VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
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

October 24, 2018

Ms. Jill Berry Bowan, Administrator
Northwestern Medical Center Inc
133 Fairfield Street
Saint Albans, VT 05478-1726

Provider ID #: 470024

Dear Ms. Berry Bowan:

The Division of Licensing and Protection completed a survey at your facility on September 12, 2018. The purpose of the survey was to determine if your facility met the conditions of participation for Acute Care Hospitals found in 42 CFR Part 482.

Following the survey, your facility submitted a Plan of Corrections (POC) which was found to be acceptable on October 24, 2018.

Sincerely,

Suzanne Leavitt, RN, MS
State Survey Agency Director
Assistant Director, Division of Licensing & Protection

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MED CARE & MEDICAID SERVICES

PRINTED 09/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	470024	A. BUILDING _____ B. WING _____	C 09/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWESTERN MEDICAL CENTER INC	133 FAIRFIELD STREET SAINT ALBANS, VT 05478

(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
A 000	INITIAL COMMENTS An unannounced on-site investigation of complaint #16904 was conducted on 9/10/18 through 9/12/18 by the Division of Licensing and Protection. As a result of the investigation, regulatory violations were identified. Based on the information gathered, the hospital was determined not to be in compliance with the Federal Conditions of Participation for Acute Care Hospitals to include CoP: Patient Rights and Emergency Services.	A 000		
A 115	PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by Based on observations, interviews, and record reviews during the course of the complaint investigation, the Condition of Participation: Patient Rights was not met as evidenced by the hospital's failure to provide sufficient interventions to ensure each patient's rights were protected. Refer to: A144: Failure to ensure that patients have the right to receive care in a safe setting A154: Failure to ensure patients were free from coercion by staff, that restraints were appropriately applied as evidenced by the use of handcuffs, and that comprehensive assessments of a patients for the use of both chemical and physical restraints were completed	A 115	POC amnts on all tags via attachmts 10.24.18 DW/SL	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE CEO | (X6) DATE 10/8/18

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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A 115	Continued From page 1 A174: Failure to ensure that restraints were discontinued at the earliest possible time. A179: Failure to show evidence that a physician, licensed independent provider (LIP), and/or trained registered nurse (RN), had conducted a one hour face to face assessment after initiation of a chemical and/or physical restraint.	A 115		
A 144	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on observation, interview, and record review the hospital failed to assess for the use of an electric bed for a psychiatric patient who had access to bed controls and who was able to mobilize the bed to utilize as a barricade; failed to ensure rooms which were occupied by psychiatric patients were free of equipment and items that could cause self-harm or harm to staff; and failed to monitor visitors resulting in inappropriate behaviors with the potential to cause increased agitation and potential for harm for 3 of 10 applicable patients (Patient #1, Patient #3, and Patient #4). Findings include: 1. Per review of a nursing triage note from 7/31/18, Patient #1 arrived at the the Emergency Department (ED) at 12:38 PM by a Northwestern Counseling and Support Services (NCSS) clinician who advised that the patient was experiencing psychosis and needed medical clearance. Upon review of the physician's progress notes from 7/31/18, the patient was medically cleared and awaiting placement for inpatient treatment at a psychiatric facility. Per	A 144	See attached	

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A 144	Continued From page 2	A 144		

review of the nursing progress notes from 8/2/18 at 8:30 AM, "Pt (patient) sitting on floor pushing buttons on the bed, pt then unlocked the bed This RN (Registered Nurse) told pt to stop pushing the buttons on the bed and leave the bed locked in place. This RN went around to the right side of the bed and locked the bed. Pt grabbed the lower left safety rail and began shaking the rail. Security officers x 2 went into room pt then grabbed the side rail and shoved the bed across the room. Security officers wrestled pt to the ground and pinned pt down on the ground. RN called the police for assistance". Upon further review of the nursing progress notes, at 8:40 AM, 4 police officers and 3 security guards were at the patient's bed side and the crisis clinician was called to evaluate the patient. At least one police officer and two security guards remained at the patient's bedside until approximately 11:30 AM Per interview on 9/12/18 at 8:47 AM with ED RN #1, s/he stated that a safe environment meant that prior to a patient entering the room, it would be cleared of any items/objects that could be used to harm one-self and/or others. S/he stated that s/he helped to prep the room for this patient to ensure that the room was safe due to the patient's potentially volatile state. S/he stated that patients who had a longer length of stay in the ED were moved into the room with a hospital bed for their comfort. S/he confirmed that the patient unlocked the bed and shoved it across the room creating a potential barricade, and that s/he failed to completely assess the bed as a potential safety hazard. S/he stated that the patient had episodes in which s/he had escalated quickly and became violent. S/he stated that the patient had assaulted security guards at least 2 times prior to this incident and that the police had been called for staff and other patients' safety.

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A 144	Continued From page 3 2. Patient #3 was admitted to the ED on 9/8/18 with a psychiatric diagnosis of bipolar and a history of noncompliance with prescribed medication and treatment. Prior to admission, Patient #3 was demonstrating erratic and severe agitation requiring emergency intervention by law enforcement. Patient #3 was evaluated by a Crisis screener from NCSS and it was determined s/he was in need of psychiatric hospitalization under involuntary status. Admission to a psychiatric hospital was pending due to a lack of bed availability. While awaiting placement, Patient #3 was held in the Emergency Department (ED) for 10 days and experienced episodes of agitation, mania, delusions, resisting care, threatening staff, refusing medication and required restraints and involuntary emergency medication. During this period of time, there was a failure of ED staff to ensure care was provided in a safe setting. a). Patient #3 was permitted visitors to include a significant other who on 9/9/18 increased Patient #3's agitation resulting in hypersexual behavior. During a tour of the ED with the ED nurse manager on 9/10/18 at 2:20 PM, Sheriff's department staff were observed sitting outside Room #9 and Patient #3 was observed laying on a stretcher in a darkened Room #9 with significant other laying beside the patient with arms partially covered by a sheet. The ED nurse manager acknowledged what was observed was inappropriate and unsafe. After the surveyor's observation, ED Physician Documentation for 9/10/18 at 15:40 states the patient's significant other "....presented back to the emergency department and climbed on the stretcher and was on the stretcher snuggling with her/him....." The	A 144		

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A 144	Continued From page 4 significant other was informed Patient #3 had an acute psychiatric illness and "...It was unsafe for her/him to be on the stretcher " with Patient #3 b). Per Ongoing Care Note dated 9/09/18 at 18:01, Security was called to Patient #3's room because patient was throwing things. Patient had been provided a water bottle which s/he gestured to throw at staff and was attempting to reach for the vital signs monitoring equipment attached to a mobile pole that had been left in Patient #3's room. If the patient had obtained access to the monitoring equipment, the potential for harm could have resulted with injury to staff and/or the patient. Per interview on 9/11/18 at 3:50 PM the ED nurse manager confirmed the vital signs monitoring equipment should not have been left in Patient #3's room due to a safety risk and potential for harm. c). Per Ongoing Care Note/Nursing Mental Health Documentation dated 9/9/18 at 22:30, Patient #3 was found with a black garbage bag wrapped around his/her wrist. Despite the fact Patient #3 was delusional with unpredictable behaviors, safety checks conducted by ED staff of Patient #3's assigned ED room noted a failure to identify the importance of removing all plastic bags which could be used for self harm. 3. Per record review on 8/4/18, Patient #4 was brought to the ED with suicidal ideation's. Per review of nursing progress notes for Patient #4 at 10:05 PM, the patient was refusing to give up his/her belongings. The patient was informed that it was the hospital policy that for anyone coming in with suicidal ideation's, s/he would need to change into a gown for his/her safety. At 10:45 PM, the patient asked for a sandwich and a drink. At 10:58 PM, the patient had attempted to leave the facility and the physician informed the patient	A 144		

