

**State of Connecticut
Department of Public Health
Division of Health Systems Regulation**

IN RE: Bristol Hospital, Inc.
 Brewster Road
 Bristol, CT 06010

CONSENT ORDER

WHEREAS, Bristol Hospital, Inc. (Licensee), has been issued License No. 0041 to operate a General Hospital known as Bristol Hospital, Inc. (Facility) under Connecticut General Statutes Section 19a-490 by the Department of Public Health (Department); and

WHEREAS, the Department's Division of Health Systems Regulation conducted an investigation commencing on July 14, 2003, up to and including August 4, 2003; and

WHEREAS, the Department during the course of the aforementioned inspections identified violations of the Regulations of Connecticut State Agencies in an amended violation letter dated January 21, 2004 (Exhibit A – copy attached); and

WHEREAS, both the Licensee and the State of Connecticut, Department of Public Health understand that the Licensee has entered into this Consent Order to bring this matter to resolution short of a formal hearing. The Licensee disputes various parts of the alleged violations, including but not limited to, claims of an alleged facility failure to assess lab work prior to patient undergoing surgery and/or an alleged failure to properly intervene. Entering into this Consent Order is not to be construed as an admission of liability on the part of the Licensee, by whom liability is expressly denied.

WHEREAS, the Licensee agrees to the conditions set forth herein.

NOW THEREFORE, the Division of Health Systems Regulations of the Department of Public Health acting herein by and through Marianne Horn, its Director, and the Licensee acting herein by Thomas Kennedy III, its President and Chief Executive Officer, hereby stipulate and agree as follows:

1. Within fourteen (14) days of the execution of this document, the facility shall develop and/or review and revise, as applicable, all policies and procedures relative to and inclusive of guidelines for communication to the appropriate staff when there is a change/deterioration in a patient's condition.
2. Within twenty-one (21) days of the execution of this document, the facility shall develop a quality assurance mechanism by which critical laboratory values and abnormal laboratory values are reported to the responsible physician(s) for assessment and outcomes of said assessments are documented in the medical record.
3. Within thirty (30) days of the execution of this document, the medical staff leadership shall review and approve any written policies and procedures developed or revised as stipulated in paragraphs #1 and #2.
4. Within forty-five (45) days of the execution of this document, the Licensee's Quality Assurance Program ^{shall} implement a mechanism to monitor staff adherence to said policies and procedures.
5. The Licensee shall within seven (7) days of the execution of this Consent Order designate an individual who shall have the overall responsibility for full implementation of the components of this Consent Order.
6. Any information, documents, meetings, reports or monetary payments required by this Consent Order shall be directed to:

Ann Marie Montemerlo, RN
Supervising Nurse Consultant
Department of Public Health
Division of Health Systems Regulation
410 Capitol Avenue, MS #12 HSR
P.O. Box 340308
Hartford, CT 06134-0308

7. The individual assigned to oversee the implementation of the requirements of this document shall submit monthly reports to the Department regarding the implementation of this Consent Order components and shall meet with a Department representative every three (3) months for the first year and every six (6) months thereafter for the duration of the Consent Order.
8. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of this document or of any other statutory or regulatory requirements. This Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Department may petition any court with proper jurisdiction for enforcement of this Consent Order in the event the Licensee fails to comply with its terms.
9. The provisions of this Consent Order, shall remain in effect for a period of two (2) years from the effective date of this document provided that the Department is satisfied that the Licensee has maintained substantial compliance with applicable State and Federal regulations.
10. The Licensee shall pay a monetary fine of fifteen thousand dollars (\$15,000.00). Said payment shall be received by the Department of Public Health no later than two (2) weeks after the effective date of this Order. The check shall be made payable to the Treasurer of the State of Connecticut.
11. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.

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IN WITNESS WHEREOF, the parties hereto have caused this Consent Order to be executed by their respective officers and officials, which Consent Order is to be effective as of the later of the two dates noted below.

BRISTOL HOSPITAL, INC

May 6, 2004
Date

By: Thomas D. Kennedy III
Thomas Kennedy III
President and Chief Executive Officer

STATE OF Connecticut

County of Hartford ss Bristol, 5/6 2004

Personally appeared the above named Thomas D. Kennedy, III and made oath to the truth of the statements contained herein.

