is unavailable*:

Restraint Initial Reason

Restraint Episode

Restraint Evaluation

Restraint Education

Restraint Prevention

Restraint Debriefing

I. Philosophy

Mt. Ascutney Hospital and Health Center (MAHHC) honors every patient's right to dignity, respect, participation in treatment decisions, and the right to be protected from neglect or physical and psychological abuse.

In accordance with this philosophy, and the Omnibus Budget Reconciliation Act of 1987, a physical restraint, as defined, may only be used in the following circumstances:

- A. To treat a specific medical condition.
- B. To provide care and services necessary for the individual to achieve the highest practicable level of well-being.
- C. To prevent self-injury or injury to others.
- D. When lesser restrictive measures have been ineffective.

Physical or chemical restraints may ***never*** be used for the purpose of convenience or discipline.

II. **Definitions**

- A. A “chemical restraint” is any drug that is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not required to treat a medical symptom.
- B. A “physical restraint” is any manual method of physical or mechanical device, material, or equipment that immobilizes or reduces the ability of the patient to move his/her arms, legs, body, or head freely.

Example: “Physical restraints” include leg and wrist restraints, hand mitts, tied jackets and vests, chair bars and trays that prevent rising, use of seat belts, which the individual cannot remove, any chair position which prevents rising, ***when physically able to rise*** (locked recline position), bedrail, and use of physical force.

- C. “Physical restraint for convenience” is any action taken by the facility to control patient behavior for the purpose of maintaining patients with a lesser amount of effort by the facility and not in the patient’s best interest.
- D. “Discipline” is any action taken by the Staff for the purpose of punishing or penalizing patients.
- E. “Least restrictive therapeutic intervention” is any device or activity that provides the individual the maximum amount of freedom of movement.

Example: 1) Pillows, pads, removal lap trays, or seat belts used to promote proper balance and body alignment and safety; 2) exercise, meaningful activity, individual attention, environmental changes to treat behavioral symptoms.

- F. “Immobilizers”: Any device used during medical, dental, diagnostic, or surgical procedures whose use is based on standard practice for the procedure. Immobilizers include, but are not limited to: full or partial body immobilizers used during surgical positioning, radiotherapy procedures, and IV arm boards. These devices are not considered restraints when used during these procedures.

III. **Use of Restraints**

A systematic process is followed throughout the facility for the consideration of use of restraints shall include:

- A. An assessment of the individual demonstrates the need for restraints related to a specific medical symptom or behavior. The care plan will state the goal(s) for the use of the restraint. Forms that are used at a minimum include:
- Restraint Initial Reason
 - Restraint Episode

- Restraint Evaluation
 - Restraint Education
 - Restraint Prevention
 - Restraint Debriefing
- B. The assessment considers use of the least-restrictive intervention(s).
- C. The therapeutic use of a restraint for positioning may be justified through the care planning process.
- D. Order for a restraint is time-limited. The use of restraints should be related to therapeutic needs. Restraints are expected to be used 24 hours or less for violent or self-destructive behavior. Additional time requires additional reorder for adults 18 or older. The need for restraints is evaluated for adults 18 and older every 4 hours, for children 9 to 17 years, every 2 hours, and children under 9 every hour.
- E. The use of restraints involves informed consent. (See below; section “Informed Consent.”)
- F. The plan of care demonstrates continued reassessment to ensure progressive removal of restraints.

IV. **Education**

- A. An individual/responsible representative must be given an explanation of the benefits and potential negative consequences related to the use of restraints, and must give consent prior to the use of restraints.
- B. In the case of a minor, or individual who is incapable of making a decision, the legal representative will be provided information for decision-making regarding restraint use.
- C. If an individual requires emergency care, or is in danger to themselves, or others, and is unable to give consent, a restraint may be used for brief periods, without prior consent.
- D. A restraint will not be used if the facility has knowledge that the individual has previously made a valid refusal of the treatment in question.
- E. Documentation that the education regarding restraints was provided to the patient or legal represented will be included in the EMR.

V. **Correct Application of Restraints**

- A. A tied sheet or a bandage may never be used as a restraint.
- B. Restraints must be applied according to manufacturer’s guidelines.