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A 144	Continued From page 5 that s/he was not allowed to leave until s/he had been evaluated by crisis. The patient eventually agreed to put on gown and remove his/her belongings. At 11:10 PM, the patient was given a turkey sandwich, a yogurt, a ginger ale, and a bottle of water. Per interview on 9/12/18 at approximately 9:00 AM with a RN, the ED Nurse Manager, and Manager of Regulatory Affairs, they confirmed that a water bottle cap could be used in a potentially harmful way and that Patient #4 should not have had a water bottle at his/her bedside while on suicide precautions. Per review of the policy, "Suicidal or Emotionally Ill Patient, Care of, C. Procedure for Maintaining a Safe Environment, 7. Remove the following items if present in the room: a. phone, b. call bell, c. hygiene supplies stored in bathroom, d. trash can liner, e. laundry hampers, f. all sharps or potential sharps from patient room, g. all cords form room: BP machine, phone, call light (replace with dummy plug), suction tubing, 02 tubing, etc. when not medically necessary, h. all non-essential furniture from room (waste baskets, chairs, night stand, linen receptacles, etc.)".	A 144		
A 154	USE OF RESTRAINT OR SECLUSION CFR(s): 482.13(e) Patient Rights: Restraint or Seclusion: All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.	A 154	See attached	

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A 154	Continued From page 6 This STANDARD is not met as evidenced by Based on interview and record review the hospital failed to ensure that patients were free from staff coercion regarding the use of police presence in the emergency department when they were not cooperative and for the purpose of submitting to involuntary medication, failed to appropriately use a restraint as evidenced by the use of handcuffs, and failed to conduct a comprehensive assessment for the use of a chemical and/or physical restraint for 2 of 10 applicable patients (Patient #1 and Patient #3). Findings include 1. Per review of nursing progress notes from 8/1/18 at 4:55 PM, Patient #1 tried to leave his/her ED room. Security had asked the patient to return to the room and the patient had refused. The patient started to push past the security officer and the officer stepped in front of the patient. The patient grabbed a keyboard from the computer outside his/her door and struck the screen of the computer several times, and then struck the keyboard on the wall. Security grabbed the patient and they wrestled around in the room with the security officer hitting his/her head on the wall during the interaction. Eventually, the security officer was able to get the patient on to the hospital bed and the patient calmed. The local police and crisis were called. At 5:00 PM the police were at the patient's bedside. At 5:40 PM, crisis was in the room evaluating the patient. At 6:00 PM, the police remained at the patient's bed side. At 8:00 PM, the police informed the staff that they were short staffed, "administration contacted to have officers on standby, pt calm at this time . . awaiting call back from administration for further plan of	A 154		

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A 154	Continued From page 7 security support". At 8:45 PM, "sleeping, awaiting local law enforcement sign on for bedside standby" At 9:30 PM, "security updated on patient care plan to call PD immediately if patient awakens". At 11:30 PM, "pd arrived briefly for assessment of pt. pt awoke momentarily. pt fell back to sleep". Per interview on 9/10/18 at approximately 1:23 PM with the Chief Nursing Officer (CNO) and Manager of Regulatory Affairs, they stated that police were only called when the staff was feeling unsafe. The police were not utilized to manage patients; the police were there to support the staff. On 9/11/18 at approximately 4:00 PM during an interview with the ED Nurse Manager, s/he stated that when police show their presence, it was comforting to visitors and other patients. S/he stated that when the situation goes beyond the security guards' capacity the police were called, and that generally when the police walk into the department, patients' tend to change their actions. Per nursing notes on 8/2/18 at 12:15 AM, "2 security officers continue at bedside for standby, PD and sheriffs unable to have officer standby due to staffing. pt sleeping". On 8/2/18 at 8:30 AM, "Pt (patient) sitting on floor pushing buttons on the bed, pt then unlocked the bed. This RN told pt to stop pushing the buttons on the bed and leave the bed locked in place. This RN went around to the right side of the bed and locked the bed. Pt grabbed the lower left safety rail and began shaking the rail. Security officers x 2 went into room pt then grabbed the side rail and shoved the bed across the room. Security officers wrestled pt to the ground and pinned down pt down on the ground. RN called the police for assistance". Upon further review of the nursing progress notes, at 8:40 AM, 4 police	A 154		

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A 154	Continued From page 8 officers and 3 security guards were at the patient's bed side and the crisis clinician was called to evaluate the patient. At least one police officer and two security guards remained at the patient's bed side until approximately 11 30 AM Per Interview on 9/12/18 at 8:47 AM with ED RN #1, s/he stated that Patient #1 had episodes in which s/he had escalated quickly and became violent. S/he stated that the patient had assaulted security guards at least 2 times prior to this incident and that the police had been called for staff and other patients' safety On 8/2/18 at 4:15 PM the nursing progress notes read, "Shortly after this RN leaving room patient ran out of room unprompted without saying anything and sheriffs tackled patient to floor outside of room and handcuffed" him/her "to facilitate getting" him/her "off the floor and into the room ...Patient requesting to keep handcuffs on .....This RN told patient would check on" him/her "shortly and handcuffs would be removed when" his/her "meal tray came for dinner". At 4 49 PM, the handcuffs were removed by the sheriffs. Per interview on 9/11/18 at approximately 4 00 PM with the ED Nurse Manager, s/he stated that the hospital did not use handcuffs as restraints. S/he stated that the staff kept the handcuffs on Patient #1 because s/he had requested to leave them on Per Interview on 9/12/18 at 11 22 AM with a ED RN #3, s/he stated that while the patient was handcuffed, the patient willingly took medication to help him/her calm down. S/he stated that s/he had asked the sheriffs' to remove the handcuffs from the patient, however, the patient requested to keep the handcuffs on. The RN confirmed that handcuffs were not an appropriate type of restraint, and that the patient was not given the option to have an appropriate restraint applied	A 154		

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A 154	Continued From page 9 2. Patient #3 was admitted to the ED on 9/8/18 with a psychiatric diagnosis of bipolar and a history of noncompliance with prescribed medication and treatment. It was determined after a crisis screening Patient 3 required psychiatric hospitalization. While awaiting involuntary placement, Patient #3 was held in the Emergency Department (ED) for 10 days and experienced episodes of agitation, mania, delusions, resisting care and refusing medication. During this period of time, Patient #1 was subjected to staff coercion regarding the use of police presence. On 9/8/18 at 17:00 Patient #3 Nursing Mental Health Documentation states one of the ED physicians informed Patient #3 that because s/he was "...acting angry and aggressive" staff will need to administer an injection. The note further states ". .s/he can either sit on the bed and take the injection or s/he needs to be restrained to the bed and then given the injection. . Pt stated s/he would not hurt anyone and would be compliant". Meanwhile at the time of the discussion and at the entrance to patient's room stood 3 St. Alban's Police Officers and 2 county Sheriffs. The patient was then administered the involuntary medication. On 09/09/18 at 23:00 Nursing Mental Health Documentation states " Pt. continues to be agitated. Walking around room-punching his/her fist in his/her hand. Discussed with MD. Decision to medicate--St. Alban's police called stand by assistance" At 09/09/18 at 23:31 a follow-up note states "Two St. Alban's PD and two NMC security guards at bedside for medication administration by two RNs-patient cooperative with the RN and team for medication." Per telephone interview on 9/12/18 at 10:40 AM a	A 154		

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A 154	Continued From page 10 security guard involved in the medication administration stated ED staff waited specifically for the police to arrive for the purpose of "showing presence" in front of Patient #3 who did not want the medication to be administered but did comply and allowed staff to perform procedure. Per interview on 9/12/18 at 11:20 AM, ED RN #2 confirmed s/he has called police "...as a back-up to our security" and further stated staff would call police "...to be present and once they are present patients will react...patient will calm down and listen."	A 154		
A 174	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(9) Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order. This STANDARD is not met as evidenced by: Based on staff interview and record review the hospital failed to ensure restraints were discontinued at the earliest time possible for 2 of 10 applicable patients. (Patients #1 and #3). Findings include: 1. Per review of the nursing progress notes from 8/4/18 at 10:40 AM, Patient #1 was pacing in the room. At 10:55 the "pt walked out of bedroom ... tried to push past security, was assisted to the floor by security and ed technician ...police department called, code green called". Due to the patient's violent and aggressive behavior, the patient was administered a chemical restraint of 2 milligrams (mg) Ativan (medication for anxiety) IM (intramuscularly) and 10 mg of Zyprexa (antipsychotic medication) IM; and bilateral upper	A 174	See attached	