My Commission Expires: 7/31/04
(If Notary Public)

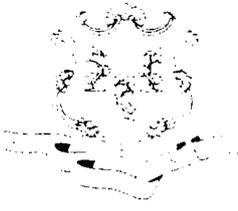
Cynthia A. White
Notary Public
Justice of the Peace
Town Clerk
Commissioner of the Superior Court

CYNTHIA A. WHITE
NOTARY PUBLIC
MY COMMISSION EXPIRES JULY 31, 2004

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

May 10, 2004
Date

By: Marianne Horn
Marianne Horn, R.N., J.D., Director
Division of Health Systems Regulation



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
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January 21, 2004

Thomas B. Kennedy, III – President
Bristol Hospital
Brewster Road
Bristol, CT 06010

Dear Mr. Kennedy:

This violation letter originally dated October 3, 2003 is hereby amended to provide as follows:

Unannounced visits were made to Bristol Hospital on July 14, 15 and 24, 2003 by representatives of the Division of Health Systems Regulation for the purpose of conducting multiple investigations with additional information received through August 4, 2003.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

If there are any questions, please do not hesitate to contact this office.

Respectfully,

Judy McDonald, RN
Supervising Nurse Consultant
Division of Health Systems Regulation

JFM:zsj

cc: Director of Nurses
vlbrstlhsp.doc
#2003-0360; #2003-0429; #2003-0507
#2003-0523; #2003-0551



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DATES OF VISIT: July 14, 15 and 24, 2003

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

1. Patient #1 had a history of peptic ulcer disease, valvular endocarditis with two valve replacements, and thromboembolism to the right thigh. The patient was on Coumadin prior to admission. The patient was admitted on 2/23/03 for acalculous cholecystitis and started on a heparin drip and Coumadin was discontinued. The patient had a Laparoscopic cholecystectomy on 2/25/03 and returned to surgery for an exploratory Laparotomy for coagulopathy with intraperitoneal hemorrhage on 2/28/03. Although on 2/25/03 at 11:00 PM through 2/28/03 at 12:00 AM the patient's blood pressure (BP) was 66/50 to 95/58 (baseline was 108/56) and heart rate was 53-124 (baseline was 50's), the medical record lacked documentation to reflect that MD #1 was notified of the low blood pressure and changes in heart rate. A second interview with MD #1 on 12/23/03 identified that he did visit the patient daily and felt the patient's low blood pressure on 2/26/03 and morning of 2/27/03 was related to over-sedation. MD #1 stated he was not informed of the patient's low blood pressure of 66/50 and pulse of 124 on 2/27/03 at 11:00 PM. MD #1 identified that staff only informed him of the patient's nausea and vomiting. Interview with the Director of Patient Systems reflected that she could not find documentation that MD #1 was notified of the change in vital signs. Interviews with RN #1 and RN #2 reflected that they did not notify MD #1 of the patient's low BP or increased heart rate. The patient became hypotensive, post procedure on 2/28/03 and developed progressive heart failure and was transferred to another facility for further treatment. Review of the additional documentation identified that the patient suffered a cardiac arrest and expired on 2/28/03 at 7:10 PM.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing Service (1).

2. Patient #1 had a Laparoscopic cholecystectomy on 2/25/03 and exploratory Laparotomy for coagulopathy with intraperitoneal hemorrhage on 2/28/03. Review of the physician orders dated 2/27/03 at 2:45 PM directed to resume Heparin at 6:00 pm at 500 units per hour. Review of the Medication/IV Administration Record dated 2/27/03 identified to resume Heparin at 6:00 PM at 500 cc/hour and the medication order lacked a registered nurses signature. Review of the Patient Care Flowsheet and Interview with RN #1 identified that the Heparin drip was administered as ordered by the physician. Review of the medical record and interview with the Director of Patient Care Systems reflected that the secretary transcribed the medication order and the order had not been verified by the nurse (RN #2). The Director of Patient Care

DATES OF VISIT: July 14, 15 and 24, 2003

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

Systems further reflected that it is facility policy that a registered nurse signs the transcribed order.

