LEGACY HEALTH
EMANUEL
MEDICAL CENTER

2801 N. Gantenbein Ave.
Portland, OR 97227
www.legacyhealth.org
503.413.2200 *phone*

August 20th, 2018

Attn: Karen Roe, RN, MHA
Certification and Enforcement Branch
Centers for Medicare & Medicaid Services
701 5th Ave, Suite 1600, M/S-400
Seattle, WA 98104
CMS_RO10_CEB@cms.hhs.gov

Dear Ms. Roe,

The following Plan of Correction is in response to the revisit survey related to #OR14992 conducted at the Unity Center for Behavioral Health 7/24/2018-7/30/2018.

Please see the completed Plan of Correction for the site's response to the findings from the survey.

If you have any questions, you may contact Legacy's Accreditation & Clinical Compliance team at 503-415-5235.

Sincerely,

Trent Green
President
Legacy Emanuel Medical Center
Unity Center for Behavioral Health

Enclosures: Plan of Correction

CC: Karyn Thrapp, RN, BSN, Lead Patient Safety Surveyor
Wendy Edwards, RN, BSN, Patient Safety Surveyor

A043 CONDITION | GOVERNING BODY | REFER TO A115, A263, A385, A700

PLAN OF CORRECTION

To ensure compliance with tag A043, the following corrective actions will be implemented by 9/11/2018.

A115

1. PROVISION OF CARE IN A SAFE SETTING (A144)

OBSERVATION PLAN/PATIENT MONITORING AND SAFETY ROUNDING

PROCEDURE/PROCESS FOR IMPLEMENTATION

A revised patient monitoring process will be implemented. In-person observation and engagement of patients in the performance of assigned patient observation checks will be the primary means of monitoring patients. Closed circuit video surveillance will only be utilized as an additional tool for unit safety; it will not be utilized in place of in-person monitoring. Upon admission, all patients will be placed on every 15-minute, in-person observation. Observation frequency level may be modified from every 15-minutes to hourly purposeful rounding only after all the following conditions have been met: patient admitted to an inpatient unit for at least 24 hours, 2 separate assessments by a licensed independent practitioner (LIP), and treatment team discussion of observation plan. The LIP will document the rationale to modify the level of observation. The level of observation will be documented by LIP order. At any time, a registered nurse (RN) may immediately increase the level of observation based on medical or behavioral conditions that create a potential risk to patient safety.
Responsible Party: Unity Vice President

LH policy #902.5201 “Guideline for Close Supervision” will be updated to “Routine and Special Observation for Patient Safety”. This updated policy will reflect the revised patient observation process. The following Unity inpatient standards of care and scope of service policies will also be revised to reflect the revised patient observation process: 902.7002, 902.1211, 902.1000, 902.7100.
Responsible Party: Unity Director of Patient Care Services

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers will receive education on the new patient monitoring policy and process by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete the education at the beginning of their next shift.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

Beginning on 8/3/2018, all admitted patients will be audited daily for 12 weeks (concluding on 11/3/2018) to assess compliance with the patient observation process and documentation. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/3/2018, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with the patient observation process and documentation. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify

themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with the patient observation process and documentation. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

Upon implementation of the revised patient observation policy, all admitted patients will be audited daily for 12 weeks to assess compliance with documentation of observation level modification process (patient admitted for 24 hours or greater, 2 separate assessments by an LIP, and treatment team discussion of observation plan). During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the LIP involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Medical Directors will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with documentation of observation level modification process. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Medical Directors will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with documentation of observation level modification process. The target for compliance is 95%. If 95% is not achieved, Medical Directors will conduct an analysis to assess areas of non-compliance. Medical Directors will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Chief Medical Officer

QAPI INTEGRATION

LH policy #902.5201 “Routine and Special Observation for Patient Safety” will be reviewed at least every three years and with changes in regulatory guidelines.

Education on patient monitoring policy and process will be included in the Unity staff and provider orientation and annual education for Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers.

To ensure long-term, continued compliance with the patient observation process and documentation is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

To ensure long-term, continued compliance with the documentation of observation level modification process is achieved, the Medical Directors will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

SUICIDE SCREENING AND ASSESSMENT AND SUICIDE PRECAUTIONS

PROCEDURE/PROCESS FOR IMPLEMENTATION

All patients presenting to the psychiatric emergency department (PES) and upon admission to inpatient units will be screened by a registered nurse (RN) for level of suicide risk using an evidence-based risk tool. Patients admitted to inpatient units will be rescreened twice daily by an RN for ongoing suicide risk. All patients presenting to the psychiatric emergency department (PES) and upon admission to inpatient units will be assessed by an LIP for suicidal risk. Daily and with change of condition, LIPs will reassess patients and place/review/modify orders for patient observation and level of suicide precautions. Patients who are assessed as at risk of suicidal behavior while hospitalized will be observed at a minimum of every 15-minutes in-person. Patients assessed as at imminent risk of suicidal behavior while hospitalized will be monitored by 1:1 in-person observation. Frequency level of patient observation will be determined by individual patient behaviors, risk factors, and protective factors. As part of the safety plan for patients at risk for suicide while hospitalized, patients on suicide precautions may have patient activities or items restricted for further protection from self-harm. For patients exhibiting an increase in self-injurious thoughts or behavior and for those whose suicide risk screen indicate an increase in suicide risk from the previous screening, staff will initiate an increase in patient observation and notify the LIP. Decreasing patient observation level may only be done with documented LIP assessment and order.
Responsible Party: Unity Vice President

LH policy #902.3108 “Suicide Precautions” will be updated to reflect the revised screening, assessment, and intervention process for patients at risk for suicide.
Responsible Party: Unity Director of Patient Care Services and Unity Chief Medical Officer

Suicide precaution order choices in the electronic health record (EHR) will be updated to be consistent with the revised patient observation and suicide precautions policy.
Responsible Party: Unity Chief Medical Officer

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers will receive education on the revised suicide precautions policy by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete the education at the beginning of their next shift.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

Beginning on 8/3/2018, all admitted patients will be audited daily for 12 weeks (concluding on 11/3/2018) to assess compliance with documentation of suicide risk screening. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/3/2018, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with documentation of suicide risk screening. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with documentation of suicide risk screening. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

Beginning on 8/3/2018, all admitted patients will be audited daily for 12 weeks (concluding on 11/3/2018) to assess compliance with provider suicide risk assessment documentation. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the LIP involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Medical Directors will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/3/2018, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with provide suicide risk assessment documentation. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Medical Directors will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with provide suicide risk assessment documentation. The target for compliance is 95%. If 95% is not achieved, Medical Directors will conduct an analysis to assess areas of non-compliance. Medical Directors will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Chief Medical Officer

QAPI INTEGRATION

LH policy #902.3108 “Suicide Precautions” will be reviewed at least every three years and with changes in regulatory guidelines.

Education on suicide precautions policy and process will be included in the Unity staff and provider orientation and annual education for Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers.

To ensure long-term, continued compliance with documentation of suicide risk screening is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

To ensure long-term, continued compliance with provide suicide risk assessment documentation is achieved, the Medical Directors will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

PATIENT BELONGINGS

PROCEDURE/PROCESS FOR IMPLEMENTATION

A revised process for managing patient belongings will be implemented. During inpatient intake process, patients may select personal items to keep with them. All items selected by patient will be inspected for safety and appropriateness and documented on the personal belongings form. The number of clothing items the patient will be allowed to have will be limited to 12. All other patient belongings will be put into sealed bags and placed in secure belongings storage. If a patient requests a personal item from secure storage, staff will retrieve and inspect the item for safety and appropriateness before giving to patient. Retrieval will be documented on the personal belongings form. This process will also apply to currently admitted patients.
Responsible Party: Unity Director of Patient Care Services

Legacy policy #902.3107 “Personal Belongings and Unsafe Items on Inpatient Psychiatric Units” was revised on 5/20/18 to categorize potentially unsafe items into four categories: never allowed, used during group, used with staff supervision, and allowed unmonitored unless an extreme risk. Items used during group or requiring staff supervision will be secured unless in use by patients.

