Western State Hospital

Organization ID: 1630

9601 Steilacoom Boulevard. S.WLakewood, WA 98498

Accreditation Activity - 60-day Evidence of Standards Compliance Form

Due Date: 4/6/2015

HAP Standard HR.01.02.05 The hospital verifies staff qualifications.

Findings: EP 2 Observed in HR File Review at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site. Hospital job description for PSA PERT required the employee to be a Safe Team Certified trainer. The hospital was unable to provide documentation that employee number #1 had this required certification. Observed in HR File Review at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site. Hospital job description for PSA PERT required the employee to be a Safe Team Certified trainer. The hospital was unable to provide documentation that employee number #2 had this required certification.

Elements of Performance:

2. When the hospital requires licensure, registration, or certification not required by law and regulation, the hospital both verifies these credentials and documents this verification at time of hire and when credentials are renewed. (See also HR.01.02.07, EP 2)

Scoring Category: C

Corrective Action Taken:

WHO:

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

WHAT:

All Position Description Forms (PDFs) have been updated to eliminate this requirement and instead include the requirement of completion of PERT Academy. The PERT mission varies from the SAFE Team mission in various ways and, therefore, the SAFE Team training in its entirety is not appropriate for PERT staff. The PERT training is specialized and focuses on the particular mission of PERT: to provide a safe, effective, and immediate plan of least-to-most response to patients experiencing a psychiatric crisis or anticipated psychiatric crisis. The PERT Academy training includes these main components: Incident Command Principles: the coordinated system of responding to a psychiatric emergency and the role of PERT staff in the response. This system is a national standard for emergency service. Crisis Response Standards: SAMHSA's publication, "Practice Guidelines: Core Elements for Responding to a Mental Health Crisis" is the resource utilized for this training. The essential values taught to PERT staff are, "Avoid Harm, Intervening in Person-Centered Ways, Shared Responsibility, Addressing Trauma, Establishing Feelings of

Personal Safety, Based on Strengths, The Whole Person, The Person as a Credible Source, Recovery, Resilience and Natural Supports, and Prevention. PERT staff are trained on procedures for enacting these essential values. Communications: how to operate the communication systems including radio, charting in the patient record, and incident charting that provides the information needed to conduct a debriefing. Best Practices for Interacting with Patients: reviews the contemporary research on therapeutic interactions and serves as the basis for training PERT staff on how to deliver therapeutic interactions while they are conducting rounds within the center. The therapeutic interactions are known to reduce the likelihood of harm to staff and patients and increase the probability that patients will have a positive response to treatment and clinical outcome. Understanding Aggression: a review of the various causes of aggression within a forensic psychiatric setting including the most up-to-date evidence that supports the idea that the cause of aggression in inpatient forensic psychiatric patients is an atmosphere whereby the patient feels at the mercy of an uncaring system or staff. De-Escalation: INSERT algorithm and the procedural application is trained. PERT staff are taught all aspects of the INSERT algorithm including safe approaches to psychiatric crises (proxemics), how to validate patient concerns, and how to handle particularly high risk situations that typically arise in a forensic psychiatric setting and involve a patient. Physical Intervention: PERT utilizes the WSH approved physical interventions that include how to restrain a patient. All skills are demonstrated by PERT staff during the PERT Academy per role plays and their performance is noted on the competency logs. Overall, the TEAM training is vastly different than the PERT Academy and does not include the training necessary to achieve the specialized mission of PERT. The PERT Academy is the only training that is available that supports the PERT mission.

WHEN:

All PDFs were updated as of 3/17/2015. Update FOLLOW UP QUESTION FROM SIG: Please revise to include the date of completion that all current PERT staff attended the PERT Academy and were trained. PERT members that were part of the initial implementation completed PERT Academy on 3/4/2014. Two new members of PERT that were hired later (in September and November 2014) completed PERT Academy on 1/23/2015. All members of PERT are required to complete PERT Academy within six months of hire per PERT procedure. All current members of PERT have completed the PERT Academy with the exception of one. The remaining PERT staff member that has not completed the PERT Academy was hired into PERT on 3/1/2015 and will complete PERT Academy within six months of hire per PERT procedure.

HOW:

Any new positions established within PERT will be modified to state that PERT Academy is required to be completed within the policy guidelines established in 3.2.3 Orientation and Competencies.

