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

June 24, 2024

Robert Adcock, CEO
Springfield Hospital
Po Box 2003
Springfield, VT 05156-2003

Dear Mr. Adcock:

The Division of Licensing and Protection completed a complaint investigation at your facility on **May 24, 2024**. The purpose of the survey was to determine if your facility met the conditions of participation for Critical Access Hospitals found in 42 CFR Part 485.

Following the survey, your facility submitted a Plan of Corrections (POC), which was found to be acceptable on **June 24, 2024.**

Sincerely,

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
	471306	A. BUILDING _____ B. WING _____	C 05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD HOSPITAL	PO BOX 2003 SPRINGFIELD, VT 05156

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 000	INITIAL COMMENTS An unannounced on-site investigation of an anonymous complaint was conducted on 5/7/24 and completed on 5/23/24 by the Division of Licensing and Protection to determine compliance with the Conditions of Participation for Critical Access Hospitals at 42 CFR. Part 485, Subpart F. The following regulatory violations were identified for complaint #22393 under Provision of Services; Construction & Quality Assurance/Performance Improvement.	C 000		
C 912	CONSTRUCTION CFR(s): 485.623(a) The CAH is constructed, arranged, and maintained to ensure access to and safety of patients, and provides adequate space for the provision of services. This STANDARD is not met as evidenced by: Based on observation and interview the CAH (Critical Access Hospital) failed to ensure the Emergency Department's (ED's) environment maintained patient safety as evidenced by failing to secure a supply room that contained sharps and other healthcare supplies that could be accessed by any passerby. Findings include: During a tour of the ED on 5/21/24 at approximately 10:15 AM with the ED Nurse Manager and the Assistant Director of Nursing, a supply room located in the hallway near beds 7, 9, 10, & 11 was noted to be open and unsecured allowing anyone to access. This hallway was a high traffic area for which patients, visitors, and staff moved about in the ED. Some of the items found in the store room were, "Pedialyte (oral electrolyte solution for children), Chlorox Bleach wipes, Hibiclens solution 32 oz (antibacterial	C 912	**C912 ACTION PLAN** - Supply Room (now labeled as SUPPLY ROOM A) will have a coded lock/badge access lock installed to restrict entry to qualified staff only. Additionally, the Supply Room door will be fitted to automatically close and will not be propped open for general access. A dual-door supply cabinet (now labeled as Supply Cabinet 1) adjacent to nursing station, will be outfitted with a lock to restrict entry to qualified staff only. This cabinet contains critical items for immediate patient care. A dual-door supply cabinet (now labeled as Supply Cabinet 2) adjacent to the Trauma room, will be outfitted with a lock to restrict entry to qualified staff only. This cabinet contains critical items for immediate patient care.	**C912** Completion Date July 8, 2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert S. Adcock | TITLE: CEO | (X6) DATE: 6/17/24