Staff will assess patients twice a day for safety regarding items in the unmonitored unless an extreme risk category and document in the EHR changes to unsafe item management.
Responsible Party: Unity Director of Patient Care Services

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, and Clerical staff will receive education on the new patient belongings policy and process by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete the education at the beginning of their next shift.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

In-room belongings will be inspected for safety and appropriateness for 30 patients per unit per month for 3 months to assess staff compliance with patient belongings policy, process, and documentation. The target for compliance is 95%. If 95% compliance is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an additional analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care Services

QAPI INTEGRATION

LH policy #902.3107 “Personal Belongings and Unsafe items on Inpatient Psychiatric Unit” will be reviewed at least every three years and with changes in regulatory guidelines.

Education on patient belongings policy and process will be included in the Unity orientation and annual education for Registered Nurses, Behavioral Health Assistants, Behavioral Health Therapists and Clerical staff.

To ensure, long-term continued compliance with patient belongings policy, process, and documentation is achieved, Nurse Managers/Assistant Nurse Managers will conduct ongoing auditing of 30 patients per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

ENVIRONMENT OF CARE: LIGATURE RISKS, UNSAFE ITEMS, AND BLIND SPOTS

PROCEDURE/PROCESS FOR IMPLEMENTATION

A comprehensive environmental risk assessment, including identification of ligature risks and unsafe items, was completed on 5/20/18 by nursing leadership for all areas where patients receive care and services. The Unity Vice President is completing another comprehensive environmental risk assessment 8/14/2018-8/24/2018 to identify additional ligature risks and unsafe items. On 8/24/2018, external subject matter experts from Oregon State Hospital are visiting Unity to tour all patient care areas to offer observations on the environment of care. The comprehensive risk assessment will be updated with additional environmental risks.
Responsible Party: Unity Vice President

To mitigate the risk associated with the camera blind spots, in-person observation and engagement of patients in the performance of assigned patient observation checks will be the primary means of monitoring patients. Closed circuit video surveillance will only be utilized as an additional tool for unit safety; it will not be utilized in place of in-person monitoring.
Responsible Party: Unity Vice President

Recliners in the PES calming rooms were removed and replaced with heavy chairs and ottomans that are ligature-resistant on 7/26/2018.
Responsible Party: PES Nurse Manager

Metal rings in seclusion rooms will be removed and replaced with a round metal rod by 8/22/2018.
Responsible Party: Facilities Manager

All patient bathroom doors (with limited exception 201, 202, 203, 204, 205, 501, 502, 521, 522, 601, 602, 603, 608, 620) were removed on 7/20/2018 and replaced with Velcro curtains. Bathroom doors were kept in place in all hardened rooms and three patient rooms on Unit 6 to meet patient care needs for patients with eating disorders. The curtains were assessed in April 2017 and reassessed on 7/20/2018 for safety. Unity Leadership Council and Director of Environmental Services determined these are safe and do not pose a suffocation risk. The Velcro consists of small strips (approximately 1 inch by 1 inch) to mitigate Velcro being used as a ligature. The Velcro mounting system was assessed to be low weight-bearing and cannot be used as a ligature point. For those patient rooms that have bathroom doors, the bathroom door will be locked at all times, and the patient will be supervised by staff when in use. If the patient is assessed to not be at risk for suicide while hospitalized, the bathroom door may be unlocked, and the patient will be observed every 15-minutes in-person.
Responsible Party: Unity Director of Patient Care Services

Hinges on the window access panels in all patient rooms will be filled with pick-proof caulk to eliminate the ligature risk. This will be completed by 8/31/2018.
Responsible Party: Facilities Manager

Cabinet doors will be removed on all patient belongings cabinets in patient rooms. The following items located within the patient cabinets will have ligature and other safety risks mitigated: internal shelf, vent, clock, and outlet. The shelf will be removed and used to cover the vent. The clocks will be covered with a protective case. This will be completed by 8/31/2018.The outlet inside the cabinet is a safety outlet and does not require further safety mitigation.
Responsible Party: Facilities Manager

The correct version of LH policy #902.5111 “Counseling and Therapy Therapeutic Guideline” was posted to the Legacy intranet site on 7/30/2018. This version explicitly states that there will always be two staff members present in the garden, and no staff will be alone in the garden while patients are using the garden.
Responsible Party: Unity Vice President

The garden environmental risk assessment was updated to include the emergency poles, gazebos, and basketball hoops on 7/30/2018. To mitigate the environmental risks in the garden, the staffing ratio is 1 staff for 5 patients, and a minimum of two staff members must be in the garden with patients at all times regardless of number of patients. All patients that attend garden group must have an order from the LIP to attend.
Responsible Party: Unity Vice President

Linen carts were removed from general milieu and secured in non-patient care areas on 7/28/2018. Soiled linen hampers will be kept in a secure area when not in use.
Responsible Party: Unity Director of Patient Care Services

The coffee stirrers identified during survey are thin black straws. The straws were reviewed on 8/3/2018 by Unity Director of Patient Care Services and Unity Vice President and determined to be safe for patient use due to flexibility. This item has been added to the comprehensive environmental risk assessment.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

High risk issues identified during the leadership safety huddle will be added to the action plan template. Action items will be reviewed at the leadership safety huddle, and the action plan will be added as a standing agenda item at Leadership Council. Action items related to the environment of care will be added to the environmental risk assessment along with a mitigation plan.
Responsible Party: Unity Vice President

All safety event reports (ICAREs) related to ligature risk or unsafe items, attempted suicide or self-harm, patient elopements or attempted elopements will be investigated, and a mitigation plan will be implemented for any ongoing risks. Response to ICAREs

includes these immediate steps: ensure the patient is safe, creation of an immediate safety plan, notification of leadership up through chain of command, documentation of the event, and investigation. Investigations will be initiated within 72 hours of receipt and completed as soon as possible or no later than two weeks after receipt, depending on the severity and complexity of the event.
Responsible Party: Unity Vice President

QAPI INTEGRATION

Legacy's Hazard Surveillance Rounds and Analyses tool was updated on 7/18/2018 to include ligature risks and unsafe items. These rounds are conducted quarterly.
Responsible Party: Environment of Care Manager

Environmental safety rounds to identify potential ligature risks and unsafe items began on 5/20/18 in accordance with revised policy #902.3107. Nursing staff will conduct environmental safety rounds twice a day in all areas where patients receive care and services.
Responsible Party: Unity Director of Patient Care Services

Prospectively, a comprehensive environmental risk assessment will be completed and reviewed for all areas where patients receive care and services, on a quarterly basis, by unit leadership or designee.
Responsible Party: Unity Vice President

RESPONSE TO URGENT AND EMERGENCY MEDICAL CONDITIONS

PROCEDURE/PROCESS FOR IMPLEMENTATION

All suction machines on Code M carts were enrolled in the Legacy preventive maintenance program in accordance with the LH policy #300.12 "Medical Equipment Management Plan" on 8/3/2018.
Responsible Party: Legacy Director of Clinical Engineering

To ensure that equipment and supplies for urgent and emergent medical response are available, the Code M carts are checked daily to ensure required cart elements are present and unexpired.
Responsible Party: Unity Director of Patient Care Services

MONITORING/TRACKING PROCEDURES

Per LH policy #300.12 "Medical Equipment Management Plan", the Director of Clinical Engineering assures that scheduled testing of all non-life support medical equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Safety Committee each quarter. If any monthly rate of completion falls below 90%, the Director of Clinical Engineering will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.
Responsible Party: Legacy Director of Clinical Engineering

All Code M carts daily checks will be audited each week for 12 weeks to assess compliance with completion and documentation of daily cart checks. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 Code M cart daily checks per unit will be audited each month for 3 months to assess compliance with completion and documentation of daily cart checks. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3

consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

The Code M carts are checked daily to ensure required cart elements are present and unexpired.

The Director of Clinical Engineering maintains the medical equipment inventory, which includes information on required scheduled maintenance for all equipment. This ensures all inventoried equipment receives timely preventive maintenance.