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

HAP Standard LD.01.03.01 The governing body is ultimately accountable for the safety and quality of care, treatment, and services.

Findings: EP 2 §482.12 - (A-0043) - §482.12 Condition of Participation: Condition of Participation: Governing Body This Condition is NOT MET as evidenced by: Observed in Individual

Tracer at Western State Hospital | 9601 Steilacoom Boulevard S.W., Lak (9601 Steilacoom Boulevard S.W., Lakewood, WA) site. Observed in Auto Score for CLD at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site. The governing body/leadership did not ensure that the following Conditions of Participation were met as determined through observations, documentation, and staff interviews:§482.13 - (A-0115), §482.23 - (A-0385), §482.62 - (B136), §482.21 - (A-0263), §482.12 - (A-0043) §482.13 - (A-0115), §482.21 - (A-0263), §482.23 (A-0385), §482.62 –(B136), §482.12 - (A-0043)

Elements of Performance:

2. The governing body provides for organization management and planning.

Scoring Category: A

Corrective Action Taken:

WHO:

The Chief Executive Officer is ultimately responsible for the corrective action and for overall and ongoing compliance

WHAT:

Please refer to all corrective action plans for individual citations :§482.13 - (A-0115), §482.23 - (A-0385), §482.62 - (B136), §482.21 - (A-0263), §482.12 - (A-0043)§482.13 - (A-0115), §482.21 - (A-0263), §482.23 (A-0385), §482.62 –(B136), §482.12 - (A-0043)

WHEN:

All actions were completed by April 23, 2015

HOW:

CEO will report to Governing Body any issues with compliance on any of the corrective action plans relating to :§482.13 - (A-0115), §482.23 - (A-0385), §482.62 - (B136), §482.21 - (A-0263), §482.12 - (A-0043) §482.13 - (A-0115), §482.21 - (A-0263), §482.23 (A-0385), §482.62 –(B136), §482.12 - (A-0043). UPDATE WITH FOLLOW UP QUESTION FROM SIG: please revise to include how often the Governing Body will be notified by the CEO and Conditions of Participation that are out of compliance. How will the Governing Body ensure compliance with the Conditions of Participation? The Governing Body meets quarterly. The CEO or designee will include agenda items specific to (1) an ongoing program for quality improvement and patient safety to ensure clear definition, implementation and maintenance of action plans; (2) the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety and that all improvement actions are evaluated; and (3) that the determination of the number of distinct improvement projects is conducted annually. The meeting minutes will document and validate the agenda item, related discussion and authorized actions taken, as a result.

HAP Standard LD.03.04.01 The hospital communicates information related to safety and quality to those who need it, including staff, licensed independent practitioners, patients, families, and external interested parties.

Findings:

EP 6 Observed in Tracer Activities at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site. The hospital implemented its new Psychiatric Emergency Response Team in March, 2014. In discussion with numerous staff (various disciplines, shifts and units) it was communicated that there was minimal communication to the staff (medical staff and nursing staff) as to the functions of this team. Examples of staff perceptions included: "The PERT team was thrown out -- we didn't know the roles/changes"; "They just showed up one day";

Elements of Performance:

6. When changes in the environment occur, the hospital communicates those changes effectively.

Scoring Category: A

Corrective Action Taken:

WHO:

The Center 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. The reiteration consists of a power point presentation given to staff on all forensic wards which underscores the way PERT fits into the hospital’s 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.

WHEN:

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 that interacts 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 has been 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. Regular meetings have begun between the PERT Supervisor, the Center Director and the Clinical Nurse Specialist to discuss issues of PERT interaction with nursing staff and various strategies to make the PERT Team effective to Nursing staff and patients. 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.

HOW:

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

HAP Standard LD.03.05.01 Leaders implement changes in existing processes to improve the performance of the hospital.

