Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

April 26, 2018

Mr. Paul Bengtson, Administrator
Northeastern Vermont Regional Hospital
1315 Hospital Drive
Saint Johnsbury, VT 05819-9758

Dear Mr. Bengtson:

Enclosed is a copy of your **acceptable plans of correction for the Immediate Jeopardy** cited during the survey conducted on **April 4, 2018.** 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,

Pamela M. Cota, RN
Licensing Chief

PRINTED: 04/06/2018
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	471303	A. BUILDING _____ B. WING _____	C 04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHEASTERN VERMONT REGIONAL HOSPITAL	1315 HOSPITAL DRIVE SAINT JOHNSBURY, VT 05819

(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 000	INITIAL COMMENTS An unannounced on-site complaint investigation was conducted on 04/02/18 through 04/04/2018 by the Division of Licensing and Protection to determine compliance with Critical Access Hospital Conditions of Participation. The following regulatory violations were identified related to Complaint #16493: Based on the information obtained through observation, staff interviews and record reviews, an Immediate Jeopardy situation was determined to exist based upon the Critical Access Hospital's (CAH) failure to provide and maintain safe care for all patients and adequate supervision to prevent a patient elopement from the Emergency Department (ED).	C 000		
C 200	EMERGENCY SERVICES CFR(s): 485.618 The CAH provides emergency care necessary to meet the needs of its inpatients and outpatients. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the CAH (Critical Access Hospital) Emergency Department (ED) failed to provide necessary care and services by qualified and sufficient personnel to ensure the safety and appropriate monitoring for patients identified to be at risk for elopement. Findings include: Patient #1, a juvenile, was evaluated in the ED on 3/22/18 for behavioral issues, threatening to harm herself/himself with a gesture of attempted strangulation. In lieu of a psychiatric admission, a discharge plan was developed by local	C 200	*C200 EMERGENCY SERVICES CFR(s)* ***The CAH's provides emergency care necessary to meet the needs of its inpatients and outpatients.*** Based on staff interviews and record review the surveyor is correct. Patient #1 was at risk for elopement and did in fact slip past Staff and assigned Cadre then quickly exit the Emergency Department through the Ambulance Bay. State Troopers, St. Johnsbury Police Department, Caledonia County Sheriff's Department and Hospital Security were immediately alerted and were in pursuit. Patient #1 was observed running across the parking lot and into the tree line. Security Officer was not able to intercept Patient #1. Northeast Kingdom Human Services (NKHS) and the St. Johnsbury Office of Vermont Department of Children and Family Service (DCF) were immediately notified. Patient #1 was receiving ongoing services through NKHS and was in DCF custody. Patient #1 was returned to the Emergency Department the next day and remained under direct observation until there was a bed available at Brattleboro Retreat. Patient #1 was then transferred for Inpatient Psychiatric Admission.	

DC amnt mm/sk C200 - 4/16/18

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

Robert M. Hersey — CFO — 04/16/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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C 200	Continued From page 1 community mental health agency staff who had evaluated Patient #1 while in the ED. A treatment/safety plan and outpatient management by the local community mental health agency was developed and Patient #1 was discharged from the ED to home with her/his parent. On 3/26/18 at 19:33 Patient #1 returned to the ED accompanied by a parent per the direction of the local community mental health agency. There had been a failure by Patient #1 to follow the treatment/safety plan initiated on 3/22/18 and the parent was unable to manage and control Patient #1. Upon arrival to the ED on 3/26/18 at approximately 08:00, Patient #1 was agitated and attempted to run from the ED waiting area. Per interview on 4/3/18 at 10:00 AM, the sheriff assigned and stationed in an office in close proximity of the ED waiting area, confirmed that s/he was able to return the patient to the ED with verbal redirection. Patient #1 expressed fear of not being able to return home with parent. A mental health crisis screening was ordered and conducted which determined Patient #1 was in need of treatment and in need of services to include hospitalization or an alternative secure setting. Per ED Physician #1 Visit Note states at 19:50 Patient #1 has "...explosive personality....with mood disruption.....security alerted to the situation the patient is at risk of elopement and given recent history in the emergency department aggressive, threatening and violent behavior. I asked him/her to remain on standby outside the emergency department..." Initially a ED nurse was ordered to provide one-to-one observation for Patient #1. At 22:00 ED Physician #1 notes that Patient #1 has verbalized voluntarily treatment and further states "Patient has been fairly cooperative with de-escalation techniques. S/he does intermittently	C 200	***C200 EMERGENCY SERVICES CFR(s)*** **Response continued from Page 1 of 5** **Corrective Action Plan** 1. In response to the Immediate Jeopardy decision, an immediate process change was implemented on 4/3/18. Effective immediately all behavioral health patients who require 1:1 direct observation will have nursing department staff assigned (LNA, LPN or RN). Michael Moss, DNP, Emergency Services Director; Sharon Mallett, DNP, M/S/Pedi/Infusion Director and Seleem Choudhury, DNP, CNO will work collaboratively to create and maintain a call list of licensed Nursing Department Staff that can be assigned to behavioral health patients who require 1:1 direct observation while on hold awaiting bed availability for Inpatient Psychiatric Admission. (Memo dated 4/3/18 attached)	

