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

December 17, 2018

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

Provider ID #: 470024

Dear Ms. Berry Bowen:

The Division of Licensing and Protection completed a survey at your facility on **November 21, 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 **December 17, 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 MEDICARE & MEDICAID SERVICES

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 _____	R-C 11/21/2018

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 follow-up survey to an investigation completed on 9/12/18; and an investigation of complaint #17116 was conducted on 11/19/18 through 11/21/18 by the Division of Licensing and Protection. As a result of the investigations, 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: Patient Rights, Quality Assessment and Performance Improvement, and Emergency Services.	{A 000}	See Attached	
{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 follow-up survey and complaint investigation, the Condition of Participation for 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: A-144: Failure to ensure that patients receive care in a safe setting. A-154: Failure to ensure patients were free from restraint and/or seclusion due to staff coercion as evidenced by the use of police presence for	{A 115}	POC accept 12.17.18 DW/SH	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 12/13/18

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 000	INITIAL COMMENTS A complaint investigation (#17116) was conducted on 11/19/18 through 11/21/18 in conjunction with a follow up survey. As a result of this complaint investigation, regulatory deficiencies were identified. Please refer to the Statement of deficiencies dated 11/21/18 addressing the follow up survey.	A 000	See Attached POC accepted 12.17.18 DW/SP	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE CEO (X6) DATE 12/13/18

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 standby, use of police force (taser), and/or use of police to assist with involuntary medication administration. A-168: Failure to ensure that there was a physician's order for the use of chemical and/or physical restraints. A-174: Failure to ensure that restraints were discontinued at the earliest possible time. A-179: 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 chemical and/or physical restraints.	{A 115}	See Attached	
{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 ensure that a room occupied by a patient who was determined to have suicidal ideation's was free of equipment and items that could cause self-harm and/or harm to staff; and failed to ensure that patient's rights remained intact and under the protection of the hospital by allowing the use of a weapon (taser) to subdue escalating behavior for 1 of 10 applicable patients (Patient #1). Findings include: Per review of a nursing triage note from 10/12/18 at 3:24 PM, Patient #1 came to the Emergency Department (ED) after s/he was involved in a verbal altercation with his/her family member's	{A 144}	POC accept 12.17.18 DW/SF	

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{A 144}	Continued From page 2	{A 144}	See Attached	

neighbor. The patient took eight milligrams (mg) of Lorazepam (medication for anxiety) in effort to calm him/her-self. Patient #1 stated," s/he would like to just be done" and that "s/he would like to kill him/her-self by hanging". Patient #1 has the following diagnoses: Anxiety, depression, diabetes, gastroesophageal reflux (acid from the stomach comes up into the esophagus), hypertension (high blood pressure), and suicide attempt/ideation. Per review of the physician progress notes from 5:46 PM, the Northwestern Counseling and Support Services (NCSS) evaluated the patient in the ED and recommended that the patient receive psychiatric care in an inpatient setting. The patient was agreeable (making him/her voluntary) and the patient was medically cleared. The nursing progress notes from 10/12/18 at 9:45 PM read, "Patient in bed resting comfortably at this time. Patient denies any needs at this time. Security continues 1:1 observation." At 10:00 PM, "Patient in bed resting comfortably at this time. Patient denies any needs at this time." At 10:12 PM, "Patient is in the room hitting his/her head off the wall. The physician is in the room at this time informing the patient that there are no beds .....and s/he would have to stay tonight. Patient states 'Then I'll just f ... ...g walk off'. The physician offered the patient some medication to help him/her sleep .... 'Nothing is going to help me sleep. I'm not going to sleep.' The physician asked the patient to stop hitting his/her head off the wall". Upon further review of the nursing notes from 10/12/18 at 10:28 PM, "Patient sitting on the floor at this time at the head of the bed hitting him/her-self in the head with a metal IV pole. The patient was instructed to stop but s/he continued to hit him/her-self in the head ....This nurse grabbed the pole to prevent further injury to

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{A 144}	Continued From page 3	{A 144}	See Attached	

the patient. At this time the patient struck his/her head on the bed frame .....The physician arrived to the room and moved the bed allowing the patient to get to a standing position and the patient retreated to the corner of the room making remarks of fighting the staff." At 10:30 PM, "Police arrive to the facility and with the patient continuing to verbalize that s/he was going to fight the police at which time the police deployed their tazers. The patient was taken to the ground via police and placed into handcuffs. The police then helped the patient get into the bed." Per interview on 11/20/18 at 2:35 PM with an ED physician, s/he stated that Patient #1 was a "little agitated initially" and then his/her behavior escalated quickly. Patient #1 was banging his/her head on the stretcher and being aggressive toward the nurse, pushed him/her; and there was blood getting everywhere. The patient became increasingly "out of control". S/he stated that s/he and the nurse were in the doorway and "did not want to get near the patient". The police were called as "we couldn't get the patient to calm down". "We needed help restraining the patient". When the police arrived, the physician discussed the case with the police. The police tried to talk the patient down. The patient was refusing to cooperate and as a result the police tasered him/her. S/he stated that tasering the patient was "very effective and caused no harm to the patient and/or anyone else". S/he stated that "when it comes to restraining, we don't know how to do that, the police are trained in this". S/he stated that s/he has had no formal training in de-escalation techniques for these types of patients; and that the goal was to keep everyone safe.

POC accepted 12.17.18 DW/SL

During a tour of the ED on 11/20/18 at 11:35 AM,

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{A 144}	Continued From page 4 of ED room 7, a large basket-type wire rack and an overhead light with an arm were each attached to the wall on the north side of the room. There was also a stretcher against the west side of the room. An IV pole with hooks at the top of the pole was attached at the head of the stretcher and could easily be moved. Per interview on 11/20/18 at 11:40 AM with the ED Nurse Manager, s/he confirmed that these objects could be used as potential ligatures and could be used to inflict self-harm. Per review of the policy, "Suicidal or Emotionally Ill Patient, Care of, (revised 10/18) C. Procedure for Maintaining a Safe Environment, 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 (oxygen) tubing, etc. when not medically necessary h. all non-essential furniture from room (wastebaskets, chairs, night stand, linen receptacles, etc.)".	{A 144}	See Attached	
{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}	12.17.18 Rec account DW/SL	

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{A 154}	Continued From page 5 This STANDARD is not met as evidenced by: Based on interview and record review the hospital failed to ensure that patients in the Emergency Department were free from restraint and/or seclusion due to staff coercion as evidenced by the use of police presence for standby, use of police force (taser), and/or use of police to assist with involuntary medication administration for 2 of 10 applicable patients (Patient #1 and Patient #3). Findings include: 1. Per review of nursing notes for Patient #1, on 10/12/18 at 10:28 PM, "Patient sitting on the floor at this time at the head of the bed hitting him/her-self in the head with a metal IV pole. The patient was instructed to stop but s/he continued to hit him/her-self in the head ....This nurse grabbed the pole to prevent further injury to the patient. At this time the patient struck his/her head on the bed frame ....The physician arrived to the room and moved the bed allowing the patient to get to a standing position and the patient retreated to the corner of the room making remarks of fighting the staff." At 10:30 PM, "Police arrive to the facility and with the patient continuing to verbalize that s/he was going to fight the police at which time the police deployed their tazers. The patient was taken to the ground via police and placed into handcuffs. The police then helped the patient get into the bed." Per interview on 11/20/18 at 2:35 PM with an ED physician, s/he stated that Patient #1 was a "little agitated initially" and then his/her behavior escalated quickly. Patient #1 was banging his/her head on the stretcher and being aggressive toward the nurse, pushed him/her; and there was blood getting everywhere. The patient became increasingly "out of control". S/he stated that s/he and the nurse were in the doorway and "did not	{A 154}	See Attached POC accepted 12.17.18 DW/SL	

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{A 154}	Continued From page 6	{A 154}	See Attached	

want to get near the patient". The police were called as "we couldn't get the patient to calm down". "We needed help restraining the patient". When the police arrived, the physician discussed the case with the police. The police tried to talk the patient down. The patient was refusing to cooperate and as a result the police tasered him/her. S/he stated that tasering the patient was "very effective and caused no harm to the patient and/or anyone else". S/he stated that "when it comes to restraining, we don't know how to do that, the police are trained in this". S/he stated that s/he has had no formal training in de-escalation techniques for these types of patients; and that the goal was to keep everyone safe.

2. Per review of a nursing triage note from 10/30/18 at 7:09 AM, Patient #3 arrived with a family member, and had not been "normal" since August. S/he was in the ED a couple days prior with the same symptoms. The patient was trying to run away and not sleeping or talking. The patient appeared paranoid, scared, and was trying to leave the ED. Per physician progress notes from 10/30/18, the patient was seen by crisis and was prescribed Zyprexa (medication for anxiety) twice daily. The patient was not compliant with taking the medication. Several days ago the patient left his/her house without telling anyone and people had to go search for him/her. Per review of nursing notes for Patient #3, on 10/30/18 at 7:00 PM, "Patient attempting to leave room, pushing, shoving past family member and security guards. MD (physician) orders IM (in the muscle) medication. Attempted to calm the patient by verbal de-escalation. City PD (police department) called to assist staff with due to concern of previous violent acts and future

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{A 154}	Continued From page 7 safety". At 7:25 PM, "IM Benadryl (antihistamine), Haldol (antipsychotic medication), and Ativan (anti-anxiety medication) given, patient held physically by 3 city PD officers and two security guards". At 7:30 PM, "Patient requiring close observation by security and police". At 7:45 PM, "Pt continues to intermittently try to leave the bed. SAPD (St. Alban's Police Department) at bedside talking with patient and keeping pt in bed with redirection and verbal commands". Per interview on 11/21/18 at 8:55 AM with the Manager of Regulatory Affairs, s/he confirmed that police should have not been utilized to manage the care of and/or assist in the administration of involuntary medication for Patient #1 and Patient #3.	{A 154}	See Attached	
A 168	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(5) The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based on interview and record review the hospital failed to ensure that physical and chemical restraints were applied in accordance with physician's orders for 1 of 10 applicable patients (Patient #1). Findings include: Per review of nursing notes for Patient #1, on 10/12/18 at 10:28 PM, "Patient sitting on the floor at this time at the head of the bed hitting	A 168	POC accepted 12.17.18 DW/81	

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			See Attached	
A 168	Continued From page 8 him/her-self in the head with a metal IV pole. The patient was instructed to stop but s/he continued to hit him/her-self in the head ....This nurse grabbed the pole to prevent further injury to the patient. At this time the patient struck his/her head on the bed frame .....The physician arrived to the room and moved the bed allowing the patient to get to a standing position and the patient retreated to the corner of the room making remarks of fighting the staff". At 10:30 PM, "Police arrive to the facility and with the patient continuing to verbalize that s/he was going to fight the police at which time the police deployed their tazers. The patient was taken to the ground via police and placed into handcuffs. The police then helped the patient get into the bed". At 10:40 PM, "Patient placed into 4 point restraints at this time and was given sedatives for his/her safety". The physician progress notes from 10/12/18 at 11:07 PM read, "Pt yanking on restraints, trying to get out, remains agitated. Ordered for additional Haldol". Per review of the Medication Administration Record (MAR) on 10/12/18 at 11:19 PM, 5 mg of Haldol was given IM to Patient #1. There was no evidence in the record that physician's orders were written for the 4 point physical restraints and the additional IM Haldol that was given to Patient #1. Per interview on 11/20/18 at 10:39 AM with the Manager of Regulatory Affairs, s/he confirmed that there were no physician orders for the physical restraints (4 points) or additional chemical restraint (IM Haldol) for Patient #1.	A 168		
{A 174}	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(9) Restraint or seclusion must be discontinued at	{A 174}	POC accepted 12.17.18 DW/SI	

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{A 174}	Continued From page 9	{A 174}	See Attached	

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 that restraints were discontinued at the earliest possible time for 2 of 10 patients in the sample. (Patient #1 and Patient #5). Findings include:

1. Per review of nursing notes for Patient #1, on 10/12/18 at 10:28 PM, "Patient sitting on the floor at this time at the head of the bed hitting him/her-self in the head with a metal IV pole. The patient was instructed to stop but s/he continued to hit him/her-self in the head ....This nurse grabbed the pole to prevent further injury to the patient. At this time the patient struck his/her head on the bed frame .....The physician arrived to the room and moved the bed allowing the patient to get to a standing position and the patient retreated to the corner of the room making remarks of fighting the staff". At 10:30 PM, "Police arrive to the facility and with the patient continuing to verbalize that s/he was going to fight the police at which time the police deployed their tazers. The patient was taken to the ground via police and placed into handcuffs. The police then helped the patient get into the bed". At 10:40 PM, "Patient placed into 4 point restraints at this time and was given sedatives for his/her safety". At 11:00 PM, "Patient in bed in 4 point restraints. Patient now calm and more lethargic." At 11:15 PM, "Patient remains lethargic and calm." At 11:30 PM, "in 4 point restraints ...Patient now calm and more lethargic." At 11:45 PM, "in 4 point restraints. Patient now calm and more lethargic." At 12:00 AM, "in 4 point restraints. Patient now calm and more lethargic." At 12:15

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{A 174}	Continued From page 10	{A 174}	See Attached	

AM, "Patient now calm and more lethargic. This nurse removed the restraint from the patient's right leg." At 12:30 AM, "Patient in bed in 3 point restraints. Patient now calm and more lethargic ...removed the restraint from the patient's left arm." At 12:45 AM, "Patient in bed in 2 point restraints ...Patient now calm and more lethargic ....restraint removed from left leg." At 1:00 AM, "Patient now calm and lethargic ...removed restraint to right arm." Per interview on 11/20/18 at 12:30 PM with the ED Nurse Manager and Manager of Regulatory Affairs, they both confirmed that Patient #1 was noted to be calm approximately 20-30 minutes after the restraints were applied and that the restraints were not removed at the earliest possible time.