Findings: EP 3 §482.21 - (A-0263) - §482.21 Condition of Participation: Condition of Participation: Quality Assessment and Performance Improvement Program This Condition is NOT MET as evidenced by: Observed in Leadership Session at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site for the Psychiatric Hospital deemed service. During leadership session, the implementation of recent change was discussed. Leaders shared that they did not have a systematic approach to change and performance improvement EP 5 §482.21 - (A-0263) - §482.21 Condition of Participation: Condition of Participation: Quality Assessment and Performance Improvement Program This Condition 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. The hospital embarked on the initiative to reduce use of restraint and seclusion. One of the identified strategies was the implementation of the Psychiatric Emergency Response Team. Some 11 months after the initiation of this team, there continues to be much resistance to the use of this team. There is clear dichotomy in regards to the role and effectiveness of this team. There were reports that one of the benefits of these team members is they have increased training and skill in therapeutic communication. It was expressed that currently the majority of events responded to by the PERT team were a result of negative staff interactions and that the staff had not received the appropriate amount of training in appropriate intervention/interaction with the patients. The hospital has just started increased training of unit based staff on such therapeutic communication. Numerous staff persons stated that they were instructed to decrease the use of restraints and seclusion, however were not provided with additional tools or education to implement. §482.21(a)(1) - (A-0286) - (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes and identify and reduce medical errors. 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. Numerous staff (various disciplines, units and shifts) reported that since the inception of the Psychiatric Emergency Response Team, that patient to patient assaults have increased. Review of data supported this. The hospital was not able to demonstrate how it was managing this noted change which posed a risk to patient safety. 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 numerous staff (various disciplines, units and shifts), it was reported that the hospital has embarked on an initiative to reduce restraint and seclusion. While the staff was each very supportive of this initiative, it was repeatedly expressed that they were not provided with unit based alternatives to the use of restraint and seclusion (as had been their culture to use).

Elements of Performance:

3. The hospital has a systematic approach to change and performance improvement.

Scoring Category: A

Corrective Action Taken:

WHO:

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

WHAT:

In January, the CEO, authorized that the Department of Quality Management develop and maintain a centralized framework for the management of approved projects, to reduce risks and increase project successes. The major goals of this centralized process are to: • Improve the quality of project deliverables. • Increase the number of projects completed on time and within budget. • Improve control over project requests and workload. • Enhance control over project changes and "scope creep". • Ensure that projects are aligned with WSH business objectives. Improve communication to impacted staff, and employees, in general. UPDATE WITH QUESTION FROM SIG: Please revise to include a description of scope creep. In the field of project management, "scope creep" (sometimes referred to as requirement creep) refers to uncontrolled changes or continuous growth in the total scope of a project. This can occur when the scope of a project is not properly defined, documented, or controlled. It is generally considered harmful and can undermine project timeframes, budget, and/or overall ability to get accomplished. Scope creep may occur if budget, resources, and schedule are increased along with the scope, the change is usually considered an acceptable addition to the project, and the term "scope creep" is not used. Scope creep is a risk in most projects, and can be a result of: • Poor change control • Lack of proper initial identification of what is required to bring about the project objectives • Weak project management • Poor communication between parties • Lack of initial product definition.

WHEN:

The action was initiated in January 2015 and was implemented February 2015.

HOW:

A policy entitled "Management of Projects" has been developed and will provide structure and reinforces business practice. The policy includes a communication and review requirement; all projects include a required status update report and reviewed once a month at the hospitals Executive Leadership Team.

5. The management of change and performance improvement supports both safety and quality throughout the hospital.

Scoring Category: A

Corrective Action Taken:

WHO:

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

WHAT:

December 20, 2013, the CEO requested that CFS's Clinical Director and Staff Development Manager develop training for all staff that works in CFS. This would be a 'basic' training that provides staff

training and education in all areas of CFS services provided to the patients of CFS. • Vision, mission and values of DSHS, BHSIA, WSH and CFS • Psychiatric and Behavioral Characteristics of Someone in CFS • How to Interact With Patients • Basic Skills Training • Problem Solving • Boundaries Training • SAMHSA Crisis Response Training • Risk Assessment and Management • How to Chart Behavioral Observations and Response to Treatment • A Cultural Competency Self-Assessment • Vicarious Trauma and Resiliency Training • Basic of PERT • Skills Practice • How Does Someone Come to CFS • How to transition out of CFS

WHEN:

April 14, 2014 was the first training in "CFS Basics", which included specific training on best practice for interacting with patients, and provides tools for de-escalation and minimizing the use of seclusion and restraint. By January 2014, 281 staff was trained in CFS Basics, across all disciplines which represents approximately one third of CFS staff. The intent is to develop a "center specific" curriculum from the CFS Basics, to customize and apply this knowledge to all staff across the hospital setting. In addition, as a part of a Plan of Correction, related to training of nursing staff for related competencies, the following trainings were completed on all nursing staff by March 30, 2015. Policy 2.6.6 Review of Sentinel Events Policy 4.2.3 Serious Assault When Victim is a Pt Procedure 201 Assignment of Pt Care Procedure 208 Code Green Response Procedure 209 Transfer of Pts between Wards Procedure 213 Utilization of Seclusion Restraint Protocol 301 Management Aggressive Assaultive Behavior Protocol 304 Management of Pt Requiring Therapeutic Engagement Protocol 307 Pt Suspected Possession Illegal Property Policy 2.1.9 Transfer of Pts within WSH

HOW:

Compliance will be sustained with the following efforts: New Employee Orientation now includes an updated section on the Culture of Safety Annual employee training requirements include all stated policies and procedures (see above).

HAP Standard LD.04.01.07 The hospital has policies and procedures that guide and support patient care, treatment, and services.

Findings: EP 1 Observed in Document Review at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site. The policy/procedure for the PERT team (July, 2014) was reviewed. It was noted that this policy did not reflect the changes that had been made to the process as of October, 2014. Observed in Leadership Session at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site. In review of policy, and in discussion in Leadership Session, it was noted that leadership had not approved the procedure entitled "Psychiatric Emergency Response Team (PERT) Procedure

Elements of Performance:

1. Leaders review and approve policies and procedures that guide and support patient care, treatment, and services. (See also NR.02.03.01, EP 1; RI.01.07.01, EP 1)

Scoring Category: A

Corrective Action Taken:

WHO:

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

WHAT:

At the time of the PERT program changes of October 2014, the WSH policy committee structure had lapsed. The policy/procedure for the PERT team was not modified, due to a lack of policy protocol. The WSH Policy Committee has been restructured and re-initiated in January 2015. This WSH policy group will serve as the primary conduit for all policies of the hospital.

WHEN:

January 2015

HOW:

The Executive Leadership Team will provide oversight and monitoring for the process of policy development.

HAP Standard LD.04.03.01 The hospital provides services that meet patient needs.

Findings: EP 14 §482.62(g)(1) - (B157) - (1) The program must be appropriate to the needs and interests of patients and be directed toward restoring and maintaining optimal levels of physical and psychosocial functioning. 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 review of documents and discussion with staff, it was noted that the hospital did not provide patients on the forensic units with therapeutic activities in the evenings or on the weekends.

Elements of Performance:

14. For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The psychiatric hospital provides psychological services, social work services, psychiatric nursing, and therapeutic activities. Note: The therapeutic activities program is appropriate to the needs and interests of patients and is directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.

Scoring Category: A

Corrective Action Taken:

WHO:

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

WHAT:

Additional programming was put in place on the Forensic wards to include: • Two hours of evening programming will be added to the Treatment and Recovery Center on weeknights (Monday-Friday). • Four Institutional Counselors will be added as additional staff support to the Competency Restoration wards to provide at least two hours each weekday evening for patient leisure activities. Increased weekend staffing will provide an additional four hours of patient therapeutic activities per weekend.

WHEN:

Additional programming was put in place by 3/28/2015

HOW:

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 100% compliance objective has been met, audits will be conducted quarterly thereafter.

HAP Standard LD.04.04.03 New or modified services or processes are well designed.

Findings: EP 6 Observed in Tracer Activities at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site. The hospital implemented the Psychiatric Emergency Response Team in March, 2014. The hospital's data indicated that there had been a significant reduction in restraint hours since inception of this team. In discussion with numerous staff (various shifts, disciplines and units) there was much discussion of the perception that patient to patient assaults had increased since development of this team. Review of data from the forensics units (presented in the safety PI data) indicated an increase of patient to patient assaults; patient injuries; severe patient injuries; accidental patient injuries; assault related patient injuries; self inflicted patient injuries. It was also communicated that since the inception of this team that fear of reporting incidence had increased. During discussion and review of documents, it was identified that the medical staff had expressed concerns of this new process in July/August, however these concerns were not addressed until a workgroup was formed in October. The hospital was not able to provide evidence that it had analyzed the increased assaults. While there was evidence that an evaluation of the process had occurred in September, 2014 there was a lack of evidence in how the concern brought by medical staff were addressed prior to the October, 2014 initiative and work team development EP 7 Observed in Tracer Activities at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site. The hospital implemented a Psychiatric Emergency Response Team (PERT) in March, 2014. Discussion with staff (various units, shifts and disciplines) indicated leaders had not involved staff and patients in the design of this new process.