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A 174	Continued From page 11 extremity neoprene restraints were applied. At 11 38 AM, the patient was reassessed by the nursing staff and was "resting". At 12 20 PM, the patient was reassessed and was "resting". At 1 00 PM, the patient was "sleeping". At 1 26 PM, the patient remained "sleeping". At 1 50 PM, the patient was "resting no acute distress". At 1 53 PM, the bilateral upper extremity restraints were removed. Per interview on 9/11/18 at approximately 4:00 PM with the ED Nurse Manager, s/he stated that restraints should be removed when the patient was calm and cooperative and no one was in danger. S/he confirmed that Patient #1 was noted by the nursing staff to be "resting/sleeping" from 11 38 AM until 1 50 PM and that the restraints were not removed at the earliest possible time. 2. During the time Patient #3 was held in the ED awaiting psychiatric placement, restraints were utilized by staff over a period of 2 days. After the application of bilateral upper extremity restraints on 9/8/18 at 20 10, nursing staff conducted 15 minute observations of Patient #3 which were documented within the Restraint Observation Sheet. On 9/8/18 at 21 45 "Patient Behavior" is documented as "resting" and at 22 00 the patient was "beginning to fall asleep". At 22 15, 22 45 and 23 00 patient continued to sleep and/or resting. At 23 30, 23 45, and 09/09/18 at 00 00 00 10 Physical Re-Assessment notes Patient #3 is "resting & drowsy". At 00 29 the right wrist restraint is removed and the left wrist restraint remains. After a brief period of agitation, Patient #3 returns to sleep at 01 15, 01 30, 01 45 and 02 00. Patient #3 has periods of agitation but returns to sleeping/resting and at 04 10 although cooperative, nursing reapplies the right wrist restraint and removes the left wrist restraint	A 174		

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	470024	A. BUILDING _____ B. WING _____	C 09/12/2018

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NORTHWESTERN MEDICAL CENTER INC	133 FAIRFIELD STREET SAINT ALBANS, VT 05478

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A 174	Continued From page 12 From 04:16 through 05:30 Patient #3's behavior was again described as "resting" and "sleeping". Patient remained in 1 restraint and continued in a pattern of some agitation associated with the restraint followed by sleeping which continued from 08:45 through 11:34 during which time the patient's behavior was documented as "resting". It was not until 13:00 on 9/9/18 that the patient was freed from the 1 extremity restraint. There was a lack of evidence to demonstrate Patient #3 remained a threat to the immediate physical safety of self or others specifically when Patient #3 remained calm, resting and or sleeping for periods greater than 2.50 hours.	A 174		
A 179	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(12) [the patient must be seen face-to-face within 1 hour after the initiation of the intervention --] §482.13(e)(12)(ii)To evaluate - 1. The patient's immediate situation; 2. The patient's reaction to the intervention; 3. The patient's medical and behavioral condition; and 4. The need to continue or terminate the restraint or seclusion. This STANDARD is not met as evidenced by: Based on interview and record review the hospital failed to show evidence that a physician, licensed independent provider (LIP), and/or trained registered nurse (RN), had conducted a one hour face to face assessment after initiation of a chemical and/or physical restraint for 2 of 10 applicable patients (Patient #1 and Patient #3). Findings include:	A 179	See attached	

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A 179	Continued From page 13 1. Per review of the nursing progress notes from 8/4/18 at 10 40 AM, Patient #1 was pacing in the room. At 10 55 the "pt walked out of bedroom ....tried to push past security, was assisted to the floor by security and ed technician ...police department called, code green called". Due to the patient's violent and aggressive behavior, the patient was administered a chemical restraint of 2 milligrams (mg) Ativan (medication for anxiety) IM (intramuscularly) and 10 mg of Zyprexa (antipsychotic medication) IM, and bilateral upper extremity neoprene restraints were applied. Per review of the physician progress notes from 8/4/18, there was no evidence that a one hour face to face assessment was done for Patient #1 after chemical and physical restraints were applied. Per interview on 9/12/18 at 9 14 AM with the Manager of Regulatory Affairs, s/he confirmed that there was no evidence that a one hour face to face assessment was done for Patient #1 by a physician after chemical and physical restraints were applied. 2. Although the documentation titled Physician Orders, Restraint state for "Violent/Behavioral Standard" "Physician must assess patient face-to-face and sign order within 1 hour of restraint application" there was no evidence in Patient #3's medical record to indicate an assessment was conducted by a physician after the application of restraints on 9/8/18 at 20 10 and chemical restraints at 20 27. There was a failure to address the patient's reaction to the chemical and physical restraints, the patient's medical and behavioral condition after the application of restraints and the administration of Zyprexa 10 mg IM, and whether there was a need to continue the use of restraints.	A 179		

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	470024	A. BUILDING _____ B. WING _____	C 08/12/2018

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A 283	QUALITY IMPROVEMENT ACTIVITIES CFR(s): 482.21(b)(2)(ii), (c)(1), (c)(3) (b) Program Data (2) [The hospital must use the data collected to - .....] (ii) Identify opportunities for improvement and changes that will lead to improvement. (c) Program Activities (1) The hospital must set priorities for its performance improvement activities that– (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care. (3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained. This STANDARD is not met as evidenced by: Based on interview and record review the hospital's Quality Assurance and Improvement Program (QA/PI) failed to analyze the incidence, prevalence, and the severity of the use of chemical and/or physical restraints in the Emergency Department and throughout the hospital, and as a result failed to identify opportunities for improvement. Findings include: 1. Per review of nursing progress notes from 8/2/18, Patient #1 tried to leave his/her ED room and was tackled to the floor by sheriffs and	A 283	See attached	

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A 283	Continued From page 15	A 283		

handcuffed. The patient willingly took medication to help him/her calm down, however, had asked to keep the handcuffs on. Per interview on 9/11/18 at approximately 4:00 PM with the ED Nurse Manager, s/he stated that the hospital did not use handcuffs as restraints, and that the handcuffs were kept on the patient because s/he had requested to keep them on. Per interview on 9/12/18 at 11:22 AM with ED RN#3, s/he stated that s/he had asked the sheriffs to remove the handcuffs, however, the patient requested to keep them on. S/he confirmed that the handcuffs were not an appropriate type of restraint, and that the patient did not have the opportunity to have an appropriate restraint applied. On 8/4/18 at 10:55 AM, Patient #1 had chemical and physical restraints applied due to violent and aggressive behavior. Per review of the nursing progress notes from 8/4/18 at 11:38 AM to 1:50 PM the patient was either "resting, sleeping, and/or in no acute distress". The restraints were removed from Patient #1 at 1:53 PM. There was approximately over 2 hours of time where the patient demonstrated that s/he was not violent and/or aggressive, and that restraints could have been removed. During the interview with the ED Nurse Manager on 9/11/18 at approximately 4:00 PM, s/he confirmed that the restraints for Patient #1 were not removed at the earliest time possible. Per review of the physician progress notes from 8/4/18, there was no evidence that a one hour face to face assessment was done after the restraints were applied to Patient #1. This was confirmed by the Manager of Regulatory Affairs on 9/12/18 at 9:14 AM.

2. Patient #3 was admitted to the ED on 9/8/18 with a psychiatric diagnosis of bipolar and a history of noncompliance with prescribed

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A 283	Continued From page 16 medication and treatment. It was determined after a crisis screening Patient #3 required psychiatric hospitalization. While awaiting involuntary placement, Patient #3 was held in the Emergency Department (ED) for 10 days and experienced episodes of agitation, mania, delusions, resisting care and refusing medication. During this time frame, Patient #3 was placed in physical restraints and also was administered chemical restraints. During administration of involuntary medication, St. Alban's police became involved "as a presence". There was also a failure to discontinue restraints at the earliest possible time when medical record review noted Patient #3 was resting and/or sleeping on 9/9/18 while remaining in a wrist restraint. If a quality review had been effectively conducted, it would have also been noted that there was a failure by a physician, licensed independent provider (LIP), and/or trained registered nurse (RN), to conduct a one hour face to face assessment after initiation of a chemical and/or physical restraint for Patient #3. Per interview on 9/12/18 at approximately 1:30 PM with the Manager of Regulatory Affairs and Director of Quality, they stated that there had been some challenges with data collection for analyzing restraint use as the facility was using both paper and electronic documents. They stated that it was the Unit Nurse Manager's responsibility to review restraint use monthly and report out to the patient care committee. They stated that some random audits had been done however, the hospital did not have a consistent, robust way to analyze the incidence, prevalence, and severity of restraint use. They confirmed that with each of these cases there were opportunities for improvement.	A 283		