2. Per review of nursing progress notes from 10/14/2018, Patient #5 began exhibiting violent and aggressive behavior including threats of harm and attempts to strike and kick others in the Emergency Department. At 22:40, mechanical restraints were applied to all four of Patient #5's extremities consistent with physician's orders. According to documentation by the Registered Nurse, at 22:54 the patient was, "calming down" and one restraint was removed from the left ankle. At 23:05, Patient #5 was documented to be "resting". At 23:20, Patient #5 was, "sleeping soundly" and a restraint on a lower extremity was removed. S/he was documented as continuing to, "sleep soundly" at 23:35. At 23:50, Patient #5, "continues to sleep" and the final restraint on the right hand was removed. Patient #5 was documented as resting or sleeping from 22:54 to 23:50. While the Registered Nurse had initiated the discontinuation of restraints, the restraints had not been removed at the earliest possible

POC accept 12.17.18 DW/8

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 _____	R-C 11/21/2018

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
			See Attached	
{A 174}	Continued From page 11 time. The lack of evidence demonstrating Patient #5 remained a threat to the immediate safety of themselves or others justifying the continued use of restraints was reviewed with the Emergency Department Nurse Manager at 11:55 AM on 11/20/2018.	{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), conducted a one hour face to face assessment after the initiation of physical and/or chemical restraints for 3 of 10 applicable patients (Patient #1, Patient #3 and Patient #5). Findings include: 1. Per review of nursing notes for Patient #1, on 10/12/18 at 10:28 PM, "Patient sitting on the floor at this time at the head of the bed hitting him/her-self in the head with a metal IV pole. The patient was instructed to stop but s/he continued to hit him/her-self in the head ....This nurse grabbed the pole to prevent further injury to the	{A 179}	RC accept 12.17.18 DW/BL	

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{A 179}	Continued From page 12 patient. At this time the patient struck his/her head on the bed frame .....The physician arrived to the room and moved the bed allowing the patient to get to a standing position and the patient retreated to the corner of the room making remarks of fighting the staff". At 10:30 PM, "Police arrive to the facility and with the patient continuing to verbalize that s/he was going to fight the police at which time the police deployed their tazers. The patient was taken to the ground via police and placed into handcuffs. The police then helped the patient get into the bed". At 10:40 PM, "Patient placed into 4 point restraints at this time and was given sedatives for his/her safety". Per review of physician progress notes from 10/12/18, there was no evidence that a one hour face to face assessment was done for Patient #1 after both physical and chemical restraints were applied. Per interview on 11/20/18 at 10:42 AM with the Manager of Regulatory Affairs, s/he confirmed that there was no face to face assessment completed by a physician, LIP, and/or RN after the initiation of physical and chemical restraints for Patient #1. 2. Per review of nursing notes for Patient #3, on 10/30/18 at 7:00 PM, "Patient attempting to leave room, pushing, shoving past family member and security guards. MD (physician) orders IM (in the muscle) medication. Attempted to calm the patient by verbal de-escalation. City PD (police department) called to assist staff with due to concern of previous violent acts and future safety". At 7:25 PM, "IM Benadryl (antihistamine), Haldol (antipsychotic medication), and Ativan (anti-anxiety medication) given, patient held physically by 3 city PD officers and two security guards". At 7:30 PM, "Patient requiring close observation by security and police". At 7:45	{A 179}	See Attached POC accepted 12.17.18 DW	

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{A 179}	Continued From page 13 PM, "Pt continues to intermittently try to leave the bed. SAPD (St. Alban's Police Department) at bedside talking with patient and keeping pt in bed with redirection and verbal commands". Per review of physician progress notes from 10/30/18, there was no evidence that a one hour face to face assessment was done for Patient #3 after both physical and chemical restraints were applied. Per interview on 11/21/18 at 10:35 AM with the Manager of Regulatory Affairs, s/he confirmed that there was no face to face assessment completed by a physician, LIP, and/or RN after the initiation of physical and chemical restraints for Patient #3. 3. Per review of Physician Progress notes, Patient #5 was placed in mechanical restraints on 10/14/2018 following an episode of physical violence and aggressive behavior demonstrated toward hospital staff and a family member. Per medical record review, a face to face assessment was completed by the physician at 23:12. Patient #5 was documented to be, "sleeping soundly in wrist restraints". There was no evidence that Patient #5 was exhibiting behavior demonstrating an imminent safety risk at the time of the physician assessment. The failure of the face to face evaluation to include justification for the continued use of restraints was confirmed with the Manager of Regulatory Affairs at 9:00 AM on 11/21/2018.	{A 179}	See Attached	
A 263	QAPI CFR(s): 482.21 The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program.	A 263	POC accpt 12.17.18 DW/SL	

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A 263	Continued From page 14 The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on observations, interviews, and record reviews during the course of the follow-up survey and complaint investigation, the Condition of Participation: Quality Assurance and Performance Improvement was not met as evidenced by the failure of the hospital to effectively evaluate, fully analyze, and fully implement activities that focused on high-risk and problem prone areas to ensure that patient rights were protected and staff were adequately trained.	A 263	See Attached	
{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	{A 283}	Pc accept 12/17/18 DW/8	

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{A 283}	Continued From page 15 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 staff interview and record review, the hospital failed to ensure that Quality Improvement activities focused on high-risk and problem prone areas as evidenced by a failure to audit patient events including mechanical restraints and evaluate the effectiveness of training for hospital personnel. Findings include: Although the hospital had revised policies and procedures associated with previously identified deficient practices, there was a failure to analyze the effectiveness of training, fully implement an auditing process and communicate to hospital personnel regarding the use of law enforcement in the management of patients presenting with behavioral health symptoms. At the time of the complaint investigation and follow up survey, there was evidence of continued deficient practices. Per review of training records, Registered Nurses had been provided with training addressing the implementation of mechanical restraints on 10/8/2018; however, there was a failure to identify the need to discontinue restraints at the earliest possible time	{A 283}	See Attached Acc accept 12/17/18 DW/S	

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			See Attached	
{A 283}	Continued From page 16 for Patient #5 and Patient #1. Per review of documentation, Emergency Department providers had been educated on 10/12/2018 about previously identified deficient practices utilizing local law enforcement, however, there was evidence of law enforcement personnel intervening in the care of Patient #1 and Patient #3. On 11/20/2018, the Manager of Regulatory Affairs confirmed that an auditing process of mechanical restraints and the utilization of law enforcement had been implemented on 10/4/2018; however, there were no corrective actions taken in response to deficiencies related to the discontinuation of restraints, lack of face to face assessments and the utilization of law enforcement in the care of patients during behavioral health emergencies.	{A 283}		
A 286	PATIENT SAFETY CFR(s): 482.21(a), (c)(2), (e)(3) (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual	A 286	POC accepted 12/17/18 DW/H	

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A 286	Continued From page 17 who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to ensure that performance improvement activities included an analysis of adverse patient safety events and implementation of preventive actions after a significant adverse patient event occurred for 1 applicable patient (Patient #1). Findings include: The Quality Assurance and Performance Improvement department failed to fully analyze all the potential causes of an adverse patient safety event and did not identify opportunities for improvement or implement corrective actions in a timely manner. On 10/12/2018, Patient #1 presented to the Emergency Department and was assessed to meet criteria for psychiatric hospitalization due to suicidal ideation and risk of harm to self . During an episode of self-injurious behavior and escalation which included threats of harm to others, Patient #1 was tazed by local law enforcement in order to be physically subdued. The Manager for Regulatory Affairs and the Director of Quality confirmed during an interview at 3:45 PM on 11/20/2018 that the event had been discussed during a case review at the hospital's Patient Care Committee and had been reviewed by members of hospital staff who were on-call and working on 10/13/2018. Per interview, the Patient Care Committee had, "determined the use of law enforcement and response to the event was appropriate". There was a failure to identify that the use of police and	A 286	See Attached Rec accpt 12.17.18 DW/SI	

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A 286	Continued From page 18 utilization of a tazer was not in compliance with regulatory requirements or identify opportunities for the hospital to implement training or protocols for managing the healthcare needs of patients exhibiting behavioral symptoms. As of the time of the investigation, there had not been a formal review of the significant chain of events which included the use of a law enforcement weapon to manage patient behavior, the practice of calling local law enforcement for assistance with the management of patient behavior, or training needs and direction needed for hospital staff regarding the management of the patients in psychiatric crises.	A 286	See Attached	
{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 follow-up survey and complaint investigation, the Condition of Participation: Emergency Services was not met as evidenced by the failure of the hospital to ensure that there was sufficiently trained staff to address the management of patients exhibiting self-injurious behavior and/or in behavioral health emergencies as evidenced by the use of police presence for standby, use of force (taser), and/or use of police to assist with involuntary medication administration for 2 of 10 applicable patients (Patient #1 and Patient #3). Findings include: 1. Per review of nursing notes for Patient #1, on	{A1100}	POC accepted 12/17/18 DW/8	

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{A1100}	Continued From page 19	{A1100}	See Attached	

10/12/18 at 10:28 PM, "Patient sitting on the floor at this time at the head of the bed hitting him/her-self in the head with a metal IV pole. The patient was instructed to stop but s/he continued to hit him/her-self in the head ....This nurse grabbed the pole to prevent further injury to the patient. At this time the patient struck his/her head on the bed frame .....The physician arrived to the room and moved the bed allowing the patient to get to a standing position and the patient retreated to the corner of the room making remarks of fighting the staff." At 10:30 PM, "Police arrive to the facility and with the patient continuing to verbalize that s/he was going to fight the police at which time the police deployed their tazers. The patient was taken to the ground via police and placed into handcuffs. The police then helped the patient get into the bed." Per interview on 11/20/18 at 2:35 PM with an ED physician, s/he stated that Patient #1 was a "little agitated initially" and then his/her behavior escalated quickly. Patient #1 was banging his/her head on the stretcher and being aggressive toward the nurse, pushed him/her, and there was blood getting everywhere. The patient became increasingly "out of control". S/he stated that s/he and the nurse were in the doorway and "did not want to get near the patient". The police were called as "we couldn't get the patient to calm down". "We needed help restraining the patient". When the police arrived, the physician discussed the case with the police. The police tried to talk the patient down. The patient was refusing to cooperate and as a result the police tasered him/her. S/he stated that tasering the patient was "very effective and caused no harm to the patient and/or anyone else". S/he stated that "when it comes to restraining, we don't know how to do that, the police are trained in this". S/he stated

POC accept 12.17.18 DW/8

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{A1100}	Continued From page 20	{A1100}	See Attached	

that s/he has had no formal training in de-escalation techniques for these types of patients; and that the goal was to keep everyone safe.