To ensure long-term, continued compliance with completion and documentation of daily cart checks is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 Code M cart daily checks per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

ELOPEMENT AND COMMUNICATION SAFETY DEVICES

PROCEDURE/PROCESS FOR IMPLEMENTATION

To mitigate elopement risk, a revised patient monitoring process will be implemented. In-person observation and engagement of patients in the performance of assigned patient observation checks will be the primary means of monitoring patients. Closed circuit video surveillance will only be utilized as an additional tool for unit safety; it will not be utilized in place of in-person monitoring. Upon admission, patients will be placed on every 15-minute, in-person observation. Observation frequency level may be modified from every 15-minutes to hourly purposeful rounding only after the following conditions have been met: patient admitted to an inpatient unit for at least 24 hours, 2 separate assessments by a licensed independent practitioner (LIP), and treatment team discussion of observation plan. The LIP will document the rationale to modify the level of observation. The level of observation will be documented by LIP order. At any time, a registered nurse (RN) may immediately increase the level of observation based on medical or behavioral conditions that create a potential risk to patient safety.
Responsible Party: Unity Vice President

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, providers, and contractors with direct patient contact will receive education on alertness to potential hazards and environmental risks by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete the education at the beginning of their next shift.
Responsible Party: Unity Vice President

30 additional Voceras (communication safety devices) were ordered on 8/20/2018 . A revised Vocera inventory process will be instituted. The revised process will include a check-in/check-out process to be conducted every shift to ensure that devices are returned from off-going shift staff and devices are allocated to all oncoming shift staff. Nurse Manager/Assistant Nurse Manager will review the Vocera report to identify and follow-up on lost or misplaced devices.
Responsible Party: Unity Director of Patient Care Services

MONITORING AND TRACKING PROCEDURES

Beginning on 8/3/2018, all admitted patients will be audited daily for 12 weeks (concluding on 11/3/2018) to assess compliance with the patient observation process and documentation. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/3/2018, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with the patient observation process and documentation. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with the patient observation process and documentation. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

LH policy #902.5201 “Routine and Special Observation for Patient Safety” will be reviewed at least every three years and with changes in regulatory guidelines.

To ensure long-term, continued compliance with the patient observation process and documentation is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

MEDICATION ADMINISTRATION (A405)

PROCEDURE/PROCESS FOR IMPLEMENTATION

Medication administration education was completed by all nurses by 7/26/2018.
Responsible Party: Unity Director of Patient Care Services

Starting on 7/28/2018 and ending 8/14/2018, medication administrations were audited in real-time by a second RN observing the medication administration process. All nurses were educated on how to use the audit tool, which includes all steps required for safe medication administration. When any instances of non-compliance were analyzed using the Just Culture Algorithm and non-compliance was addressed with the staff member involved.
Responsible Party: Unity Director of Patient Care Services

Medication administration education was completed by all nurses by 7/26/2018.
Responsible Party: Unity Director of Patient Care Services

New ICARE follow-up guidelines were developed to provide the Nurse Managers/Assistant Nurse Managers with additional guidance on what to include in their investigation of safety event reports on their units. The guidelines include a template for investigating distinct categories of safety event reports, including medication errors as previously described. Nurse Managers/Assistant Nurse Managers are to choose the appropriate category and template and input it into the ICARE system to document findings from their investigation. The template includes sections to list contributing factors, patient condition/outcome, mitigation plan, and just culture findings.
Responsible Party: Unity Director of Patient Care Services

MONITORING AND TRACKING PROCEDURES

After confirming adoption of the barcode medication administration process, as validated by improvement in barcode scanning percentages and daily audit results, beginning on 8/14/2018, 30 medication administration on each adult inpatient unit and PES and 20 medication administrations on the adolescent inpatient unit (approximately 50%) will be audited daily for 12 weeks (concluding on 11/14/2018) to assess compliance with the medication administration process. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/14/2018, 30 medication administrations on each adult inpatient unit and PES and 20 medication administrations on the adolescent inpatient unit will be audited each week for 12 weeks to assess compliance with the medication administration process. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 medication administrations will be audited each month for 3 months to assess compliance with the medication administration process. The target for compliance is 95% If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.

To ensure long-term, continued compliance with the medication administration process is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

All Nurse Managers/Assistant Nurse Managers will review individual nurse barcode medication administration scanning compliance percentages monthly. For any nurse that does not meet scanning expectations, the Nurse Manager/Assistant Nurse Manager will investigate and determine if correct medication administration process was followed. If it is determined the nurse did not follow correct medication administration process, the Nurse Manager/Assistant Nurse Manager will provide coaching on correct medication administration process and expectations.

2. TIMELY AND COMPLETE INVESTIGATION OF EVENTS (A145)

PROCEDURE/PROCESS FOR IMPLEMENTATION

Reeducation on safety event reporting (ICARE) was provided to all direct care staff, including Registered Nurses, Behavioral Health Assistants, Behavioral Health Therapists, Counseling and Therapy staff, Care Management staff, Security staff, and Contractors with direct patient contact on 7/20/2018. This education included information on types of incidents and events that should be reported along with what constitutes abuse and neglect. Staff that have not completed the education will complete the education prior to their next work shift.
Responsible Party: Unity Vice President

New ICARE follow-up guidelines were developed to provide the Nurse Managers/Assistant Nurse Managers with additional guidance on what to include in their investigation of safety event reports on their units. The guidelines include a template for investigating distinct categories of ICAREs, including ligature risks, elopements (attempted or actual), cheeking medications, medication errors,

unsafe items, Code M (medical emergency), self-harm or suicide attempts, restraint and seclusion, abuse or assault allegations from patients (including neglect), falls, and abuse or assault allegations from staff. Nurse Managers/Assistant Nurse Managers verify that the appropriate event category is documented. The Nurse Managers/Assistant Nurse Managers use a follow-up template and input the template into the ICARE system along with the investigation findings. The template includes sections to list contributing factors, patient condition/outcome, mitigation plan, and just culture findings.
Responsible Party: Unity Director of Patient Care Services

Abuse and neglect allegations are investigated immediately. Response to abuse or neglect allegations includes these immediate steps: ensure the patient is safe, creation of an immediate safety plan, notification of leadership up through chain of command, documentation of the alleged or suspected abuse or neglect, and investigation of all allegations. Cases of abuse and neglect will be escalated to Risk Management for additional investigation per the department's established abuse investigation process. Investigation findings are reviewed by senior leadership and risk management. This group determines if the allegation of abuse or neglect is substantiated. If the allegation is substantiated, mandatory reporting processes will be followed. After the investigation is complete, the Nurse Managers/Assistant Nurse Managers will document the outcome of the investigation and whether the allegation of abuse or neglect is substantiated.
Responsible Party: Manager of Risk Management

Communication was provided in-person and reiterated in writing on 7/5/2018 to Nurse Managers and Assistant Nurse Managers reinforcing expectations for reviewing ICAREs along with a copy of the newly developed ICARE report guidelines with instructions for use. Part of the expectations included what constitutes a timely investigation and response to ICAREs: Managers are expected to initiate investigation of their ICAREs within 72 hours of receipt and complete their investigation as soon as possible or no later than two weeks after receipt, depending on the severity and complexity of the case.
Responsible Party: Unity Director of Patient Care Services

MONITORING AND TRACKING PROCEDURES

20 ICAREs will be audited each week for 12 weeks to ensure all elements of the ICAREs are completed and allegations and cases of abuse or neglect are investigated and documented per standard process. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, the Unity Director of Patient Care Services will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 ICAREs will be audited each month for 3 months to ensure all elements of the ICAREs are completed and allegations and cases of abuse or neglect are investigated and documented per standard process. The target for compliance is 95%. If 95% is not achieved, Unity Director of Patient Care Services will conduct an analysis to assess areas of non-compliance. Unity Director of Patient Care Services will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

Upon hire, all direct care staff, including Registered Nurses, Behavioral Health Assistants, Behavioral Health Therapists, Counseling and Therapy staff, Care Management staff, Security staff, and contractors with direct patient contact receive education on safety event reporting in the ICARE system and the types of incidents and events that should be reported and identification of cases of abuse and neglect.