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

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C 912	Continued From page 1 cleansing solution), germicidal surface wipes, 20g IV catheters (needles used to put in IV's), 22g IV Catheters, 18g IV catheters, Butterfly 21G (needles used to draw blood), Butterfly 23G, Normal saline flushes (syringes containing sodium chloride commonly used to flush IV's), RX destroyer formula (material used to destroy medications), and "Gallant disposable prep razors". Per interview at that time with the ED Nurse Manager, S/He confirmed that the supply room was open and "never" locked and anyone could access.	C 912	**C912 RESPONSIBLE PARTY** - Assistant Nurse Manager of the Emergency Department **C912 MONITORING/AUDITING** - The responsible monitoring function and assurance of future compliance will be performed by the ED Nurse Manager who will educate and advise existing staff as well as new staff and travel nursing on the criticality of keeping potentially harmful items accessible only by qualified staff. Training will be documented during on-boarding and records retained through training records, subject to QA Audit.	
C1006	PATIENT CARE POLICIES CFR(s): 485.635(a)(1) (1) The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law. This STANDARD is not met as evidenced by: Based on interviews, record and policy review the CAH failed to ensure care was provided in accordance with written policies and procedures regarding the use of chemical and physical restraints for 1 applicable patient (Patient #11). Findings include: Per review of nursing triage notes from 2/01/24 at 09:50, Patient #11 arrived at the ED via ambulance accompanied by police. The patient had come to the ED after calling 911 numerous times. Upon arrival the patient was "praying and yelling" at the EMS squad and not able to communicate effectively with the ED staff. Per review of nursing progress notes from 2/01/24, at 09:43 AM, "Lorazepam (anti-anxiety medication) IM (intramuscularly) 2 mg (milligrams) given" in right ventral gluteus	C1006	**Tag C912 POC accepted on 6/24/24 by M. McIntosh/S. Leavitt** **C1006 ACTION PLAN** - A computer field will be added to the T System orders (CPOE) forcing the provider to describe the medication(s) indication for use. This forcing function will disallow the provider to complete the order without inputting a reason for medication administration. Training on the new forcing function will take place 06/25/2024 with training reenforcement and policy updates occurring simultaneously. Other key actions: new policies and procedures (New Restraint Policy developing under interdisciplinary work group; a New EMTALA Policy; a New Order Form for Restraints to include indication requirement and face-to-face requirements (Note EMR build will be Oct 1, 2024 however paper based will be complete by 07/31/2024 commitment), new Observation Tool for restraints with New Restraint Use Audit Tool (Nursing) and New Restraint Use Audit Tool (Quality), using blended Online learning, practicum and violent/aggressive patient table top drills.	**C1006 Completion Date** 10/01/24 with interim milestone action completion in preceding months

RSA 6/17/24

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C1006	Continued From page 2 (bottom) ...at 09:53 AM, "Diphenhydramine (antihistamine) IM 50 mg given" in right ventral gluteus ...at 09:53 AM "Lorazepam IM 2 mg given" right anterior thigh. Review of "Medication Orders" reveals these medications were ordered; however, there was no indication and/or documentation in the record as to why these medications were given. Per interview on 5/22/24 at 2:03 PM with an ED provider, S/He stated that S/He does not use "chemical restraints" and that if a patient was hallucinating and/or violent they would treat the patient's symptoms with medications to ensure safety. At 10:00 AM a nursing progress note states, "Patient yelling and fighting with the police and EMS staff as well as hospital staff. Patient attempted to be calmed down with a staff hold. Patient continues to yell, scratch, bite towards the staff as well as attempting to throw (him/her-self) off stretcher. ED physician ordering 4 point locked restraints." Review of the physician's "General Orders" dated 2/01/24 reveal, "Restraints protocol (4 point locked)" were ordered at 10:58. There was no documentation in the record of an order for the physical hold noted above. A providers note, from 2/01/24 [signed at 17:41] states that Patient #11, "was found extremely anxious and aggressive ...Multiple de-escalation attempts were performed without avail. Intramuscular medications were given to treat agitation with little to no improvement. 4 point restraint was then placed after patient started biting ...self and attempting to bite and scratch ED personnel ...Patient reassessed at the bedside	C1006	**C1006 RESPONSIBLE PARTIES** - ED Nursing Manager and Medical Director of the ED and Director of Quality **C1006 MONITORING/AUDITING** - Dept leaders will continue to monitor chart daily to ensure that the providers are using appropriately. A comprehensive new policy and procedure review will be the primary topic at July 2024 Dept Staff Meeting with documentation of attendance and attestation by all involved staff. Because of the degree of process change and the criticality of adherence, Restraint Education and Patient Bill Of Rights education will be implemented as mandatory for ED Staff, including Nursing, Contract ED Providers, Employed Hospitalists, Respiratory Therapy, Pharmacy and Contracted Security. SPH will be vetting policy changes and new policies through a review committee process. An aggressive test-and-learn approach will be employed and documented. 100% of restraint care will be audited by Nurse Manager, with a distinct and separate audit by quality department to ensure ongoing compliance with policy and procedures. **Tag C1006 POC accepted on 6/24/24 by M. McIntosh/S. Leavitt**	

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C1006	Continued From page 3	C1006		

after 4-point restraints were removed." There was no documentation in the record that a face-to-face evaluation of the patient was done by a provider within 1 hour of the application of the restraints.