2. Per review of a nursing triage note from 10/30/18 at 7:09 AM, Patient #3 arrived with a family member, and had not been "normal" since August. S/he was in the ED a couple days prior with the same symptoms. The patient was trying to run away and not sleeping or talking. The patient appeared paranoid, scared, and was trying to leave the ED. Per physician progress notes from 10/30/18, the patient was seen by crisis and was prescribed Zyprexa (medication for anxiety) twice daily. The patient was not compliant with taking the medication. Several days ago the patient left his/her house without telling anyone and people had to go search for him/her. Per review of nursing notes for Patient #3, on 10/30/18 at 7:00 PM, "Patient attempting to leave room, pushing, shoving past family member and security guards. MD (physician) orders IM (in the muscle) medication. Attempted to calm the patient by verbal de-escalation. City PD (police department) called to assist staff with due to concern of previous violent acts and future safety". At 7:25 PM, "IM Benadryl (antihistamine), Haldol (antipsychotic medication), and Ativan (anti-anxiety medication) given, patient held physically by 3 city PD officers and two security guards". At 7:30 PM, "Patient requiring close observation by security and police". At 7:45 PM, "Pt continues to intermittently try to leave the bed. SAPD (St. Alban's Police Department) at bedside talking with patient and keeping pt in bed with redirection and verbal commands". Per interview on 11/21/18 at 8:55 AM with the Manager of Regulatory Affairs, s/he confirmed

POC accent 12.17.18 DW/81

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

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{A1100}	Continued From page 21 that police should have not been utilized to manage the care of and/or assist in the administration of involuntary medication for Patient #1 and Patient #3. Per review of the policy, "Security Event: Code Green" (revised 3/16), a "Security Incident is any event where a person creates a disturbance, is threatening in any way or otherwise disturbs the normal business operations." Per interview with the Coordinator of Emergency Management and Safety on 11/20/18 at 9:49 AM, s/he confirmed that a Code Green was not called to manage Patient #1 on 10/12/18. Per review of training records on 10/8/18, Registered Nurses had been provided with training regarding policy changes and the implementation of mechanical restraints. On 10/12/18, ED Providers had been educated about previously identified deficient practices utilizing local law enforcement. The above examples show that there was an inadequate response by hospital staff and that police continue to be utilized to manage patients exhibiting behavioral health emergencies.	{A1100}	See Attached POC accept 12.17.18 DW/8	

Northwestern Medical Center

CMS Certification Number 470024
Survey ID 15L311 & ZR9L12, 12/13/2018

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 (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 and Emotionally Ill Patient" policy to reflect enhanced safety checks on all applicable patients.

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

Implement concurrent reviews of all patient charts where the "Care of the Suicidal and Emotionally Ill Patient" policy is utilized to ensure that policy is followed and ligature risk as well as all other risks for harm are mitigated for all patients as appropriate.

Procedure for implementing:
The "Care of the Suicidal and 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 be removed if present in a room and a more detailed list of items to remain in a room. Language also added to include a requirement that the checklist/assessment tool for a safe room is re-assessed for continued safety on every primary nurse hand-off.

Educate staff to policy revisions and require that they demonstrate competency and understanding of all policy revisions and associated procedures.

Create tools and place on all acute and emergency care areas to support concurrent reviews of all applicable patients.

Educate staff to the expectation that tools are used to complete concurrent reviews on every shift for every applicable patient in the acute and emergency settings.

Completion date for correction: January 1, 2019

Monitoring and tracking:
The unit manager or designee will ensure that a review is done on every qualifying patient on every shift with a goal of 100% compliance.

POC accept 12.17.18 DW/SP

Implement interdisciplinary Restraint & Emotionally Ill/Suicidal Patient Review Team to review all qualifying cases retrospectively, identify areas of non-compliance (if any) and create action plans to ensure that non-compliance does not happen again. This team will meet weekly until 100% compliance is achieved for 3 months, then will meet monthly thereafter. Results from this team's review will be reported quarterly at the Patient Care Committee. Minutes from the Patient Care Committee are sent to the Medical Executive Committee of the Medical Staff monthly for review and acceptance.

Title of person(s) responsible:
Director of Inpatient Services
Emergency Department Nurse Manager
Manager of Regulatory Affairs
Medical Director of the Emergency Department and Hospitalist Program
Director of Quality
Chief Medical Quality Officer
Chief Nursing Officer
Chief Executive Officer

482.13 (e) Use of Restraint or Seclusion (free from coercion) **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 Emotionally Ill and Suicidal Patient" policy.
Revise the "Restraint Use" policy.
Revise the "Security Event (Code Green)" policy.
Create the "Law Enforcement Involvement in the Healthcare Setting" policy.
Create the "Use of Force" policy.
Create a dedicated de-escalation response team comprised of MANDT trained NMC workforce members to respond to Code Green events, including de-escalation of a violent and/or threatening patient.
Ensure that all ED Charge nurses and at least one other staff member per shift are trained in MANDT.
Ensure that all security and shift administrators are trained in MANDT.

Procedure for implementing:
"Care of the Suicidal and Emotionally Ill Patient" policy revised to add the following language in Section D.6: "NMC does not utilize law enforcement to intervene in the care or treatment of patients which includes and is not limited to assisting in the restraint of patients. If law enforcement is not maintaining custody of a patient at NMC, they cannot

POC accepted 12.17.18 DW/SA

engage with the patient. See the Law Enforcement Involvement in the Healthcare Setting policy.

The "Restraint Use" policy revised to include the following language under the Training Requirements Section: "NMC does not use law enforcement to assist in the restraint of patients. Hospital security officers will assist the direct care staff by holding the patient, when necessary, in the application of restraints and therefore are expected to be trained and able to demonstrate competency in their role in safe application of physical hold for restraint application."

Revise the "Security Event: Code Green" policy to include a new definition and language for a dedicated Code Green Security Response team. Per the revision to the policy, the Code Green Security Response team is defined as: "identified members of the NMC workforce specifically assigned to assist in the management of a security incident." Additional language added to the revised version of the "Security Event: Code Green Policy" in Section C.6 that states: "NMC does not utilize law enforcement to intervene in the care or treatment of patients which includes and is not limited to assisting in the restraint of patients. Law Enforcement should only be contacted as outlined in the Law Enforcement Involvement in the Healthcare Setting.

Create "Law Enforcement Involvement in the Healthcare Setting" to clearly define the roles and expectations of staff and law enforcement when they are in the healthcare setting at NMC. The policy statement for this policy is as follows: "NMC does not utilize law enforcement to intervene in the care or treatment of patients which includes and is not limited to assisting in the restraint of patients. NMC only contacts law enforcement to respond to a criminal act that cannot be addressed by NMC Security or Code Green Security Response Team and the individual will be charged, arrested and taken into custody." This policy clearly outlines what staff expectations are if law enforcement is in the department for unrelated reasons. It is clear that law enforcement cannot participate or intervene in the care of patients at NMC.

Create "Use of Force" policy to clearly define and outline the continuum of de-escalation and ultimately the use of force allowable by NMC Workforce members to manage violent, threatening or harmful behavior in patients consistently with the Conditions of Participation in the use of restraint and seclusion. The policy statement for this policy is as follows: "It is the policy of Northwestern Medical Center (NMC) that qualified NMC staff use only the force that reasonably appears necessary to effectively bring an incident under control, while protecting the lives and safety of the patients, visitors, employees, and others as is reasonably possible. Security personnel should attempt to de-escalate any situation before using any level of force upon a person. Should the use of physical force be deemed required, security personnel are to use only that amount of force necessary to overcome the opposing resistance. The use of force must be objectively reasonable. The security personnel must only use that force which a reasonably prudent person would use under similar circumstances."

POC accept 12.17.18 DM

Identify a dedicated Security Response Team known as the Code Green Security Response Team with membership on all shifts who are trained in MANDT and additional de-escalation techniques. This team as per the "Security Event: Code Green" policy is trained to respond to any Code Green called in the organization. This team will be well versed in the Use of Force policy and is meant to be called any time a patient is escalating to a point where safety and security are a concern. This team will receive on-going education and hands on training throughout the year to ensure that they are well equipped to intervene in patient care and restraint if necessary.

As the area of highest risk for escalated behaviors, sending ED physicians and clinicians through MANDT Training is a top priority. To ensure that we have trained staff available to manage escalating patient security events, the ED Nurse Manager will schedule all shifts to include at least one MANDT trained staff member, a MANDT trained Charge Nurse and a MANDT trained Shift Administrator. MANDT trained individuals will be assigned to work with suicidal and emotionally ill patients in the department.

Appropriate staff will be educated to policy revisions and will be required to demonstrate competency and understanding of all policy revisions and associated procedures.

Identified staff will receive appropriate MANDT and De-escalation training that will include hands-on and table top reviews and drills. An on-going schedule of drills and training established, and training and drills begun.

Completion date for correction: January 1, 2019

Monitoring and tracking:
The unit manager or designee will ensure that there is a review done on every qualifying patient on every shift with a goal of 100% compliance as applicable with all policy and procedure revisions.

Implement interdisciplinary Restraint & Emotionally Ill/Suicidal Patient Review Team to review all qualifying cases retrospectively, identify areas of non-compliance (if any) and create action plans to ensure that non-compliance does not happen again. This team will meet weekly until 100% compliance is achieved for 3 months, then will meet monthly thereafter. Results from this team's review will be reported quarterly at the Patient Care Committee. Minutes from the Patient Care Committee are sent to the Medical Executive Committee of the Medical Staff monthly for review and acceptance.

An event report, debrief and subsequent quality process review will occur for every Code Green Security Event that is called. Opportunities for improvement will be identified and subsequent documentation changes, policy and procedure updates and

POC accept 12.17.18 DW/BL

additional training put in place to ensure that the Code Green Security Event continues to improve and becomes hardwired across the organization.

In the event that the Code Green Security Event, The Use of Force Policy, the Restraint Policy or the Law Enforcement in the Healthcare Setting policy is not complied with, an immediate Root Cause Analysis will occur, and any identified areas of non-compliance will be addressed with specific action plans to ensure that the non-compliant event never happens again.

Title of person(s) responsible:

Emergency Department Nurse Manager
Director of Inpatient Services
Medical Director of the Emergency Department and Hospitalist Program
Manager of Regulatory Affairs
Chief Nursing Officer
Manager of Clinical Education
Safety Officer
Director of Facilities
Director of Quality
Chief Executive Officer

482.13 (e)(9) Patient Rights: Use of Restraint or Seclusion Tag A-168
(order for the use of chemical and/or physical restraint)

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 under the Procedure for Violent/ Behavioral Restraint section under the Registered Nurse responsibilities: "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."

Real time concurrent reviews on every patient, on every shift who have had chemical or physical restraints applied to them to ensure that there is a time stamped physician order for physical restraint and for chemical restraints if applicable in the patient's

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chart. Any missing signatures or appropriate restraint information will be obtained in real time from the physician.

All Licensed independent practitioners educated on policy updates and specific requirements for physical and chemical restraint orders for the Violent/Behavioral restraints. This includes the requirement for an independent order for chemical and physical restraint, even if the physical restrajnt entails patient's being physically held to receive chemical restraint.

Appropriate staff will be educated to policy revisions and will be required to demonstrate competency and understanding of all policy revisions and associated procedures.

Appropriate staff will be educated a prepared tool kit that includes all audit tools, relevant policies and procedures and steps to take to follow up made available at all acute care locations.

Completion date for correction:
January 1, 2019

Monitoring and tracking:
The unit manager or designee will ensure that there is a review done on every qualifying patient on every shift with a goal of 100% compliance as applicable with all policy and procedure revisions.

