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

July 22, 2019

Mr. Claudio Fort, CEO
Rutland Regional Medical Center
160 Allen St
Rutland, VT 05701-4560

Provider ID #: 470005

Dear Mr. Fort:

The Division of Licensing and Protection completed an investigation at your facility on **June 27, 2019**. 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 July 22, 2019.

Sincerely,

Suzanne E. Leavitt RN, MS

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

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	470005	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUTLAND REGIONAL MEDICAL CENTER	160 ALLEN ST RUTLAND, VT 05701

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A 000	INITIAL COMMENTS An unannounced, onsite complaint investigation was conducted by the Division of Licensing and Protection on 6/24/19 - 6/27/19 as authorized by the Centers for Medicare and Medicaid to determine compliance with the following Conditions of Participation for Acute Care Hospitals: Emergency Services; Patient Rights & Quality Assurance/Performance Improvement. During the course of the investigation for Complaint # 17743 regulatory violations were identified. Based on the evidence gathered during the investigation, the hospital was determined not to be in compliance with the Condition of Participation: Patient Rights.	A 000	Rutland Regional Medical Center's paramount commitment is to safeguard each patient's right to care in a safe setting. To that end, Rutland Regional has prioritized facility improvements, and increased staffing to continuously improve the safety of patients who are at risk of self-harm. The survey results have provided an opportunity to make additional improvements to policies, forms, communication, teamwork, monitoring and training as described in this Plan of Correction. A number of corrective actions have been completed prior to this submission. The corrective actions applicable to the Emergency Department and the Psychiatric Services Inpatient Unit (PSIU) will be completed by July 26, 2019 and actions that relate to all inpatient units will be completed by August 12, 2019.	7/26/2019
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 observation, interview and record review, the Condition of Participation for Patient Rights was not met as evidenced by the hospital's failure to provide sufficient observation and 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 115		
A 144	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2)	A 144	Action: Updated initial environmental ligature risk evaluations for all inpatient medical units to identify potential risks to be incorporated into environmental risk evaluation process. Completed 7/15/2019.	7/15/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Claudia D. Foot	President & CEO	7/18/2019

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.

tag A115 + A144
PoC accepted
7/22/19 FM/SS

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A 144	Continued From page 1 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 Emergency Department (ED) staff failed to effectively assess for the use of nasal cannula tubing for the delivery of oxygen used by a psychiatric patient with suicidal ideation; and failed to assign qualified staff to provide consistent direct observation of the patient resulting in the patient attempting self-harm by strangulation. (Patient #2) Findings include: On 4/16/19 at 21:13 Patient #2 was brought to the ED via ambulance after ingesting an overdose of prescribed medications to include unknown amounts of Atenolol and Cardizem (both used to treat high blood pressure and cardiac symptoms); and Klonopin (sedative also used to treat seizures, anxiety and panic disorder). Per Emergency Documentation the triage assessment states upon arrival Patient #2 was "....somnolent, arousable only to painful stimuli..." however able to maintain his/her airway. Because of the drugs ingested, Patient #2 was placed on a cardiac monitor to observe changes in heart rate and blood pressure. On 4/17/19 at 01:59 while sleeping, Patient #2's oxygen saturation and heart rate had decreased and the patient was provided oxygen via a nasal cannula at 2 liters. Due to an attempted suicide the patient was placed on 1:1 observations and when medically cleared the patient would be evaluated for a psychiatric admission. At approximately 10:55 AM on 4/17/19 Patient #2 was found to have tied and knotted the oxygen tubing around his/her neck, requiring it to be cut by staff. A red line was noted around the patient's neck, but oxygen level was at 98 % (normal /100%) and heart rate was stable.	A 144	Continued- Action:Highest risk items identified in evaluations included in new form # 4949 "Inpatient Medical-Surgical Patient Safety and Environmental Risk Evaluation." Monitoring: Quality and Safety Department to retain copy of each evaluation. Evaluations to be repeated at least annually or after any significant change in the environment Responsibility: Senior Director of Nursing, Quality and Safety, Training and Education. (Senior Director of Nursing) Vice President of Community and Behavioral Health Action: Create new form #4946D "Patient Safety and Environmental Risk Evaluation" to replace both form #4030a "Suicide Precautions Environmental Risk Assessment" and form #5005 "Safety Observation Form." Form is used to identify and document both safety risks and mitigation of those risks. This form is specific to the Emergency Department and reflects risks present in ED patient care areas. Form finalized 7/15/2019. Monitoring: Copy of revised form Responsibility: Senior Director of Nursing and Vice President of Community and Behavioral Health. Action: Created new process for conducting and documenting Patient Safety Environmental Risk Evaluation to include RN and staff performing 1:1 observation in order to improve supervision of patients at high risk of self-harm. The evaluation (using Form #4946D) will be completed for patients on 1:1 at the following intervals in the Emergency Department: upon admission (rooming) and upon primary RN shift change(s). It also will be conducted and completed upon room change within the Emergency Department.	7/16/2019 7/15/2019 7/26/2019