To ensure sustainment of the ICARE and abuse or neglect investigation processes, the Unity Director of Patient Care Services will conduct ongoing audits of 30 ICAREs per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

3. RESTRAINT/SECLUSION ASSESSMENT AND MONITORING (A175)

PROCEDURE/PROCESS FOR IMPLEMENTATION

Registered Nurses, Behavioral Health Assistants, Behavioral Health Therapists, Counseling and Therapy staff, and Security staff will complete restraint/seclusion education, including restraint policy and all restraint types, by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete restraint and seclusion education at the beginning of their next shift.
Responsible Party: Unity Vice President

Legacy's policy #900.5274 "Restraint and Seclusion for Patient Safety" will be revised to include which role may complete every 2-hour assessments and every 15-minute monitoring for patients with violent or self-destructive behaviors. Additionally, the required elements of the every 2-hour nursing assessments will be specified in the policy.
Responsible Party: Clinical Nurse Specialist

MONITORING AND TRACKING PROCEDURES

Beginning on 8/3/2018, all restraint and seclusion events will be audited each week for 12 weeks (concluding on 11/3/2018) to assess compliance with restraint/seclusion documentation requirements. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, the Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved but not before 11/3/2018, 30 restraint and seclusion events per unit will be audited each month for 3 months to assess compliance with restraint/seclusion documentation requirements. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

Legacy's policy #900.5274 "Restraint and Seclusion for Patient Safety" will be reviewed at least every 3 years and with changes in regulatory guidelines.

Legacy's standard of care 900.1012 "Use of Restraint and Seclusion" will be reviewed at least every 3 years and with changes in regulatory guidelines.

Restraint/seclusion requirements are included in direct care staff, who are involved in restraint/seclusion events, orientation and annual education.

To ensure long-term, continued compliance with c restraint/seclusion requirements is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 restraint and seclusion events per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

4. RESTRAINT/SECLUSION TRAINING (A202)

PROCEDURE/PROCESS FOR IMPLEMENTATION

Legacy's policy #900.5274 "Restraint and Seclusion for Patient Safety" will be updated to include a list of specific restraint types that are utilized at Unity. Unity does not use nonviolent restraints.
Responsible Party: Unity Director of Patient Care Services

The restraint and seclusion education and return demonstration will be updated to reflect the specific restraint types that are utilized at Unity.
Responsible Party: Unity Director of Patient Care Services

Registered Nurses, Behavioral Health Assistants, Behavioral Health Therapists, Counseling and Therapy staff, and Security staff will complete restraint/seclusion education, including restraint policy and all restraint types, by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete restraint and seclusion education at the beginning of their next shift.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

Each staff person's education record (including Registered Nurses, Behavioral Health Assistants, Behavioral Health Therapists, Counseling and Therapy staff, and Security staff) will be audited by 9/11/2018 to ensure completion of required restraint/seclusion training, education, and competencies.
Responsible Party: Department Leadership

QAPI INTEGRATION

Legacy's policy #900.5274 "Restraint and Seclusion for Patient Safety" will be reviewed at least every 3 years and with changes in regulatory guidelines.

Legacy's standard of care 900.1012 "Use of Restraint and Seclusion" will be reviewed at least every 3 years and with changes in regulatory guidelines.

Restraint/seclusion requirements are included in direct care staff, who are involved in restraint/seclusion events orientation, and annual education.A385

A385

1. RN ASSESSMENT, MONITORING, AND OBSERVATION (A395)

OBSERVATION PLAN/PATIENT MONITORING AND SAFETY ROUNDING

PROCEDURE/PROCESS FOR IMPLEMENTATION

A revised patient monitoring process will be implemented. In-person observation and engagement of patients in the performance of assigned patient observation checks will be the primary means of monitoring patients. Closed circuit video surveillance will only be utilized as an additional tool for unit safety; it will not be utilized in place of in-person monitoring. Upon admission, all patients will

be placed on every 15-minute, in-person observation. Observation frequency level may be modified from every 15-minutes to hourly purposeful rounding only after all the following conditions have been met: patient admitted to an inpatient unit for at least 24 hours, 2 separate assessments by a licensed independent practitioner (LIP), and treatment team discussion of observation plan. The LIP will document the rationale to modify the level of observation. The level of observation will be documented by LIP order. At any time, a registered nurse (RN) may immediately increase the level of observation based on medical or behavioral conditions that create a potential risk to patient safety.
Responsible Party: Unity Vice President

LH policy #902.5201 "Guideline for Close Supervision" will be updated to "Routine and Special Observation for Patient Safety". This updated policy will reflect the revised patient observation process. The following Unity inpatient standards of care and scope of service policies will also be revised to reflect the revised patient observation process: 902.7002, 902.1211, 902.1000, 902.7100.
Responsible Party: Unity Director of Patient Care Services

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers will receive education on the new patient monitoring policy and process by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete the education at the beginning of their next shift.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

Beginning on 8/3/2018, all admitted patients will be audited daily for 12 weeks (concluding on 11/3/2018) to assess compliance with the patient observation process and documentation. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/3/2018, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with the patient observation process and documentation. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with the patient observation process and documentation. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

LH policy #902.5201 "Routine and Special Observation for Patient Safety" will be reviewed at least every three years and with changes in regulatory guidelines.

Education on patient monitoring policy and process will be included in the Unity staff and provider orientation and annual education for Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers.

To ensure long-term, continued compliance with the patient observation process and documentation is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

SUICIDE SCREENING AND ASSESSMENT AND SUICIDE PRECAUTIONS

PROCEDURE/PROCESS FOR IMPLEMENTATION

All patients presenting to the psychiatric emergency department (PES) and upon admission to inpatient units will be screened by a registered nurse (RN) for level of suicide risk using an evidence-based risk tool. Patients admitted to inpatient units will be rescreened twice daily by an RN for ongoing suicide risk. All patients presenting to the psychiatric emergency department (PES) and upon admission to inpatient units will be assessed by an LIP for suicidal risk. Daily and with change of condition, LIPs will reassess patients and place/review/modify orders for patient observation and level of suicide precautions. Patients who are assessed as at risk of suicidal behavior while hospitalized will be observed at a minimum of every 15-minutes in-person. Patients assessed as at imminent risk of suicidal behavior while hospitalized will be monitored by 1:1 in-person observation. Frequency level of patient observation will be determined by individual patient behaviors, risk factors, and protective factors. As part of the safety plan for patients at risk for suicide while hospitalized, patients on suicide precautions may have patient activities or items restricted for further protection from self-harm. For patients exhibiting an increase in self-injurious thoughts or behavior and for those whose suicide risk screen indicate an increase in suicide risk from the previous screening, staff will initiate an increase in patient observation and notify the LIP. Decreasing patient observation level may only be done with documented LIP assessment and order.
Responsible Party: Unity Vice President

LH policy #902.3108 “Suicide Precautions” will be updated to reflect the revised screening, assessment, and intervention process for patients at risk for suicide.
Responsible Party: Unity Vice President

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers will receive education on the revised suicide precautions policy by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete the education at the beginning of their next shift.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

Beginning on 8/3/2018, all admitted patients will be audited daily for 12 weeks (concluding on 11/3/2018) to assess compliance with documentation of suicide risk screening. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/3/2018, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with documentation of suicide risk screening. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with documentation of suicide risk screening. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

LH policy #902.3108 “Suicide Precautions” will be reviewed at least every three years and with changes in regulatory guidelines.

Education on suicide precautions policy and process will be included in the Unity staff and provider orientation and annual education for Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers.