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A 283	Continued From page 17 Refer to Tags: A- 0154; A-0174; A-179	A 283		
A1100	EMERGENCY SERVICES CFR(s): 482.55 The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice. This CONDITION is not met as evidenced by: Based on observations, interviews, and record reviews during the course of the complaint investigation, the Condition of Participation: Emergency Services was not met as evidenced by the failure of the hospital to ensure there was sufficiently trained staff to address behavioral management as evidenced by the periodic use of law enforcement presence for standby for potentially violent and/or self-destructive patients, and use of police presence during involuntary medication administration for 2 of 10 applicable patients (Patient #1, Patient #3). Findings include: 1. Per review of nursing progress notes from 8/1/18 at 4:55 PM, Patient #1 tried to leave his/her ED room. Security had asked the patient to return to the room and the patient had refused. The patient started to push past the security officer and the officer stepped in front of the patient. The patient grabbed a keyboard from the computer outside his/her door and struck the screen of the computer several times, and then struck the keyboard on the wall. Security grabbed the patient and they wrestled around in the room with the security officer hitting his/her head on the wall during the interaction. Eventually, the security officer was able to get the	A1100	See attached	

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A1100	Continued From page 18	A1100		

patient on to the hospital bed and the patient calmed. The local police and crisis were called. At 5:00 PM the police were at the patient's bedside. At 5:40 PM, crisis was in the room evaluating the patient. At 6:00 PM, the police remained at the patient's bed side. At 8:00 PM, the police informed the staff that they were short staffed, "administration contacted to have officers on standby, pt calm at this time ....awaiting call back from administration for further plan of security support". At 8:45 PM, "sleeping. awaiting local law enforcement sign on for bedside standby". At 9:30 PM, "security updated on patient care plan to call PD immediately if patient awakens". At 11:30 PM, "pd arrived briefly for assessment of pt. pt awoke momentarily. pt fell back to sleep". Per interview on 9/10/18 at approximately 1:23 PM with the Chief Nursing Officer (CNO) and Manager of Regulatory Affairs, they stated that police were only called when the staff was feeling unsafe. The police were not utilized to manage patients. the police were there to support the staff. On 9/11/18 at approximately 4:00 PM during an interview with the ED Nurse Manager, s/he stated that when police show their presence, it was comforting to visitors and other patients. S/he stated that when the situation goes beyond the security guards' capacity the police were called, and that generally when the police walk into the department, patients' tend to change their actions.

Per nursing notes on 8/2/18 at 12:15 AM, "2 security officers continue at bedside for standby, PD and sheriffs unable to have officer standby due to staffing pt sleeping" On 8/2/18 at 8:30 AM, "Pt (patient) sitting on floor pushing buttons on the bed, pt then unlocked the bed. This RN told pt to stop pushing the buttons on the bed and

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A1100	Continued From page 19 leave the bed locked in place. This RN went around to the right side of the bed and locked the bed. Pt grabbed the lower left safety rail and began shaking the rail. Security officers x 2 went into room pt then grabbed the side rail and shoved the bed across the room. Security officers wrestled pt to the ground and pinned down pt down on the ground. RN called the police for assistance". Upon further review of the nursing progress notes, at 8 40 AM, 4 police officers and 3 security guards were at the patient's bed side and the crisis clinician was called to evaluate the patient. At least one police officer and two security guards remained at the patient's bed side until approximately 11 30 AM. Per interview on 9/12/18 at 8 47 AM with ED RN #1, s/he stated that Patient #1 had episodes in which s/he had escalated quickly and became violent S/he stated that the patient had assaulted security guards at least 2 times prior to this incident and that the police had been called for staff and other patients' safety. 2. Patient #3 was admitted to the ED on 9/8/18 with a psychiatric diagnosis of bipolar and a history of noncompliance with prescribed medication and treatment It was determined after a crisis screening Patient #3 required psychiatric hospitalization. While awaiting involuntary placement, Patient #3 was held in the Emergency Department (ED) for 10 days and experienced episodes of agitation, mania, delusions, resisting care and refusing medication. During this period of time, Patient #1 was subjected to staff coercion regarding the use of police presence On 9/8/18 at 17 00 Nursing Mental Health Documentation states one of the ED physicians informed Patient #3 that because s/he was " .acting angry and aggressive" staff will	A1100		

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A1100	Continued From page 20	A1100		

need to administer an injection. The note further states "...s/he can either sit on the bed and take the injection or s/he needs to be restrained to the bed and then given the injection. Pt stated s/he would not hurt anyone and would be compliant". Meanwhile during the time of the discussion between ED nursing staff and Patient #3, at the door entrance stood 3 St. Alban's Police Officers and 2 county Sheriffs. The patient was then administered the involuntary medication of Zyprexa (antipsychotic) 10 mg. IM

On 09/09/18 at 23:00 Nursing Mental Health Documentation states " Pt. continues to be agitated. Walking around room-punching his/her fist in his/her hand. Discussed with MD. Decision to medicate--St. Alban's police called stand by assistance" At 09/09/18 at 23:31 a follow-up note states: "Two St. Alban's PD and two NMC security guards at bedside for medication administration by two RNs-patient cooperative with the RN and team for medication." The patient was administered Zyprexa 20 mg. IM. Per interview on 9/12/18 at 10:40 AM, Security guard #1 confirmed that at times with past events in the ED the St. Alban's police would be utilized to assist staff to hold down a patient in an emergent behavioral situation. During the events on 9/8/18 and 9/9/18 involving Patient #3, the police remained " a show of presence". Per interview on 9/12/18 at 11:20 AM, ED RN #2 confirmed s/he has called police "...as a back-up to our security" and further stated staff would call police "...to be present and once they are present patients will react...patient will calm down and listen." In addition, per ED Physician Documentation in regards to ED staffing and the use of restraints for Patient #3, On 9/9/18 at 06:53 s/he states: "May be worth trying him/her off restraints during

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A1100	Continued From page 21 the day if adequate security is present to manage him/her if s/he tried to leave". Per interview on 9/11/18 at 3 02 PM with the Director of Facilities and the Manager of Security, they stated that all of the security officers take the MANDT training which was a type of training that focuses on preventing, deescalating and if necessary intervening when the behavior of an individual poses a threat of harm to themselves and/or others. The Manager of Security stated that security's role was to maintain one to one observation, patrol the facility, check parking lots, check other buildings that that hospital owns, and help to maintain outside community relations. Per the Director of Facilities, s/he stated that security would coordinate with the local police department when necessary, however, the police would only be called with acts that were possibly criminal in nature, and that it was not very often that police were called. Per review of the hospital education transcripts for the security guards, there was evidence that only 2 of 6 staff members had MANDT training. Per interview on 9/12/18 at 2 28 PM with the Manager of Regulatory affairs, s/he confirmed that only 2 of the 6 security officers had MANDT training. S/he stated that it was the hospital's goal to have everyone trained within the year.	A1100		

Northwestern Medical Center

CMS Certification Number 470024
Survey ID EN6911, 9/10/18 through 9/12/18

Attachment to Form CMS-2567, Statement of Deficiencies and Plan of Correction

482.13 Patient Rights ***Tag A-115***

482.13(c) (2) Patient Rights: Care in Safe Setting **Tag A-144**

Plan of Correction:

The plan for improving the process that led to this deficiency is as follows:
Revise the "Care of the Suicidal or Emotionally Ill Patient "policy.

Update provider and nursing documentation fields in the electronic medical record to address policy revisions and to better reflect workflow.

Procedure for implementing:
The "Care of the Suicidal or Emotionally Ill Patient "policy revised to include changes to section C. : Procedure for Maintaining a Safe Environment to include a more detailed list of items to remove if present in a room and a more detailed list of items to remain in a room.

A documentation template/checklist that delineates the procedure for maintaining a safe environment in the room of a suicidal and/or emotionally ill patient will be designed and implemented in the Northwestern Medical Center electronic medical record.

NMC Clinical Staff will be trained on the updated policy on the Care of Suicidal and Emotionally Ill Patient's Procedure for Maintaining a Safe Environment to include a more detailed list of items to be removed if present in a room and a more detailed list of items to remain in a room and to the use of the enhanced medical record documentation to support this work.