4/3/18 Callen Sr VP Quality Improvement Program

Robert M Hersey CFO 04/16/2018

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C 200	Continued From page 2 get upset and at one point threatened that s/he was going to hang himself/herself." Because no psychiatric hospital beds were available Patient #1 would remain in the ED until a bed became available. A Safety Plan was developed on 3/26/18 which included ED nursing staff, ED Physician #1, nursing house supervisor and QMHP (Qualified Mental Health Professional) from the local community mental health agency. Patient #1 was allowed to remain in street clothes and s/he was placed on suicide precautions and under "..direct supervision of nurse, staff or patient observer". Per CAH policy: Subject: Mental Health Patient approved 02/01/17 states: "If patient presents with indications of suicidal tendencies, they will be closely monitored and asked to change into paper scrubs or hospital gown if appropriate." Per interview on 4/2/18 at 1:30 PM, the ED Nurse Manager confirmed the ED does utilize non-hospital staff to provide patient observations, being only the "eyes and ears". S/he further confirmed the non-hospital staff are not employed by the CAH, and can be volunteers from a local community health agency and frequently augment the CAH staff when one-to-one observations have been ordered by a ED physician. With the exception of the ED nurse who initially provided one-to-one observations for Patient #1's at the time of admission, non-hospital staff were utilized to provide suicide precautions and one-to-one observations for Patient #1. Per interview on 4/2/18 at 1:45 PM, the Vice President for Quality Management Programs further confirmed the non-hospital staff are not employees of the CAH, and are without CAH training, however were assigned on 3/26/18 and 3/27/18 to provide	C 200	***C200 EMERGENCY SERVICES CFR(s)*** **Response is located on Page 1 and 2 of 5** ***C200 EMERGENCY SERVICES CFR(s)*** ***The CAH's provides emergency care necessary to meet the needs of its inpatients and outpatients.*** Based on staff interviews and record review the surveyor is correct. Patient #1 remained in his own clothes. The Emergency Department specific policy titled "Mental Health Patient" does state that "if patient presents with indications of suicidal tendencies, they will be closely monitored and asked to change into paper scrubs or hospital gown if appropriate". Appropriate size was not available for Patient #1. **Corrective Action Plan** 1. In addition to the Adult sized M, L and XL we will purchase and stock in the ED Pediatric sized paper scrubs and gowns. Michael Moss, DNP, Emergency Services Director, in collaboration with the ED Staff, will order and maintain adequate supplies of paper scrubs in the various sizes needed for both Adult and Pediatric patients. ***C200 EMERGENCY SERVICES CFR(s)*** **Response is located on Page 1 and 2 of 5**	4/16/18

