Western State Hospital

Organization ID: 1630

9601 Steilacoom Boulevard. S.WLakewood, WA 98498

Accreditation Activity - 45-day Evidence of Standards Compliance Form

Due Date: 3/22/2015

HAP Standard HR.01.06.01 Staff are competent to perform their responsibilities.

Findings: EP 5 Observed in HR File Review at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site. In review of the initial competencies for PSA PERT member #1, it was noted that the identified skill checklist was dated 2/26/14. This skill checklist indicated that the staff member had performed procedures of therapeutic interactions, response to high risk scenarios and validation levels. While this was a new position, initiated on March 5, 2014 it was noted that there was a lack of competency validation related to the specific duties of this position including: "provides crisis management services to patient experiencing psychiatric emergencies or escalation toward psychiatric emergencies", Maintains milieu management and security....", "provides immediate response, direct interaction and incident stabilization before or during behavioral emergencies". Observed in HR File Review at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site. In review of the initial competencies for PSA PERT member #2, it was noted that the identified skill checklist was dated 2/26/14. This skill checklist indicated that the staff member had performed procedures of therapeutic interactions, response to high risk scenarios and validation levels. While this was a new position, initiated on March 5, 2014 it was noted that there was a lack of competency validation related to the specific duties of this position including: "provides crisis management services to patient experiencing psychiatric emergencies or escalation toward psychiatric emergencies", Maintains milieu management and security....", "provides immediate response, direct interaction and incident stabilization before or during behavioral emergencies". Observed in HR File Review at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site. In review of the initial competencies for PSA PERT member #3, it was noted that the identified skill checklist was dated 2/26/14. This skill checklist indicated that the staff member had performed procedures of therapeutic interactions, response to high risk scenarios and validation levels. While this was a new position, initiated on March 5, 2014 it was noted that there was a lack of competency validation related to the specific duties of this position including: "provides crisis management services to patient experiencing psychiatric emergencies or escalation toward psychiatric emergencies", Maintains milieu management and security....", "provides immediate response, direct interaction and incident stabilization before or during behavioral emergencies". EP 6 Observed in HR File Review at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site. It was reported that the forensic unit experienced ongoing patient assaults. In review of the RN2 competency record, the hospital was unable to demonstrate that this nurse had received ongoing competencies regarding the use of the de-escalation techniques. Observed in HR File Review at Western

State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site. It was reported that the forensic unit experienced ongoing patient assaults. In review of the PSN competency record, the hospital was unable to demonstrate that this nurse had received ongoing competencies regarding the use of the de-escalation techniques. Observed in HR File Review at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site. It was reported that the forensic unit experienced ongoing patient assaults. In review of the PSA competency record, the hospital was unable to demonstrate that this nurse had received ongoing competencies regarding the use of the de-escalation techniques.

Elements of Performance:

5. Staff competence is initially assessed and documented as part of orientation.

Scoring Category: C

Corrective Action Taken:

WHO:

The Center Directors are ultimately responsible for the corrective action and for overall and ongoing compliance.

WHAT:

The Position Description Forms (PDFs) were updated to reflect the current duties and required competencies of each member. This Competency Checklist now contains a measurement of specific behaviors that PERT Team members need to demonstrate to show adherence to best practices in crisis management services.

WHEN:

PDFs were updated by 3/17/2015. PDFs were signed by all employees by 3/26/2015. Competencies updated by 3/17/15 in conjunction with updated PDFs. Policy 3.2.3 Orientation and Competency is in place to ensure supervisors are responsible for their staff completing competencies yearly or sooner if needed. Per policy assessment of competencies can occur during the annual review for each employee, but no less frequently than once every three years. Staff holding the PERT positions have been in these positions for a year and are currently being re-assessed per hospital policy. All competencies will be completed by April 30th, 2015 (date approved by Cynthia Leslie).

HOW:

Supervisor will ensure PDFs and competencies will stay current and that each new staff member signed their PDF and completes competencies prior to working alone or being assigned as PERT Leader. Competency assessments will be completed annually using the PERT Competency Checklist.

Evaluation Method: New PERT staff (denominator), New PERT staff competencies evaluated (numerator). These results will be reviewed by Quality Council.