Implement interdisciplinary Restraint & Emotionally Ill/Suicidal Patient Review Team to review all qualifying cases retrospectively, identify areas of non-compliance (if any) and create action plans to ensure that non-compliance does not happen again. This team will meet weekly until 100% compliance is achieved for 3 months, then will meet monthly thereafter. Results from this team's review will be reported quarterly at the Patient Care Committee. Minutes from the Patient Care Committee are sent to the Medical Executive Committee of the Medical Staff monthly for review and acceptance.

Title of person(s) responsible:
Emergency Department Nurse Manager
Director of Inpatient Services
Manager of Clinical Education
Medical Director of the Emergency Department and Hospitalist Program
Manager of Regulatory Affairs
Chief Nursing Officer
Director of Quality
Chief Executive Officer

POC accept 12.17.18
DW/SL

482.13 (e)(9) Patient Rights: Use of Restraint or Seclusion Tag A-174
(discontinue restraints at earliest time)

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 following language in the Procedure for Non-Violent/ Non-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."

"Restraint Use" Policy revised under the Procedure for Violent/ Behavioral Restraint section under the Registered Nurse responsibilities: Additional language written into the policy providing enhanced clarity around what removal at the earliest possible time means. The language added states "If the decision is made to discontinue restraints, RN should begin removing restraints as soon as decision is made, and removal of ALL restraints should be completed in the earliest time frame possible. For Example: If patient is sleeping at a 15-minute check, all restraints should be removed during this check as long as each one is removed safely and sleeping and or calm demeanor continues."

Appropriate staff will be educated to policy revisions and will be required to demonstrate competency and understanding of all policy revisions and associated procedures.

Hands on training for Emergency Department and Acute staff who will participate in applying and removing restraints to/from patients to commence and be on-going through annual refreshers and skills labs.

Completion date for correction:
January 1, 2019

POC accept 12.17.18 DW/SC

Monitoring and tracking:
The unit manager or designee will ensure that there is a review done on every qualifying patient on every shift with a goal of 100% compliance as applicable with all policy and procedure revisions.

Implement interdisciplinary Restraint & Emotionally Ill/Suicidal Patient Review Team to review all qualifying cases retrospectively, identify areas of non-compliance (if any) and create action plans to ensure that non-compliance does not happen again. This team will meet weekly until 100% compliance is achieved for 3 months, then will meet monthly thereafter. Results from this team's review will be reported quarterly at the Patient Care Committee. Minutes from the Patient Care Committee are sent to the Medical Executive Committee of the Medical Staff monthly for review and acceptance.

Title of person(s) responsible:
Emergency Department Nurse Manager
Director of Inpatient Services
Medical Director of the Emergency Department and Hospitalist Program
Manager of Regulatory Affairs
Manager of Clinical Education
Regulatory Affairs Manager
Chief Nursing Officer
Director of Quality
Chief Executive Officer

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

The Restraint Use Policy has been revised under the Procedure for Violent/ Behavioral Restraint section under LIP Responsibilities for violent/behavioral restraints. It states LIP:

- "Views and evaluates the patient for a face-to-face assessment within 1 hour of application of restraint or seclusion of the patient. This face-to-face must occur once every 24 hours.
- The LIP documents findings of their evaluation in the medical record.
- Views and assesses the patient for need for on-going 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."

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Real time concurrent reviews on every patient, on every shift who have had chemical or physical restraints applied to them to ensure that there is time stamped physician documentation

All Licensed independent practitioners will receive education on policy updates and specific requirements for physical and chemical restraint orders for the Violent/Behavioral restraints to include the requirement for an independent order for chemical and physical restraint, even if the physical restraint entails patient's being physically held to receive chemical restraint.

Appropriate staff will be educated to policy revisions and will be required to demonstrate competency and understanding of all policy revisions and associated procedures.

Appropriate staff will be educated to use of a prepared tool kit that includes all audit tools, relevant policies and procedures and steps to take to follow up made available at all acute care locations.

Completion date for correction:
January 1, 2019

Monitoring and tracking:
The unit manager or designee will ensure that there is a review done on every qualifying patient on every shift with a goal of 100% compliance as applicable with all policy and procedure revisions.

Implement interdisciplinary Restraint & Emotionally Ill/Suicidal Patient Review Team to review all qualifying cases retrospectively, identify areas of non-compliance (if any) and create action plans to ensure that non-compliance does not happen again. This team will meet weekly until 100% compliance is achieved for 3 months, then will meet monthly thereafter. Results from this team's review will be reported quarterly at the Patient Care Committee. Minutes from the Patient Care Committee are sent to the Medical Executive Committee of the Medical Staff monthly for review and acceptance.

Title of person(s) responsible:
Emergency Department Nurse Manager
Director of Inpatient Services
Medical Director of the Emergency Department and Hospitalist Program
Manager of Regulatory Affairs
Manager of Clinical Education
Chief Medical/Quality Officer
Chief Nursing Officer

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Director of Quality
Chief Executive Officer

482.21 Quality Assessment & Performance Improvement Tag A-263

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

Plan of Correction:

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

Update the NMC "Event Reporting" policy to clarify reporting and notification requirements for high level events.

Embed additional language into the "Law Enforcement in the Healthcare Setting" to ensure that any deviation from this policy follows a notification process that is in line with NMC's defined quality assurance and performance improvement program.

Enhance existing quality improvement review of charts for emotionally ill and suicidal patients, patients who were in restraints at any time, patients who were in the custody of law enforcement to include routine review, identification of areas of improvement and past non-compliance. Once those areas (if any) have been identified, action plans to prevent future non-compliance will be developed and reviewed with NMC's appropriate governing bodies.

Provide education and training around any identified areas of non-compliance discovered during concurrent reviews, retrospective reviews of restraint and suicidal and emotionally ill patient charts.

<u>Procedure for implementing:</u>

The NMC "Event Reporting" policy updated with the following language to clarify immediate notification requirements for high level/high risk events: "Any event requiring increased level of care, transfer to tertiary care, causing initial or prolonged hospitalization or intervention to prolong life or causes temporary harm, permanent harm or death DUE TO THE EVENT is escalated to Department Manager, Shift Administrator, Administrator on call, CNO, CIO, and or CEO level immediately as appropriate to time of the event. Examples include but are not limited to: suicide attempt, injury to patient, staff or provider." Additional language also added to ensure that high level events are automatically referred to the Quality/Process Improvement department for quality review. It states: "Any event that scores a 7,8,9, or 10 on the event scoring grid is referred to the Quality/Process Improvement Department for

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review. Any event may be referred to the Quality/Process Improvement Department for review as deemed appropriate."

Language added to the NMC "Law Enforcement in the Healthcare Setting" to ensure that immediate notification of any deviation to ensure that quality process review and analysis of these events occur. The policy states: "Any deviation from this policy must be reported to the Department Manager, Shift Administrator and Risk Management immediately. Senior Leadership for the area or Administrator on Call will also be notified immediately."

The unit manager or designee will ensure that there is a review done on every qualifying patient on every shift with a goal of 100% compliance as applicable with all policies and procedures.

Implement interdisciplinary Restraint & Emotionally Ill/Suicidal Patient Review Team to review all qualifying cases retrospectively, identify areas of non-compliance (if any) and create action plans to ensure that non-compliance does not happen again. This team will meet weekly until 100% compliance is achieved for 3 months, then will meet monthly thereafter. Results from this team's review will be reported quarterly at the Patient Care Committee. Minutes from the Patient Care Committee are sent to the Medical Executive Committee of the Medical Staff monthly for review and acceptance.

Appropriate staff will be educated to policy revisions and will be required to demonstrate competency and understanding of all policy revisions and associated procedures.

Completion date for correction:
December 14,2018

Monitoring and tracking:
The Manager of Regulatory Affairs ensures that all events requiring Concentrated Review or Root Cause Analysis per policy, their findings and their follow up action items are reviewed at the NMC Patient Care Committee and the Quality and Safety Committee of the Board.

The Director of Quality and the Chief Medical/Quality Officer ensures that data is reviewed monthly and quality improvement occurs on all identified areas of non-compliance to ensure that the event does not happen.

The Manager of Clinical Education will track all education and training related to restraint application and removal and policy education and competency. This data will be reported to the Interdisciplinary Restraint & Emotionally Ill and Suicidal Patient Review task force monthly and quarterly to the NMC Patient Care Committee. Minutes

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from the Patient Care Committee are sent to the Medical Executive Committee of the Medical Staff monthly for review and acceptance.

Title of person(s) responsible
Manager of Regulatory Affairs
Manager of Clinical Education
Chief Nursing Officer
Director of Quality
Chief Quality/Medical Officer
Chief Executive Officer

482.21 (a)(, (c)(2), (e)(3)
PATIENT SAFETY **Tag A-286**
(analyzing high level events)

Plan of Correction:

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

Conduct Root Cause Analysis on any high-level event (as defined by policy) identified either through survey process, event reporting process or through concurrent or retrospective review process. Report identified root cause, opportunities for improvement and action plan for ensuring event does not happen again to the NMC Patient Care Committee and to the Quality and Safety Committee of the Board.

Update NMC "Event Reporting" policy to clarify reporting and notification requirements for high level events.

Embed additional language into the "Law Enforcement in the Healthcare Setting" to ensure that any deviation from this policy follows a notification process that is in line with NMC's defined quality assurance and performance improvement program.

Procedure for implementing:

Conduct Root Cause Analysis or Concentrated review on any event that scores a 7,8,9, or 10 on the event scoring grid is referred to the Quality/Process Improvement Department for review. Once analysis of the event is complete, the identified root

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cause, opportunities for improvement and the status of action items deployed to prevent the event from ever happening again will be reviewed in-depth at the NMC Patient Care Committee (whose minutes are reviewed and approved by the Medical Executive Committee of the Medical Staff) and at the Quality and Safety Committee of the Board.

The NMC "Event Reporting" policy updated with the following language to clarify immediate notification requirements for high level/high risk events: "Any event requiring increased level of care, transfer to tertiary care, causing initial or prolonged hospitalization or intervention to prolong life or causes temporary harm, permanent harm or death DUE TO THE EVENT is escalated to Department Manager, Shift Administrator, Administrator on call, CNO, CIO, and or CEO level immediately as appropriate to time of the event. Examples include but are not limited to: suicide attempt, injury to patient, staff or provider." Additional language also added to ensure that high level events are automatically referred to the Quality/Process Improvement department for quality review. It states: "Any event that scores a 7,8,9, or 10 on the event scoring grid is referred to the Quality/Process Improvement Department for review. Any event may be referred to the Quality/Process Improvement Department for review as deemed appropriate."

Language added to the NMC "Law Enforcement in the Healthcare Setting" to ensure that immediate notification of any deviation to ensure that quality process review and analysis of these events occur. The policy states: "Any deviation from this policy must be reported to the Department Manager, Shift Administrator and Risk Management immediately. Senior Leadership for the area or Administrator on Call will also be notified immediately."

The unit manager or designee will ensure that there is a review done on every qualifying patient on every shift with a goal of 100% compliance as applicable with all policies and procedures.

Implement interdisciplinary Restraint & Emotionally Ill/Suicidal Patient Review Team to review all qualifying cases retrospectively, identify areas of non-compliance (if any) and create action plans to ensure that non-compliance does not happen again. This team will meet weekly until 100% compliance is achieved for 3 months, then will meet monthly thereafter. Results from this team's review will be reported quarterly at the Patient Care Committee. Minutes from the Patient Care Committee are sent to the Medical Executive Committee of the Medical Staff monthly for review and acceptance.

Completion date for correction:
January 2, 2018

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Monitoring and tracking:
The Manager of Regulatory Affairs ensures that all events requiring Concentrated Review or Root Cause Analysis per policy, their findings and their follow up action items are reviewed at the NMC Patient Care Committee and the Quality and Safety Committee of the Board.

The Director of Quality and the Chief Medical/Quality Officer ensures that data is reviewed monthly and quality improvement occurs on all identified areas of non-compliance to ensure that the event does not happen.

The Manager of Clinical Education will ensure that all follow up education that occurs as a result of a quality process review will be completed within the allotted time frames and will report any deficiencies to the NMC Patient Care Committee.