3. Patient #2 was evaluated in the emergency department (ED) on 2/19/03 for complaint of back spasm. Review of the ED record identified that the patient had an x-ray, was treated with pain and anti-anxiety medications, and received an instructions sheet that excused the patient from work. Review of the After Care Instructions identified that the patient was treated in the ED and did not have x-rays done and did not have excuses and limitations written. Although the patient had an x-ray and excuse sheet, the After Care Instructions were inaccurate when the patient was discharged. Interview with the Director of Outpatient Services reflected that there was a discrepancy in the After Care Instructions and that the facility was in the process of revising the form and changing the preset defaults in the After Care Instruction program.

The above are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing Service (1) and/or (d) Medical Records (2)

4. Patient #1 had a history of peptic ulcer disease, valvular endocarditis with two valve replacements, and thromboembolism to the right thigh. The patient was on Coumadin prior to admission. The patient was admitted on 2/23/03 for acalculous cholecystitis and started on a heparin drip and Coumadin was discontinued. The PTT level on 2/25/03 at 6:00 AM was 173 (normal 25-34.3), the Heparin drip was discontinued on 2/25/03 at 8:10 AM, and the patient underwent a Laparoscopic cholecystectomy on 2/25/03 at 12:02 PM. Although the patient had a PTT level at 6:00 AM, repeat lab work to assess coagulation status was not done prior to surgery on 2/25/03. The nursing flow sheets dated 2/25/03 at 11:00 PM through 2/28/03 at 12:00 am identified the patient's blood pressure (BP) was 66/50 to 95/58 (baseline was 108/56) and heart rate was 53-124 (baseline was 50's), the physician progress notes lacked documentation to reflect the low blood pressure, changes in heart rate and prompt intervention for the changes in vital signs. Interview with MD #1 reflected that he could not recall if he was notified of the vital sign changes for 2/25/03 through 2/27/03 but he reviewed the flowsheets located on the clipboard dated 2/26/03 and was aware of the BP's 75/63 to 87/48. MD #1 further reflected that he made rounds daily and could not find documentation in the progress notes about the changes in vital signs or identify interventions for these vital sign changes except for discontinuing morphine injections. The patient returned to surgery for an exploratory

DATES OF VISIT: July 14, 15 and 24, 2003

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
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WERE IDENTIFIED

Laparotomy for coagulopathy with intraperitoneal hemorrhage on 2/28/03. The patient became hypotensive, post procedure on 2/28/03 and developed progressive heart failure and was transferred to another facility for further treatment. Review of the additional documentation identified that the patient suffered a cardiac arrest and expired on 2/28/03 at 7:10 pm. Review of the autopsy report dated 3/1/03 identified a massive myocardial infarction.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (4)(A) and/or (e) Nursing Service (1).

5. Patient #13 has a physician's order dated 7/10/03 that directed the insertion of a nasogastric tube (NGT). Review of the medical record with the Director of Patient System revealed that the NGT was inserted by a physician at approximately 10:00 PM on 7/10/03. The record lacked documentation that assessment of proper placement of the tube was completed. The patient began having feedings via the tube per physician's order at approximately 1:30 AM on 7/11/03. A review of facility policies for tube placement (Levin Tube) reflected proper placement was ascertained when stomach contents were aspirated.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3) and/or (e) Nursing Service (1).

6. Patients #7, #8, #9 and #10 had CT or MRI diagnostic examinations at the facility. A review of the medical record failed to identify that an informed consent had been obtained for the exam for Patient #7. Consents for Patients #8, #9 and #10 identified that they were witnessed by a department secretary and lacked a physician signature as the form indicated. A review of the facility policy for administration of IV contrast in CT Scan identified a CT Tech should explain the procedure and obtain signed consent. During an interview, RN #3 stated consents for contrast testing were required. During an interview, the Director of Outpatient Services stated the form indicated a physician signature was needed by the form would be revised because this was not done and a secretary witnessing the form did not meet the facility policy requirement.

FACILITY: Bristol Hospital

DATES OF VISIT: July 14, 15 and 24, 2003

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3) and/or (e) Nursing Service (1) and/or (f) Diagnostic and therapeutic facilities.

7. A review of the facility restraint logs failed to identify descriptive behavioral reasons for the restraint use for the patients listed.

The above is a violation of the Connecticut General Statutes Section 46a-153 and/or a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing Service (1) and/or (i) General (7).