Completion date for correction: October 27, 2018

Monitoring and tracking:
The unit manager or designee will perform rounds, every shift, on all patients that are in restraints to verify compliance with the policy requiring removal of unsafe items for a period of October, November and December 2018 with the target of at least 90% compliance.
Once this goal is achieved for three consecutive months, the manager or designee will perform random audits to check for continued compliance.

Title of person(s) responsible:
Director of Inpatient Services
Emergency Department Nurse Manager

POC cmt 10.24.18
DW/SC

482.13 (e) Use of Restraint or Seclusion **Tag A-154**

Plan of Correction:

The plan for improving the process that led to this deficiency is as follows:
Revise the "Care of the Suicidal or Emotionally Ill Patient "policy.

Procedure for implementing:
"Care of the Suicidal or Emotionally Ill Patient "policy revised to add the following language in the Safety Risks and Intervention section: 'Contact Local Law Enforcement if criminal act is committed such as assault on healthcare worker (the intent to commit harm and the present ability to do so), battery, theft or other crime. This is applicable to patients at all stages of Safety Risk Assessment.

The "Restraint Use" policy revised to include the following language: "Hospital security officers may assist direct care staff by holding the patient, when requested, in the application of restraints and therefore are expected to be trained and able to demonstrate competency in their role in safe application of restraint and seclusion."

Update provider and nursing documentation fields in the electronic medical record to address policy revisions and to better reflect workflow.

Appropriate staff will be educated to these policy revisions and documentation enhancements

Completion date for correction: October 27, 2018

Monitoring and tracking:
The unit manager or designee will perform an audit of the medical records of all patients in violent/behavioral restraints for the period of October, November and December 2018 with the target of at least 90% compliance.
Once this goal is achieved for three consecutive months, the manager or designee will perform random audits to check for continued compliance.

Title of person(s) responsible:

Director of Inpatient Services
Emergency Department Nurse Manager

NC want 10.24.18
Dr/SL 2

482.13 (e)(9) Patient Rights: Use of Restraint or Seclusion Tag A-174

Plan of Correction:

The plan for improving the process that led to this deficiency is as follows:

Procedure for implementing:

The "Restraint Use" policy revised to include the language in the Procedure for Non-Violent/ Non- Behavioral Restraint section and in the Procedure for Violent / Behavioral Restraint section under the Registered Nurse responsibilities: "frequently assesses the patient's need for continued restraint; may make the decision to discontinue restraint early, based on patient assessment; may make the decision to reapply restraint under the most recent order if still within the 24 hour time frame, if a patient's medical condition or reason for which the restraint was originally used continues, or recurs after discontinuing the restraint early."

Also this revision under the Procedure for Violent/ Behavioral Restraint section under the Registered Nurse responsibilities and Documentation responsibilities: "initial assesses patient, documents unsafe behavior warranting the use of restraint; ...behavior observed that supports the use of restraint or the discontinuation of restraint. . . . Frequently assesses the patient's need for continued restraint "

Appropriate staff will be educated to these policy revisions.

Completion date for correction:
October 27, 2018

Monitoring and tracking:
The unit manager or designee will perform an audit of the medical records of all patients in restraints for compliance with the requirement that the documentation of patients' behavior supports the continued use of restraint. This audit will be for the period of October, November and December 2018 with the target of at least 100% compliance.
Once this goal is achieved for three consecutive months, the manager or designee will perform random audits to check for continued compliance.

Title of person(s) responsible:
Director of Inpatient Services
Emergency Department Nurse Manager

AC amt 10.24.18
DW/SL

482.13 (e)(12) Patient Rights: Use of Restraint or Seclusion **Tag A-179**

Plan of Correction:

The plan for improving the process that led to this deficiency is as follows:

Procedure for implementing:
Re-educate all appropriate staff regarding language already in the Restraint policy specifying that in the procedure for Violent / Behavioral Management Restraint, the LIP "views and evaluates the patient for a face-to-face assessment within 1 hour of application of restraint or seclusion of the patient."

Appropriate staff will be educated to these policy revisions.

Completion date for correction: October 27, 2018

Monitoring and tracking:
The unit manager or designee will perform rounds on all patients that are in Violent/Behavioral Management Restraint and verify that the face-to-face assessment within 1 hour of application of restraint has been performed, for the period of October, November and December 2018 with the target of at least 100% compliance.
Once this goal is achieved for three consecutive months, the manager or designee will perform random audits to check for continued compliance.

Title of person(s) responsible:
Director of Inpatient Services
Emergency Department Nurse Manager

Poc amt 10.24.18
Dir/sl

482.21 (b)(2)(ii), (c)(1), (c)(3)
QUALITY ASSURANCE / PERFORMANCE IMPROVEMENT Tag A-283

Plan of Correction:

The plan for improving the process that led to this deficiency is as follows:

Procedure for implementing:
Re-establish the process of measuring, analyzing and tracking restraint usage to determine opportunities for improvement and recommend changes that will lead to improved health outcomes, patient safety and quality of care. Results of this analysis will be presented monthly at the multidisciplinary meeting of the Patient Care Committee

Appropriate staff will be educated to these quality enhancements.

Completion date for correction:
October 27, 2018

Monitoring and tracking:
The unit manager or designee will perform an audit of the medical records of all patients in restraints for compliance with all policy requirements. This audit will be for the period of October, November and December 2018 with the target of at least 90% compliance. Subsequently unit managers or their designee will monitor unit specific data monthly and report data quarterly at the Patient Care Committee. Minutes of the Patient Care Committee are sent to the Medical Executive Committee for information and acceptance.

Title of person(s) responsible:
Director of Inpatient Services
Emergency Department Nurse Manager
Director of Quality

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poc amt 10.24.18
DW/SL

482.55 Emergency Services **Tag A-1100**

Plan of Correction:

The plan for improving the process that led to this deficiency is as follows:

The "Care of Suicidal or Emotionally Ill Patient" Policy has been revised to delineate how NMC staff will manage these patients with very limited and specific use of law enforcement.

Procedure for implementing:

- MANDT training – currently 140 clinical staff have participated ---course will be offered monthly starting in Jan 2019. All NMC Contracted Security guards will have MANDT Training completed by November 2018.
- "Care of the Suicidal or Emotionally Ill Patient "policy revised to add the following language in the Safety Risks and Intervention section: 'Contact Local Law Enforcement if criminal act is committed such as assault on healthcare worker (the intent to commit harm and the present ability to do so), battery, theft or other crime. This is applicable to patients at all stages of Safety Risk Assessment.

Appropriate staff will be educated to these changes.

Completion date for correction: October 27, 2018

Monitoring and tracking:

MANDT Training for clinical personnel and security detail will be initiated on hire and tracked through NMC Learning Management System called NetLearning – transcripts will be available. The unit manager or designee will perform an audit of the medical records of all Emotionally Ill and Suicidal patients identified with a risk level of III or greater for compliance with the policy related to the appropriate use of law enforcement. This audit will be for the period of October, November and December 2018 with the target of at least 90% compliance.
Once this goal is achieved for three consecutive months, the manager or designee will perform random audits to check for continued compliance.

Title of person(s) responsible:
Director of Inpatient Services
Emergency Department Nurse Manager
Emergency Preparedness and Security Coordinator
Lead Clinical Educator

Respectfully submitted,

Maggie Conklin

Maggie Conklin/Interim Chief Nursing Officer

POC sent 10.24.18
DW/BL

Restraint Use

Applicability: Organizational	**Date Effective:** 6/04
Department: Clinical Services	**Date Last Reviewed:** 10/18
Supersedes: Restraint	**Or** **Date Last Revision:** 1/16, 10/18
Administration Approval: Maggie Conklin, RN, Interim Chief Nursing Officer	

Purpose:

To assure safe and effective care is provided when restraints are used for the support of medical healing or behavioral emergencies.

To describe NMC's commitment to progressively minimizing the use of restraints by offering interventions and alternatives.

To assure restraints are used only when medically necessary and are used for patient benefit and safety.