To ensure long-term, continued compliance with documentation of suicide risk screening is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

2. MEDICATION ADMINISTRATION (A405)

PROCEDURE/PROCESS FOR IMPLEMENTATION

Medication administration education was completed by all nurses by 7/26/2018.
Responsible Party: Unity Director of Patient Care Services

Starting on 7/28/2018 and ending 8/14/2018, medication administrations were audited in real-time by a second RN observing the medication administration process. All nurses were educated on how to use the audit tool, which includes all steps required for safe medication administration. When any instances of non-compliance were analyzed using the Just Culture Algorithm and non-compliance was addressed with the staff member involved.
Responsible Party: Unity Director of Patient Care Services

Medication administration education was completed by all nurses by 7/26/2018.
Responsible Party: Unity Director of Patient Care Services

New ICARE follow-up guidelines were developed to provide the Nurse Managers/Assistant Nurse Managers with additional guidance on what to include in their investigation of safety event reports on their units. The guidelines include a template for investigating distinct categories of safety event reports, including medication errors as previously described. Nurse Managers/Assistant Nurse Managers are to choose the appropriate category and template and input it into the ICARE system to document findings from their investigation. The template includes sections to list contributing factors, patient condition/outcome, mitigation plan, and just culture findings.
Responsible Party: Unity Director of Patient Care Services

MONITORING AND TRACKING PROCEDURES

After confirming adoption of the barcode medication administration process, as validated by improvement in barcode scanning percentages and daily audit results, beginning on 8/14/2018, 30 medication administration on each adult inpatient unit and PES and 20 medication administrations on the adolescent inpatient unit (approximately 50%) will be audited daily for 12 weeks (concluding on 11/14/2018) to assess compliance with the medication administration process. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit

findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/14/2018, 30 medication administrations on each adult inpatient unit and PES and 20 medication administrations on the adolescent inpatient unit will be audited each week for 12 weeks to assess compliance with the medication administration process. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 medication administrations will be audited each month for 3 months to assess compliance with the medication administration process. The target for compliance is 95% If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.

To ensure long-term, continued compliance with the medication administration process is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

All Nurse Managers/Assistant Nurse Managers will review individual nurse barcode medication administration scanning compliance percentages monthly. For any nurse that does not meet scanning expectations, the Nurse Manager/Assistant Nurse Manager will investigate and determine if correct medication administration process was followed. If it is determined the nurse did not follow correct medication administration process, the Nurse Manager/Assistant Nurse Manager will provide coaching on correct medication administration process and expectations.

A700

PLAN OF CORRECTION

To ensure compliance with tag A700, the following corrective actions will be implemented by 9/11/2018.

ENVIRONMENT OF CARE: LIGATURE RISKS, UNSAFE ITEMS, AND BLIND SPOTS

PROCEDURE/PROCESS FOR IMPLEMENTATION

A comprehensive environmental risk assessment, including identification of ligature risks and unsafe items, was completed on 5/20/18 by nursing leadership for all areas where patients receive care and services. The Unity Vice President is completing another comprehensive environmental risk assessment 8/14/2018-8/24/2018 to identify additional ligature risks and unsafe items. On 8/24/2018, external subject matter experts from Oregon State Hospital are visiting Unity to tour all patient care areas to offer observations on the environment of care. The comprehensive risk assessment will be updated with additional environmental risks.
Responsible Party: Unity Vice President

To mitigate the risk associated with the camera blind spots, in-person observation and engagement of patients in the performance of assigned patient observation checks will be the primary means of monitoring patients. Closed circuit video surveillance will only be utilized as an additional tool for unit safety; it will not be utilized in place of in-person monitoring.
Responsible Party: Unity Vice President

Recliners in the PES calming rooms were removed and replaced with heavy chairs and ottomans that are ligature-resistant on 7/26/2018.
Responsible Party: PES Nurse Manager

Metal rings in seclusion rooms will be removed and replaced with a round metal rod by 8/22/2018.
Responsible Party: Facilities Manager

All patient bathroom doors (with limited exception 201, 202, 203, 204, 205, 501, 502, 521, 522, 601, 602, 603, 608, 620) were removed on 7/20/2018 and replaced with Velcro curtains. Bathroom doors were kept in place in all hardened rooms and three patient rooms on Unit 6 to meet patient care needs for patients with eating disorders. The curtains were assessed in April 2017 and reassessed on 7/20/2018 for safety. Unity Leadership Council and Director of Environmental Services determined these are safe and do not pose a suffocation risk. The Velcro consists of small strips (approximately 1 inch by 1 inch) to mitigate Velcro being used as a ligature. The Velcro mounting system was assessed to be low weight-bearing and cannot be used as a ligature point. For those patient rooms that have bathroom doors, the bathroom door will be locked at all times, and the patient will be supervised by staff when in use. If the patient is assessed to not be at risk for suicide while hospitalized, the bathroom door may be unlocked, and the patient will be observed every 15-minutes in-person.
Responsible Party: Unity Director of Patient Care Services

Hinges on the window access panels in all patient rooms will be filled with pick-proof caulk to eliminate the ligature risk. This will be completed by 8/31/2018.
Responsible Party: Facilities Manager

Cabinet doors will be removed on all patient belongings cabinets in patient rooms. The following items located within the patient cabinets will have ligature and other safety risks mitigated: internal shelf, vent, clock, and outlet. The shelf will be removed and used to cover the vent. The clocks will be covered with a protective case. This will be completed by 8/31/2018.The outlet inside the cabinet is a safety outlet and does not require further safety mitigation.
Responsible Party: Facilities Manager

The correct version of LH policy #902.5111 “Counseling and Therapy Therapeutic Guideline” was posted to the Legacy intranet site on 7/30/2018. This version explicitly states that there will always be two staff members present in the garden, and no staff will be alone in the garden while patients are using the garden.
Responsible Party: Unity Vice President

The garden environmental risk assessment was updated to include the emergency poles, gazebos, and basketball hoops on 7/30/2018. To mitigate the environmental risks in the garden, the staffing ratio is 1 staff for 5 patients, and a minimum of two staff members must be in the garden with patients at all times regardless of number of patients. All patients that attend garden group must have an order from the LIP to attend.
Responsible Party: Unity Vice President

Linen carts were removed from general milieu and secured in non-patient care areas on 7/28/2018. Soiled linen hampers will be kept in a secure area when not in use.
Responsible Party: Unity Director of Patient Care Services

The coffee stirrers identified during survey are thin black straws. The straws were reviewed on 8/3/2018 by Unity Director of Patient Care Services and Unity Vice President and determined to be safe for patient use due to flexibility. This item has been added to the comprehensive environmental risk assessment.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

High risk issues identified during the leadership safety huddle will be added to the action plan template. Action items will be reviewed at the leadership safety huddle, and the action plan will be added as a standing agenda item at Leadership Council. Action items related to the environment of care will be added to the environmental risk assessment along with a mitigation plan.
Responsible Party: Unity Vice President

All safety event reports (ICAREs) related to ligature risk or unsafe items, attempted suicide or self-harm, patient elopements or attempted elopements will be investigated, and a mitigation plan will be implemented for any ongoing risks. Response to ICAREs includes these immediate steps: ensure the patient is safe, creation of an immediate safety plan, notification of leadership up through chain of command, documentation of the event, and investigation. Investigations will be initiated within 72 hours of receipt and completed as soon as possible or no later than two weeks after receipt, depending on the severity and complexity of the event.
Responsible Party: Unity Vice President

QAPI INTEGRATION

Legacy's Hazard Surveillance Rounds and Analyses tool was updated on 7/18/2018 to include ligature risks and unsafe items. These rounds are conducted quarterly.
Responsible Party: Environment of Care Manager

Environmental safety rounds to identify potential ligature risks and unsafe items began on 5/20/18 in accordance with revised policy #902.3107. Nursing staff will conduct environmental safety rounds twice a day in all areas where patients receive care and services.
Responsible Party: Unity Director of Patient Care Services

Prospectively, a comprehensive environmental risk assessment will be completed and reviewed for all areas where patients receive care and services, on a quarterly basis, by unit leadership or designee.
Responsible Party: Unity Vice President

RESPONSE TO URGENT AND EMERGENCY MEDICAL CONDITIONS

PROCEDURE/PROCESS FOR IMPLEMENTATION

All suction machines on Code M carts were enrolled in the Legacy preventive maintenance program in accordance with the LH policy #300.12 "Medical Equipment Management Plan" on 8/3/2018.
Responsible Party: Legacy Director of Clinical Engineering

To ensure that equipment and supplies for urgent and emergent medical response are available, the Code M carts are checked daily to ensure required cart elements are present and unexpired.
Responsible Party: Unity Director of Patient Care Services

MONITORING/TRACKING PROCEDURES

Per LH policy #300.12 "Medical Equipment Management Plan", the Director of Clinical Engineering assures that scheduled testing of all non-life support medical equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Safety Committee each quarter. If any monthly rate of completion falls below 90%, the Director of Clinical Engineering will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.
Responsible Party: Legacy Director of Clinical Engineering

All Code M carts daily checks will be audited each week for 12 weeks to assess compliance with completion and documentation of daily cart checks. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit

findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 Code M cart daily checks per unit will be audited each month for 3 months to assess compliance with completion and documentation of daily cart checks. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

The Code M carts are checked daily to ensure required cart elements are present and unexpired.