Per interview on 5/23/24 at 1:38 PM with the ED Nurse Manager, S/He confirmed that a physical hold is a restraint, that a physician's order is required, and that there was no order documented in the record for Patient #11. S/He stated that when Ativan (Lorazepam), Haldol (antipsychotic medication), and Benadryl were used for a patient with behaviors that are violent or self-destructive those medications were considered chemical restraints. At 3:21 PM the Nurse Manager further confirmed that there was no documentation in the record that a face to face was done by a provider within one hour of restraint application for Patient #11 per the hospital policy.

The Restraint and Seclusion Policy-Approved 12/14/2021, states for " Violent or Self Destructive Restraint and/or Seclusion-Patients may be subject to Restraint and/or Seclusion, including medications used as a restraint, in emergency situations where their behavior is violent or self-destructive and jeopardizes the immediate safety of the patient, a staff member, or others, and less restrictive methods of managing the behavior would be ineffective ... MD, DO, PA-C or APRN responsibilities...Issuing an order, or declining to issue an order ...Completing a face to face evaluation ...within one (1) hour of the initiation of Violent or Self-Destructive Restraint and/or Seclusion ...Definitions...Drug used as a Restraint means where a drug is used to manage the patient's behavior or restrict the patient's

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C1006	Continued From page 4 freedom of movement and is not a standard treatment or dosage for the patients' condition ...Restraint means any manual method, physical or mechanical device, material, or equipment that involuntarily immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely ...Methods of Restraint and Applications of Restraint...Physical Hold...A Physical Hold involves holding a patient in a manner that restricts the patient's movement against the patient's will. This is considered a restraint."	C1006		
C1008	PATIENT CARE POLICIES CFR(s): 485.635(a)(2) , 485.635(a)(4) §485.635(a)(2) The policies are developed with the advice of members of the CAH's professional healthcare staff, including one or more doctors of medicine or osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists, if they are on staff under the provisions of §485.631(a)(1). §485.635(a)(4) These policies are reviewed at least biennially by the group of professional personnel required under paragraph (a)(2) of this section, and reviewed as necessary by the CAH. This STANDARD is not met as evidenced by: Based on interviews and policy review the CAH failed to ensure the policies for restraints/seclusion and EMTALA were reviewed and updated biennially. Findings include: 1.) Per review, the CAH's "Restraint/Seclusion Policy" was implemented on "2/1/2002" and was last approved on "12/14/2021". There was no documentation that shows this policy has been reviewed and/or updated since this time.	C1008	**C1008 ACTION PLAN** - Finding 1 - A new Restraint Policy will be developed by an interdisciplinary team. Finding 2 - A new and detailed EMTALA policy is being developed and routed through a comprehensive campus-wide review cycle. Final review and approval of both policies are planned for July 2024 Clinical Practice Committee Meeting, Medical Executive Committee and Board meetings completion date July 31, 2024. New and approved polices will be uploaded into new policy system (PowerDMS) with access to all Springfield Hospital staff and providers. Completion date July 31, 2024. Education on new restraint policies and practices will be completed with all ED staff, inpatient staff, and providers.- October 1, 2024 EMTALA education will be completed by all staff and providers by October 1, 2024. The policies will be integrated into our new hire, provider, and travel orientation.	**C1008 Completion** 10/01/2024 with interim milestones completed in preceding months