Policy Statement: Patients have the right to be free of restraint. Restraints are used only when clinically justified to prevent serious disruption of the therapeutic environment or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others. Restraints may be used for non-violent / non-behavioral conditions or for violent / behavioral conditions, only after less restrictive interventions have failed, and by using the least restrictive form of restraint possible. An order is obtained for each restraint and **cannot** be a PRN (use if needed) order. Restrained patients are continually assessed, monitored, and re-evaluated with the goal to discontinue the restraint as soon as is clinically possible.

All evaluations of the patient regarding need for restraint by the Licensed Independent Professional (LIP) are documented in the medical record.

This policy is not applicable to standard practices that include limitation of mobility or use of medically necessary positioning or securing device used to maintain the position, limit mobility, or temporarily immobilize the patient related to medical, dental, diagnostic, or surgical procedures and the related post-procedure care processes and forensic and correction restrictions used for security.

Northwestern Medical Center reports the death of any restrained or secluded patient.

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DH/BL

Background: [Any medical, legal, standards-based, or field specific terminology clarification?]

Definitions:

Physical Restraint: Any manual method, physical or mechanical device, material or equipment attached or adjacent to the patient's body that he/she cannot easily remove or that restricts freedom of movement or normal access to one's body. Types of physical restraint include: safety belt, soft limb restraint, neoprene limb restraint, and possibly geriatric/cardiac chair and bed rails.

The application of physical force to administer a medication against the patient's wishes is considered a physical restraint.

Seclusion: The involuntary confinement of a person in a room or an area where the person is physically prevented from leaving. Seclusion is a type of physical restraint.

Chemical Restraint: **See Addendum 1 (Chemical Restraint Decision Tree).** Any medication used to control behavior to restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition.

The application of physical force to administer a medication acting as a chemical restraint (against the patient's wishes) is considered a physical restraint and requires an additional separate order.

Interruption: Brief removal of restraint to render care with no plan for discontinuation of restraint.

Break: Trial period of restraint removal to assess need for continued use.

Licensed Independent Practitioner (LIP): A Physician or a Nurse Practitioner

Non-Violent/ Non-Behavioral Standard: applies to the use of restraint to temporarily immobilize a patient due to a medical condition or to promote healing.

Violent/ Behavioral Management Standard: applies to the emergent use of a restraint to control violent, or potentially violent, behavior.

Procedure for Non-Violent/Non-Behavioral Restraint:

Registered Nurse (RN) responsibilities:

- Initially assesses patient, documents unsafe behavior warranting the use of restraint.

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DW/SL

- Initially describes patient behaviors posing immediate threat to the safety of the patient, a staff member, or others.

- Documents all interventions attempted prior to implementing a restraint
- After assessment of the patient, may make the decision to apply restraint prior to receiving an order but obtains a restraint order from an LIP as soon as possible.
- Selects the type of restraint that is the least restrictive intervention based on the initial and current patient assessment and addresses the risk associated with vulnerable patient populations, such as geriatric, pediatric, and cognitively or physically-limited patients.
- Frequently assesses the patient's need for continued restraint
- May make the decision to discontinue restraint early, based on patient assessment
- May make the decision to reapply restraint under the most recent order if still within the 24 hour time frame, if a patient's medical condition or reason for which the restraint was originally used continues, or recurs after discontinuing the restraint early.

LIP responsibilities:

- Views and assesses the patient for need for restraint
- Documents findings of their evaluation in the medical record.
- Signs the restraint order within 12 hours of the application of restraint.

    - Utilizing Restraint Orders. Documentation includes:

        - Date & time of order
        - Specific patient condition/behavior clinically justifying need for restraint
        - Specific type of restraint and location(s)
        - Specific start and stop times

Nursing (RN, LPN, LNA or Tech under the direction of an RN) responsibilities:

- Nursing (or the LIP) explains the procedure and rationale for using restraint, including the condition/behavior required for release from restraint to the patient and family whenever possible.
- Nursing applies restraint in accordance with safe and appropriate restraining techniques following manufacturer's guidelines, including elevating head of bed for patient comfort if indicated.
- Nursing monitors the patient in person, and provides care based on patient needs a minimum of every 2 hours,
- Nursing documents a minimum of every 2 hours. An LIP may renew a restraint order ONCE PER CALENDAR DAY if continued restraint is clinically indicated based on the LIP's examination and evaluation of the patient.

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- Restraint(s) order(s) written by a LIP in any department may be continued by receiving unit upon patient transfer.

Documentation responsibilities:

- Initial assessment of patient for need for restraint

- Specific reason for the use of restraint
- All less-restrictive alternatives attempted prior to restraint
- Monitoring and care rendered every 2 hours based on patient need

Procedure for Violent/Behavioral Management Restraint:

Registered Nurse (RN) responsibilities:

- Initially assesses patient, documents unsafe behavior warranting the use of restraint.
- Describes patient behaviors posing immediate threat to the safety of the patient, a staff member, or others.
- Documents all interventions attempted prior to implementing a restraint.
- After assessment of the patient, may make the decision to apply restraint prior to receiving an order but obtains an order from an LIP for restraint as soon as possible and always within 1 hour of the application of restraint.
- The type of restraint selected is the least restrictive based on the initial and current patient assessment and addresses the risk associated with vulnerable patient populations, such as geriatric, pediatric, and cognitively or physically-limited patients.
- Frequently assesses the patient's need for continued restraint

LIP Responsibilities

- Views and evaluates the patient for a face-to-face assessment within 1 hour of application of restraint or seclusion of the patient.
- The LIP documents findings of their evaluation in the medical record.
- Views and assesses the patient for need for restraint
- Documents findings of their evaluation in the medical record.
- Signs the restraint order within 24 hours of the application of restraint.
- Each restraint order is documented, utilizing Restraint Orders. Documentation includes:

  - Date & time of order
  - Specific patient condition/behavior clinically justifying need for restraint
  - Specific type of restraint and location(s)

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DW/SL

- Specific start and stop times (see following)
- Each written order for physical restraint is limited to the following time frames:

  - Orders for adults (age 18 or older) are valid for 4 hours
  - Orders for adults (age 18 or older) in involuntary hold (Emergency Evaluation – EE) status are valid for 2 hours.
  - Orders for children/adolescents (ages 9 - 17) are valid for 2 hours
  - Orders for patients under 9 years of age are valid for 1 hour.

Nursing (RN, LPN, LNA or Tech under the direction of an RN) responsibilities:

- Nursing (or the LIP) explains the procedure and rationale for using restraint, including the condition/behavior required for release from restraint to the patient and family whenever possible
- Nursing applies restraint in accordance with safe and appropriate restraining techniques following manufacturer's guidelines, including elevating head of bed for patient comfort if indicated.
- If physical restraint is required to administer a chemical restraint , the nurse obtains an additional separate order for physical restraint
- Nursing monitors the patient in person, and provides care based on patient needs a minimum of every 2 hours
- Nursing documents a minimum of every 15 minutes.
- A patient who is both restrained and secluded requires 1:1 observation. A patient requiring 1:1 observation is continuously monitored face to face or by use of simultaneous video and audio equipment
- An RN assesses the patient's need for restraint.
- A RN may obtain a renewal of a restraint order if continued restraint is clinically indicated, based on assessment of patient condition:
  - Orders for adults (age 18 or older) can be renewed via telephone order for an additional 4 hours.
  - Orders for children/adolescents (ages 9 - 17) can be renewed via telephone order for an additional 2 hours.
  - Orders for patients under 9 years of age can be renewed via telephone order for an additional 1 hour.
- Orders may be renewed according to the time limits for a maximum of 24 consecutive hours. If a patient remains in restraint or seclusion 24 hours after the original order, an LIP must see the patient and conduct a face-to-face re-evaluation before issuing a new order for the continued use of restraint or seclusion.
- An RN may make the decision to discontinue restraint prior to expiration of the order, based on patient assessment; however, if restraint or seclusion is discontinued early, a new order must be obtained before restraint is reinitiated.

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- Restraint order written by a LIP in any department may be continued by the receiving unit upon patient transfer.

Documentation responsibilities:

Restraint for Violent/ Behavioral Management reasons

Require 1:1 or frequent monitoring and documentation **every** 15 minutes.