Elements of Performance:

6. The hospital tests and analyzes its design of new or modified services or processes to determine whether the proposed design or modification is an improvement.

Scoring Category: A

Corrective Action Taken:

WHO:

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

WHAT:

RE: Analysis of data Quality Management research staff has conducted statistical analyses on hospital assault and seclusion/restraint data to identify patterns and contributing factors to inform quality of care, patient and staff safety. Specifically, research staff utilized existing AROI (Administrative Report of Incidents) assault data as well as seclusion/restraint data to determine whether there are statistically significant associations between these data and ward select indicators/performance indicators. In addition, analyses have been conducted to determine whether there are statistically significant differences in the patterns of assaults on the weekdays versus the weekends and between shifts. It is important to note that all assault data used in these analyses are from the database of reported assaults and therefore include all assault data including assaults that have and have not reached the level of a compensable or non-compensable claim. RE: Reporting incidents 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. RE: Medical Staff Concerns The PERT program was initiated in March of 2014. This program provoked multiple challenges within the culture of the CFS program, medical staff and other disciplines, resulting in many expressed concerns. Due to these and other concerns by staff, a PERT program evaluation was conducted in August, 2014, and finalized in September. This is verified within the document entitled "Psychiatric Emergency Response Team: A program Evaluation", dated September 18, 2014. WSH Executive Leadership authorized the formation of a PERT Work Group. This is documented in a memo to the Medical Director and the Patient Care Committee, dated October 14, 2014. The memo states …."I am authorizing the following group to be assembled and conduct a formal and structured review of the various PERT charter, training materials, and other related documents. This process will include recommendations in modification of the PERT program in order to insure compliance with all related standards of care……" "The goal of this workgroup is to maximize the Western State Hospital PERT Program to effectively improve the quality of care with the reduction of restraint, seclusion, staff assaults and injuries." Additional actions include a memo from the Medical Director dated October 22, 2014 that addresses medical staff concerns, and describes clarification and/or modification of the program. Additional actions to communicate with medical staff and other disciplines include the formulation and distribution of the PERT Frequently Asked Questions document.

WHEN:

RE: Analysis of data Analyses of the assault data occurred on 4/10/2015 and 4/16-17/2015. Analyses of these data continue to be ongoing as new data are collected and as new software is acquired to conduct a more thorough examination of the data to investigate trends in the data over time and also to compare trends in the data pre and post program implementation. RE: Reporting incidents Weekly safety announcements began March 23rd, 2015. The Code of Conduct and the Culture of Safety policy was distributed to all staff via Electronic Bulletin Board on April 8th, 2015. RE: Medical Staff Concerns Please note the imbedded dates listed in 'WHAT'.

HOW:

RE: Analysis of data Research staff will report the results of the analyses to the Quality Council during the first meeting in May 2015. Action plans will be developed for ongoing performance

improvement as indicated. Documentation of the analysis will be formalized in a report to assist in communication to the hospital. The research staff from Quality Management will compile data to monitor monthly compliance and performance improvement. RE: Reporting incidents 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 by April 30th, 2015 and presented to Quality Council committee on May 5th, 2015. 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. RE: Medical Staff Concerns The Pert Work Group is an authorized initiative by the CEO and Executive Leadership Team and provides monitoring and oversight.

7. Leaders involve staff and patients in the design of new or modified services or processes.

Scoring Category: A

Corrective Action Taken:

WHO:

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

WHAT:

In September 2013, the CEO requested proposals for safety initiatives from all WSH employees. The only proposal submitted included the program entitled the Psychiatric Emergency Response Team (PERT; similar to the highly successful Pennsylvania PERT model). Within the same month, the CEO shared this proposal with the WSH Clinical Operations Director, CFS RN4 and the CFS Clinical Director. The CEO approved the PERT safety initiative idea and roll out of the program began. On January 16, 2014, PERT Supervisor and the Quality Director met with CFS day nurse managers and RN3s and briefed them on the PERT concept. A second meeting with CFS day nurse managers and RN3s was held later that month to further brief them on the PERT concept. During the course of the roll out, nurse managers requested information from planning staff about the PERT concept. Multiple communications occurred through e-mailed information and multiple conversations with nurse managers about the concept and roll out in CFS. PERT was then rolled out in CFS day and swing shift on March 4, 2014.