- C. When a patient is seated in a Geri or cardiac chair with tray in place: the patient must be monitored to make sure the tray is not too tight against the patient's abdomen and that the patient has not slipped down in the chair causing possible injury or airway obstruction.
- D. The restraints' ties are attached to the bed or chair frame.
- E. Seat belts can be attached, as indicated, to a wheelchair to prevent patient from falling out of the chair. These are attached to the wheelchair by either nursing, therapies, or the Maintenance Department, depending on the type of seat belt to be used.
- F. Staff will be trained in MOAB techniques to effectively de-escalate and handle violent behavior. Annual competencies for ED, Acute, Rehab and Security will include hands-on restraint training.

VI. Nursing Responsibilities: Acute, Swing, ED, Rehab

The systematic process for use of restraints will be documented as follows:

- A. Assessment of specific problems, for which a restraint is considered, will be made upon admission and whenever use of a restraint is initiated. Upon initiation of use of a restraint, the specific problem will be documented in the patient record to include interventions, and evidence that less restrictive means of restraint were attempted, but ineffective.
- B. A nurse may initiate the use of a physical restraint utilizing nursing judgment, but must obtain a Physician Order within one (1) hour. The order must include the type of restraint to be used, the reason for use, and time frame (i.e., while in bed).
- C. The treating physician must be consulted as soon as possible, if the patient's treating physician does not order the restraint.
- D. A physician, or other licensed independent practitioner, must see and evaluate the need for restraint within one (1) hour after the initiation of this intervention.
- E. Evaluation of the Patient – An evaluation will be done every 30 minutes. Every two (2) hours, when a restraint is in use, the patient will have: restraint released, position changed, skin checked, patient care for toileting, cleansing, and eating will be provided, as needed. Nursing documents care in the EMR.
- F. Police and correctional staff are responsible for the handcuffs and leg irons that are used on patients brought in from the correctional facilities. Nursing will check skin integrity, provide for physical needs, and document the type of restraint being used.
- G. The Restraint/Seclusion Death Report Worksheet will be completed for any death related to restraint usage. This report will be sent to Risk Management, who will then report to the Agency of Licensing and Protection.

- H. Any application of physical or chemical restraint will require nursing staff to initiate a Quantros incident report for restraint/seclusion so that the incident will trigger a quality review to evaluate compliance with standards. See attached *Restraint Audit Quality Checklist*.

VII. Reassessment

A licensed nurse will document justification for continued use and consideration of lesser restrictive interventions, as per State requirements, and obtain a new order, if justified, as indicated below:

- A. ED/Acute/Swing/Rehab – Every 24 hours in the EMR

VIII. OR/Recovery Room

- A. The therapeutic use of full stretcher or bedside rails is implemented as deemed necessary for patient and staff safety during the post-anesthesia recovery period without using the Side Rails Assessment form. Other positioning/restraining devices are utilized according to OR procedure and standard of care.
- B. Restraining/positioning devices are utilized during the perioperative period to assure access by the interdisciplinary team to the surgical site, the patient's airway, intravenous lines, and monitoring devices. The use/application of such devices should not compromise integumentary, circulatory, respiratory, musculoskeletal, or neurological structures. The comfort of the patient is considered in the initial and ongoing assessment. The application of the devices takes on special importance in the anesthetized patient who is unable to sense and/or communicate discomfort.
- C. Restraining/positioning devices are utilized with the following considerations:
- * Specific patient needs are identified prior to positioning;
 - * Restraining/positioning devices are kept readily available, clean, and in working order;
 - * Surgical patients will be assessed during and after positioning for correct body alignment, circulation, and tissue integrity;
 - * Use of restraining/positioning devices is documented in the OR record.
- D. Application – The application of restraints during the perioperative period is dependent upon anatomical position, type of anesthesia, and assessed patient needs.

Knee straps are:

- * Applied over the thighs, just above the knees;
- * Applied over padding, such as folded sheet or bath blanket;
- * Fastened securely to the OR table;

- * Applied snugly enough to provide security, but not to impede superficial circulation (fingers should slip easily between the straps and legs).