Documentation includes:

- Any changes in behavior
- Behavior observed that supports the continued use of restraint or the discontinuation of restraint

Training requirements:

All staff designated as having direct patient care responsibilities, including contract or agency personnel, must demonstrate the competencies specified prior to participating in the application of restraints, monitoring, assessment, or care of a patient in restraint or seclusion. These competencies are demonstrated initially as part of orientation and subsequently on a periodic basis consistent with the hospital education plan.

Hospital security officers may assist the direct care staff by holding the patient, when requested, in the application of restraints and therefore are expected to be trained and able to demonstrate competency in their role in safe application of restraint and seclusion.

Hospital has documented evidence that all the required levels of staff have been trained and are able to demonstrate competency in the safe use of seclusion and the safe application and use of restraints.

Staff education programs include:

- techniques related to the specific patient populations being served
- techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint and seclusion.
- more in-depth training in the areas included in the regulation for staff members who routinely provide care to patients who exhibit violent or self destructive behavior.
- address the use of nonphysical intervention skills
- choosing the least restrictive intervention based on an individualized assessment of the patient's medical or behavioral status or condition
- training in how to recognize and respond to signs of physical and psychological distress

- clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.
- Monitoring the physical and psychological well-being of the patient who is retrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and and special requirements
- The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.

Physicians and other LIPs authorized to order restraint or seclusion by hospital policy in accordance with State law must have a working knowledge of hospital policy regarding the use of restraint and seclusion.

Reporting of Deaths:

1. Death of any restrained or secluded patient, or patient restrained or secluded within past 7 days is reported to NMC's Risk Management immediately. (See Sentinel Events policy).

2. NMC's Risk Management reports applicable deaths to the Center for Medicare and Medicaid Services within close of business the next business day following knowledge of the patient's death Deaths reported include:

    - Deaths that occur while a patient is restrained or secluded
    - Deaths that occur within 24 hours after a patient has been removed from restraint or seclusion
    - Deaths known to the hospital that occur within one week after restraint or seclusion where it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to the patient's death

3. NMC Risk Management verifies that the date and time the death was reported to CMS is documented in the patient's medical record.

Note Well: Law Enforcement or Corrections officers who maintain custody and direct supervision of their prisoner (the hospital's patient) are responsible for the use, application, and monitoring of these restrictive devices (handcuffs, manacles, shackles) in accordance with Federal and State law.
The use of such devices are considered law enforcement restraint devices and would not be considered safe, appropriate health care restraint interventions for use by hospital staff to restrain patients.

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Related Policies:

Suicide/Violent Admitted Observation Patient Precautions

Fall Risk Assessment

Correctional Center Patient Guidelines

Sentinel Events Policy

References:

CMS Conditions of Participation and Regulations and Interpretive Guidelines for Hospitals Appendix A (Rev. 176, 12-29-17).

Joint Commission Comprehensive Accreditation Manual for Hospitals

Regulation Establishing Standards for Emergency Involuntary Procedures

Reviewers

A. **Key Stakeholders:**
   - John Minadeo, MD., Director of Emergency Medicine
   - Jodi Frei, Director of Quality
   - Chris Giroux, Manager, Informatics, data Management and Integration Services
   - Chris Reinfurt, Emergency Management and Safety Coordinator
   - Abbie Neville, RN Clinical Informaticist
   - Jane Suder, RN, Manger Care Management
   - Michelle LeClair, RN, Manager Clinical Education
   - JoAnn Manahan, RN, ED Nurse Manager
   - Deb Durant, RN, Director Inpatient Services
   - Tara Sibley, RN Clinical Informaticist
   - Maggie Conklin, RN, Interim Chief Nursing Officer
   - Jamie Pinkham, Manager Regulatory Affairs & Health information Integrity
   - Nilda Gonnella-French, Risk & Accreditation Analyst

B. **Committees:**
   Patient Care Committee
   Medical Staff Committee

C. **Key Process Owner (KPO):** Deb Durant, RN, Director of Inpatient Services

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Keywords - Not part of policy: **Restraint, Chemical Restraint, Non-Violent, Non-Behavioral, Violent, Behavioral Management, emergency involuntary**

POC mgt 10.24.18
D. W/SL

Suicidal or Emotionally Ill Patient, Care of

Applicability: Hospital	**Date Effective:** 2/96
Department: Clinical Services	**Date Last Reviewed:** 1/16
Supersedes: Care of the Emotionally Ill/Suicidal Admitted Observation Patient; Suicide / Violent Admitted/Observation Pt. Precautions	**Or** **Date Last Revision:** 3/2018
Administration Approval: Jane Catton, Sr. VP, CNO, COO	

Purpose: To define the care, treatment and services for patients who are emotionally ill.

Policy Statement:
Northwestern Medical Center (NMC) provides care, treatment and services to all patients in a safe environment and takes appropriate steps to prevent harm to patients, staff and providers.

Background: N/A

Definitions:
Emotionally Ill: A psychological disorder characterized by irrational and uncontrollable fears, persistent anxiety or extreme hostility

NCSS Crisis-Northwestern Counseling Support Services Crisis team

EE-Emergency Examination

Safety Risk-Potential to harm self, property or others (Based on NCSS assessment)

Observation Flow Sheet-Tool used by sitter program on PCU to document patient activity during 1:1 sitter intervention.

Department of Mental Health Designated Law Enforcement-A designated law enforcement group contracted by the Department of Mental Health (DMH) to provide secure monitoring of patients in DMH custody.

A. Procedure for Depressed or Suicidal Patient Risk Assessment:

1. All patients exhibiting depression with suicidal ideation, whether inpatient or outpatient, will receive the following suicide risk assessments on arrival or as indicated:

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a. All patients exhibiting depression of suicidal nature will be evaluated by nursing using the Modified SAD PERSONS scale (Appendix A). Results will be discussed with the provider.

b. NCSS Crisis evaluates patient within sixty (60) minutes of notification that patient is medically cleared for discharge. Their evaluation must be face to face unless agreed upon otherwise by both NMC provider/NCSS. NCSS Crisis evaluation note is available to NMC within 2 hours of evaluation.
Once NCSS has made their determination, a safe discharge plan or referral will be made.

B. Safety Risk Assessment Procedure:

Potential to harm self, property or others (Per NCSS assessment)

Stage I/Low Risk:
Patients who are able to demonstrate through behavior and verbally, that they can refrain from hurting themselves, someone else or property. They may have expressed thoughts about harm to self or others but can clearly state that they will not do so or that they will ask for help if they think they might do so.

Stage II/Moderate Risk:
Patients presenting with frequent thoughts of harm to self, others or property; poor impulse control; frequent medications; significant decrease in appetite or change in sleep pattern, expressing hopelessness, helplessness, anxiety or other reasons for concern. Or staff has increased concern about safety. Patient is still able to agree to not harm self; others or property, or to let staff know if he/she will harm.

Stage III/High Risk
Symptoms listed under Stage II have increased. Patient is not able to agree to not harming self; others or property and/or patient's behavior suggests a lack of self-control to insure safety. A high risk patient is an individual who attempts or shows positive intent to harm to self, others and/or property.

Physician Emergency Exam (EE)
The Commissioner of the Vermont Department of Mental Health (DMH) designates physicians/APRNs who are not specialists in psychiatry to perform Emergency Examinations of individuals screened at general hospital emergency departments or within the Department of Corrections. These patients can arrive to the hospital on their own accord or with law enforcement. They should be considered Stage III/High Risk and all appropriate safety measures should apply.