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A 144	Continued From page 2 Per interview on 6/26/19 at 10:10 AM, the day charge nurse confirmed on the morning of 4/17/19 s/he had requested a replacement of the present psychiatric technician who was assigned to provide 1:1 observation for Patient #2. "I wanted someone more present....better suited for the situation..." The charge nurse further stated the staff member assigned to this responsibility was "...standing across from the patient's room...", not sitting at the entrance to Patient #2's room as required. Per hospital policy Levels of Observation last reviewed on 2/24/17 which states " 2. One to One a. Continuous observation is ordered when a patient is at risk of harm to self or others. When this level of observation is indicated, the following will occur: 2. Staff responsibilities.... Maintain constant view of the patient....avoid placing barriers between staff and patient...Will not become engaged in active conversation with other patients or staff while assigned to the one-to-one. The patient on one-to-one needs will be the complete focus of the staff member doing one-to-one." At approximately 09:00 on 4/17/19 a replacement was found to provide constant observations for Patient #2. At approximately 10:00 a case manager for the mental health agency who provides Patient #2 community services arrives to visit with Patient #2. The visiting case manager left Patient #2's room at approximately 10:30 around the same time a third staff member was relieving the second staff member. Per telephone interview on 6/26/19 at 9:00 AM, the third observer identified to be a Psychiatric Tech I confirmed s/he sat outside the door way of room #11 where Patient #2 was resting. It was further confirmed after visiting with Patient #2 the case	A 144	Continued- Action: The evaluation will be conducted by the patient's primary RN in conjunction with the person providing 1:1 constant monitoring, each of whom will sign the form upon completion Monitoring: Psychiatric Technician Manager will verbally assess patient observer's understanding of environmental risk for a sample of current patients. This will occur 10 times each week for 10 weeks and will be recorded on an audit sheet. Audit sheets will be maintained by the Emergency Department Director. There will be an evaluation at 6-months following completion of 10 week audit period. Responsibility: Senior Director of Nursing and Vice President, Community and Behavioral Health. Action: Created new form #4948 "ED Patient Safety Observation Documentation Worksheet" for use by psychiatric technicians or others performing 1:1 monitoring in the Emergency Department. The form functions as a log to track any activities such as visitors, a change in items allowed in the room, or crisis evaluation over an 8-hour period. Each 1:1 will acknowledge the information on the log by signing at time of handoff. Monitoring: Psychiatric Technician Manager will verbally assess patient observer's understanding of environmental risk for a sample of current patients. This will occur 10 times each week for 10 weeks and will be recorded on an audit sheet. Audit records will be maintained by the Director, PSIU who will review for trends over the course of 10 weeks. There will be an evaluation at 6-months following completion of 10 week audit period. Responsibility: Vice President, Behavioral Health.	7/26/2019