BSA 6/14/24

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C1008	Continued From page 5 Per interview on 5/23/24 at 3:10 PM with the Quality/Improvement/Risk Manager, S/He stated that the hospital's Director of Quality left the hospital in December and that "Quality was on hold" since that time. The interim Chief Nursing Officer (CNO) stepped in to manage the quality program; however, it was at a very broad level. S/He confirmed that the CAH was aware that the restraint/seclusion policy should have been reviewed and updated and it was not done. 2.) The EMTALA (Emergency Medical Treatment and Labor Act) requires hospitals with Emergency Departments (ED) to provide a Medical Screening Examine (MSE) to any individual who comes to the ED and requests such an exam, and prohibits hospitals with an ED from refusing to examine and treat an individual with an emergency medical condition. Per review of the CAH policy Patients Seeking Care in the Emergency Department last approved on 1/15/2020, was insufficient, outdated (must be reviewed biannually) and did not reflect the necessary requirements/components necessary for the CAH ED to maintain compliance with EMTALA requirements. ED staff confirmed this was the only policy available.	C1008	**C1008 RESPONSIBLE PARTY -** The Department Director assigned as Key Policy Owner is responsible for the policy life cycle and ensuring the policy meets regulatory compliance. **C1008 MONITORING/AUDITING -** The new policy system will trigger mandatory review. Approval governance is based on job title and senior leadership final approval. The Quality Department has an obligation and responsibility to monitor new regulatory COPs to ensure compliance. This will be a standing agenda item for Quality Committee. **Tag C1008 POC accepted on 6/24/24 by M. McIntosh/S. Leavitt**	
C1306	QAPI CFR(s): 485.641(b)(2), (b)(3) (b) Standard: QAPI Program Design and scope. The CAH's QAPI program must: (2) Be ongoing and comprehensive. (3) Involve all departments of the CAH and services (including those services furnished	C1306	**C1306 ACTION PLAN background -** Springfield Hospital has a new Senior Leadership Team that is committed to a successful transition to a well-structured and governed Critical Access Hospital.	

RSA 6/14/24

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C1306	Continued From page 6 under contract or arrangement). This STANDARD is not met as evidenced by: Based on staff interview and record review, there was a failure of the CAH to ensure the QA/PI (Quality Assurance/Performance Improvement) was ongoing and comprehensive involving all hospital departments. Findings include: Per interview on 5/23/24 at 2:15 PM staff identified to be part of QA/PI confirmed due to staff changes in December 2023, "Quality was on hold". Staff further stated for the past 5-6 months any CAH QA/PI activities stopped functioning leaving only limited guidance to re-establish the QA/PI program. Staff confirmed the QA/PI program was not ongoing or comprehensive as required. However, it was noted a interim QA/PI consultant had been contracted 1 day per week to assist QA/PI staff in the redevelopment of the program.	C1306	**C1306 ACTION PLAN background, cont. -** There has been turnover of staff and replacement leaders added, that have the core competencies to move the necessary work forward. The organization is committed to providing education, resources, and leadership development for the team in place. The following is a recap of Quality activities Since December 2023 December 2023: The VP of Quality, Risk, and Compliance and Technology Management Systems departed Springfield Hospital. Lori Profota, Interim COO/CNO assumed responsibility for Quality and Clinical Applications Departments. A role and responsibilities assessment of all staff in the department was completed. Activity inventories were used to assess daily work. A current state assessment was completed to include practice, policy, procedure for occurrence reporting, quality improvement work, quality of care monitoring, and regulatory readiness. Recent priorities/projects in progress prior to receipt of the Statement of Deficiencies: Create a Quality and Committee Structure for the organization- approved at Board of Directors and Medical Staff. BoD and Med Staff will participate in the policy approval processes in new policy system. Develop daily procedures for review of all occurrence reporting – develop criteria for clinical review QA, revised focus on RCA process. NOTE - Additional page added - total 8 pages	

Tag C1306 POC accepted on 6/24/24 by M. McIntosh/S. Leavitt

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FACILITY ID 471306

C1306 ACTION PLAN, cont. recent priorities/projects in progress prior or partially completed prior to receipt of the Statement of Deficiencies: Created internal documents that identify all reporting requirements and associated person department responsible. Developed Quality education for department staff, and department leaders. Objective to develop quality knowledge foundation and begin work toward identification of Annual Review of Services Plans to include annual QA/QI plan per department. Department staff will review current state workflows for complaints, participation on committees and focus on the identified priorities. SPH hired a permanent Director with the experience and competencies necessary to strategically move the organization forward using a culturally competent, safe, efficient, effective, and relationship-based approach.