WHEN:

Specific dates are included above.

HOW:

In January 2015, the CEO, authorized that the Department of Quality Management develop and maintain a centralized framework for the management of approved projects, to reduce risks and increase project successes. The major goals of this centralized process are to: • Improve the quality of project deliverables. • Increase the number of projects completed on time and within budget. • Improve control over project requests and workload. • Enhance control over project changes and “scope creep”. • Ensure that projects are aligned with WSH business objectives. • Improve communication to impacted staff, and employees, in general. A policy entitled “Management of Projects” has been developed and will provide structure and reinforces business practice. The policy includes a communication and review requirement; all projects include a required status update report and reviewed once a month at the hospitals Executive Leadership Team. UPDATE WITH QUESTION FROM SIG: Please revise to

include a description of scope creep. In the field of project management, “scope creep” (sometimes referred to as requirement creep) refers to uncontrolled changes or continuous growth in the total scope of a project. This can occur when the scope of a project is not properly defined, documented, or controlled. It is generally considered harmful and can undermine project timeframes, budget, and/or overall ability to get accomplished. Scope creep may occur if budget, resources, and schedule are increased along with the scope, the change is usually considered an acceptable addition to the project, and the term “scope creep” is not used. Scope creep is a risk in most projects, and can be a result of: • Poor change control • Lack of proper initial identification of what is required to bring about the project objectives • Weak project management • Poor communication between parties • Lack of initial product definition.

HAP Standard NR.02.01.01 The nurse executive directs the hospital’s nursing services.

Findings: EP 2 §482.23(a) - (A-0386) - §482.23(a) Standard: Organization The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed registered nurse. He or she is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital. This Standard is NOT MET as evidenced by: Observed in Document Review at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site for the Psychiatric Hospital deemed service. In review of the hospital's policy "Psychiatric Emergency Response Team (PERT) Procedure (7/1/2014), it was noted that the policy identified roles for a Registered Nurse This policy indicated that physical restraint techniques would be directed by the PERT captain, provided the captain is an RN. This policy further indicates that the role of the PERT captain includes monitoring the overall well-being of the patient throughout a crisis; direct staff response, including use of physical holds and/or physical restraint techniques; directing nursing staff to check on any existing medical condition the patient may have that could alter the team's response, etc. While this policy addresses how nursing care needs are met during times of crisis, the nurse executive did not coordinate these activities. These nurses report to a supervisor who is not a nurse.

Elements of Performance:

2. The nurse executive coordinates: The development of hospitalwide programs, policies, and procedures that address how nursing care needs of the patient population are assessed, met, and evaluated. Note: Examples of patient populations include pediatric, diabetic, and geriatric patients.

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:

Quality Improvement Staff met with the Nurse Executive team to review nursing policies and PERT procedures. This meeting discussed and developed a process for solid line supervision to the PERT lead and dotted line supervisions to the designated Nurse Manager. This will allow nursing staff to coordinate supervision and training of clinical nursing skills. Both the PERT lead and the Nurse Manager will work together to provide joint supervision of PERT nurses. 1. Psychiatric Emergency Response Team Procedures has been amended to reflect the supervision of nursing. This will ensure clinical skills are assessed on a regular basis and nursing completes competencies of each nurse. 2. Nursing Services Standard Procedure 213 has been amended to reflect supervision of PERT Lead for therapeutic engagements.

WHEN:

April 23, 2015

HOW:

PERT team members that are nurses will have their disciplines annual competencies completed by their Nurse Manager and reflected in their personnel file. Annual Competencies are tracked by the MHT5, quarterly reports of failures are provided to the Psychiatric Nurse Executive.

HAP Standard PC.03.05.05 For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital initiates restraint or seclusion based on an individual order.

Findings: EP 1 §482.13(e)(5) - (A-0168) - (5) The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §481.12(c) and authorized to order restraint or seclusion 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. Discussion with staff (multiple units, disciplines and shifts) indicated that they had observed patients being placed in physical holds without a physician order. In review of a report confirmed that on 10/13/14, the patient was placed in a manual hold and there were no orders from a physician for this restraint.