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A 144	Continued From page 3 manager engaged this employee and the previous observer in a distracting conversation at approximately 10:30 about charging Patient #2's cell phone. The Psychiatric Tech I further stated s/he had not observed any oxygen tubing including the nasal cannula in the patient's nose or connected to the oxygen outlet within Patient # 2's room. Also during the "hand-off" with the previous staff member s/he was not alerted to any special safety precautions when monitoring Patient #2, to include the use of oxygen tubing and cardiac monitor lines/cable for a patient who was recently actively suicidal. S/he also added they are not assigned to perform clinical responsibilities, it is not within the job description for Psych Tech I. Per interview on 6/25/19 at 10:00 AM, the ED Director also confirmed Level I Psychiatric Technicians perform essential functions associated with behavioral safety but are not responsible for performing vital signs and would not provide hands on medical care such as the application of oxygen or taking a patient's blood pressure. The charge nurse did confirm when s/he entered Patient #2's room at 10:55 to prepare the patient for transfer to the East Wing by disconnecting Patient #2 from the cardiac monitor and oxygen, s/he observed the oxygen was still flowing and tubing was connected to the wall outlet. Upon further examination the charge nurse discovered hidden under the patient's hospital gown the nasal cannula oxygen tubing wrapped tightly around the patient's neck. Patient #2 did not respond to the nurse's greeting. The charge nurse called for help and the oxygen tubing was cut and removed. Patient #2 was assessed and examined for any possible injury sustained from the attempted strangulation. It was determined	A 144	Action: Created electronic education module titled "ED Environmental Risk Evaluation" used to educate on the policy and practice related to care of patients at high risk of self-harm. Covers identification and mitigation of risk, completion of form #4946D "ED Patient Safety and Environmental Risk Assessment," and related policy changes. Monitoring: Copy of electric education module. The Director of each service will confirm completion of education Responsibility: Senior Director of Nursing and Vice President of Community and Behavioral Health.	7/26/2019
			Action: Conduct education to include: a) electronic education module titled "ED Environmental Risk Evaluation" and b) live training (return demonstration) on evaluation of patient safety risks and completion of form #4946D "ED Patient Safety and Environmental Risk Evaluation." This will be completed by Psychiatric Technicians, ED RNs, ED Technicians, and security staff by 7/26/2019 or before the first shift during which they care for a patient on 1:1 observation. Monitoring: Copy of electronic education module. Report listing staff who have completed this module. Copy of curriculum for live training and return demonstration. Sign-in sheet and documentation of competency for staff who complete live training. The Director of each service will confirm the completion of education. Responsibility: Senior Director of Nursing and Vice President, Community and Behavioral Health.	7/26/2019

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A 144	Continued From page 4 Patient #2 did not sustain injury and was hemodynamically stable with the exception of red marks embedded in the patient's neck. Per hospital policy Suicide Risk Screening and Precautions last revised 6/1/2017 states: " Implementing Precautions: Emergency Department g. The risks presented by the physical environment shall be carefully assessed by nursing staff for all patients for whom suicide precautions have been initiated. 1. The level of patient observation should take into account the degree to which identifiable environmental risks have been addressed. 2. Efforts should be made to reduce the risk of patient self-harm through modification of the physical environment and/or the provision of adequate staff supervision." However, although Patient #2 was placed in a "safe room" within the ED, the additional caution for ligature risks were not acknowledged or addressed by nursing with supervised staff who were providing 1:1 observations. In addition, the form Suicide Precautions Environmental Risk Assessment was not completed by nursing for Patient #2 which allows staff to review and update environmental risks (to include medical equipment) and acknowledged by all staff taking responsibility for observations. The ED Director acknowledged on 6/25/19 at 10:10 AM staff had failed to follow hospital policy related to assuring the safety of the environment for Patient #2. Despite the significant suicide attempt made by Patient #2 prior to ED arrival, the patient's room had not been assessed for ligature risks to include both oxygen tubing and cardiac monitor cables/wires. The intent to ensure patient safety to include close monitoring and awareness of potential risks of self-harm by utilizing medical equipment did not occur during the provision of	A 144	Action: Create new form #4949 "Inpatient Medical/Surgical Patient Safety Environmental Risk Evaluation" to replace both form #4130a "Suicide Precautions Environmental Risk Assessment" and form #5005 "Safety Observation Form." Form is used to identify and document both safety risks and mitigation of those risks. This form is specific to the inpatient medical and surgical units and reflects risks present in those patient care areas. Responsibility: Senior Director of Nursing and Vice President, Community and Behavioral Health. Action: Online education module on form # 4949 "Inpatient Medical Surgical Patient Safety and Environmental Risk Evaluation" will be completed by Inpatient Medical/ Surgical RNs and LNAs by 8/12/2019 or before the first shift during which they care for a patient on 1:1 observation. Monitoring: Copy of electronic education module. Report listing staff who have completed this module. Education will occur annually or upon hire. The Director of each service will confirm the completion of eduction. Responsibility: Senior Director of Nursing and Vice President, Community and Behavioral Health. Action: Revised policy "Suicide Risk Screening and Precautions" as follows: a. A 1:1 observer will be present with the patient at all times, including during meetings with staff not trained in the 1:1 role, and all visitors. b. Other revisions to align policy with updated practice. Monitoring: Conduct initial electronic education to all relevant staff upon hire. The Director of each service will confirm the completion of education	7/17/2019 8/12/2019 7/18/2019