Measure of Success Goal (%): 90

6. Staff competence is assessed and documented once every three years, or more frequently as required by hospital policy or in accordance with law and regulation.

Scoring Category: C

Corrective Action Taken:

WHO:

The Center Director is ultimately responsible for the corrective action and for overall and ongoing compliance.

WHAT:

The revised Competency Checklist now contains a measurement of specific behaviors that PERT Team members need to demonstrate to show adherence to best practices in crisis management services and de-escalation techniques.

WHEN:

The Competency Checklist was updated to include de-escalation techniques on 3/17/15. Policy 3.2.3 Orientation and Competency is in place to ensure supervisors are responsible for their staff completing competencies yearly or sooner if needed. Per policy assessment of competencies can occur during the annual review for each employee, but no less frequently than once every three years. Staff holding the PERT positions have been in these positions for a year and are currently being re-assessed per hospital policy. All competencies will be completed by April 30th, 2015 (date approved by Cynthia Leslie).

HOW:

Supervisor will ensure competencies will stay current and that each new staff member completes competencies prior to working alone. Competency assessments will be completed annually using the PERT Competency Checklist. Policy 3.2.3 Orientation and Competency is in place to ensure supervisors are responsible for their staff completing competencies yearly or sooner if needed. Per policy assessment of competencies can occur during the annual review for each employee, but no less frequently than once every three years.

Evaluation Method: New PERT staff (denominator), New PERT staff competencies evaluated in de-escalation (numerator). These results will be reviewed by Quality Council.

Measure of Success Goal (%): 90

HAP Standard LD.03.01.01 Leaders create and maintain a culture of safety and quality throughout the hospital.

Findings: EP 1 Observed in Document Review at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site. At time of survey, the hospital was able to confirm they had conducted an employee satisfaction survey. The hospital also demonstrated that they had retained a consultant to "identify gaps in the workplace violence prevention programs". This document remarked on the Organizational Culture, however, neither of these documents reflected an evaluation of the culture of safety and quality. EP 5 Observed in Tracer Activities at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site. During document review and discussion with staff and leadership, the hospital was not able to demonstrated that leaders had created and implemented a process for managing behaviors that undermine the culture of safety. EP 7 Observed in Tracer Activities at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site. In discussion with numerous staff (various disciplines, units and shifts) there was a

perceived lack of team approach among staff. There was a clear dichotomy on the need, benefit, role and functions of the Psychiatric Emergency Response Team. EP 8 Observed in Tracer Activities at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site. During discussion with staff (various disciplines, units and shifts), numerous staff stated they did not feel open to discuss issues of safety and quality. Several staff reported feeling fear of retaliation from leadership should they discuss/report safety concerns. Observed in Tracer Activities at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site. During discussion with staff (various disciplines, units and shifts) numerous staff reported that they were hesitant to employ interventions with the patients due to fear of retaliation from member of the PERT team. Staff reported they often will choose to do nothing for fear of being "written up".

Elements of Performance:

1. Leaders regularly evaluate the culture of safety and quality using valid and reliable tools.

Scoring Category: A

Corrective Action Taken:

WHO:

The Quality Director is ultimately responsible for the corrective action and for overall and ongoing compliance.

WHAT:

A Safety & Quality survey was disseminated to all staff for feedback regarding the safety culture. The data received from this survey will be analyzed and evaluated by 4/30/2015 (date approved by Cynthia Leslie) the Research Department and presented to Quality Council committee on 5/6/2015 (date approved by Cynthia Leslie). An action plan will be developed to address identified concerns and Quality Council members will approve the action plan. Once the action plan is approved, members of leadership will be assigned tasks presented in the action plan and present their progress bi-weekly to Quality Council. Quality Management will include the action plan in the QAPI and track each item to ensure the plan is being addressed and implemented.

WHEN:

Culture of Safety & Quality survey was disseminated to all staff on 4/3/2015. The data received from this survey will be analyzed and evaluated by 4/30/2015 (date approved by Cynthia Leslie) the Research Department and presented to Quality Council committee on 5/6/2015 (date approved by Cynthia Leslie).