Title of person(s) responsible
Emergency Department Nurse Manager
Director of Inpatient Services
Medical Director of the Emergency Department and Hospitalist Program
Manager of Regulatory Affairs
Manager of Clinical Education
Chief Nursing Officer
Director of Quality
Chief Quality/Medical Officer
Chief Executive Officer

482.55 Emergency Services **Tag A-1100**
(failure to ensure properly trained staff – periodic use of law enforcement and use of police)

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

Plan of Correction:

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

Revise the "Care of the Emotionally Ill and Suicidal Patient" policy.
Revise the "Restraint Use" policy.
Revise the "Security Event (Code Green)" policy.
Create the "Law Enforcement Involvement in the Healthcare Setting" policy.
Create the "Use of Force" policy.
Create a dedicated de-escalation response team comprised of MANDT trained NMC workforce members to respond to Code Green events, including de-escalation of a violent and/or threatening patient.

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DW 18

Ensure that all ED Charge nurses and at least one other staff member per shift are trained in MANDT.
Ensure that all security and shift administrators are trained in MANDT.

Procedure for implementing:
"Care of the Suicidal and Emotionally Ill Patient" policy revised to add the following language in Section D.6: "NMC does not utilize law enforcement to intervene in the care or treatment of patients which includes and is not limited to assisting in the restraint of patients. If law enforcement is not maintaining custody of a patient at NMC, they cannot engage with the patient. See the Law Enforcement Involvement in the Healthcare Setting policy.

The "Restraint Use" policy revised to include the following language under the Training Requirements Section: "NMC does not use law enforcement to assist in the restraint of patients. Hospital security officers will assist the direct care staff by holding the patient, when necessary, in the application of restraints and therefore are expected to be trained and able to demonstrate competency in their role in safe application of physical hold for restraint application."

Revise the "Security Event: Code Green" policy to include a new definition and language for a dedicated Code Green Security Response team. Per the revision to the policy, the Code Green Security Response team is defined as: "identified members of the NMC workforce specifically assigned to assist in the management of a security incident." Additional language added to the revised version of the "Security Event: Code Green Policy" in Section C.6 that states: "NMC does not utilize law enforcement to intervene in the care or treatment of patients which includes and is not limited to assisting in the restraint of patients. Law Enforcement should only be contacted as outlined in the Law Enforcement Involvement in the Healthcare Setting.

Create "Law Enforcement Involvement in the Healthcare Setting" to clearly define the roles and expectations of staff and law enforcement when they are in the healthcare setting at NMC. The policy statement for this policy is as follows: "NMC does not utilize law enforcement to intervene in the care or treatment of patients which includes and is not limited to assisting in the restraint of patients. NMC only contacts law enforcement to respond to a criminal act that cannot be addressed by NMC Security or Code Green Security Response Team and the individual will be charged, arrested and taken into custody." This policy clearly outlines what staff expectations are if law enforcement is in the department for unrelated reasons. It is clear that law enforcement cannot participate or intervene in the care of patients at NMC.

Create "Use of Force" policy to clearly define and outline the continuum of de-escalation and ultimately the use of force allowable by NMC Workforce members to manage violent, threatening or harmful behavior in patients consistently with the Conditions of Participation in the use of restraint and seclusion. The policy statement

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DW 18

for this policy is as follows: "It is the policy of Northwestern Medical Center (NMC) that qualified NMC staff use only the force that reasonably appears necessary to effectively bring an incident under control, while protecting the lives and safety of the patients, visitors, employees, and others as is reasonably possible. Security personnel should attempt to de-escalate any situation before using any level of force upon a person. Should the use of physical force be deemed required, security personnel are to use only that amount of force necessary to overcome the opposing resistance. The use of force must be objectively reasonable. The security personnel must only use that force which a reasonably prudent person would use under similar circumstances."

Identify a dedicated Security Response Team known as the Code Green Security Response Team with membership on all shifts who are trained in MANDT and additional de-escalation techniques. This team as per the "Security Event: Code Green" policy is trained to respond to any Code Green called in the organization. This team will be well versed in the Use of Force policy and is meant to be called any time a patient is escalating to a point where safety and security are a concern. This team will receive on-going education and hands on training throughout the year to ensure that they are well equipped to intervene in patient care and restraint if necessary.

As the area of highest risk for escalated behaviors, sending ED physicians and clinicians through MANDT Training is a top priority. To ensure that we have trained staff available to manage escalating patient security events, the ED Nurse Manager will schedule all shifts to include at least one MANDT trained staff member, a MANDT trained Charge Nurse and a MANDT trained Shift Administrator. MANDT trained individuals will be assigned to work with suicidal and emotionally ill patients in the department.

Appropriate staff will be educated to policy revisions and will be required to demonstrate competency and understanding of all policy revisions and associated procedures.

Identified staff will receive appropriate MANDT and De-escalation training that will include hands-on and table top reviews and drills. An on-going schedule of drills and training established, and training and drills begun.

Completion date for correction: January 1, 2019

Monitoring and tracking:
The unit manager or designee will ensure that there is a review done on every qualifying patient on every shift with a goal of 100% compliance as applicable with all policy and procedure revisions.

Implement interdisciplinary Restraint & Emotionally Ill/Suicidal Patient Review Team to review all qualifying cases retrospectively, identify areas of non-compliance (if any) and

create action plans to ensure that non-compliance does not happen again. This team will meet weekly until 100% compliance is achieved for 3 months, then will meet monthly thereafter. Results from this team's review will be reported quarterly at the Patient Care Committee. Minutes from the Patient Care Committee are sent to the Medical Executive Committee of the Medical Staff monthly for review and acceptance.

An event report, debrief, and subsequent quality process review will occur for every Code Green Security Event that is called. Opportunities for improvement will be identified and subsequent documentation changes, policy and procedure updates and additional training put in place to ensure that the Code Green Security Event continues to improve and becomes hardwired across the organization.

In the event that the Code Green Security Event, The Use of Force Policy, the Restraint Policy or the Law Enforcement in the Healthcare Setting policy is not complied with, an immediate Root Cause Analysis will occur, and any identified areas of non-compliance will be addressed with specific action plans to ensure that the non-compliant event never happens again.

Title of person(s) responsible:

Emergency Department Nurse Manager
Director of Inpatient Services
Medical Director of the Emergency Department and Hospitalist Program
Manager of Regulatory Affairs
Chief Nursing Officer
Manager of Clinical Education
Safety Officer
Director of Facilities
Director of Quality
Chief Executive Officer

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DW ISL

Respectfully submitted,

Jill Berry Bowen, RN, Chief Executive Officer

POC accnt 12.17.18
DW 181

NMC
Northwestern Medical Center

Event Reporting and Follow-up

Applicability: Organizational	**Date Effective:** 7/00
Department: Regulatory Affairs	**Date Last Reviewed:** 12/18
Supersedes: Confidential Event Report; Incidents; Linkage for Risk Management and Process Improvement Activities; and Risk Management Program; Medication Events	**Or** **Date Last Revision:** 12/18
Administration Approval: Joel Benware, Chief Information, Innovation and Compliance Officer	

Purpose: To provide a process for al staff to log patient safety and quality related events. To provide a framework for aggregate reporting of events, trending of system issues and identification of areas for improvement. To maintain a culture of safety by creating a process to effectively evaluate, fully analyze and fully implement immediate actions when a significant adverse patient event occurs.

Policy Statement: Regulatory Affairs maintains a comprehensive event reporting system and develops and maintains a system for trending and analysis of reported events. Patient safety reports are generated. This process occurs in conjunction with peer review, and quality assurance/improvement activities of the medical staff and clinical departments. (Vermont Statutes Annotated, Title 26, Section(s) 1441-1443)

Background: The hospital must develop, implement and maintain an effective, ongoing, organization - wide data driven quality assessment and performance improvement plan. Focus is on a full range of safety issues, including areas of specific risks and hazardous conditions, potential errors, near miss events, and no harm events, adverse events requiring unanticipated care and sentinel events.

Definitions:

ADVERSE EVENT: An untoward incident, therapeutic misadventure, iatrogenic injury or other undesirable occurrence directly associated with care or service provided by a health care provider or health care facility.

EVENT: Any situation which is not consistent with routine operation of the facility or routine care of the patient. Event may involve a patient, a visitor, a volunteer, or an environmental condition. Example of events includes but are not limited to: medication events, falls, deviations from procedures, and surgical misadventures.

CAUSAL ANALYSIS: A formal root cause analysis, similar analytic methodology or any similarly effective but simplified processes that uses a systematic approach to identify the basic or causal

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factors that underlie the occurrence or possible occurrence of a reportable adverse event , or near miss.

CONCENTRATED REVIEW: A review process conducted by a multi-disciplinary Ad Hoc group of the Quality and Safety Committee to improve patient outcomes related to a reported event and eliminate the possible recurrence..

HOSPITAL STAFF: A health care provider, employee or volunteer providing services at the hospital

INTENTIONAL UNSAFE ACT: An adverse event or near miss that results from a criminal act, a purposefully unsafe act, alcohol or substance abuse, or patient abuse

INVESTIGATION: A formal, systematic examination or research of the facts leading to an event; the investigation is documented.

NEAR MISS: A process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome. (also known as: close call or good catch

REPORTABLE ADVERSE EVENT: Those adverse events a hospital is required to report to the Vermont Department of Health pursuant to the Patient Safety Surveillance and Improvement System regulation

RISK THEREOF: Includes any process variation for which a recurrence would carry a significant chance of serious adverse outcome.

ROOT CAUSE ANALYSIS: A process for identifying the basic or causal factor(s) that underlies variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not on individual performance.

SERIOUS BODILY INJURY: Bodily injury that creates a substantial risk of death or that causes substantial loss or impairment of the function of any bodily member or organ or substantial impairment of health or substantial disfigurement.

CATEGORIES OF EVENTS:

1. Unsafe condition , refers to general security and safety issues
2. Near Miss/ Good Catch outcome not affected this time
3. Minor event, No Harm, reached the patient, caused no harm
4. Minor event, Minimal Harm, may require increased need for monitoring
5. Moderate, Inconvenience, Discomfort required increased need for treatment /intervention
6. Moderate, Additional Treatment Required, may require initial or prolonged hospitalization
7. Moderate, Increased Level of Care, increased level of care, transfer to tertiary care due to

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8. Serious Event, Temporary Harm, or the risk thereof required initial or prolonged hospitalization
9. Serious Event, Permanent Harm, or the risk thereof required initial or prolonged hospitalization, required intervention necessary to sustain life
10. Sentinel Event, contributed to or resulted in unexpected death

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Event Significance	Severity Level	Tracking and Trend	Investigation (I) Concentrated Review (CR) Root Cause Analysis (RCA)	Immediate Administrative Notification
1	Unsafe condition, general security and safety issues	Yes	I and/or CR and/or RCA and Department Review	Not required
2	Near Miss/Good Catch, outcome not affected this time	Yes	I and/or CR and/or RCA and Department Review	Not required
3	Minor Event / No Harm, reached the patient, caused no harm	Yes	Department Review	Not required
4	Minor event / Minimal Harm /may require need for monitoring or intervention	Yes	Department Review	Not required
5	Moderate, inconvenience, discomfort, increased need for intervention	Yes	I and /or CR and/or RCA and Department Review	Not required
6	Moderate, additional treatment required, required initial or prolonged hospitalization	Yes	I and/or CR and/or RCA and Department Review	Not required
7	Moderate event - increased level of care, transfer to tertiary care due to event	Yes	CR and/or RCA	Required
8	Serious event - temporary harm (or the risk thereof) required initial or prolonged hospitalization, additional treatment required	Yes	RCA	Required
9	Serious event - permanent harm (or the risk thereof) required initial or prolonged hospitalization, required intervention necessary to sustain life	Yes	RCA	Required
10	Sentinel event - contributed to or resulted in	Yes	RCA	Required

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Event Scoring Grid:

Identification:

1. Upon identification of an event involving a patient or the safety of a patient, changes in the patients' condition are addressed immediately.
2. Attending physician and department manager and /or shift administrator are notified.

Tracking

1. Events are reported by hospital staff or physician by describing details of the event.
2. Events identified or witnessed are documented using the Event Reportal accessed via a pink icon on the NMC desktop.