Arm restraints are:

- * Applied to arms which have been anatomically positioned on padded arm boards, which are placed at no greater than 90 degrees to the OR table;
- * Applied snugly enough to protect the arm from moving off the arm board, but not to impede superficial circulation;
- * Arms may also be restrained by tucking them under the draw sheet with elbows padded and palms down with fingers extended or with palms turned so they are against the body.

IX. Reporting of Death Associated to Use of Restraint or Seclusion

- A. CMS is designated to collect information necessary to report deaths associated with restraint/seclusion on a timely basis from facilities, under hospital reporting requirements 42 CFR 482.1 3(g).
1. Hospitals must report the following information to CMS:
 - Each death that occurs while a patient is in restraint or seclusion.
 - Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
 - Each death known to the facility that occurs within one week after restraint or seclusion, where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to the patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing, or asphyxiation.
 2. Each death must be reported to CMS by telephone, (617-565-1307) no later than the close of business the next CMS business day following knowledge of the patient's death.
 3. Hospital staff must document in the patient's medical record, the date and time and how (via e-mail, fax, or phone) the death was reported to CMS.
- B. Completed worksheet should be e-mailed to theresa.smith@cms.hhs.gov or faxed to 443-380-5648.

Bibliography

1. JCAHO 1995 Comprehensive Accreditation Manual for Hospitals.
2. Medicare/Medicaid Conditions for Participation. Published by HCFA, Sept. 26, 1991 and Sept. 23, 1992 in the Federal Register.
3. 1994 Standards and Recommended Practices: AORN, Denver, CO, 1994, pp. 211-214.

4. Alexander's Care of the Patient in Surgery: Barbara J. Gruendemann, RN, BS, MS; Margaret Huth Meeker, RN, BSN, CNOR, the CV Mosby.
5. Surgical Technology – Principles and Practice: Joanna R. Fuller, WB Saunders, Co., Philadelphia, 1994, pp. 91-98.

SAFETY 100CT P-P\ restraints *{Typed by, and revisions to: c. burrows}*

(Nursing P&P/Pt Rights&Organizational Ethics/Rights & Responsibilities of Patients/Restraints) (CAH C381-384)

Jill/P&P/Restraints 1-6-14

MT. ASCUTNEY HOSPITAL AND HEALTH CENTER

**Restraint Audit
Quality Checklist**

All use of chemical or physical restraints charts will be reviewed.

FIN: _____ Audit completed by: _____

Date: _____ Time of arrival in department: _____ Time restraint started: _____

Less restrictive measures documented: Yes No

Provider's order Yes No Time of order: _____

Reordered every 24 hours Yes No

Chemical restraint used:
Medication given: _____ Time: _____

Type of physical restraint used: _____

Soft restraints: Wrist Hand Chest

Hard restraints 4 point wrist and legs Wrist Legs

Is the patient in police custody Yes No

Is the patient in handcuff's Yes No

Does the patient have a spit hood on Yes No

Was there one-on-one supervision Yes No

Were EMR templates on restraints completed Yes No

Were vital signs documented at time of initiation Yes No

Were restraints checked as per policy Yes No

Was there ongoing assessment done per policy:

 Vital signs Yes No

 Skin condition Yes No

 Patient behavior Yes No

Was education done per policy Yes No

Time restraints discontinued: _____

Did they have to be reapplied Yes No

Problems identified:

*Please submit completed form to Director of Risk Management.
Results to be presented quarterly at the Clinical Incident Prevention Committee.*

RESTRAINT/SECLUSION DEATH REPORT WORKSHEET

A. Regional Office (RO) Contact Information

RO Contact's Name: Theresa Smith theresa.smith@cms.hhs.gov – E-mail
443-380-5648 – FAX 617-565-1307 – PH