HOW:

The survey will be conducted in June of every year and distributed for all staff to participate. Data will be evaluated and analyzed by the Research Department and presented to the hospital’s Quality Council and Executive Leadership. Each year in June this same process will occur to ensure compliance.

5. Leaders create and implement a process for managing behaviors that undermine a culture of safety.

Scoring Category: A

Corrective Action Taken:

WHO:

The Quality Director is ultimately responsible for the corrective action and for overall and ongoing compliance.

WHAT:

New Employee Orientation (NEO) has been restructured to include a training module on “It’s all about Safety”. An annual Culture of Safety training is included in the mandatory yearly training for all employees. Culture of Safety policy was revised with progressive disciplinary steps to take in instances of behaviors that undermine a Culture of Safety. Code of Conduct details ‘standards of behavior, service, staff, safety, and stewardship'. The Code of Conduct also covers what are considered disruptive behaviors and what supervisors and managers will do to educate their staff and engage in behaviors that undermine a culture of safety.

WHEN:

Restructuring of NEO was done by 3/16/2015. The Code of Conduct and the Culture of Safety policy was distributed to all staff via Electronic Bulletin Board on 4/8/2015.

HOW:

Each new employee is mandated to attend New Employee Orientation. Within orientation the new employee is required to attend the training module titled “It’s all about Safety”. The Code of Conduct is reviewed and signed. Yearly refresher training on the Culture of Safety is mandated of all staff via electronic training system. Compliance will be tracked via LMS and reported to Quality Council quarterly.

7. Leaders establish a team approach among all staff at all levels.

Scoring Category: A

Corrective Action Taken:

WHO:

The Quality Director is ultimately responsible for the corrective action and for overall and ongoing compliance.

WHAT:

The forensic center leadership communicated information about PERT through a series of meetings which invited feedback and collaboration. Based on staff feedback that the initial implementation of PERT was not effective, a “PERT roll-out” was redone and completed as of March 26th. The reiteration consists of a power point presentation given to staff on all forensic wards which underscores the way PERT fits in to our array of services and aligns with the standards of both CMS and The Joint Commission. On the dates listed below, the clinical leadership briefed ward teams on the PERT mission and invited questions and feedback. Following the power point training, staff were invited to ask questions to clarify the PERT process and to express concerns of current PERT implementation. A survey was disseminated on April 3rd, 2015 to all Forensics staff that interacts with PERT members for feedback regarding the training and the re-roll out. Data from this survey will be analyzed by April 30th, 2015 (date approved by Cynthia Leslie). Analysis will be presented to Quality Council by May 6th, 2015 (date approved by Cynthia Leslie).

WHEN:

PERT re-roll out was completed on March 26th, 2015, as of that date, all Forensics staff that participated have been educated. These informational sessions were conducted by the Acting Center Director, the Clinical Nurse Specialist, the CFS Clinical Director, Nurse Manager and the CFS Manager of Social Work for all staff who interact with the PERT Team. The informational sessions

lasted approximately an hour. • January 15 Ward F1. • January 22 Ward F2. • January 29 Ward F6. • February 5 Ward F5. (These four wards represent the admit wards on the Center for Forensic Services and high risk interventions such as seclusion and restraint are more likely on these wards and thus their utilization of PERT is higher). • March 5 Ward F3. • March 12 Ward F4. • March 19 Ward F7. • March 26 Ward F8. In addition, rounding is occurring by the acting Center Director to discuss staff questions and concerns and to follow up with critical safety issues expressed. The Center Director or designee makes weekly visits, works one evening a week and does spot checks one weekend a month to ensure open communication on all shifts and wards. Also, regular weekly meetings have begun between the PERT Supervisor, the Center Director and the Clinical Nurse Specialist to discuss issues of PERT interaction with nursing staff. Members of the PERT team participate in the morning management meeting in CFS where patient safety and security issues are discussed. A member of the senior clinical team has been meeting with evening shift staff on a regular basis to facilitate communication. A survey was disseminated on April 3rd, 2015 to all Forensics staff that interacts with PERT members for feedback regarding the training and the re-roll out.

HOW:

The Quality Management Research Department implemented a staff survey on April 3rd, 2015 to monitor the perception of teamwork, transparency and communication as it applies to PERT.