Robert M Hersey CFO 04/16/2018

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C 200	Continued From page 3 monitoring for the safety of Patient #1. In addition, the Vice President for Quality Management Programs confirmed a policy has not been developed for CAH staff to provide direction and process when conducting the practice of patient observations. Although fairly quiet most of the early morning of 3/27/18, Patient #1 became agitated when it was brought to the patient's attention by the community human services case worker, s/he would be admitted to a psychiatric hospital. Under the observation of non-hospital staff, Patient #1 attempted to leave assigned room #5 and required redirection by ED staff and eventually became cooperative. Patient #1 requested to use a phone to contact parent. Staff decision was to allow Patient #1 to have the phone and contact was made to parent who happened to be entering the ED through the waiting room. Patient #1, being aware of parent's arrival, ran out from ED room #5 into the waiting room. The parent had arrived with a backpack filled with clothes/items for Patient #1. The parent was re-directed to leave and Patient #1 attempted to run after parent but was physically prevented by sheriff, who put hands on the juvenile and led him/her back inside into the ED waiting room. Per Care Management Progress Note, " Patient started screaming, yelling, swearing. Stating "I'm not going back in that room.....". Minutes later, at 12:08 PM Physician #2 arrived in the ED waiting room to de-escalate the situation involving Patient #1. Per ED Continuation of Care note, ED Physician #2 states: "Patient was verbally redirected by me and walked/escorted back into the emergency department. Shortly after entering the emergency department the patient ran away from his/her one-to-one through the back door, outside the	C 200	***C200 EMERGENCY SERVICES CFR(s)*** ***The CAH's provides emergency care necessary to meet the needs of its inpatients and outpatients.*** Based on staff interviews and record review the surveyor is correct. A policy had not been developed for CAH staff to provide direction and outline process for conducting patient observations. **Corrective Action Plan:** 1. Licensed staff members assigned to Direct observation of admitted behavioral health patients immediately were directed to document their observations in the Nursing notes section of the electronic medical record. Effective as of 4/3/18. 2. A policy is in the process of being developed to outline the process and provide direction for the licensed staff assigned to provide direct observation for admitted behavioral health patients admitted and on hold waiting for bed availability for Inpatient Psychiatric Admission. Seleem Choudhury, DNP, Chief Nursing Officer in collaboration with Michael Moss, DNP, Emergency Services Director; Sharon Mallett, DNP, M/S/Pedi/Infusion Director, Rachel Malachuk, Manager of Clinical Informatics and Colleen Sinon, VP Quality Management Programs, are responsible for development and full implementation of the policy by May 11, 2018. ***C200 EMERGENCY SERVICES CFR(s)*** **Response is located on Page 1 and 2 of 5**	4/4/18 Colleen S VP Quality Management Programs

Robert M Hersey CFO 04/16/2018

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C 200	Continued From page 4 ambulance bay and ran across a parking lot. Sheriffs were enlisted immediately to pursue patient and bring him/her back to the emergency department". Both the state and local police were alerted of the elopement of the juvenile. Per observation on 4/3/18 at 10:00 AM of close circuit video of the elopement incident which occurred on 3/27/18, Patient #1 was observed returning from the ED waiting room with non-hospital staff who had been assigned to provide one-on-one observations. Patient #1 delays returning to assigned room #5 and turns from room, passes by nurses station and rapidly exits out the ambulance entrance. At that time, Patient #1 was not wearing outer wear, local temperatures in this rural area registered between 34 - 43 degrees F (Fahrenheit). Prior to the elopement, and after the incident in the ED waiting room, ED staff failed to recognize the potential for further elopement attempts by Patient #1. As a result, ED staff failed to develop an emergency safety plan which incorporated immediate interventions; trained and qualified CAH staff to provide appropriate monitoring to ensure the safety of the juvenile, preventing the opportunity for elopement with the risk for potential harm. Subsequently, Patient #1 was found hours later and was returned to the ED on 3/28/17, approximately 28 hours after the elopement, and eventually transferred to a psychiatric hospital.	C 200	*C200 EMERGENCY SERVICES CFR(s)* **Response is located on Page 1 and 2 of 5** *C200 EMERGENCY SERVICES CFR(s)* **Response is located on Page 1 and 2 of 5**	

Robert M Hersey CFO 04/16/2018

Northeastern Vermont Regional Hospital 1315 Hospital Drive St Johnsbury, VT 05819	Subject: Mental Health Patient
Department: Emergency Department	Page 1 of 2
Approved By: Medical Director Emergency Services, Director Emergency Services, Emergency Services Assistant Director of MH and SA, Clinical Director of Children's and Adult MH and SA.	