The Director of Clinical Engineering maintains the medical equipment inventory, which includes information on required scheduled maintenance for all equipment. This ensures all inventoried equipment receives timely preventive maintenance.

To ensure long-term, continued compliance with completion and documentation of daily cart checks is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 Code M cart daily checks per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

ELOPEMENT AND COMMUNICATION SAFETY DEVICES

PROCEDURE/PROCESS FOR IMPLEMENTATION

To mitigate elopement risk, a revised patient monitoring process will be implemented. In-person observation and engagement of patients in the performance of assigned patient observation checks will be the primary means of monitoring patients. Closed circuit video surveillance will only be utilized as an additional tool for unit safety; it will not be utilized in place of in-person monitoring. Upon admission, patients will be placed on every 15-minute, in-person observation. Observation frequency level may be modified from every 15-minutes to hourly purposeful rounding only after the following conditions have been met: patient admitted to an inpatient unit for at least 24 hours, 2 separate assessments by a licensed independent practitioner (LIP), and treatment team discussion of observation plan. The LIP will document the rationale to modify the level of observation. The level of observation will be documented by LIP order. At any time, a registered nurse (RN) may immediately increase the level of observation based on medical or behavioral conditions that create a potential risk to patient safety.
Responsible Party: Unity Vice President

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, providers, and contractors with direct patient contact will receive education on alertness to potential hazards and environmental risks by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete the education at the beginning of their next shift.
Responsible Party: Unity Vice President

30 additional Voceras (communication safety devices) were ordered on 8/20/2018 . A revised Vocera inventory process will be instituted. The revised process will include a check-in/check-out process to be conducted every shift to ensure that devices are returned from off-going shift staff and devices are allocated to all oncoming shift staff. Nurse Manager/Assistant Nurse Manager will review the Vocera report to identify and follow-up on lost or misplaced devices.
Responsible Party: Unity Director of Patient Care Services

MONITORING AND TRACKING PROCEDURES

Beginning on 8/3/2018, all admitted patients will be audited daily for 12 weeks (concluding on 11/3/2018) to assess compliance with the patient observation process and documentation. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/3/2018, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with the patient observation process and documentation. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with the patient observation process and documentation. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

LH policy #902.5201 “Routine and Special Observation for Patient Safety” will be reviewed at least every three years and with changes in regulatory guidelines.

To ensure long-term, continued compliance with the patient observation process and documentation is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

A115 CONDITION | PATIENT RIGHTS | REFER TO A144, A145, A175, A202

PLAN OF CORRECTION

To ensure compliance with tag A115, the following corrective actions will be implemented by 9/11/2018.

1. PROVISION OF CARE IN A SAFE SETTING (A144)

OBSERVATION PLAN/PATIENT MONITORING AND SAFETY ROUNDING

PROCEDURE/PROCESS FOR IMPLEMENTATION

A revised patient monitoring process will be implemented. In-person observation and engagement of patients in the performance of assigned patient observation checks will be the primary means of monitoring patients. Closed circuit video surveillance will only be utilized as an additional tool for unit safety; it will not be utilized in place of in-person monitoring. Upon admission, all patients will be placed on every 15-minute, in-person observation. Observation frequency level may be modified from every 15-minutes to hourly purposeful rounding only after all the following conditions have been met: patient admitted to an inpatient unit for at least 24 hours, 2 separate assessments by a licensed independent practitioner (LIP), and treatment team discussion of observation plan. The LIP will document the rationale to modify the level of observation. The level of observation will be documented by LIP order. At any time, a registered nurse (RN) may immediately increase the level of observation based on medical or behavioral conditions that create a potential risk to patient safety.
Responsible Party: Unity Vice President

LH policy #902.5201 “Guideline for Close Supervision” will be updated to “Routine and Special Observation for Patient Safety”. This updated policy will reflect the revised patient observation process. The following Unity inpatient standards of care and scope of service policies will also be revised to reflect the revised patient observation process: 902.7002, 902.1211, 902.1000, 902.7100.
Responsible Party: Unity Director of Patient Care Services

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers will receive education on the new patient monitoring policy and process by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete the education at the beginning of their next shift.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

Beginning on 8/3/2018, all admitted patients will be audited daily for 12 weeks (concluding on 11/3/2018) to assess compliance with the patient observation process and documentation. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/3/2018, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with the patient observation process and documentation. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with the patient observation process and documentation. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

Upon implementation of the revised patient observation policy, all admitted patients will be audited daily for 12 weeks to assess compliance with documentation of observation level modification process (patient admitted for 24 hours or greater, 2 separate assessments by an LIP, and treatment team discussion of observation plan). During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the LIP involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Medical Directors will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with documentation of observation level modification process. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Medical Directors will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with documentation of observation level modification process. The target for compliance is 95%. If 95% is not achieved, Medical Directors will conduct an analysis to assess areas of non-compliance. Medical Directors will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Chief Medical Officer

QAPI INTEGRATION

LH policy #902.5201 “Routine and Special Observation for Patient Safety” will be reviewed at least every three years and with changes in regulatory guidelines.

Education on patient monitoring policy and process will be included in the Unity staff and provider orientation and annual education for Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers.

To ensure long-term, continued compliance with the patient observation process and documentation is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

To ensure long-term, continued compliance with the documentation of observation level modification process is achieved, the Medical Directors will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

SUICIDE SCREENING AND ASSESSMENT AND SUICIDE PRECAUTIONS

PROCEDURE/PROCESS FOR IMPLEMENTATION

All patients presenting to the psychiatric emergency department (PES) and upon admission to inpatient units will be screened by a registered nurse (RN) for level of suicide risk using an evidence-based risk tool. Patients admitted to inpatient units will be rescreened twice daily by an RN for ongoing suicide risk. All patients presenting to the psychiatric emergency department (PES) and upon admission to inpatient units will be assessed by an LIP for suicidal risk. Daily and with change of condition, LIPs will reassess patients and place/review/modify orders for patient observation and level of suicide precautions. Patients who are assessed as at risk of suicidal behavior while hospitalized will be observed at a minimum of every 15-minutes in-person. Patients assessed as at imminent risk of suicidal behavior while hospitalized will be monitored by 1:1 in-person observation. Frequency level of patient observation will be determined by individual patient behaviors, risk factors, and protective factors. As part of the safety plan for patients at risk for suicide while hospitalized, patients on suicide precautions may have patient activities or items restricted for further protection from self-harm. For patients exhibiting an increase in self-injurious thoughts or behavior and for those whose suicide risk screen indicate an increase in suicide risk from the previous screening, staff will initiate an increase in patient observation and notify the LIP. Decreasing patient observation level may only be done with documented LIP assessment and order.
Responsible Party: Unity Vice President

LH policy #902.3108 “Suicide Precautions” will be updated to reflect the revised screening, assessment, and intervention process for patients at risk for suicide.
Responsible Party: Unity Director of Patient Care Services and Unity Chief Medical Officer

Suicide precaution order choices in the electronic health record (EHR) will be updated to be consistent with the revised patient observation and suicide precautions policy.
Responsible Party: Unity Chief Medical Officer

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers will receive education on the revised suicide precautions policy by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete the education at the beginning of their next shift.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

Beginning on 8/3/2018, all admitted patients will be audited daily for 12 weeks (concluding on 11/3/2018) to assess compliance with documentation of suicide risk screening. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/3/2018, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with documentation of suicide risk screening. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with documentation of suicide risk screening. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

Beginning on 8/3/2018, all admitted patients will be audited daily for 12 weeks (concluding on 11/3/2018) to assess compliance with provider suicide risk assessment documentation. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the LIP involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Medical Directors will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/3/2018, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with provide suicide risk assessment documentation. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Medical Directors will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with provide suicide risk assessment documentation. The target for compliance is 95%. If 95% is not achieved, Medical Directors will conduct an analysis to assess areas of non-compliance. Medical Directors will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Chief Medical Officer

QAPI INTEGRATION

LH policy #902.3108 “Suicide Precautions” will be reviewed at least every three years and with changes in regulatory guidelines.