8. All individuals who work in the hospital, including staff and licensed independent practitioners, are able to openly discuss issues of safety and quality. (See also LD.04.04.05, EP 6)

Scoring Category: A

Corrective Action Taken:

WHO:

The Center Directors are ultimately responsible for the corrective action and for overall and ongoing compliance.

WHAT:

The all staff training provided in New Employee Orientation and as part of the yearly mandatory training for all existing staff on the Culture of Safety emphasizes the importance of reporting all safety concerns as well as the hospital's commitment to ensuring that all staff concerns are heard without fear of reprisal. The Code of Conduct and the Culture of Safety policy was distributed to all staff via Electronic Bulletin Board on 4/8/2015. A weekly reminder is sent to all staff stating: Safety for patients and staff is one of WSH's most important issues. In order to improve the safety of our hospital we encourage all staff to report any safety concerns to their supervisor, center director, or via the Safety Hotline 1-888-346-8824. The Safety Hotline is managed by the WSH Safety office and if employees want to report concerns anonymously, they may do so through this hotline. It is up to each employee to report safety concerns when observed. WSH sees this as an act of professionalism and is sincerely thankful to all employees who report their concerns. In addition, weekly rounding has been occurring by the acting Center Director to encourage staff to ask questions and share concerns about the PERT Team. The Center Director or designee makes weekly visits, works one evening a week and does spot checks one weekend a month to ensure open communication on all shifts and wards. Nursing staff are especially encouraged to share feedback about the PERT Team (positive or negative) in the regular meetings that are occurring between the PERT Supervisor, the Center Director and the Clinical Nurse Specialist. Members of the PERT team participate in the morning management meeting in CFS where patient safety and security issues are discussed. A member of the senior clinical team has been meeting with evening shift staff on a regular basis to facilitate communication.

WHEN:

Weekly safety announcements began March 23rd, 2015. Informational sessions were conducted by the Acting Center Director, the Clinical Nurse Specialist, the CFS Clinical Director, Nurse Manager and the CFS Manager of Social Work for all staff who interact with the PERT Team and was completed by March 26th, 2015. The informational sessions lasted approximately an hour. • January 15 Ward F1. • January 22 Ward F2. • January 29 Ward F6. • February 5 Ward F5. (These four wards represent the admit wards on the Center for Forensic Services and high risk interventions such as seclusion and restraint are more likely on these wards and thus their utilization of PERT is higher). • March 5 Ward F3. • March 12 Ward F4. • March 19 Ward F7. • March 26 Ward F8. The Code of Conduct and the Culture of Safety policy was distributed to all staff via Electronic Bulletin Board on 4/8/2015.

HOW:

A Safety & Quality survey was disseminated to all staff on April 3rd, 2015. The data received from this survey will be analyzed and evaluated by the Research Department and presented to Quality Council committee. An action plan will be developed to address identified concerns and Quality Council members will approve the action plan. Once the action plan is approved, members of leadership will be assigned tasks presented in the action plan and present their progress bi-weekly to Quality Council. Quality Management will include the action plan in the QAPI and track each item to ensure the plan is being addressed and implemented.

HAP Standard LD.03.06.01 Those who work in the hospital are focused on improving safety and quality.

Findings: EP 3 §482.62(g)(2) - (B158) - (2) The number of qualified therapists, support personnel, and consultants must be adequate to provide comprehensive therapeutic activities consistent with each patient's active treatment program. This Standard is NOT MET as evidenced by: Observed in Tracer Activities at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site for the Psychiatric Hospital deemed service. In discussion with staff and review of documents, it was noted that the hospital offered therapeutic group activities only during day shift Monday through Friday. Therapists and support personnel were not available in the evenings or on the weekends to provide patients with therapeutic activities. §482.62(d)(2) - (B150) - (2) There must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide the nursing care necessary under each patient's active treatment program. This Standard is NOT MET as evidenced by: Observed in Tracer Activities at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site for the Psychiatric Hospital deemed service. During tracer activity numerous staff (various disciplines, units and shifts) expressed a concern with the number of staff on the forensic units and expressed that they often felt vulnerable related to staff available on the unit. More than one staff expressed that there were times when they were left alone on the unit due to staff issues. Areas of concern expressed included that if there is one patient on a 1:1 monitoring, that this must be absorbed into the base staffing. It was reported that additional staff is not realized until there were two patients required 1:1 monitoring. Additionally, it was reported that a recent change included staff performing rounds every 15 minutes (vs. every 30 minutes) which consumes the time of one of the staff. Additional staff duties (including 2 staff to escort patients off unit, following lab, covering outside breaks, staff breaks) take staff off the unit.