Elements of Performance:

1. For hospitals that use Joint Commission accreditation for deemed status purposes: A physician, clinical psychologist, or other authorized licensed independent practitioner primarily responsible for the patient's ongoing care orders the use of restraint or seclusion in accordance with hospital policy and law and regulation. Note: The definition of 'physician' is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

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:

The Nurse Executive has issued a memo ensuring each staff reviews and signs the Nursing Services Standard Procedure 213 Utilization of Seclusion and Restraint. This is also incorporated into the hospital's annual training update. UPDATE WITH QUESTION FROM SIG: Please revise to address the surveyor's observation. Please address how the action plan will address a physical hold not having a physician's order. Please address the education of nursing and medical staff regarding this issue. Observation: An investigation regarding the incident was completed by the Clinical Risk Management Department following the incident and was completed on 10/29/2014. Upon review of the incident it was determined that training was necessary regarding policy 2.4.1 "Seclusion & Restraint" and Nursing Standard 213 "Utilization of Seclusion or Restraint". Education of Nursing & Medical Staff: On 10/23/2014 a memo was posted to all Nursing Staff stating "This is a reminder to all nursing staff that all restraints require an MD order according to Nursing Standard Procedure 213 Utilization of Seclusion or Restraint. Any method physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, or body freely is considered a restraint. This includes all manual holds." Another reminder memo was sent to ALL staff (to include Nursing and Medical staff) on 3/13/2015 regarding restraints. Memo from Psychiatric Nurse Executive states: "This is a reminder/clarification regarding the use of Manual Restraint per WSH Policy 2.4.1 and Nursing Standards 213; Utilization of Seclusion/Restraint Restraint refers to: 1. Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely Any hands placed on a patient for other than supportive touch is restraint and must have a doctor's order. Manual Restraint The following care interventions constitute manual restraint and require an MD order: a. The placement of "hands on" a patient or patients for the purpose of controlling behavior and to prevent injury while the patient attempts to regain control. (This includes separating patients who are having physical contact with each other) b. Holding or putting hands on a combative patient to administer medication is restraint. c. The placement of "hands on" a patient to contain physical aggression during the application of mechanical restraint or placement into seclusion. (An order for seclusion/restraints includes, if necessary, a brief period of manual restraint in order to escort the patient to the seclusion room. d. One order for manual restraint shall not exceed 15 minutes. The following care interventions DO NOT constitute manual restraint and do not require an MD order: a. Physical prompting, escorting, or guiding of a person to assist in development or use of ADL's. b. Physically holding a cooperative person in a manner necessary to administer needed medical, dental, or nursing care. c. Physically redirecting a non-resistant person to avoid a physical confrontation with another person. d. Supportive touch provided to accomplish routine medical and nursing care." As part of the PERT re-roll out training, all PERT staff were re-trained on Policy 213 "Seclusion & Restraint" 11/4/2014. Policy 2.4.1 "Seclusion & Restraint" and Nursing Standard 213 "Utilization of Seclusion or Restraint" was reviewed with all Nursing staff involved and documentation of the review was placed in the supervisory file. Please address how the action plan will address a physical hold not having a physician's order: All physical holds are required to have a physician's order per policy 2.4.1 and Nursing Standard 213.

WHEN:

April 23, 2015

HOW:

Nurses will have their disciplines annual competencies completed by their Nurse Manager and reflected in their personnel file. Annual Competencies are tracked by the MHT5, quarterly reports of

failures are provided to the Psychiatric Nurse Executive.

HAP Standard PI.01.01.01 The hospital collects data to monitor its performance.

Findings: EP 3 §482.21(a)(2) - (A-0286) - (2) The hospital must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital service and operations. 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. The hospital leaders had set a priority of decreasing restraints and staff/patient injuries. In review of the data related to assaults, it was noted that in the various documents reviewed related to assaults (both staff and patients), there were inconsistencies in the data. For instance two different staff shared known occurrences of staff assault, however, these occurrences were not indicated on the assault log. The number of assaults reported in meeting minutes was not congruent with the number of assaults on the assault log. Staff reported a perception that if staff was not out of work due to the assault that the assault was not included in the data. Discussion with leaders indicated that there was more of a focus on compensable assaults stating this information had been fully investigated.