DEFINITIONS:

All Patients presenting to the ED for help with a suspected Psychiatric diagnosis will be evaluated initially by the ED provider and then by the on-call Northeast Kingdom Human Service's (NKHS) Crisis Clinician.

The patient will be cared for in the same manner as all other patients presenting to the ED for care. At all times, the patient's dignity should be maintained as long as safety for the patient and the staff can be assured.

The ED provider, in collaboration with the NKHS crisis clinician, will ensure appropriate disposition of the mental health patient. This may include admission to NVRH or transfer to another facility for appropriate care, treatment, crisis planning, and discharge planning.

POLICY: KEY POINTS

1. The patient will be triaged and registered per admitting protocol. If patient presents with indications of suicidal tendencies, they will be closely monitored and asked to change into paper scrubs or a hospital gown if appropriate. All personal items will be removed, placed in a hospital bag, and secured at the nurse's station as long as the patient is in the department.

2. All patients presenting with a potential psychiatric diagnosis should be triaged at an ESI level 2.

3. Patients presenting with potential psychiatric issues should be placed in room 9 or room 5 to allow close monitoring. Prior to bringing the patient to either room, all equipment, supplies, removable items should be removed from the room and stored away from the patient's reach.

4. ED provider will complete a medical screening exam to ensure medical stability. If adequate information is available regarding the patient on their arrival, the ED provider may contact mental health to request assessment prior to receiving completed lab reports, etc.

5. ED provider or designee will contact the on-call crisis clinician using the main NKHS number (802-748-3181), including after hour when clinicians are paged. The NKHS crisis clinician will respond to the ED and offer approximate time of arrival (within one hour).

6. A supervisor, a member of the medical staff, and/or a psychiatrist (if available) from NKHS will be available for consultation to the crisis clinician and ED as appropriate.

7. If deemed appropriate for admission at NVRH, the ED provider will contact the on-call physician for admission orders.

8. The crisis clinician will collaborate in the admission process discussing the admission directly with the on-call physicians involved.

Northeastern Vermont Regional Hospital 1315 Hospital Drive St Johnsbury, VT 05819	Subject: Mental Health Patient
Department: Emergency Department	Page 2 of 2
Approved By: Medical Director Emergency Services, Director Emergency Services, Emergency Services Assistant Director of MH and SA, Clinical Director of Children's and Adult MH and SA.	

9. The admitting physician will decide if definitive care will be completed at NVRH or transferred to another facility in the case of a more complicated psychiatric presentation.

10. It is the responsibility of the NKHS crisis clinician to arrange admission to an inpatient psychiatric facility or a crisis stabilization program if the on-call physician denies admission to the facility (NVRH). The Crisis Clinician and the ED provider will collaboratively determine the most appropriate means of transportation to the facility.

11. The ED provider is responsible for completion of all transfer paperwork required under EMTALA.

12. If the patient is transferred to another facility and the ED provider and/or ambulance deem it necessary. Providers will work collaboratively to determine personnel necessary for transfer. The NKHS staff is not required to accompany the patient. Human Service's staff, or designee, may be asked to accompany the patient if the ED provider and/or ambulance personnel deem it necessary.

13. When inpatient psychiatric hospitalization is deemed necessary by all parties to ensure patient and community safety and the patient is not in agreement, involuntary hospitalization (EE) procedures will be followed. When an NKHS psychiatrist is not available to assist the qualified mental health professional (QMHP) in the evaluation, a hospital physician approved by the Department of Mental Health can assist with the procedure. When no physician is available, court warrant procedures will be enacted. See Involuntary Commitment policy

REFERENCES:

Northeast Kingdom Human Services
Michael Moss DNP, FNP-BC
Vermont State Statue 18 VSA 7505

Northeastern Vermont Regional Hospital 1315 Hospital Drive St Johnsbury, VT 05819	Subject: Behavioral Health Patient Management of the Admitted
Department: Nursing PCS	Page 1 of 4
Approved By: Nursing PCS Chair, CNO	

DEFINITIONS:

ABCD's: basic A-B-C's of caring for patients with mental disorders at NVRH
EE: emergency evaluation (involuntary hospitalization)
EMR: Electronic Medical Record
MSE: Mental Status Examination
NKHS: Northeast Kingdom Human Services

Supplemental Data:

At all times, the patient's dignity and privacy should be maintained as long as safety for the patient and the staff can be assured. If the patient is deemed to be harmful to themselves or others and attempt to leave the facility, regardless of the in-facility location, de-escalation techniques should be utilized.