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A 144	Continued From page 5 care for Patient #2.	A 144	Continued- Responsibility: Senior Director of Nursing and Vice President, Community and Behavioral Health.	
A 283	QUALITY IMPROVEMENT ACTIVITIES CFR(s): 482.21(b)(2)(ii), (c)(1), (c)(3) (b) Program Data (2) [The hospital must use the data collected to -.....] (ii) Identify opportunities for improvement and changes that will lead to improvement. (c) Program Activities (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care. (3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained. This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to fully develop and implement preventative actions to address deficient practice and opportunities for improvement, identified as a result of a significant adverse event associated with the care and services provided to a patient in the Emergency Department. Findings include: On 4/22/19 a Root Cause Analysis (RCA) was	A 283	Action: Director of Quality and Safety will track completion of actionable items on all corrective action plans and provide feedback to senior leaders as necessary. Follow up meetings within 28 days of action plan development completion to capture status updates of action items. Systematic review of Corrective Action Plans began 6/24/2019. Tracking sheet created 7/17/2019. Monitoring: Tracking sheet for all Corrective Action Plans will be updated during biweekly Quality and Safety Event review meetings. The Director will report any action that are not completed in accordance with place to the responsible leader and utilize the responsible Leader's chain of command to ensure completion as necessary. Responsibility: Director of Quality and Safety	7/17/2019

tag A 283
POC accepted
7/22/19 FW/SS

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A 283	Continued From page 6	A 283		

conducted by members of the Quality and Safety Department; Emergency Services, Nursing and other staff directly associated with an incident that had occurred on 4/17/19 when a patient attempted self-harm by strangulation using oxygen nasal cannula tubing while on continuous 1:1 observation in the ED. It was not until this significant event had occurred when it was recognized psychiatric technicians assigned to provide 1:1 continuous observation were not being informed by nursing regarding individual patient safety concerns; the apparent difficulties ensuring staff appreciated the intent of hospital policies associated with the responsibilities when providing 1:1 continuous observation; and the failure of staff to consistently conduct suicide precautions environmental safety risk assessments.

Subsequent to the RCA, an Action Plan was developed. However, although communication was sent via email to all ED Nursing and Psychiatric Technicians specifying responsibilities associated with the need for environmental screening, a formal validation process beyond assuring emails were read was not evident. Changes were made to the 1:1 psych technician observation flow sheet, trials of forms are still in progress and although the initial test period was reported to be completed by 5/19/19, a final determination and potentially more revision continued as of 6/27/19.

It was further recognized the case manager for Patient #2 who is employed by Rutland Mental Health in the Community Rehabilitation and Treatment Program (CRT) visitation was upsetting to Patient #2, associating this case manager's visit and later actions and response by