Elements of Performance:

3. Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. (See also IC.01.01.01, EP 3) Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered.

Scoring Category: A

Corrective Action Taken:

WHO:

The Center Director is ultimately responsible for the corrective action and for overall and ongoing compliance for evening & weekend programming. The Psychiatric Nursing Executive is ultimately responsible for the corrective action and for overall and ongoing compliance for nurse staffing levels.

WHAT:

Weekend & evening programming was initiated in Forensics on 3/23/2015 to include evening and weekend programming. Other wards throughout the facility have the ability to attend offered recreational activities on and off-ward during the weekend and evenings to include recreational sports, bingo, hygiene education and room care, as well as arts & crafts and card games. With regard to staffing levels: 1.An MHT5 was assigned to the Nursing Administration office on Night shift seven days a week to allow the RN4 Nurse Managers the opportunity to make rounds, review the staffing on all wards in all centers and redeploy staff in accordance with the needs of the wards. 2.Security assists with escorting of patients reducing the need for ward staff. Security is already trained in escorting patients. This is an existing process. 3.Laboratory staff completes blood draws in CFS on Wednesdays to allow scheduling of staff assistance, if blood draws are needed other than Wednesday Security assists with escorting patents to the Lab. 4.Ward staff are to call RN3 for additional staff coverage if needed who will subsequently notify the RN4 Nurse Manager in accordance with Nursing Standard Procedure 216. If additional staff are needed: The Hospital uses a program (Scheduler) to determine the staffing needs. The Scheduler program is automatically populated by input from Charge Nurses throughout the hospital on all shifts. The program lists every ward and the number of staff scheduled to work the ward by skill levels. For example if a ward requires two RNs but only has one RN scheduled, the RN/Charge Nurse section will display the deficit in red. After a staff is deployed the deficit will be removed. The staffing numbers on balanced wards are displayed in black. The RN4 Shift Manager reviews the staffing levels beginning one hour prior to the beginning of the shift to ensure all wards meet the base staffing levels. Every ward has a minimum number of staff required; the Charge Nurse will enter the number of patients on 1:1 monitoring, suicide watch, seclusion or restraint in a computer program called Cache. Cache sends the information to the scheduler program allowing the Nurse Manager to determine if additional staff are needed to ensure the safety of the ward. Occasionally wards may request additional staff related to an increase ward activity rather than 1:1 monitoring. The RN3 Nurse Supervisor will contact the Shift Manager who will deploy staff from another ward, assign an on-call staff, or call in overtime staff.

WHEN:

One evening group a day will be provided in the Treatment and Recovery Center and each Competency Restoration ward by March 23rd, 2015. An additional evening group was added in both areas April 1st, 2015. Other wards throughout the facility have the ability to attend offered recreational activities on and off-ward during the weekend and evenings to include recreational sports, bingo, hygiene education and room care, as well as arts & crafts and card games. With regard to staffing: 1.RN4 Nurse Managers began rounds the second week of February. 2.Verified process with security March 13, 2015 3.Verified process with lab supervisor

HOW:

With regard to programming: The CFS Center Director and the Clinical Director will conduct monthly audits of evening and weekend programming documentation. Audits will continue for three months with 90% compliance of expected groups. Once 90% compliance objective has been met, audits will be conducted quarterly thereafter. With regard to staffing: 1.Monitor all safe staffing reports. 2.Monitor QI reports for increase in assaults on a quarterly basis 3.Report results to PCC

HAP Standard PC.03.05.03 For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital uses restraint or seclusion safely.