NOTE: If the event involves a patient, then notation in the chart describes the event and subsequent care to patient.

Disclosure of event

Medical providers explain the outcomes of any treatments or procedures to the patient and, when appropriate, the family, whenever those outcomes differ significantly from the anticipated outcomes. Adverse events that cause death or serious bodily injury, including those resulting from intentional unsafe acts are disclosed to patients, or, in the case of patient death, an adult member of the immediate family by the medical provider ***as soon as possible and within 72 hours after discovery or recognition of an adverse event.*** *Documentation of this disclosure is in the medical record.*

Administrative Notification and Review:

Any event requiring increased level of care, transfer to tertiary care, causing initial or prolonged hospitalization or intervention to prolong life or causes temporary harm, permanent harm or death DUE TO THE EVENT is escalated to Department Manager, Shift Administrator, Administrator on call, CNO, CIO, and or CEO level immediately as appropriate to time of the event. Examples include but are not limited to: suicide attempt, injury to patient, staff or provider.

Any event that scores a 7, 8, 9, or 10 on the event scoring grid is directly reported to the COO/CNO, CEO, & CIO, immediately and an administrative review is conducted within 24 hours of becoming aware of an event to determine interim measures.

Analysis:

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Department manager, services manager and Regulatory Affairs reviews the Event Report investigates event as needed, documents his/her action taken in comment section,, including details of investigation performed and plan of action, initials, and dates the form within 72 hours from receiving the report.

For clinically significant errors (for example: medication events), fact gathering and investigation should be initiated immediately. Facts that should be determined and documented include what happened, where the event occurred, why the event occurred, how the event occurred and who was involved.

Risk Management assigns the reported event a level of severity: minor, moderate, major, or sentinel event using the criteria in the EVENT GRID.

Any event that scores a 7,8,9, or 10 on the event scoring grid is referrd to the Quality/Process Improvement Department for review. Any event may be referred to the Quality/Process Improvement Department for review as deemed appropriate.

Causal Analysis and Action plan

Regulatory Affairs/Risk Management conducts a follow-up in this manner:

Minor Events: Data is aggregated and trended to identify areas for system improvements. When a trend is noted, a concentrated review is conducted to identify areas for system improvement.

Moderate Events: A multi-disciplinary investigation or concentrated review and/or a physician peer review process takes place to identify real or potential causes of the event and areas for system improvement.

Serious Events: A multi-disciplinary Root Cause Analysis is conducted to identify real or potential causes of the event and areas for system improvement.

- The Root Cause Analysis process allows for 30 days for the concentrated review and report to be completed.
- With Clinical events, the Service Chief, or designee, will be given appropriate notice of the date of the Root Cause Analysis so that he/she may attend. The review should not be delayed due to the Chief or designee's schedule.

- Improvement initiatives are conducted based on data from reported events
- The relevant service Quality Improvement committee review will be completed at their next meeting; however, if there is an extended delay, a special meeting will be scheduled.

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Sentinel Event: A root cause (causal) analysis is conducted as immediate to the event as possible to bring those involved together, as outlined in the Sentinel Event Policy. All sentinel events must be reviewed by the hospital and are subject to review by the joint Commission

Reporting:

NMC's Liability Insurance provider is notified of events at the discretion of Risk Management.

A quarterly report of events and patient safety is presented to Patient Care Committee and Quality Improvement Committee (QIC). Reports are also provided as needed to Process Improvement Teams, department managers, and Leadership (QIC) and Board.

Reporting-Specific to the Vermont Patient Safety Surveillance and Improvement System:

Each hospital submits the following reports to the Vermont Department of Health

Initial report: Each hospital submit shall submit an initial report as soon as reasonably possible and no later than seven (7) calendar days after discovery or recognition of the reportable adverse event.

Causal analysis and corrective action plan: Each hospital shall submit the causal analysis and corrective action plan no later than sixty (60) calendar days from the submission of the initial report. The Patient Safety Surveillance and Improvement System will review the causal analysis and corrective action plan and may require the Hospital too provide additional information, including periodic interim reports and /or modification to the causal analysis or to the corrective action plan.

The submission required by this section shall be on a form approved by the Vermont Department of Health, unless the reportable adverse event must also by law be reported to another department or agency, in which instance the hospital may notify the Department or provide a copy of any written report provided to the other department or agency. When the hospital submits a copy of a written report provided to another department or agency, the Patient Safety Surveillance and improvement System will review the report and may require additional causal analysis information from the hospital.

Note Well: N/A

Monitoring Plan:

The Patient Safety Surveillance and Improvement System will conduct routine periodic reviews to evaluate a hospital's compliance with the requirements of 18 VSA 43A and specifically review the following:

- The hospital's policies and procedures with respect to near misses, non-reportable adverse events, reportable adverse events, and intentional unsafe acts;

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- The implementation of hospital policies and procedures with respect to near misses, non-reportable adverse events, reportable adverse events, and intentional unsafe acts;
- The effectiveness of any corrective action plans implemented to address reportable adverse events or intentional unsafe acts.

Related Policies: Medical Device Reporting Program, Sentinel Events

References:

To Err is Human: Building a Safer Health System, Institute of Medicine, 2000.

Joint Commission Comprehensive Accreditation Manual for Hospitals

Medical Mutual Insurance Company of Maine, Confidential Event Report.

Vermont Statutes Annotated, Title 26, Section(s) 1441-1443.

Vermont Statutes Annotated, Title 18, Act 215, Chapter 43A. Patient Safety Surveillance and Improvement System 1912-1919.

List of National Quality Forum Serious Reportable Events

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

Reviewers:

A. **Key Stakeholders:** Managers and Leadership Team
B. **Committees:** Management Team
C. **Key Process Owner (KPO):** Nilda Gonnella-French, Risk & Accreditation Coordinator

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Keywords - Not part of policy: Sentinel Event, Adverse Event, Root Cause Analysis, Concentrated Review, Event Report, serious reportable event, SRE, temporary harm, permanent harm, near miss

Approved 11.17.18
DW18

NMC
Northwestern Medical Center

Appendix I
National Quality Forum Serious Reportable Events

1. SURGICAL EVENTS	
EVENT	**ADDITIONAL SPECIFICATIONS**
A. Surgery or other invasive procedure performed on the wrong site.	Defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient.1 Surgery includes endoscopies and other invasive procedures. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent.
B. Surgery or other invasive procedure performed on the wrong patient	Defined as any surgery on a patient that is not consistent with the correctly documented informed consent for that patient. Surgery includes endoscopies and other invasive procedures.
C. Wrong surgical or other invasive procedure performed on a patient	Defined as any surgery on a patient that is not consistent with the correctly documented informed consent for that patient. Surgery includes endoscopies and other invasive procedures. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent.
D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure	Excludes a) objects present prior to surgery that were intentionally left in place; b) objects intentionally

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	implanted as part of a planned intervention; and c) objects not present prior to surgery that are intentionally left in when the risk of removal exceeds the risk of retention (such as macroneedles, broken screws).
E. Intraoperative or immediately post-operative/postprocedural death in an ASA Class I patient	Includes all ASA Class I patient deaths in situations in which anesthesia was administered; the planned surgical procedure may or may not have been carried out. Immediately postoperative means within 24 hours after surgery or other invasive procedure was completed, or after administration of anesthesia (if surgery not completed).

2. PRODUCT OR DEVICE EVENTS	
EVENT	**ADDITIONAL SPECIFICATIONS**
A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting.	Includes detectable contaminants in drugs, devices, or biologics regardless of the source of contamination and/or product.
B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended	Includes, but is not limited to, catheters, drains and other specialized tubes, infusion pumps, and ventilators.
C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting	Excludes deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

1 Except in the case of an emergency, a physician must obtain a patient's agreement (informed consent) to any course of treatment. Physicians are required to tell the patient anything that

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would substantially affect the patient's decision. Such information typically includes the nature and purpose of the treatment, its risks and consequences and alternative courses of treatment.

3. PATIENT PROTECTION EVENTS	
EVENT	**ADDITIONAL SPECIFICATIONS**
A. Discharge or release of a patient of any age, who is unable to make decisions, to other than an authorized person.	
B. Patient death or serious injury associated with patient elopement (disappearance)	Excludes events involving competent adults.
C. Patient suicide, or attempted suicide or self-harm that results in serious injury while being cared for in a healthcare setting.	Defined as events that result from patient actions after admission to a healthcare facility. Excludes deaths resulting from self-inflicted injuries that were the reason for admission to the healthcare facility.

4. CARE MANAGEMENT EVENTS	
EVENT	**ADDITIONAL SPECIFICATIONS**
4 A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)	Excludes reasonable differences in clinical judgment on drug selection and dose. Includes administration of a medication to which a patient has a known allergy and drug-drug interactions for which there is known potential for death or serious disability.
4 B. Patient death or serious injury associated with unsafe administration of blood products	

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4 C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting	Includes events that occur within 42 days post-delivery. Excludes deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy or cardiomyopathy.
4 D. Death or serious injury of a neonate associated with labor or delivery in a low risk pregnancy.	
4 E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting	
4 F. Any Stage 3, Stage 4 and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting	Excludes progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.
4 G. – N/A	
4 H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen	
4 I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results	

5. ENVIRONMENTAL EVENTS	
EVENT	**ADDITIONAL SPECIFICATIONS**
A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting	Excludes events involving planned treatments such as electric countershock /elective cardioversion.

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B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains the no gas, the wrong gas or is contaminated by toxic substances	
C. Patient death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting.	
D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting.	

6 RADIOLOGIC EVENTS	
Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.	
7. CRIMINAL EVENTS	
EVENT	**ADDITIONAL SPECIFICATIONS**
A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider	
B. Abduction of a patient of any age	
C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting.	
D. Death or serious significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of the healthcare setting. facility	

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Law Enforcement Involvement in the Healthcare Setting

Applicability: Organizational	**Date Effective:** 12/15/2018
Department: Facilities	**Date Last Reviewed:**
Supersedes: N/A	**Or** **Date Last Revision:**
Administration Approval: Chris Hickey, SVP CFO	

Purpose: The purpose of this policy is to ensure that Northwestern Medical Center (NMC) Staff/Workforce does not involve law enforcement in the care or treatment of its patients. This policy also outlines for NMC staff that any communication with and involvement of law enforcement in operations must be consistent with the Center for Medicare and Medicaid Services (CMS) Conditions of Participation, EMTALA, the HIPAA Privacy Rule, and other applicable legal requirements.

Policy Statement: NMC does not utilize law enforcement to intervene in the care or treatment of patients which includes and is not limited to assisting in the restraint of patients. NMC only contacts law enforcement to respond to a criminal act that cannot be addressed by NMC Security or the Code Green Security Response Team and the individual will be charged, arrested and taken into custody.

Background: The Center for Medicare and Medicaid Services (CMS) as part of its Conditions of Participation (COP) provides specific expectations around the use of law enforcement in a hospital setting. The COP's state that hospital patients have a right to care in a safe environment and a right to be free from improper restraints, including not being restrained by law enforcement or being subject to the use of weapons unless they are engaged in criminal activity. Therefore, it is inappropriate for health care facilities to use law enforcement as an extension of their staff to manage patient's behavior.

Definitions:

- *Violent and/or Threatening Patients* - A patient who is engaging in an act of violence that has or is likely to cause serious bodily injury. A threatening patient refers to threats and actions that put another in reasonable fear of imminent serious bodily injury as defined by aggravated assault.

- *Aggravated Assault*: The attempt to cause or cause serious bodily injury to another purposely, knowingly and/or recklessly under circumstances manifesting extreme indifference to the value of human life.

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- *Medically Unstable Patients:* Medically unstable, including psychiatrically unstable patients should not be removed from the Hospital by law enforcement unless they are being transferred to another hospital or a physician determines that they can be treated on an outpatient basis.

- *Code Green Security Event:* A code utilized for security related events that requires all trained members in the facility of the Code Green Team to respond to assist in de-escalating the violent or threatening behavior. This Code SHOULD NOT be used when there is an armed intruder
- (Code Silver) is the code utilized by NMC that warns occupants of an NMC building that there is an armed intruder on campus or within the facility.