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A 283	Continued From page 7 Patient #2. The communication to CRT staff was to be conducted by the hospital Senior Director of Social Work. When asked for evidence of communication with Rutland Mental Health only an email was noted to exist without any formal process to ensure CRT case managers would acknowledge to ED nursing staff and/or physician their intent to visit with a patient. A brief consultation with ED staff by the case manager, would help facilitate a safe and appropriate encounter with a patient. In addition, reporting off to ED staff after completion of the visit would also be an effective approach when maintaining a behavioral safety plan. The RCA had also identified a need to revise the Suicide Precautions Environmental Risk Assessment (form 4130 A), however no date for completion has been identified and form revision has not been completed as of 6/27/19. The RCA and the plans to correct have not been fully implemented with specific expectations for dates of completion and a monitoring/auditing process to analyze the changes and actions are effective in assuring sustainability of patient safety in the ED.	A 283		
A1112	QUALIFIED EMERGENCY SERVICES PERSONNEL CFR(s): 482.55(b)(2) There must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility. This STANDARD is not met as evidenced by: Based on staff interview and record review, nursing staff in the Emergency Department failed	A1112	tag A 1112 POC accepted 7/22/19 FM/SS	

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A1112	Continued From page 8 to follow policy and procedures to ensure staff were appropriately prepared to provide 1:1 observations of a suicidal patient and failed to complete an environmental risk assessment to include potential ligature risks for 1 applicable patient. (Patient #2). There was also a failure of both ED physicians and nurses to remain compliant with completion of required documentation during the utilization of restraints and emergency involuntary medication as directed per ED policy and procedures. 1. Per hospital policy Suicide Risk Screening and Precautions last revised 6/1/2017 states: " Implementing Precautions: Emergency Department g. The risks presented by the physical environment shall be carefully assessed by nursing staff for all patients for whom suicide precautions have been initiated. 1. The level of patient observation should take into account the degree to which identifiable environmental risks have been addressed. 2. Efforts should be made to reduce the risk of patient self-harm through modification of the physical environment and/or the provision of adequate staff supervision." However, On 4/16/19 at 21:13 Patient #2 was brought to the ED via ambulance after ingesting an overdose of prescribed medications to include unknown amounts of Atenolol and Cardizem (both used to treat high blood pressure and cardiac symptoms); and Klonopin (sedative also used to treat seizures, anxiety and panic disorder). Per Emergency Documentation the triage assessment states upon arrival Patient #2 was "....somnolent, arousable only to painful stimuli..." but able to maintain his/her airway. Because of the drugs ingested, Patient #2 was placed on a cardiac monitor to observe changes in heart rate and blood pressure. On 4/17/19 at	A1112	Regarding "failure to follow policy and procedures to ensure staff were appropriately prepared to provide 1:1 observations of a suicidal patient" please see response to Tag A144 above. Regarding failure "to complete an environmental risk assessment to include potential ligature risks for 1 applicable patient" please see response to Tag A144 above. Regarding failure "of both ED physicians and nurses to remain compliant with completion of required documentation during the utilization of restraints and emergency involuntary medication as directed per ED policy and procedures" please see response to Tag A1112 starting on page 10 below.	