*Date of Report to RO: _____ Time: _____

B. Provider Information

*Hospital Name: Mt. Ascutney Hospital and Health Center *CCN: _____

Address: 289 County Road City: Windsor State: VT Zip: 05089

Person Filing the Report: _____ Filer's Phone Number: _____

C. Patient Information

*Name: _____ *Date of Birth: ____/____/____

Admitting Diagnoses: _____ *Date of Admission: ____/____/____

*Date of Death: ____/____/____ Time of Death: _____

*Cause of Death: _____

*Did the Patient Die: {check one only}

- _____ While in Restraint, Seclusion, or Both
- _____ Within 24 Hours of Removal of Restraint, Seclusion, or Both
- _____ Within 1 Week, Where Restraint, Seclusion, or Both Contributed to the Patient's Death

*Type: Physical Restraint _____ Seclusion _____ Drug Used as a Restraint _____

***Was a Two-Point Soft Wrist Restraint used alone, without seclusion or chemical restraint, or any other type of physical restraint? Yes ___ No ___**

If YES, check "02" below and stop. No further information is required.

If NO, complete the rest of the worksheet.

*If Physical Restraint(s), Type(s):

- | | |
|--------------------------------------|-------------------------------------|
| _____ 01 Side Rails | _____ 08 Take-downs |
| _____ 02 Two-Point, Soft Wrist | _____ 09 Other Physical Holds |
| _____ 03 Two-Point, Hard Wrist | _____ 10 Enclosed Beds |
| _____ 04 Four-Point, Soft Restraints | _____ 11 Vest Restraints |
| _____ 05 Four-Point, Hard Restraints | _____ 12 Elbow Immobilizers |
| _____ 06 Forced Medication Holds | _____ 13 Law Enforcement Restraints |
| _____ 07 Therapeutic Holds | _____ 14 Other Physical Holds |

If Drug Used as Restraint: *Drug Name: _____ Dosage: _____

*** = Mandatory Field**

MT. ASCUTNEY HOSPITAL AND HEALTH CENTER

**Restraint Audit
Quality Checklist**

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Reordered every 24 hours Yes No

Chemical restraint used:

Medication given: _____ Time: _____

Type of physical restraint used: _____

Soft restraints: Wrist Hand Chest

Hard restraints 4 point wrist and legs Wrist Legs

Is the patient in police custody Yes No

Is the patient in handcuff's Yes No

Does the patient have a spit hood on Yes No

Was there one-on-one supervision Yes No

Were EMR templates on restraints completed Yes No

Were vital signs documented at time of initiation Yes No

Were restraints checked as per policy Yes No

Was there ongoing assessment done per policy:

Vital signs Yes No

Skin condition Yes No

Patient behavior Yes No

Was education done per policy Yes No

Time restraints discontinued: _____

Did they have to be reapplied Yes No

Problems identified:

***Please submit completed form to Director of Risk Management.
Results to be presented quarterly at the Clinical Incident Prevention Committee.***

MT. ASCUTNEY HOSPITAL AND HEALTH CENTER

PATIENT ASSESSMENT – HOSPITAL-WIDE

Initiated by: Director of Patient Care Services

Dept: Nursing Services

Approved by Dept. Head/Committee: B. Needham-Shropshire, Rehab Director/P&P Committee

Approved by Administration: Jill Lord, RN, Director of Patient Care Services/CNO

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I. PURPOSE

To define Mt. Ascutney Hospital's policy for Patient Assessment. Individual disciplines may have more detailed policies within their departmental policies.

II. DEFINITION

Assessment is defined as the systematic collection and review of patient specific data necessary to determine patient care and treatment needs. The assessment procedure is to be performed by appropriate disciplines and is integrated in the medical record. It is intended to provide information upon which treatment decisions are based.

III. PROCEDURE

- A. **Scope of Assessment Data:** The data set and scope of the initial assessment process are reflected on the various admission and evaluation tools in the EMR which then become available for use by the interdisciplinary team.
- B. **Time Frames:** At a minimum, the following disciplines are expected to perform initial assessments with the following time frames:
- C. **Provider:** Completes or updates an H&P within 24 hours of admission. If significant change has occurred, this is recorded in an admission note. For ICU see policy entitled, "Physician – Care of the Patient in ICU."
- D. **Nursing:**
1. Acute/Rehab – Completed upon admission.
 2. ICU – Completed upon admission.
 3. ER - Will be triaged immediately and an assessment is completed within that episode of care.
 4. OR - Prior to surgery
 5. Clinic – Completed as intake assessment
- E. **Reassessments:** Reassessments are determined by the patient's condition, treatment regime, patient's desire for and response to treatment.