- *Code Green Security Response Team*: Identified members of the NMC workforce specifically assigned to assist in the management of a security incident.

Procedure:

A. Contacting law enforcement to respond to the Hospital will only occur after contacting Security and / or the Code Green Security Response Team, Manager/Director and/or Shift Administrator and/or the Administrator on-call. This requirement excludes routine matters such as arranging transportation of involuntary patients and emergencies in off campus facilities. See Security Event: Code Green Policy for details.

B. Hospital patients have the right to care in a safe environment and the right to be free from restraints, including not being restrained by law enforcement or being subject to the use of weapons unless they are engaged in criminal activity. However, law enforcement officers and corrections officers may use their own restraints for patients in their custody.

C. *Violent and/or Threatening Patients*-Staff in the main Hospital including the Emergency Department may not contact or request assistance from law enforcement to intervene in patient care, manage patient behavior or restrain a violent and/or threatening patient. Staff will contact Security or call a Code Green to help manage violent and/or threatening patients. Law enforcement will only be contacted to respond to the hospital when there are on-going, criminal acts of violence that could be considered aggravated assault as defined in this policy and NMC is asking the police to respond to that criminal behavior by charging, arresting and taking that individual into custody.

1. Staff may not ask law enforcement to coerce a patient to comply with clinical direction.
2. If staff need to use medical (non-violent) or behavioral (violent) restraints and a law enforcement officer offers to assist with the patient, staff should ask the officer not to intervene unless the officer believes that the individual is

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committing a crime that will result in them taking custody of the patient. Staff shall not, however, obstruct or impede an officer who is responding to a crime.

3. It is Hospital policy that if a law enforcement officer initiates the use of force on a patient in response to criminal activity Hospital staff and Leadership shall make all reasonable efforts to ensure that the individual is charged with a crime and encourage witnesses to cooperate with investigations.
4. The identified individual in charge of the incident should document the police incident number and the names of the officers who were involved.
5. If the officer takes a patient into custody, the Hospital remains responsible for the individual's medical needs while they remain in the Hospital, and the law enforcement officer is responsible for the individual's physical custody.

D. *Medically Unstable Patients*-Medically unstable, including psychiatrically unstable patients should not be removed from the Hospital by law enforcement unless they are being transferred to another hospital or a physician determines that they can be treated on an outpatient basis.

E. *Patients who are in law enforcement custody* – Staff are responsible for providing medical supervision and treatment to patients who are in law enforcement or corrections custody.

1. Staff may not assist law enforcement or correctional officers in maintaining custody of a patient. A Security Officer may provide a brief break for Law Enforcement to use the restroom.

2. Staff are required to immediately report to Security if a law enforcement officer or correctional officer leaves a patient that is in their custody unattended. In such an event Security must contact the officer or their supervisor to ensure that the patient is appropriately supervised. Security is responsible for immediately contacting the officer's supervisor if a patient is left unattended while in law enforcement restraints.

F. *Crime in a Hospital Facility or on Hospital Property* – Staff are required to contact Security whenever they witness criminal behavior in the Hospital, Hospital Property, or in a Hospital Facility.

1. *Inpatient Units* - Staff on inpatient units may not contact law enforcement directly to address patient behavior. Any communication with law enforcement regarding a patient or visitor on an inpatient unit must be coordinated with Security, and/or Shift Administrator and/or Administrator on Call.

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2. *Emergency Department* – Staff in the Emergency Department may not contact law enforcement directly to address patient behavior. Any communication with law enforcement regarding a patient or visitor in the Emergency Department must be coordinated with Security, and/or Shift Administrator and/or Administrator on Call.

3. *Offsite facilities* – Staff in offsite clinics and other facilities should call 911 if they need assistance from law enforcement because there is no offsite security coverage for emergency situations.

G. *Obtaining law enforcement assistance for non-emergency situations.*

1. Staff shall contact Security whenever they need assistance in dealing with non-emergency situations such as dealing with violations of abuse prevention orders and obtaining or enforcing a no trespass order.

H. *Staff interviews with law enforcement officers.*

1. The Hospital encourages staff who are victims or witnesses of a crime on the premises to cooperate with any investigation and prosecution. If staff are interviewed by law enforcement officer when a patient is a suspect, staff may only disclose the following information about the patient:

    a. Patient name and address;

    b. Patient date and place of birth;

    c. Patient ABO blood type and Rh factor;

    d. Type of patient injury treated by NMC;

    e. Date and type of treatment;

    f. Patient's distinguishing characteristics, including height, weight, gender, race, hair, and eye color; and

    g. Observations of the alleged crime that constitute evidence of criminal conduct.

I. Staff may not disclose any additional clinical information including, but not limited to medical history, past treatment or involvement unless specifically authorized by the Hospital.

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Note Well: Any deviation from this policy must be reported to the Department Manager, Shift Administrator and Risk Management immediately. Senior Leadership for the area or Administrator on Call will also be notified immediately.

Related Policies:
Use of Force
Care of the Emotionally Ill or Suicidal Patient
Event Reporting
Code Green
Restraint Use

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

Reviewers:

A. **Key Stakeholders:**
   - Jamie Pinkham – Manager, Regulatory Affairs and Health Information Integrity
   - JoAnn Manahan – Nurse Manager, Emergency Department
   - Maggie Conklin - Chief Nursing Officer (Interim)
   - Chris Reinfurt - Coordinator, Emergency Preparedness and Safety
   - Dr. John Minadeo - Medical Director, Emergency Department & Hospitalists

B. **Committees:**
   - Patient Care Committee 12/11/2018
   - Environment of Care Committee
   - Medical Staff 12/13/2018
   - Management Staff

C. **Key Process Owner (KPO):** Tyson Moulton – Director, Facilities.

Keywords - Not part of policy: Police, Security, Restraints, Crime, Criminal, Violence, Code Green, Weapons, Use of Force

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Use of Force

Applicability: Organizational	**Date Effective:** 12/15/2018
Department: Facilities	**Date Last Reviewed:**
Supersedes: N/A	**Or** **Date Last Revision:**
Administration Approval: Chris Hickey, SVP CFO	

Purpose: To establish a hospital policy regarding the use of force by NMC workforce when necessary, to maintain a safe and secure environment for staff, visitors, and patient care.

Policy Statement: It is the policy of Northwestern Medical Center (NMC) that qualified NMC staff use only the force that reasonably appears necessary to effectively bring an incident under control, while protecting the lives and safety of the patients, visitors, employees, and others as is reasonably possible. Security personnel should attempt to de-escalate any situation before using any level of force upon a person. Should the use of physical force be deemed required, security personnel are to use only that amount of force necessary to overcome the opposing resistance. The use of force must be objectively reasonable. The security personnel must only use that force which a reasonably prudent person would use under similar circumstances.

Background: The Center for Medicare and Medicaid Services (CMS) as part of its Conditions of Participation (COP) provides specific expectations around the use of law enforcement in a hospital setting. The COP's state that hospital patients have a right to care in a safe environment and a right to be free from improper restraints, including not being restrained by law enforcement or being subject to the use of weapons unless they are engaged in criminal activity. Therefore, it is inappropriate for health care facilities to use law enforcement as an extension of their staff to manage patient's behavior and identified members of hospital workforce must be equipped to manage this behavior and understand the Use of Force Continuum.

Definitions:

- *Use of Force* is defined as any force beyond a guiding touch.
- *Physical Interaction* shall mean the use of physical presence or skill to either assist or limit a person's behavior. Physical interaction includes accompanying, assisting, escorting, supporting, avoiding, redirecting, releasing, separating, and restraining.

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- *Qualified NMC Staff* shall mean any member of the NMC workforce that have been trained in de-escalation and restraint techniques.

Procedure:

1. Qualified NMC Staff will employ the minimum use of force necessary based upon their training and experience to establish a safe environment for patients, staff and visitors per NMC's Restraint Use Policy, Care of Emotionally Ill and Suicidal Patient and Code Amber as applicable.

2. Qualified staff will use the continuum of force beginning with presence, de-escalation techniques, Code Green and physical interaction.

3. Qualified NMC staff must take directions from the medical staff when dealing with a patient. When dealing with another person (staff, visitor) qualified NMC staff can take the lead to de-escalate the security incident.

4. Use-of-force continuum
   a. When faced with an incident that may require the use of force, Qualified NMC Staff should assess the situation and determine which of the following alternatives will most effectively bring the situation under control with the least amount of injury to everyone involved. These alternatives are listed in order below, from the least severe to the most drastic. Sometimes situations escalate rapidly and the most appropriate step to take must be assessed based on the situation. A security officer must never use a greater level of force than necessary without first exhausting all less severe alternatives or reasonably believing that any lesser degree of force would be ineffective.
      a. Level one—Presence: Presence is defined as psychological force established by the Qualified NMC staff's arrival in the area, and symbols of authority, such as the officer's uniform. The security officers' positioning, stance, and reaction times may control confrontations and facilitate officer safety.
      b. Level two—De-escalation Techniques: Use of conversation, advice or instruction by qualified NMC staff to control or de-escalate a confrontation describes the level of use of force. They will use the de-escalation techniques when appropriate. Verbal de-escalation is the most desirable of the use of-force options.
      c. Level three-Call Code Green: The prompt appearance of additional individuals frequently brings situations under control. Security officers should refrain from initiating contact until adequate backup has arrived, unless immediate action is required to preserve human life.

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d. Level four—Physical Interaction: Use of physical contact includes touching, assisting, grabbing, and manipulating joints. Contact may include staff using his or her hands.

Note Well: N/A

Related Policies:
Security Event (Code Green)
Restraint Use
Use of Law Enforcement in the Healthcare Setting

References:
Consider Four Tips When Writing Your Use-of-Force Policy. HCPro, 1 Jan. 2005, www.hcpro.com/HOM-44742-742/Consider-four-tips-when-writing-your-useofforce-policy.html

Use of Force by Security Personnel. International Association of Professional Security Consultants, undated, https://iapsc.org/?wpfb_dl=378

Guidelines, 05. Security Officer Use of Physical Force. International Association for Healthcare Security & Safety, Apr. 2016

Reviewers:

A. **Key Stakeholders:**
   - Chris Reinfurt, Coordinator Emergency Management and Safety
   - Jamie Pinkham, Manager Regulatory Affairs and Health Information Integrity

B. **Committees:**
   - Environment of Care
   - Management

C. **Key Process Owner (KPO):** Tyson Moulton, Facilities Director

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Keywords - Not part of policy: **Security, Law Enforcement, Violence, Weapons, Restraint**

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Security Event: Code Green

Applicability: Organizational	**Date Effective:** 02/02
Department: Facilities	**Date Last Reviewed / or Date Last Revision:** 12/18
Supersedes: N/A	
Administration Approval: Chris Hickey, SVP CFO	

Purpose: To provide a rapid, organized and effective response to a security incident.

Policy Statement: It is the policy of Northwestern Medical Center (NMC) to provide a safe environment for staff, patients and visitors. When a security incident occurs a Code Green alert shall be given, and the Code Green Security Response Team will respond immediately to provide assistance.

Background: The Center for Medicare and Medicaid Services (CMS) as part of its Conditions of Participation (COP) provides specific expectations around the use of law enforcement in a hospital setting. The COP's state that hospital patients have a right to care in a safe environment and a right to be free from improper restraints, including not being restrained by law enforcement or being subject to the use of weapons unless they are engaged in criminal activity. Therefore, it is inappropriate for health care facilities to use law enforcement as an extension of their staff to manage patient's behavior. Following an escalation protocol that includes identified members of the hospital workforce is part of ensuring compliance with this rule.

Definitions:

- *Code Green Security Response Team* Identified members of the NMC workforce specifically assigned to assist in the management of a security incident
- *Security Incident* is any event where a person (visitor, workforce member, or patient) creates a disturbance, is threatening in any way or otherwise disturbs the normal business operations.
- *Workforce Members* Employees, volunteers, students, contract workers, business partners or vendors, affiliated educational organizations and other persons whose conduct in the performance of work for Northwestern Medical Center or its wholly owned subsidiaries and its offices or programs, regardless of whether they are paid.