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A1112	Continued From page 9 01:59 while sleeping, Patient #2's oxygen saturation and heart rate had decreased and the patient was provided oxygen via a nasal cannula at 2 liters. Due to an attempted suicide the patient was placed on 1:1 observations and when medically cleared the patient would be evaluated for a psychiatric admission. At approximately 10:55 AM on 4/17/19 Patient #2 was found to have tied and knotted the oxygen nasal cannula tubing around his/her neck, requiring it to be cut by staff. A red line was noted around the patient's neck, but oxygen level was at 98 % (normal /100%) and heart rate was stable. The physical environment for Patient #2 was not assessed as per ED policy. The Suicide Precautions Environmental Risk Assessment was not completed by nursing for Patient #2 which allows staff to review and update environmental risks (to include medical equipment) which must be reviewed and acknowledged by all staff taking responsibility for observations. The ED Director acknowledged on 6/25/19 at 10:10 AM staff had failed to follow hospital policy related to assuring the safety of the environment for Patient #2. Despite the significant suicide attempt made by Patient #2 prior to ED arrival, the patient's room had not been assessed for ligature risks to include both oxygen tubing and cardiac monitor cables/wires. As a result of this failure staff assigned to conduct 1:1 observations were not appraised by nurses of additional safety concerns. In addition, staff assigned to Patient #2 failed to provide continuous observations as directed in hospital policy Levels of Observation last reviewed on 2/24/17. The policy states: " 2. One to One a. Continuous observation is ordered when a patient is at risk of harm to self or others. When this level of observation is indicated, the	A1112	Action: Revised restraint documentation forms for use in the Emergency Department to improve quality, timeliness, and completeness of documentation to ensure the appropriate use of restraints. Restraint packet in Emergency Department now includes the following forms: #4943A "Emergency Department - Behavioral Restraint Packet/Worksheet" #4944B "Nursing Restraint Flow Sheet (ED)" #4945C "Emergency Involuntary Procedures" #4946D "ED Patient Safety and Environmental Risk Evaluation" #4947WKSHT "ED Emergency Procedure Packet Instructions For Restraints." The use of form #4086 "Patient Safety Observation Documentation Worksheet" is discontinued in the Emergency Department. New restraint forms go into use on 7/26/2019. Monitoring: Copy of revised restraint documentation forms. Education as described below. Monitoring: Daily review by Emergency Department Director or designee of restraint documentation for patients restrained in the Emergency Department during the previous 24 hours. Daily review began 7/14/2019. Monitoring: For deficits in documentation: Nursing - email to specific nurse Provider - email to Medical Director and Assistant Medical Director, Emergency Department. Monthly audit of restraint documentation by Quality & Safety Department. Track trends and discuss in the RRMC restraint committee. Responsibility: Senior Director of Nursing, Medical Director of Emergency Services, and Vice President, Community and Behavioral.	7/26/2019

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	470005	A. BUILDING _____ B. WING _____	C 06/27/2019

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A1112	Continued From page 10 following will occur: 2. Staff responsibilities.... Maintain constant view of the patient,...avoid placing barriers between staff and patient...Will not become engaged in active conversation with other patients or staff while assigned to the one-to-one. The patient on one-to-one needs will be the complete focus of the staff member doing one-to-one." Per interview on 6/26/19 at 10:10 the day charge nurse in the ED confirmed a staff member who was providing 1:1 during the early hours of 4/17/19 from 7:15 to 9:00 was distracted at times and not sustaining observations in close proximity of the patient. In addition, during the "handoff" between staff assigned to observe the patient at approximately 10:30 were engaged in conversation with a case manager who had visited Patient #2. Patient #2 reported later to staff, the visit by the case manager had been significantly upsetting to her/him resulting in the emotional distress. Conversation and concerns between Patient #2 and the case manager were not noted by the 1:1 observers, nor were they able to identify a period in time when the patient was able to perform the attempted strangulation using the oxygen nasal annular tubing. There was a failure of both nursing staff and ED physicians to complete necessary documentation during the application of restraints and emergency medications for 2 of 10 applicable patients (Patients # 3, 8): 1. Patient #3 was brought to the ED on 3/28/19 at 17:05 by police after being arrested and later expressing suicidal and homicidal ideation. Patient #3 became agitated and threatening and did not respond to multiple attempts by staff to de-escalate. Due to ongoing combative and threatening behavior 4 point restraints were	A1112	Action: Revise electronic orders for restraints utilized by Emergency Department Physicians to simplify options in drop-down menu for type of restraint used to improve consistency in restraint order documentation. Monitoring: Ongoing restraint documentation monitoring by Emergency Department Leadership and Quality and Safety Department. Responsibility: Senior Director of Nursing, Medical Director of Emergency Services, and Vice President, Community and Behavioral Health Action: Education titled "Emergency Medicine: De-escalation and Restraint Education" and case study with discussion occurred at Emergency Medicine Medical Staff Section meeting on 7/16/2019. Email with expectation of review of education materials sent to any providers unable to attend meeting. Monitoring: Copy of PowerPoint presentation, copy of case study, copy of email sent to providers following meeting, copy of meeting attendance list. Education will be provided annually or upon hire. The effectiveness of the restraint education will be confirmed by the ongoing monitoring of restraint documentation conducted by the Emergency Department Leadership, and the Quality and Safety Department. Responsibility: Senior Director of Nursing, Medical Director of Emergency Services, and Vice President of Psychiatric Services Action: Created electronic education module titled "ED Behavioral Restraint Process" used to educate on the policy and practice related to care of patients at high risk of self-harm.	7/16/2019 7/26/2019