All patients presenting with a Behavioral Health concern will be cared for in the same manner as all other patients presenting for care. The behavioral concerns can include poor impulse control, a low frustration tolerance, difficulty in communicating needs, and an inability to think clearly.

These behaviors often lead to challenging circumstances for medical personnel; resulting in labeling patients as difficult, different or impossible. It is therefore necessary to not only understand the need behind the behavior, but also develop an awareness of potential interventions including psychopharmacology, therapeutic communication, and therapeutic relationships and the role they play in the treatment of the individual. At no time should staff place themselves in danger.

Expected Outcomes:

1. The patient will be closely observed in a safe environment.
2. The patient will not inflict self-injury.
3. The patient will be given an opportunity to voice needs and concerns.
4. The patient will have a discharge plan that includes a safe environment and timely follow up.
5. The patient will be compliant with medication regiment.

Admission:

1. Patient admission status will be either EE or voluntary.
2. Admission status will drive level of patient observation.
3. A caregiver huddle prior to transfer to any NVRH Unit shall include a staff nurse from the receiving Unit.
4. Restraints may be required, refer to:

Northeastern Vermont Regional Hospital 1315 Hospital Drive St Johnsbury, VT 05819	Subject: Behavioral Health Patient – Management of the Admitted
Department: Nursing PCS	Page 2 of 4
Approved By: Nursing PCS Chair, CNO	

Restraint Application and Monitoring
http://mns.elsevierperformancemanager.com/SkillsConnect/Default.aspx?Token=NH702_f&SkillID=585
Restraint-Free Environment
http://mns.elsevierperformancemanager.com/SkillsConnect/Default.aspx?Token=NH702_f&SkillID=584
Suicide Assessment & Precautions:
http://mns.elsevierperformancemanager.com/SkillsConnect/Default.aspx?Token=NH702_f&SkillID=1238

5. BID visits from NKHS Crisis Clinician.
6. Suggested blood draws to be drawn upon admission: CBC, HCG, Toxicology Screen, and TSH.

Assessment:

1. Caregiver huddles should occur at the time the patient is admitted to an inpatient Unit, at change of shift and prn, with outcomes posted at the Nurses' station.
2. Assess vitals and MSE (may utilize ABCD's) as ordered and prn.
3. Assess for signs and symptoms/triggers of escalation and de-escalation in behavior.
4. Assess any co-morbidities which were present at the time of initial admission.
5. Assess inpatient medication compliance.

Safety: based on behavioral status and provider order

1. The patient admitted EE will require one-on-one observation. Requiring a patient observer or law enforcement, as determined by the patient's behavioral.
2. Frequent observation (q15 minutes).
3. Routine observation (q30 minutes).
4. Be alert and aware to the possible risk factors for violence among this population
5. Remove all potentially harmful objects from patient and patient's belongings. This may include removal of personal belongings.
6. Providers' orders may require the removal of electronics devises (cell phone, iPad, computer, etc.).

Planning:

1. Set daily goals
2. Assess behavior of visitors and impact on patient

Restrictions: based on behavioral status

1. Restrict to room, door to remain open unless staff with patient
2. Restrict to Unit

Food Options: based on behavioral status

1. Food may be limited to finger foods only and no hot food
2. Utensils may be limited to plastic/rubber flatware and paper products

Northeastern Vermont Regional Hospital 1315 Hospital Drive St Johnsbury, VT 05819	Subject: Behavioral Health Patient Management of the Admitted
Department: Nursing PCS	Page 3 of 4
Approved By: Nursing PCS Chair, CNO	

Personal Belongings:

1. Patient will be allowed personal belonging based on behavioral status.

Activities of Daily Living Allowed: based on behavioral status

1. Bathing may require supervision
2. Ambulation may be restricted to patient's room or require supervision

Visitors: will be limited if identified as triggers to the patient's behavioral escalation.