Education on suicide precautions policy and process will be included in the Unity staff and provider orientation and annual education for Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers.

To ensure long-term, continued compliance with documentation of suicide risk screening is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

To ensure long-term, continued compliance with provide suicide risk assessment documentation is achieved, the Medical Directors will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

PATIENT BELONGINGS

PROCEDURE/PROCESS FOR IMPLEMENTATION

A revised process for managing patient belongings will be implemented. During inpatient intake process, patients may select personal items to keep with them. All items selected by patient will be inspected for safety and appropriateness and documented on the personal belongings form. The number of clothing items the patient will be allowed to have will be limited to 12. All other patient belongings will be put into sealed bags and placed in secure belongings storage. If a patient requests a personal item from secure storage, staff will retrieve and inspect the item for safety and appropriateness before giving to patient. Retrieval will be documented on the personal belongings form. This process will also apply to currently admitted patients.
Responsible Party: Unity Director of Patient Care Services

Legacy policy #902.3107 “Personal Belongings and Unsafe Items on Inpatient Psychiatric Units” was revised on 5/20/18 to categorize potentially unsafe items into four categories: never allowed, used during group, used with staff supervision, and allowed

unmonitored unless an extreme risk. Items used during group or requiring staff supervision will be secured unless in use by patients. Staff will assess patients twice a day for safety regarding items in the unmonitored unless an extreme risk category and document in the EHR changes to unsafe item management.
Responsible Party: Unity Director of Patient Care Services

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, and Clerical staff will receive education on the new patient belongings policy and process by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete the education at the beginning of their next shift.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

In-room belongings will be inspected for safety and appropriateness for 30 patients per unit per month for 3 months to assess staff compliance with patient belongings policy, process, and documentation. The target for compliance is 95%. If 95% compliance is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an additional analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care Services

QAPI INTEGRATION

LH policy #902.3107 “Personal Belongings and Unsafe items on Inpatient Psychiatric Unit” will be reviewed at least every three years and with changes in regulatory guidelines.

Education on patient belongings policy and process will be included in the Unity orientation and annual education for Registered Nurses, Behavioral Health Assistants, Behavioral Health Therapists and Clerical staff.

To ensure, long-term continued compliance with patient belongings policy, process, and documentation is achieved, Nurse Managers/Assistant Nurse Managers will conduct ongoing auditing of 30 patients per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

ENVIRONMENT OF CARE: LIGATURE RISKS, UNSAFE ITEMS, AND BLIND SPOTS

PROCEDURE/PROCESS FOR IMPLEMENTATION

A comprehensive environmental risk assessment, including identification of ligature risks and unsafe items, was completed on 5/20/18 by nursing leadership for all areas where patients receive care and services. The Unity Vice President is completing another comprehensive environmental risk assessment 8/14/2018-8/24/2018 to identify additional ligature risks and unsafe items. On 8/24/2018, external subject matter experts from Oregon State Hospital are visiting Unity to tour all patient care areas to offer observations on the environment of care. The comprehensive risk assessment will be updated with additional environmental risks.
Responsible Party: Unity Vice President

To mitigate the risk associated with the camera blind spots, in-person observation and engagement of patients in the performance of assigned patient observation checks will be the primary means of monitoring patients. Closed circuit video surveillance will only be utilized as an additional tool for unit safety; it will not be utilized in place of in-person monitoring.
Responsible Party: Unity Vice President

Recliners in the PES calming rooms were removed and replaced with heavy chairs and ottomans that are ligature-resistant on 7/26/2018.
Responsible Party: PES Nurse Manager

Metal rings in seclusion rooms will be removed and replaced with a round metal rod by 8/22/2018.
Responsible Party: Facilities Manager

All patient bathroom doors (with limited exception 201, 202, 203, 204, 205, 501, 502, 521, 522, 601, 602, 603, 608, 620) were removed on 7/20/2018 and replaced with Velcro curtains. Bathroom doors were kept in place in all hardened rooms and three patient rooms on Unit 6 to meet patient care needs for patients with eating disorders. The curtains were assessed in April 2017 and reassessed on 7/20/2018 for safety. Unity Leadership Council and Director of Environmental Services determined these are safe and do not pose a suffocation risk. The Velcro consists of small strips (approximately 1 inch by 1 inch) to mitigate Velcro being used as a ligature. The Velcro mounting system was assessed to be low weight-bearing and cannot be used as a ligature point. For those patient rooms that have bathroom doors, the bathroom door will be locked at all times, and the patient will be supervised by staff when in use. If the patient is assessed to not be at risk for suicide while hospitalized, the bathroom door may be unlocked, and the patient will be observed every 15-minutes in-person.
Responsible Party: Unity Director of Patient Care Services

Hinges on the window access panels in all patient rooms will be filled with pick-proof caulk to eliminate the ligature risk. This will be completed by 8/31/2018.
Responsible Party: Facilities Manager

Cabinet doors will be removed on all patient belongings cabinets in patient rooms. The following items located within the patient cabinets will have ligature and other safety risks mitigated: internal shelf, vent, clock, and outlet. The shelf will be removed and used to cover the vent. The clocks will be covered with a protective case. This will be completed by 8/31/2018.The outlet inside the cabinet is a safety outlet and does not require further safety mitigation.
Responsible Party: Facilities Manager

The correct version of LH policy #902.5111 “Counseling and Therapy Therapeutic Guideline” was posted to the Legacy intranet site on 7/30/2018. This version explicitly states that there will always be two staff members present in the garden, and no staff will be alone in the garden while patients are using the garden.
Responsible Party: Unity Vice President

The garden environmental risk assessment was updated to include the emergency poles, gazebos, and basketball hoops on 7/30/2018. To mitigate the environmental risks in the garden, the staffing ratio is 1 staff for 5 patients, and a minimum of two staff members must be in the garden with patients at all times regardless of number of patients. All patients that attend garden group must have an order from the LIP to attend.
Responsible Party: Unity Vice President

Linen carts were removed from general milieu and secured in non-patient care areas on 7/28/2018. Soiled linen hampers will be kept in a secure area when not in use.
Responsible Party: Unity Director of Patient Care Services

The coffee stirrers identified during survey are thin black straws. The straws were reviewed on 8/3/2018 by Unity Director of Patient Care Services and Unity Vice President and determined to be safe for patient use due to flexibility. This item has been added to the comprehensive environmental risk assessment.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

High risk issues identified during the leadership safety huddle will be added to the action plan template. Action items will be reviewed at the leadership safety huddle, and the action plan will be added as a standing agenda item at Leadership Council. Action items related to the environment of care will be added to the environmental risk assessment along with a mitigation plan.
Responsible Party: Unity Vice President

All safety event reports (ICAREs) related to ligature risk or unsafe items, attempted suicide or self-harm, patient elopements or attempted elopements will be investigated, and a mitigation plan will be implemented for any ongoing risks. Response to ICAREs includes these immediate steps: ensure the patient is safe, creation of an immediate safety plan, notification of leadership up through chain of command, documentation of the event, and investigation. Investigations will be initiated within 72 hours of receipt and completed as soon as possible or no later than two weeks after receipt, depending on the severity and complexity of the event.
Responsible Party: Unity Vice President

QAPI INTEGRATION

Legacy's Hazard Surveillance Rounds and Analyses tool was updated on 7/18/2018 to include ligature risks and unsafe items. These rounds are conducted quarterly.
Responsible Party: Environment of Care Manager

Environmental safety rounds to identify potential ligature risks and unsafe items began on 5/20/18 in accordance with revised policy #902.3107. Nursing staff will conduct environmental safety rounds twice a day in all areas where patients receive care and services.
Responsible Party: Unity Director of Patient Care Services

Prospectively, a comprehensive environmental risk assessment will be completed and reviewed for all areas where patients receive care and services, on a quarterly basis, by unit leadership or designee.
Responsible Party: Unity Vice President

RESPONSE TO URGENT AND EMERGENCY MEDICAL CONDITIONS

PROCEDURE/PROCESS FOR IMPLEMENTATION

All suction machines on Code M carts were enrolled in the Legacy preventive maintenance program in accordance with the LH policy #300.12 "Medical Equipment Management Plan" on 8/3/2018.
Responsible Party: Legacy Director of Clinical Engineering

To ensure that equipment and supplies for urgent and emergent medical response are available, the Code M carts are checked daily to ensure required cart elements are present and unexpired.
Responsible Party: Unity Director of Patient Care Services

MONITORING/TRACKING PROCEDURES

Per LH policy #300.12 "Medical Equipment Management Plan", the Director of Clinical Engineering assures that scheduled testing of all non-life support medical equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Safety Committee each quarter. If any monthly rate of completion falls below 90%, the Director of Clinical Engineering will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.
Responsible Party: Legacy Director of Clinical Engineering

All Code M carts daily checks will be audited each week for 12 weeks to assess compliance with completion and documentation of daily cart checks. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 Code M cart daily checks per unit will be audited each month for 3 months to assess compliance with completion and documentation of daily cart checks. The target for compliance is 95%. If 95% is

not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

The Code M carts are checked daily to ensure required cart elements are present and unexpired.