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A1112	Continued From page 11 ordered and applied at 18:25. The Patient Evaluation form must be completed within 1 hour of initiation of emergency procedures and completed by the ED physician or a specially trained RN. The date/time of the evaluation was not documented by the physician who conducted the 1 hour face to face. In addition, emergency involuntary medications Geodon 20 mg and Benadryl 25 mg were administered intramuscularly to Patient #3. The nurse failed to document the time of administration of the medications on the Emergency Involuntary Procedures form. 2. Patient #8 was brought to the ED by police on 5/17/19 at 17:20. Patient #8 was described as belligerent, combative and threatening. Shortly after arrival involuntary emergency medications were administered to include Haldol 4 mg and Ativan 2 mg intramuscularly and 4 point restraints then applied at 17:25 and were discontinued at 19:05 The 1 hour face to face was not conducted until 19:30, 2 hours after the application of restraints. In addition, on the Nursing Restraint Flow Sheet nursing staff failed to describe the patient's actual behavior while in restraints. During the 15 minute monitoring from 18:25 to 18:55 a nurse documents " Non-compliant with disc.criteria" within the column on the form intended for staff to describe the actual behavior demonstrated by Patient #8 to justify the continued use of 4 point restraints. Per hospital policy Restraints and Seclusion: Behavioral last revised on 1/12/18 states: "6. Documentation for the use of Behavioral Restraint and/or Seclusion shall include: b. a description of the patient's behavior...." Per interview with the Quality Manager on 6/27/19 at 2:30 confirmed staff documentation was not meeting the intent of the hospital policy.	A1112	Continued- Action: Covers proper process for initiating and discontinuing restraints, necessary documentation (both completion of documents in new restraint packet and documentation in EMR), and related policy changes. This will be completed by ED RNs by 7/26/2019 or before the first shift during which they work following that date. Monitoring: The effectiveness of the restraint education will be confirmed by the ongoing monitoring of restraint documentation conducted by the Emergency Department Leadership, and the Quality and Safety Department. Responsibility: Senior Director of Nursing, Medical Director of Emergency Services, and Vice President, Community and Behavioral Health. Action: Job aids created 7/15/2019, including a reference binder that includes instructions, by role, for each task required as part of a restraint. Binder is available at two ED nursing stations or from ED Director or designee to be used as a reference for staff as they are documenting and/or reviewing the documentation of restraints. Form #4947 "ED Emergency Procedure Packet Instructions For Restraints" created. This is a checklist of all steps related to restraint documentation and is included in revised restraint packet. Monitoring: Copy of restraint binder. Copy of Form# 4947 "ED Emergency Procedure Packet Instructions for Restraints." The effectiveness of the restraint education will be confirmed by the ongoing monitoring of restraint documentation conducted by the Emergency Department Leadership, and the Quality and Safety Department Responsibility: Senior Director of Nursing, Medical Director of Emergency Services, and Vice President, Community and Behavioral Health.	7/26/2019 7/15/2019

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			Continued-	
			Action: Revised policy "Restraints and Seclusion: Behavioral" to align with updated practice. Education to occur via electronic education module "ED Behavioral Restraint Process" as above. Monitoring: Copy of revised policy, copy of electronic education module. Report listing staff who have completed this module. Education will occur annually or upon hire. Responsibility: Senior Director or Nursing, Medical Director of Emergency Services, and Vice President, Community and Behavioral Health.	7/18/2019
			Action: Provide periodic education to Emergency Department nursing staff on special issues related to the care of psychiatric patients. The first education module is "Borderline Personality Disorder - Case Study" to be completed by ED RNs, psychiatric technicians, and ED technicians by 8/12/2019. Action: Additional Education to be provided twice yearly. Monitoring: Emergency Department Nurse Leaders will monitor the effectiveness of education through day-to-day clinical oversight. Responsibility: Senior Director of Nursing, Medical Director of Emergency Services, and Vice President, Community and Behavioral Health	8/12/2019
			POC accepted 7/24/19 FMLSS	