Findings: EP 1 §482.13(e)(4)(ii) - (A-0167) - [The use of restraint or seclusion must be --] (ii) implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law. This Standard is NOT MET as evidenced by: Observed in Tracer Activities at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site for the Psychiatric Hospital deemed service. Hospital policy "Utilization of Seclusion/Restraint" indicated that the use of seclusion and/or restrain is an emergency intervention of a last resort to manage behaviors that pose imminent risk of harm to the patient, staff, or others. During tracer activity, it was learned that on January 16, 2015 the unit went on a "lock down" due to two patients in an altercation. Staff reported that during this lock-down, each of the patients on the unit was locked into their own room for a period of approximately 15 minutes. Review of patient behavior in chart #1 indicated that the patient was sleeping at this time, and the patient's behavior was described as "patient was a bystander". Observed in Tracer Visit at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site for the Psychiatric Hospital deemed service. Hospital policy "Utilization of Seclusion/Restraint" indicated that the use of seclusion and/or restrain is an emergency intervention of a last resort to manage behaviors that pose imminent risk of harm to the patient, staff, or others. During tracer activity, it was learned that on January 16, 2015 the unit went on a "lock down" due to two patients in an altercation. Staff reported that during this lock-down, each of the patients on the unit was locked into their own room for a period of approximately 15 minutes. Review of patient behavior in chart #2 indicated that the "ward milieu was high; ward on lock down, all patients secluded. Had no behavior; was part of lock down".

Elements of Performance:

1. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements restraint or seclusion using safe techniques identified by the hospital’s policies and procedures in accordance with law and regulation.

Scoring Category: A

Corrective Action Taken:
WHO:

The Center Director is ultimately responsible for the corrective action and for overall and ongoing

compliance.

WHAT:

A thorough review was undertaken in regard to the events of January 16, 2015, which confirmed that "locking down" of patients in the manner that occurred on that date is at variance with hospital policies/procedures as well as TJC and CMS standards. The review also identified risk factors which led to this process variance and identified ways to ensure that future seclusion events, if necessary, fully comply with hospital policies/procedures. Immediately following this review, the hospital implemented a training to educate staff involved on the appropriate uses for seclusion and contraindications for same, ensuring that all forensic staffs are complying with these policies/procedures. There is a button on the on a control panel in the Nursing Station that locks down all doors to the patient rooms simultaneously that exists on Wards F1 & F2. The button is now inactive and does not exist on other wards.

WHEN:

This staff education included: • A meeting with swing shift staff from Ward F2 on February 25, 2015, to discuss decision making and teamwork on the ward. As part of that discussion, we reviewed with them the policy variance that occurred on January 16, 2015, and educated them as to actions which would have been appropriate and congruent with acceptable patient care standards. • Management briefed on improper seclusion and need for 'read and sign' March 6, 2015. • A 'read and sign' was prepared and distributed on March 6, 2015, to management staff for their staff to review and sign. This 'read and sign' is a comprehensive explanation of the policy of seclusion and staffs were required to indicate their understanding of this policy. All staff reviewed and signed this document by 3/20/15. • A meeting with the staff who were specifically working the night of the incident has been scheduled to bring the issues of variance to their attention occurred on 3/19/15. • The button which locked all the doors was disabled on Wards F1 and F2 on 3/18/15. When the button was disabled a memo from the Nurse Manager RN4 was sent out to all affected staff on March 27th, 2015. The RN4 Shift Nurse Manager was educated on February 2nd, 2015; the RN Manager educated the RN3 on resources available in assisting staff to contain similar situations in the future without use of seclusion and/or restraint. The RN4 Nurse Managers meet with the RN3s on a weekly basis to follow up with concerns. Yearly competencies, which inform staff of the appropriate practice of the use of seclusion and restraint, are completed by all Nursing staff and are documented in the supervisory file.

HOW:

The button which locked all the doors was disabled on Wards F1 and F2 on 3/18/15. Trainings on the Seclusion and Restraint policy are ongoing and must be completed by all Nursing staff by 3/29/2015. Yearly competencies, which inform staff of the appropriate practice of the use of seclusion and restraint, are completed by all Nursing staff and are documented in the supervisory file.

HAP Standard PC.03.05.11 For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital evaluates and reevaluates the patient who is restrained or secluded.