Reassessments are expected to be performed throughout the patient's admission. The content and intensity of reassessments vary according to the patient's response to treatment when a change occurs in the patient's condition, a new diagnosis, or an event occurs.

Reassessments can be found recorded by the interdisciplinary team in the EMR. At a minimum, nursing assessment intervals occur as follows:

1. Acute/Rehab - Every shift.
2. ED - Every 15 minutes for unstable patients and at least every hour for stable patients.
3. OR - Intraoperatively in the Intraoperative Nursing Report and upon admission and discharge from the recovery room.
4. Anesthesia - Immediately prior to induction of anesthesia upon admission to and discharge from the peri-operative area. Post-operative notes when indicated will be written within 48 hours.
5. ICU – Hourly unless specified otherwise.

F. **Other Interdisciplinary Assessments and Reassessments**

1. Nutrition Services – All inpatients are screened for nutritional risk factors within the admission assessment. The results of the screening may trigger a nutrition consult.
2. Case Management/Social Services will perform an assessment of any patient who is referred as high risk. This may include discharge planning, literacy status and deficits, insurance issues, and other psychosocial needs. This assessment is documented in the EMR. Assessments are completed, as referred, for patients at any level of care (outpatient observation, acute, rehabilitation, swing, or custodial). Reassessments are documented in the EMR.
3. Rehabilitation Services – Interdisciplinary team meets weekly and rounds bi weekly.
4. Acute/Swing – An interdisciplinary admission assessment is accomplished by the team. If new deficits are found or occur during the hospital stay, the provider will determine if further evaluation and intervention is needed. The provider may order intervention as follows:
 - Occupational Therapy
 - Physical Therapy
 - Speech-Language
 - Therapeutic Recreation

An evaluation, with findings and outline of treatment plan and established goals, will be documented in the EMR and shared with the patient. Ongoing interventions and response to treatment, as well as regular reassessment, will be documented.

5. Pharmacy – as per their Standards of Care.
6. Respiratory Therapy – as per their Standard of Care.

7. Inpatient Rehab - See policy outlining Comprehensive Inpatient Rehabilitation Program.

G. Unique Assessment Processes

1. Alcohol and Drug Dependencies - Mt. Ascutney Hospital does not provide treatment programs for alcoholism or drug dependencies. Problems resulting from alcoholism or drug dependencies, such as toxicity, are managed (when they occur during medical or surgical admission) as directed by the provider. Treatment for alcoholism and drug dependence is referred to specialized provider.
2. Victims of Abuse/Neglect – Criteria have been developed to help staff identify victims of abuse or neglect. This information is contained within hospital policies as a resource for staff.
3. Infants, Children, or Adolescent - Infants, children and adolescents are treated on the ER, OR, acute units and Rehabilitation Unit on a case-by-case basis. Initial assessments are completed for pediatric patients. This data set and scope of the initial assessment process is reflected within the pediatric nursing admission assessment in the EMR. Reassessments vary according to patient conditions and response to treatment. At a minimum, reassessments occur every shift by nursing.
4. Smoking – All patients are assessed for smoking status and referred to cessation services as appropriate.

H. Diagnostic Testing

The need for diagnostic testing, including laboratory and other invasive, non-invasive diagnostic, and imaging procedures, are determined and ordered by the provider when the patient enters service in any setting and in conjunction with actual care or treatment. The report of test results include clinical interpretation and can be found in the electronic medical record.

1. Assessment and Surgery - Surgery is performed only after an H&P, consent, pre-operative diagnosis, and diagnostic tests have been completed and recorded in the EMR. In emergencies, or special situations, a brief note, including preoperative diagnosis, is recorded.
2. Discharge Assessments - Discharge planning is initiated when a patient enters a treatment setting to provide for continuity of care and appropriate timely discharge utilizing the depart process in the EMR. The interdisciplinary team, comprised of at least nursing and social services, meets to respond to discharge issues raised as a result of these assessments, interventions, and patient/family meetings that occur as needed as a result of identified needs.