1. Obtain a list of visitors **allowed** to visit from the guardian/Providers.
2. Obtain a list of visitors **not allowed** to visit from the guardian/Providers.
3. Determine the time of day and length visits will be allowed.

Privileges:

1. Privileges, such as use of a telephone, writing materials, television, and electronics will be granted based on the level of cooperation with care providers and behavioral status. Granted privileges may have time constraints and can be revoked if behavioral status deteriorates.

Evaluation & Documentation:

1. Document via EMR interventions to include, but not limited to: Shift Assessment, Psychological Assessment, and education.

REFERENCES:

Beyond acting out: Managing pediatric psychiatric emergencies in the emergency department. (2012). Advanced Emergency Nursing Journal.

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MOAB Introduction with Strategies for Managing Physical Confrontations. (n.d.). MOAB Management of Aggressive Behavior, 1-67.

Sabella, D. (2014). Mental Illness and Violence: How can nurses identify and address signs of potential violence in their patients? American Journal of Nursing, 114(1), 49-53.

Northeastern Vermont Regional Hospital 1315 Hospital Drive St Johnsbury, VT 05819	Subject: Behavioral Health Patient – Management of the Admitted
Department: Nursing PCS	Page 4 of 4
Approved By: Nursing PCS Chair, CNO	

Scanlon, A. (2006). Psychiatric nurses perceptions of the constituents of the therapeutic relationship: A grounded theory study. J Psychiatr Ment Health Nurs Journal of Psychiatric and Mental Health Nursing, 319-329.

Shattell, M., Starr, S., & Thomas, S. (n.d.). "Take my hand, help me out": Mental health service recipients' experience of the therapeutic relationship. Int J Ment Health Nurs International Journal of Mental Health Nursing, 274-284. doi:10.1111/j.1447-0349.2007.00477.x

NORTHEASTERN VERMONT REGIONAL HOSPITAL

nvrh

April 3, 2018

Immediate Process Change Required for Management of the Admitted Behavioral Health Patient

Effective immediately all behavioral health patients receiving care in the hospital who require 1:1 Direct Observation will have Nursing department staff assigned, this includes trained LNAs. NKHS Peer Cadre and Patient Observers can only be used as supplemental support for the patient as directed by the trained NVRH Staff member assigned to the case. CPI (Crisis Prevention Institute) non-violent intervention training classes will be offered monthly to NVRH employees along with MOAB, Management of Aggressive Behavior, training as available.

This **URGENT** communication has been hand delivered to the House Supervisor on duty as of 4/3/18 at 18:00. Copies have been physically delivered to the offices and emailed to key organizational leaders as noted in the carbon copy (cc) section below. I have contacted the NKHS (Northeast Kingdom Human Services) Frontline Crisis worker and informed the agency of this immediate change. The House Supervisor will communicate the change to all clinical staff currently on duty and staff arriving for duty on the night shift. Clinical Department Directors and Physicians will be responsible for communicating the change to all staff members in their respective areas of responsibility.

Colleen Sinon, RN, CPHQ, CPHRM
VP Quality Management Programs
Northeastern Vermont Regional Hospital

Accepted,
Marifrances McIntosh, RN
Nurse Survey
4/3/18 @ 5:43 pm

cc:

Paul Bengtson, CEO
Seleem Choudhury, CNO
Michael Moss, DNP, Operations Director of Emergency Services
Ryan Sexton, MD, Medical Director of Emergency Services
Michael Rousse, MD, VP Medical Affairs, Chief Hospitalist
Sharon Mallett, DNP, Director of Medical/Surgical/Pediatric/Infusion Services
Laura Sophrin, MSN, Director of ICU
Vickie Jenkins, RN, Nursing Supervisor
Terry Larsen, MD, Medical Staff President

Northeastern Vermont
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