Findings: EP 3 §482.13(e)(12)(ii)(B) - (A-0179) - (B) The patient's reaction to the intervention; This Standard is NOT MET as evidenced by: Observed in Tracer Activities at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site for the Psychiatric Hospital deemed service. It was noted that on January 16, 2015 the unit went into "lock-down" during which all the patients on the unit were secluded (locked) in their rooms for

approximately 15 minutes. In the two charts that were reviewed, there was no documentation that reflected that an in-person evaluation had been conducted that included the required components.

Elements of Performance:

3. For hospitals that use Joint Commission accreditation for deemed status purposes: The in-person evaluation, conducted within one hour of the initiation of restraint or seclusion for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others, includes the following: - An evaluation of the patient's immediate situation - The patient's reaction to the intervention - The patient's medical and behavioral condition - The need to continue or terminate the restraint or seclusion

Scoring Category: A

Corrective Action Taken:

WHO:

The Psychiatric Nurse Executive is ultimately responsible for the corrective action and for overall and ongoing compliance.

WHAT:

1.The RN4 Nurse Manager educated the RN3 on resources available in assisting the staff to contain similar situations in the future without the use of seclusion and/or restraint. 2.RN3 Nurse supervisors audit every episode of Seclusion and Restraint for completion and compliance. 3.The shift manager was educated on available resources and alternative methods of containing a volatile situation. Additional questions posed by surveyor: Please describe the resources available to RN3 and shift manager for assisting staff on containing similar situations in the future without the use of seclusion. 1. Bringing in third person (unfamiliar person) to assist with de-escalation of the patient 2. Milieu awareness, know where patients are at all times and their behavior 3. Security presence (presence of uniform) 4. Coordination with other wards of movement of patients 5. Encouraging patients to voluntarily return to their rooms until a volatile situation is contained Please identify the concerns that RN3 Nurse supervisors may have that will be discussed. The RN3 Nurse supervisors and the RN4 Nurse Managers meet weekly. All concerns related to the safety of patients and staff are discussed. For example: 1. Transferring patients for protection or safety 2. Identification of educational needs of staff 3. Discussion of educational resources such as on-line training, instructor led training, sharing of literature, or collaboration with nursing administration to schedule instructors. Please address the observation that an evaluation of a patient in seclusion did not occur. The incident was isolated, twenty-nine patients were secluded to ensure patients remained safe during potentially riotous activity by patients scheduled to be transferred to jail. Patients were observed for safety during the incident; however, due to the limited time the patients were secluded the face-to-face assessment was not complete. Please describe your face to face evaluation process and documentation. WSH Nursing Standard Procedure 213 and Nursing Standard Protocol 302 govern the responsibilities of Nursing Staff with utilizing seclusion and restraint. Protocol 302 specifically addresses the four elements of assessment to be completed within one hour: evaluate the individual’s immediate situation, evaluate the individual’s reaction to seclusion or restraint intervention, evaluate medical or behavioral condition, and evaluate the need to continue or discontinue seclusion/restraint. The RN documents the results of the face to face evaluation on form WSH-23-116 Seclusion/Restraint Assessment Flowsheet. At two hours the RN completes another face to face evaluation to determine if the seclusion and restraint remains necessary.

WHEN:

1. The RN4 Nurse Managers meets with the RN3 Nurse Supervisors on a weekly basis to follow-up with concerns. 2. The Post Seclusion and Restraint audits are on-going, as of March 1, 2015 an MHT5 in Nursing Administration is tracking the audits for any discrepancies. 3. The RN4 Shift Nurse Manager was educated on February 2, 2015. 4. Training related to the face to face evaluations was implemented on 03/26/15 for RNs.

HOW:

1.The RN4 Nurse Managers meets with the RN3 Nurse Supervisors on a weekly basis to follow-up with concerns. 2.The Post Seclusion and Restraint audits are on-going, as of March 1, 2015 an MHT5 in Nursing Administration is tracking the audits for any discrepancies. All seclusion and restraint forms are audited by the RN3 Nurse Supervisor The audit results are submitted to Nursing Administration for review of data All evidence of training related to face to face evaluations are kept in a file 3.The RN4 Shift Nurse Manager was educated on February 2, 2015.