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Safety Risks and Intervention

Intervention	Stage I	Stage II	Stage III	EE
Patients are checked once every thirty minutes with documentation in EMR	X			
Patients are restricted to the clinical unit unless accompanied by staff, security, or Sheriff for medically necessary reasons.	X	X	X	X
Remove patient's clothing and have patient dress in a hospital issued attire	X	X	X	X
Patients are checked minimally every 15 minutes with documentation in the observation flow sheet/EMR.		X		
Remove potentially harmful equipment/supplies - See room set up		X	X	X
Limit number of staff caring for patient as much as possible			X	X
Decrease environmental stimulation as much as possible			X	X
Document patient behavior every 15 minutes on the observation flow sheet/EMR			X	X
1:1 observation by NMC security or NMC staff with documentation on the observation flow sheet/EMR as appropriate			X	X
Contact Local Law Enforcement if criminal act is committed such as assault on healthcare worker (the intent to commit harm and the present ability to do so), battery, theft or other crime.	X	X	X	X
1:1 observation by DMH Designated Law Enforcement, or NMC security or NMC staff if LE/security not available.				X
NCSS eval every 12 hours for medically cleared Emergency Examination patients (EE'd) awaiting placement				X

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C. Procedure for Maintaining a Safe Environment:

1. All Emotionally Ill or Suicidal patients will be rounded on minimally daily with a multidisciplinary team. Based on the team's assessment, a "SAFTE" Sheet (Appendix B) will be developed. "SAFTE" stands for Security/Safety/Situation, Activity, Flight risk, Triggers/Treatment and Environment. This document will be the daily communication tool between NMC staff and NCSS and it will be part of the permanent medical record.
2. Room will be prepared by NMC Clinical Staff
3. All staff entering the room will bring in only necessary items to perform care. Lab coats, items in pockets that are sharp (pens, scissors), stethoscopes, computers etc. will be left outside the room whenever possible.
4. Patients must wear hospital issued clothing only; If patient refuses to remove clothing security will conduct a pat down search for potentially harmful objects, same gender staff member will accompany patient during this process if the security officer and patient are opposite genders, I.e. If the patient is a female, a female staff person will always be present with the patient during this process.
5. Privacy Curtains will remain open if possible.
6. 4 Point Restraints will be available for use if applicable per the NMC Restraint Policy
7. Belongings are removed from the patient and secured. Personal belongings are placed in storage bins and kept in designated secure area.
8. Remove following items if present in room:
    a. Phone
    b. Call bell
    c. Hygiene supplies stored in bathroom
    d. Trash can liner
    e. Laundry hampers
    f. All sharps or potential sharps from patient room.
    g. All cords from room: BP machine, phone, call light (replace with dummy plug), suction tubing, 02 tubing, etc. when not medically necessary.
    h. All non-essential furniture from room (wastebaskets, chairs, night stand, linen receptacles, etc.)
9. Ensure only the following items remain in the room:
    a. Bed
    b. Wireless remote (obtain from facilities)
    c. Privacy curtains must remain open at all times unless at least two staff are present to perform hygiene needs.

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d. Plastic/paper utensils only on food trays. (Note on computer order to dietary).
e. Paper cups for drinking. Plastic bottles allowable per NCSS assessment (No other bottles or cans)

10. Assign staff according to risk assessment (nursing staff, security, law enforcement).
11. Use the following procedure to ensure safe toileting and hygiene practices:
    a. While patient is using the bathroom, door remains open and patient is within direct view of staff at all times.
    b. If a shower is necessary, door remains open, clear shower curtain is utilized or shower curtain is removed and patient is within direct view of staff at all times.
12. Assure patient is safe and document patient behavior per risk assessment on the "Observation Flow Sheet" or in electronic medical record.
13. Visitors and or items coming into patient room are at the discretion of patient's primary nurse and/or charge nurse. All items will be searched prior to entering the patient's room and authorized by Security and/or designated NMC Staff . It is preferred that all searching occur outside the view of the patient.

D. Patients Presenting When in Custody of Law Enforcement/Corrections:

1. Law enforcement remains in the room, if possible.
2. Law enforcement notifies nursing or NMC staff prior to leaving the room for any reason.
3. If patient is not under arrest, law enforcement can remain in the department until a full safety transition has occurred and they are comfortable patient is not a threat to themselves or others.
4. For patients in the custody of Corrections see Inmate Policy
5. NMC staff/security is responsible to maintain visual contact of patient at all times.
6. If patient transfer to another facility is recommended by NCSS Crisis, notify attending physician to obtain order for transfer and to determine mode of transportation (follow "Transfer of Patient to Another Institution" policy).

E. Elopement of the Suicidal or Emotionally ill patient:

1. In the event that a suicidal or homicidal patient elopes, regardless of their risk level (I, II or III or EE), follow NMC's Code Amber Policy.
2. Immediately call 4222 and report a Code Amber with full description and name of patient. Switchboard will notify the local police and NMC security with a description and name of the patient, then notify NCSS Crisis.
3. Per the NMC Restraint Policy, members of NMC's security workforce can use reasonable amount of physical restraint to keep a patient safe until the patient can be assessed by MD or APP managing the patient's care.

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Note Well:
Visitors are admitted at the discretion of clinical staff.

All suicidal patients are considered high risk (Stage III) until the risk evaluation by Northwestern Counseling and Support Services (NCSS) is completed and they are released from Stage III risk. All patients exhibiting behavior or verbal communication that demonstrates a safety risk are evaluated by Mental Health Crisis Worker.

1:1 Observation may be waived for patient's Stage III or above who are on a mechanical vent. Once the vent is removed the 1:1 observation must be reinstated.

Monitoring Plan: N/A

Related Policies:
Restraint Policy
Leaving the Hospital AMA
Missing Person (Code Amber) Policy

References:
CMS Conditions of Participation and Regulations, Interpretive Guidelines for Hospitals (Rev. 1, 5/21/04)

Patterson; Dohn: Patterson (April 1983). Evaluation of suicidal patients: the SAD PERSONS scale. PMID 6867245.

Oxford Handbook of Emergency Medicine. Third Edition. Page 609.

Reviewers

A. **Key Stakeholders:**
   - JoAnn Manahan - ED Nurse Manager
   - Tyson Moulton - Director of Facilities
   - John Minadeo, MD - ED Medical Director
   - Chris Reinfurt - Emergency Preparedness and Safety Coordinator

B. **Committees:**
   - Patient Care Committee: 04/03/18
   - Medical Staff: 05/10/18

C. **Key Process Owner (KPO):** Deborah Durant - Director of Inpatient Services

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Key Words: **Suicide, Depression, Emergency Evaluation**

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Appendix A

Modified SAD PERSONS Scale:
The score is calculated from ten yes/no questions, with points given for each affirmative answer as follows:

- S: Male sex—1
- A: Age <19 or >45 years—1
- D: Depression or hopelessness—2
- P: Previous suicidal attempts or psychiatric care—1
- E: Excessive ethanol or drug use—1
- R: Rational thinking loss (psychotic or organic illness)—2
- S: Single, widowed or divorced—1
- O: Organized or serious attempt—2
- N: No social support—1
- S: Stated future intent (determined to repeat or ambivalent)—2

This score is then mapped onto a risk assessment scale as follows:

- 0-5: May be safe to discharge (depending upon circumstances)
- 6-8: Probably requires psychiatric consultation
- >8: Probably requires hospital admission

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NMC

Appendix B

Facility	Contact Number	Response/Comment
University of Vermont Medical Center	847-0000	
Central VT Medical Center	229-9121	
Rutland Regional Medical Center	775-7111	
Windham Center	463-1346	
Brattleboro Retreat	800-345-5550	
VT Psychiatric Care Hospital	828-2799	
Dept. of Mental Health Admissions	828-2799	

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NMC

Safety Risk Assessment Tool (SAFTE)

Situation (brief history) _____ Safty risk Stage I II III EE

1:1 sitter needed

☐ No ☐Yes (if Yes, ☐ Care companion ☐ LNA ☐ Security ☐ Law enforcement-if available)

Is patient in custody of, or under arrest by Law Enforcement? ☐ No ☐ Yes _____

Is patient being held on Emergency Examination? (EE'D) ☐ No ☐ Yes _____

Suicide Attempts or threats in previous 24 hours? ☐ No ☐ Yes _____

Activities/Environment deemed safe unless assessed otherwise (please check all that apply):

☐ Ambulation	☐ Music	☐ Cell phone
☐ Pens/Pencils	☐ Visitors	☐ Internet access
☐ Showering	☐ NMC Phone	☐ _____
☐ Reading	☐ Television	☐ _____

If **Visitors** are **NOT** allowed, ***must*** document reason:_____

If **NMC Phone** or **Cell Phone** is **NOT** allowed, ***must*** document reason:_____

Flight risk? ☐ No ☐ Yes (if Yes, ☐ Room close to a nurse's station ☐ Room far from an egress)

Triggers/Treatments

Does the patient have any known triggers? _____

What is the pharmacological and non-pharmacological treatment plan for this patient over the next 24 hours?_____

Signature of NMC RN completing SAFTE Sheet_____Date_____Time_____

Name of NCSS staff consulting: _____

PIC cont 10.24.18 DW/BH