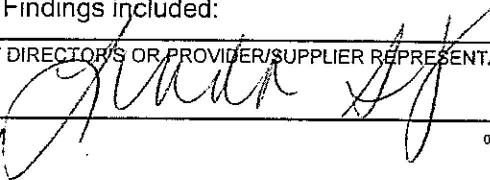
MA DPH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	220008	A. BUILDING ______ B. WING ______	01/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STURDY MEMORIAL HOSPITAL	211 PARK STREET ATTLEBORO, MA 02703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
P 000	INITIAL COMMENTS An Onsite Licensure Survey was conducted in response to a complaint received by the Department of Public Health (reference # 06-1518).	P 000		
P 009	130.200 Inc of Medicare Condi of Participation in Hos Each hospital shall meet all of the requirements of the Medicare Conditions of Participation for Hospitals, 42 C.F.R. 482.11 through 482.62 (hereinafter Conditions of Participation), as they may be amended from time to time, except the requirement for institutional plan and budget specified in 42 C.F.R. 482.12(d), for utilization review specified in 42 C.F.R. 482.30, the requirement for compliance with the Life Safety Code specified in 42 C.F.R. 482.41(b), and any requirement that conflicts with the supplementary standards in 105 CMR 130.000 Subparts C and D. This Requirement is not met as evidenced by: I. Based on interview and documentation review the Hospital was not in compliance with Standard A-0079 (In accordance with the order of a physician or other licensed independent practitioner permitted by the State and hospital to order seclusion or restraint.) of the Conditions of Participation Patients' Rights (4842.13) because it failed to ensure restraints were utilized in accordance with a physician order in one of one applicable medical record reviewed. Findings included:	P 009	RECEIVED 2007 FEB -2 PM 1:29 HEALTH CARE QUALITY Physician #1 signed the first order for seclusion at 2100. As part of the order there was a face to face assessment within one hour of the order that the physician attests to. It is not a practice of our ECC physicians to write progress notes, there-fore we have used the order sheet to document the face to face assessment. (See Attachment A.)	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE: President and CEO

(X6) DATE: 1/31/07

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P 009	Continued From Page 1 Review of 8/12/06, 2:30 AM nursing documentation indicated the the Patient behavior became aggressive and included clenching his fists and charging the door. At 2:35 AM, when the police were present, the Patient was placed in 4 point leather restraints. ED Physician #1 was interviewed in person on 1/8/06, at 1:30 PM. She said she had ordered Haldol and Ativan administered and probably ordered the restraints at the same time. Review of ED Physician #1 ' s, 8/12/06 2:00 AM through 5:00 AM, restraint and seclusion orders did not indicated there was a written order for the utilization of leather limb holders . Review of 8/12/06, 7:30 AM nursing documentation indicated when nursing staff entered the Patient ' s room to administer the ordered medications he was seated in a chair and he requested to be placed in restraints. Review of 8/12/06 the Security Officer ' s documentation indicated 4 point restraints were applied at 7:25 AM at the direction of nursing staff. Review of ED Physician #2 ' s, 8/12/06 6:45 AM through 9:00 AM, restraint and seclusion orders did not indicated there was a written order for the utilization of leather limb holders . II. Based on documentation review it was determined the Hospital was not in compliance with Standard A-0082 (A physician or other licensed independent practitioner must see and evaluate the need for restraint or seclusion within 1 hour after the initiation of this intervention.) of	P 009	At 0230 the patient's behavior changed. The police were called and with the physician, nurse, police, and security present the patient was placed in leather restraints for 10 minutes. The physician reported to the interviewer that she "probably ordered restraints at that time". The physician could not remember the patient and used the word "probably" because that would have been her practice. The nurse, when interviewed by the Director of Ambulatory Services stated there was no doubt in her mind that there was an order for restraint, however, due to the short time frame she neglected to revise the written order but documented it in her ECC nursing note. There was a written order at 0500 by physician #2 on the first page of the restraint orders form. At 0730 the patient requested restraints be placed back on prior to being medicated. Documentation of patient reassessments had carried over to a second page of restraint orders and it was on this page that the documentation for limb holders and leather limb holders was added to coincide with the application of restraints. This was confusing because the order was on one page and the reassessment and application on a second page. (See Attachments A & B).	

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NAME OF PROVIDER OR SUPPLIER: STURDY MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE: 211 PARK STREET ATTLEBORO, MA 02703		

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P 009	Continued From Page 2 the Conditions of Participation Patients' Rights (4842.13) because it failed to ensure a face to face assessment was performed to determine 4 point restraints were an appropriate intervention in one of one applicable patient record review. Findings included: Review of 8/11/06-8/12/06 physician documentation did not indicate a face to face evaluation was performed within 1 hour related to the utilization of 4 point restraint on the Patient. III. Based on documentation review it was determined the Hospital was not in compliance with Standard A-0085 (After the original order expires, a physician or other licensed independent practitioner [if allowed under state law] must see and assess the patient before issuing a new order.) of the Conditions of Participation Patients' Rights (4842.13) because it failed to ensure an assessment was performed prior to the issuance of a new order for seclusion in one of one applicable medical records reviewed. Findings Included: Review of 8/12/06 and two undated Alternative/Restraint & Seclusion Record documentation indicted the Patient remained in seclusion, for greater than 24 hours. Review of 8/12/06-8/13/06 physician documentation did not indicated the Patient was assessed for the need to continue seclusion before a new order was issued. IV. Based on documentation review it was	P 009	We have amended the restraint form used in the ECC to make this clearer to reviewers. (See Attachment C.) Education on the new form has included: 1) presentation at the ECC January staff meeting for discussion and input; 2) posted to staff at large; 3) discussed at January physician meeting. Copies of the new form were distributed, highlighted, and discussed. Face to face assessments are part of the physician's order (See Attachment A.) It is not the practice of our ECC physicians's to write progress notes. Nursing documentation supports that the physician was in the room either prior, during, and/or after restraint application. There is also overlap between physicians, e.g. both physician #1 and physician #2 were evaluating the patient during the same shift. A third ECC physician was also involved in the restraint use.	

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P 009	Continued From Page 3 determined the Hospital was not in compliance with Standard A-0230 (All entries must be legible and complete, and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished.) of the Conditions of Participation Medical Record Service (482.24) because it failed to ensure all documentation was dated and timed in one of one applicable medical record reviewed. Findings included: Review of Alternative /Restraint and Seclusion Record documentation did not indicate physicians orders for the utilization of restraints were dated or that Alernative/Restraint & Seclusion Record documentation was consistently dated.	P 009	We agree that the date was not consistently included on the forms. This was an oversight on our part when the form was developed because of the documented time lines of assessment and reassessment. We have amended the form to include the date. See Attachment C. Conclusion: While we agree that the form was confusing and inconsistently dated, we do not agree that the patient's complaint that he was inappropriately restrained was valid. Documentation reviewed and interviews conducted by the DPH investigator clearly support the need for restraint. The nurses never felt they lacked an order for restraint and there is documentation of a physician face-to-face performed associated with each order.	1/31/07