January 2024

CNO hired a known colleague who is an experienced quality resource Advanced Practice Nurse. They were hired to work per diem (8-16 hours a week) to work on priorities with department staff to mentor and coach on quality. Early development of structures and processes to support a Quality/Risk tracking and reporting system of all patient care that is provided within the Springfield Hospital System. Work included the following:

- Reviewing the standards of care required by critical access hospital accreditation standards that related to each specialty, identifying what indicators need to be tracked on a systematic schedule (CNO Implemented Standards of Care project for IPCU).
- Created an ongoing education curriculum on Quality and Risk
- Defined the quality process and introduced PDSA auditing (Plan, Do, Study, Act)
- Educated staff how quality and safety relates to patient care outcomes.
- Initiated the development of policies and scope of services for each department, identifying reporting structure and accountability
- Identified the reporting structure (who, what, when, outcomes) of the data revealed
- Completed education on how to enter an occurrence report– Role of Manager/Director in Event Reporting and Resolution

New Policy and Procedures governance structures and policy systems implementation

- Convened Policy Steering Committee
- Developed Overarching Policy and Procedures – Governing Policies and Procedures.
- Developed new templates for policy, procedure, protocol, standing orders, guidelines.
- Created a new Quality and Committee Structure for policy management and approval.
- Piloted sev'l workflows and system improvement goals with small group of policies via steering committee.

Jan/Feb/ March 2024

- Piloted the new governance process, tools(templates) and use of system with two moderate size departments: The Windham Center and Pharmacy. Focused on review of all old polices, tested new review processes, retired polices and developed training for the policy owners.

Pharmacy: Identified 129 policies/procedures to review

Pharmacy – 40 policies/procedures have been reviewed, updated and approved since January. Twenty-one (21) archived.

Windham Center- 42 policies/procedures have been reviewed and approved and added to the PowerDMS(R) platform* since January. Fourteen archived.

- Developed new job description for Director Quality, Risk and Compliance. Position posted externally and candidate submissions reviewed ,candidates interviewed. Michael Sutch, MT(ASCP), CPXP, CPHQ, CPHRM was successfully recruited and hired with a start date of May 6, 2023.

April 2024: A Per Diem(10 hours week), experienced quality, risk and informatics RN was hired to assist with a large project focused on the standardization of all forms and standardization of all Order Set development.

April 18, 2024 Presentation - Quality education provided to all Department Directors at the April Key Managers meeting. Introduction to concepts of quality healthcare employing the PDSA Model.

April/May 2024

- May 6, 2024 - New director for Quality Risk and Compliance started full time employment.
- Rolled out new policy and procedure platform to additional department directors.
  - Cardiopulmonary
  - Environmental and Nutritional Services
  - Adult Day Services
  - Diagnostic Imaging
  - Emergency Department
- Convened New Peri-Operative leadership Committee- New Membership. Focused on P&P, QA,QI

June 2024

June 3, 2024 - Sunsetted our former Patient Care Policy and Procedure Committee and convened our new Clinical Practice Committee, including new committee membership and charter.

Implementation Plan for Power DMS finalized to roll out to all employees beginning 6/15/2024.

C1306 ACTION PLAN- Completion Date 08/19/2024 (with interim milestone completion in preceding months)

- Introduce QI/QA Plan at Department Head Meeting July 2024
- All Department Directors- Review Scope of Services and Complete an Annual Review of Service Plan to include QA monitoring goals/ plan and QI plans.
- Implement Provider Peer Review
- Develop Policy and Procedure -Approve through Med Exc in July- August 2024
- Convene Committee in July
- Reconvene Board Quality Committee
- Convene internal Hospital Quality Committee - a work-group is charged with the oversight of Quality Metrics, Annual Review of Services, to ensure the Quality Committee Structure (QA/QI Plan) outputs are met.

**PowerDMS is a commercial software platform to manage, distribute and track policies and procedures*

C1306 RESPONSIBLE PARTY/MONITORING/AUDITING - Quality Department

RSA
6/17/24