Elements of Performance:

3. The hospital collects data on the following: Performance improvement priorities identified by leaders. (See also LD.04.04.01, EP 1)

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 finding reflects that the WSH presentation of data was conducted in a manner that resulted in confusion over three separate issues: (1) Multiple data sources that are incongruent in their respective “numbers” due to, (2) the distinct purpose of each data sources, and (3) the logic underlying each data source (including timelines, criteria for an event qualifying as a “count” etc.). Quality Management research staff met with the WSH Safety Office, to clarify (1) the data processes (methods, times, data sources) and (2) purpose this data served, and (3) recognized that this method and purpose is different than other sources that are reported hospital wide. It was agreed that this confusion would be eliminated by implementing the following: (1) centralizing all data reporting through the QM Research Unit, and (2) QM Research staff will develop a data dictionary that provides clarity on each data element reported: source, with explanation of potential discrepancies of counts, and role, function and purpose.

WHEN:

This action was initiated April 22, 2015.

HOW:

The Quality Management Department director will include the data dictionary as an agenda item for annual departmental review.

HAP Standard PI.02.01.01 The hospital compiles and analyzes data.

Findings: EP 4 §482.21(a)(2) - (A-0286) - (2) The hospital must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital service and operations. 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. While the hospital did present restraint and assault data in graph form, they were not able to provide evidence that this data had been analyzed to identify levels of performance, patterns, trends and variations. For instance, anecdotally, the staff reported an increase in assaults on the weekends when there was no group activity, however, there was no evidence that the data had been analyzed to determine if in fact assault rates increased on the weekends. §482.21 (c)(2) - (A-0286) - (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. 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 review of hospital data related to assaults and in discussion with leadership, it was noted that the hospital focused much of their assault data analysis on compensable assaults. It was reported that the hospital focused "heavily" on these compensable assaults as it was viewed that the assaults reported through the incident reporting process was "inaccurate". At the time of survey, the hospital could not provide an analysis of assaults that included the full range of assaults (compensable and non-compensable events).

Elements of Performance:

4. The hospital analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations.

Scoring Category: A

Corrective Action Taken:

WHO:

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

WHAT:

Quality Management research staff has conducted statistical analyses on hospital assault and seclusion/restraint data to identify patterns and contributing factors to inform quality of care, patient and staff safety. Specifically, research staff utilized existing AROI (Administrative Report of Incidents) assault data as well as seclusion/restraint data to determine whether there are statistically

significant associations between these data and ward select indicators/performance indicators. In addition, analyses have been conducted to determine whether there are statistically significant differences in the patterns of assaults on the weekdays versus the weekends and between shifts. It is important to note that all assault data used in these analyses are from the database of reported assaults and therefore include all assault data including assaults that have and have not reached the level of a compensable or non-compensable claim.

WHEN:

Analyses of the assault data occurred on 4/10/2015 and 4/16-17/2015. Analyses of these data continue to be ongoing as new data are collected and as new software is acquired to conduct a more thorough examination of the data to investigate trends in the data over time and also to compare trends in the data pre and post program implementation.

HOW:

Research staff will report the results of the analyses to the Quality Council during the first meeting in May 2015. Action plans will be developed for ongoing performance improvement as indicated. Documentation of the analysis will be formalized in a report to assist in communication to the hospital. The research staff from Quality Management will compile data to monitor monthly compliance and performance improvement.

HAP Standard RI.01.01.01 The hospital respects, protects, and promotes patient rights.

Findings: EP 4 §482.13 - (A-0115) - §482.13 Condition of Participation: Condition of Participation: Patient's Rights This Condition 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 review of records and discussion with staff, it was noted that during a unit lock down all patients were secluded in their rooms. Observed in Tracer Activities at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site for the Psychiatric Hospital deemed service. In review of records and discussion with staff, it was noted that during a unit lock down all patients were secluded in their rooms.

Elements of Performance:

4. The hospital treats the patient in a dignified and respectful manner that supports his or her dignity.

Scoring Category: C

Corrective Action Taken:

WHO:

The Psychiatric Nurse Executive 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.

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.

HOW:

Trainings on the Seclusion and Restraint policy are ongoing and were 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.

Evaluation Method: All seclusion episodes for the next four months are reviewed by Nursing to ensure proper documentation, justification and doctors' orders per policy and Nursing Standard. All seclusion episodes (denominator). Seclusions without proper documentation, justification, and/or doctor's orders (numerator). UPDATE WITH QUESTION FROM SIG: These audits will be reviewed by the Quality Council on a monthly basis.

Measure of Success Goal (%): 90