Procedure

A. Initiating a Response for this Policy

1. When a security incident is recognized and an immediate need for security is warranted a call will be made to the Switchboard operator on the emergency extension 4222 by any staff member or volunteer if the incident is located within the hospital, any NMC Suite located at Doctor Office

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Commons or Cobblestone Medical Building as well as surrounding parking lots.

2. When security incidents occur off NMC's campus, staff shall call 911 to request assistance.
3. The staff member or volunteer shall describe the security incident and give its location to the Switchboard Operator or 911 operator.
4. The staff member or volunteer will continue to monitor the security incident and report updates to the Switchboard if safe to do so.
5. NMC staff members shall initiate an event report after the event is resolved.

B. The Switchboard Operator shall:

1. When receiving a call about a security incident the operator shall gather as much pertinent information as possible to include the type of disturbance and its location.
2. The operator shall immediately make an overhead page announcing a code green and location twice. Example: "Code Green, PCU, Code Green, PCU".
3. The operator shall then make a Code Green Security Response Team page which shall include security, safety officer, shift administrator and the Administrator on-call.
4. The operator will then contact security by radio to inform them of the security incident and its location.
5. Continue to monitor the incident and provide assistance when requested.
6. Announce the all clear twice when the Incident Commander/Shift Administrator/Administrator on-call authorizes. "Code Green All Clear, Code Green All Clear".

C. Code Green Response Team shall:

1. Immediately respond to the incident location.
2. Meet with staff to receive a briefing
3. Determine if anyone has an established relationship with person who could assist in de-escalating
4. Assess the situation and determine the best course of action to de-escalate the incident based on Code Green Response Team Procedure.
5. Things to consider include:

    a. Seriousness of the act or crime
    b. Size, age, strength, and weight of the subject
    c. Apparent physical ability of the subject
    d. Weapons possessed by or available to the subject
    e. Known history of violence by the subject
    f. Whether the subject appears to be under the influence of an intoxicating substance

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g. Presence of bystanders
h. Distance from the threat, ability to retreat, and the availability of assistance
i. Mental Health Status (Voluntary vs. Involuntary)

6. Staff shall only use the minimum force necessary to gain control of the security event as outlined in the Use of Force Policy.

7. Request or demobilize resources as needed.

8. NMC does not utilize law enforcement to intervene in the care or treatment of patients which includes and is not limited to assisting in the restraint of patients. Law Enforcement should only be contacted as outlined in the Law Enforcement Involvement in the Healthcare Setting.

D. Leadership Staff member or Shift Administrator shall:

1. Proceed to the scene and assess the security incident to determine if more resources are necessary.

2. Determine if Law Enforcement is needed as per policy.

3. Contact Switchboard Operator when security threat no longer exists and request that an all clear be announced.

4. If a long-term security incident exists consider calling a Code Brown to inform staff of the situation.

E. Ensure a debriefing and event report is completed and submit information to the Emergency Management, Safety and Security Coordinator

F. Training:

1. Each member of the code Green Response Team shall have training in the techniques of de-escalation annually.

2. Each member of the Code Green Response Team shall also have training in the techniques of restraining.

3. At least semi –annually the team will drill the response to a Security Incident to assess its ability to de-escalate and or restraining a person.

Note Well:

This policy applies to NMC hospital, NMC Suites at the Doctor Office Commons, and Cobblestone facilities only. All other facilities report security incidents to law enforcement by calling 911 then contact the hospital and on call leadership member.

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Related Policies:
Use of Force
Law Enforcement Involvement in the Healthcare Setting
Restraint Use
Suicidal or Emotionally Ill Patient, Care of

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

Reviewers:

A. **Key Stakeholders:** Managers
B. **Committees:** Patient Care Committee Environment of Care, Management
C. **Key Process Owner (KPO):** Chris Reinfurt, Coordinator, Emergency Management & Safety

Keywords - Not part of policy: **[ADD Key words for policy search if end user didn't know the name]**

Code Green, Security Event, Security Incident, Security Response

Reviewed 12.17.18 PWH

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 / Psychiatric Emergencies	**Or** **Date Last Revision:** 12/2018
Administration Approval: Maggie Conklin, Interim Chief Nursing Officer	

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:

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 and transport 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:

Rec amended 12.17.18 DH 181

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. NMC defines the SAD PERSONS scale

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. Patient's at a Stage I are cleared and may be appropriate for discharge.

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 NMC Security and/or Code Green Security Response Team if patient's violent or threatening behavior escalates.	X	X	X	X
1:1 observation by NMC staff or security				X
NCSS eval every 12 hours for medically cleared Emergency Examination patients (EE'd) awaiting placement				X

C. Procedure for Maintaining a Safe Environment:

1. All Emotionally Ill or Suicidal patients will be rounded on minimally daily with a multidisciplinary team. All Stage III patients require a face-to-face crisis consult with NCSS, and a "SAFTE" sheet (Appendix B) will be initiated at that time. "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.

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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.
    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. Room checks for safety completed at every change in primary nurse.

Rec'd Acute 12.17.18 DH

12. 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.
13. Assure patient is safe and document patient behavior per risk assessment on the "Observation Flow Sheet" or in electronic medical record.
14. 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. For patients in the custody of Corrections see Inmate Policy
4. NMC staff/security is responsible to maintain visual contact of patient at all times.
5. 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).
6. NMC does not utilize law enforcement to intervene in the care or treatment of patients which includes and is not limited to assisting in the restraint of patients. If law enforcement is not maintaining custody of a patient at NMC, they cannot engage with the patient. See the Law Enforcement Involvement in the Healthcare Setting 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.

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

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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.

Patient's on 1:1 Observation prior to medical clearance and NCSS assessment may be allowed certain items for de-escalation purposes as allowed and documented by treating provider.

Monitoring Plan: N/A

Related Policies:
Restraint Use
Leaving the Hospital AMA
Missing Person (Code Amber) Policy
Law Enforcement in the Healthcare Setting

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:**
   - Deb Durant-Director of Inpatient Services
   - Tyson Moulton - Director of Facilities
   - John Minadeo, MD - ED Medical Director
   - Chris Reinfurt - Emergency Preparedness and Safety Coordinator

B. **Committees:**
   - Patient Care Committee: Approved 12/11/2018
   - Medical Staff: (MEC 10/22/2018)

C. **Key Process Owner (KPO):** JoAnn Manahan, Manager, Emergency Department

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

P.C Accepts 12.17.18 DW

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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

Rx accepted 12.17.18 DW RN

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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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Safety Risk Assessment Tool (SAFTE)

Situation (brief history) _____ Safety risk stage I II III EE

☐ Cleared for Discharge

1:1 Sitter Needed ☐ No ☐ Yes (if Yes, ☐ Care companion ☐ LNA ☐ Security ☐ Law enforcement-if available)

Is patient in the 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? _____

_____

_____ _____ ___/___/___ ___:___ **AM / PM**

Signature NMC RN completing SAFTE Sheet Signature of Physician completing SAFTE Sheet Date Time

_____ ___/___/___ ___:___ **AM / PM**

Signature of NCSS staff consulting Date Time

Dc order 12.12.15 Dw RN

Restraint Use

Applicability: Organizational	**Date Effective:** 6/04
Department: Clinical Services	**Date Last Reviewed:** 12/18
Supersedes: Restraint	**Or** **Date Last Revision:** 12/18
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 alternative, 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.

Background: Non-Violent/Non-Behavioral Restraints are applied to prevent interferences with necessary care and to support medical healing. Violent/Behavioral Restraints are applied for the management of behavior that is violent or self-destructive and/or jeopardizes the immediate safety of

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the patient, staff or others.

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:

I. **Procedure for Non-Violent/Non-Behavioral Restraint:**

A. Registered Nurse (RN) responsibilities for non-violent/non-behavioral restraints:

- Initially assesses patient, documents unsafe behavior warranting the use of restraint.
- Describes patient behaviors posing immediate threat to the safety of the patient.

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- 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.
- The type of restraint selected 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.

B. LIP responsibilities for non-violent/non-behavioral restraints:
   - 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.
   - 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.

   LIP documentation for non-violent/non-behavioral restraints 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

C. Nursing (RN, LPN, LNA or Tech under the direction of an RN) responsibilities for non-violent/non-behavioral restraints:
   - 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.
   - Restraint(s) order(s) written by a LIP in any department may be continued by

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receiving unit upon patient transfer.

Nursing documentation for non-violent/non-behavioral restraints Includes:

- 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

II. Procedure for Violent/Behavioral Management Restraint:

A. Registered Nurse (RN) responsibilities for violent/behavioral restraints:

- Initially assesses patient, documents unsafe behavior warranting the use of restraint.
- Describes patient behaviors posing immediate threat to the safety of the patient, 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 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
- Require a new order if need to reapply restraint

B. LIP Responsibilities for violent/behavioral restraints:

- Views and evaluates the patient for a face-to-face assessment within 1 hour of application of restraint or seclusion of the patient. This face-to-face must occur once every 24 hours.
- The LIP documents findings of their evaluation in the medical record.
- Views and assesses the patient for need for on-going 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.

LIP documentation for violent/behavioral restraints includes:

- Date & time of order
- Specific patient condition/behavior clinically justifying need for restraint

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- Specific type of restraint and location(s)
- Specific start and stop times (see following time frames)
- 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.

C. Nursing (RN, LPN, LNA or Tech under the direction of an RN) responsibilities for violent/behavioral restraints:
   - 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 frequently assesses the patient 's need for continued restraint.
   - An RN may obtain a renewal of a restraint order if continued restraint is clinically indicated, based on assessment of patient condition using the time frames below:
     - 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.
   - New orders may be entered 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

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discontinued early, a new order must be obtained before restraint is reinitiated.

- If the decision is made to discontinue restraints, RN should begin removing restraints as soon as decision is made, and removal of ALL restraints should be completed in the earliest time frame possible.
  - For Example: If patient is sleeping at a 15-minute check, all restraints should be removed during this check as long as each one is removed safely and sleeping and or calm demeanor continues.
- Restraint order written by a LIP in any department may be continued by the receiving unit upon patient transfer.

Nursing documentation for violent/behavioral restraints includes:

- Initial assessment of patient for need for restraint
- Specific reason for the use of restraint
- All less-restrictive alternatives attempted prior to restraint
- Requires 1:1 or frequent monitoring and documentation **every** 15 minutes
- 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.

NMC does not use law enforcement to assist in the restraint of patients. 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 physical hold for restraint application.

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.

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- 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 restrained 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 is considered law enforcement restraint devices and would not be considered safe, appropriate health care restraint interventions for use by hospital staff to restrain patients.

Related Policies:

Suicide/Violent Admitted Observation Patient Precautions
Fall Risk Assessment

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Correctional Center Patient Guidelines
Sentinel Events Policy
Security Event – Code Green
Law Enforcement Involvement in the Healthcare Setting
Use of Force

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 - Medical Director, Emergency Department & Hospitalists
- Jodi Frei - Director of Quality
- Chris Giroux - Manager, Informatics, Data Management and Integration Services
- Chris Reinfurt – Coordinator, Emergency Management and Safety
- Abbie Neville, RN - Clinical Informaticist
- Jane Suder, RN – Manger, Care Management
- Kelly Campbell, RN – Manager, Clinical Education
- JoAnn Manahan, RN - Nurse Manager, Emergency Department
- 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 Coordinator

B. **Committees:**
Patient Care Committee – 12/11/18
Medical Staff Committee

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

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

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NORTHWESTERN MEDICAL CENTER

December 13, 2018

State of Vermont
DAIL/Division of Licensing & Protection
Waterbury, VT 05671-2060

Submitted via email to:
SurvevandCertification@Vermont.gov
and Denise.McCarty@Vermont.gov

Ms. McCarty,

Please find attached a copy of our Plan of Correction resulting from deficiencies noted from the CMS unannounced on-site complaint investigation and follow-up survey performed at Northwestern Medical Center on November 21,2018 through November 23, 2018 from which we received our final report dated December 5,2018.

Sincerely,

Jill Berry Bowen, RN, Chief Executive Officer

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