The Director of Clinical Engineering maintains the medical equipment inventory, which includes information on required scheduled maintenance for all equipment. This ensures all inventoried equipment receives timely preventive maintenance.

To ensure long-term, continued compliance with completion and documentation of daily cart checks is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 Code M cart daily checks per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

ELOPEMENT AND COMMUNICATION SAFETY DEVICES

PROCEDURE/PROCESS FOR IMPLEMENTATION

To mitigate elopement risk, a revised patient monitoring process will be implemented. In-person observation and engagement of patients in the performance of assigned patient observation checks will be the primary means of monitoring patients. Closed circuit video surveillance will only be utilized as an additional tool for unit safety; it will not be utilized in place of in-person monitoring. Upon admission, patients will be placed on every 15-minute, in-person observation. Observation frequency level may be modified from every 15-minutes to hourly purposeful rounding only after the following conditions have been met: patient admitted to an inpatient unit for at least 24 hours, 2 separate assessments by a licensed independent practitioner (LIP), and treatment team discussion of observation plan. The LIP will document the rationale to modify the level of observation. The level of observation will be documented by LIP order. At any time, a registered nurse (RN) may immediately increase the level of observation based on medical or behavioral conditions that create a potential risk to patient safety.
Responsible Party: Unity Vice President

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, providers, and contractors with direct patient contact will receive education on alertness to potential hazards and environmental risks by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete the education at the beginning of their next shift.
Responsible Party: Unity Vice President

30 additional Voceras (communication safety devices) were ordered on 8/20/2018 . A revised Vocera inventory process will be instituted. The revised process will include a check-in/check-out process to be conducted every shift to ensure that devices are returned from off-going shift staff and devices are allocated to all oncoming shift staff. Nurse Manager/Assistant Nurse Manager will review the Vocera report to identify and follow-up on lost or misplaced devices.
Responsible Party: Unity Director of Patient Care Services

MONITORING AND TRACKING PROCEDURES

Beginning on 8/3/2018, all admitted patients will be audited daily for 12 weeks (concluding on 11/3/2018) to assess compliance with the patient observation process and documentation. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of

non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/3/2018, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with the patient observation process and documentation. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with the patient observation process and documentation. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

LH policy #902.5201 “Routine and Special Observation for Patient Safety” will be reviewed at least every three years and with changes in regulatory guidelines.

To ensure long-term, continued compliance with the patient observation process and documentation is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

MEDICATION ADMINISTRATION (A405)

PROCEDURE/PROCESS FOR IMPLEMENTATION

Medication administration education was completed by all nurses by 7/26/2018.
Responsible Party: Unity Director of Patient Care Services

Starting on 7/28/2018 and ending 8/14/2018, medication administrations were audited in real-time by a second RN observing the medication administration process. All nurses were educated on how to use the audit tool, which includes all steps required for safe medication administration. When any instances of non-compliance were analyzed using the Just Culture Algorithm and non-compliance was addressed with the staff member involved.
Responsible Party: Unity Director of Patient Care Services

Medication administration education was completed by all nurses by 7/26/2018.
Responsible Party: Unity Director of Patient Care Services

New ICARE follow-up guidelines were developed to provide the Nurse Managers/Assistant Nurse Managers with additional guidance on what to include in their investigation of safety event reports on their units. The guidelines include a template for investigating distinct categories of safety event reports, including medication errors as previously described. Nurse Managers/Assistant Nurse Managers are to choose the appropriate category and template and input it into the ICARE system to document findings from their investigation. The template includes sections to list contributing factors, patient condition/outcome, mitigation plan, and just culture findings.
Responsible Party: Unity Director of Patient Care Services

MONITORING AND TRACKING PROCEDURES

After confirming adoption of the barcode medication administration process, as validated by improvement in barcode scanning percentages and daily audit results, beginning on 8/14/2018, 30 medication administration on each adult inpatient unit and PES and 20 medication administrations on the adolescent inpatient unit (approximately 50%) will be audited daily for 12 weeks (concluding on 11/14/2018) to assess compliance with the medication administration process. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/14/2018, 30 medication administrations on each adult inpatient unit and PES and 20 medication administrations on the adolescent inpatient unit will be audited each week for 12 weeks to assess compliance with the medication administration process. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 medication administrations will be audited each month for 3 months to assess compliance with the medication administration process. The target for compliance is 95% If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.

To ensure long-term, continued compliance with the medication administration process is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

All Nurse Managers/Assistant Nurse Managers will review individual nurse barcode medication administration scanning compliance percentages monthly. For any nurse that does not meet scanning expectations, the Nurse Manager/Assistant Nurse Manager will investigate and determine if correct medication administration process was followed. If it is determined the nurse did not follow correct medication administration process, the Nurse Manager/Assistant Nurse Manager will provide coaching on correct medication administration process and expectations.

2. TIMELY AND COMPLETE INVESTIGATION OF EVENTS (A145)

PROCEDURE/PROCESS FOR IMPLEMENTATION

Reeducation on safety event reporting (ICARE) was provided to all direct care staff, including Registered Nurses, Behavioral Health Assistants, Behavioral Health Therapists, Counseling and Therapy staff, Care Management staff, Security staff, and Contractors with direct patient contact on 7/20/2018. This education included information on types of incidents and events that should be reported along with what constitutes abuse and neglect. Staff that have not completed the education will complete the education prior to their next work shift.
Responsible Party: Unity Vice President

New ICARE follow-up guidelines were developed to provide the Nurse Managers/Assistant Nurse Managers with additional guidance on what to include in their investigation of safety event reports on their units. The guidelines include a template for investigating distinct categories of ICAREs, including ligature risks, elopements (attempted or actual), cheeking medications, medication errors, unsafe items, Code M (medical emergency), self-harm or suicide attempts, restraint and seclusion, abuse or assault allegations from patients (including neglect), falls, and abuse or assault allegations from staff. Nurse Managers/Assistant Nurse Managers verify that the appropriate event category is documented. The Nurse Managers/Assistant Nurse Managers use a follow-up template and input the template into the ICARE system along with the investigation findings. The template includes sections to list contributing factors, patient condition/outcome, mitigation plan, and just culture findings.
Responsible Party: Unity Director of Patient Care Services

Abuse and neglect allegations are investigated immediately. Response to abuse or neglect allegations includes these immediate steps: ensure the patient is safe, creation of an immediate safety plan, notification of leadership up through chain of command, documentation of the alleged or suspected abuse or neglect, and investigation of all allegations. Cases of abuse and neglect will be escalated to Risk Management for additional investigation per the department's established abuse investigation process. Investigation findings are reviewed by senior leadership and risk management. This group determines if the allegation of abuse or neglect is substantiated. If the allegation is substantiated, mandatory reporting processes will be followed. After the investigation is complete, the Nurse Managers/Assistant Nurse Managers will document the outcome of the investigation and whether the allegation of abuse or neglect is substantiated.
Responsible Party: Manager of Risk Management

Communication was provided in-person and reiterated in writing on 7/5/2018 to Nurse Managers and Assistant Nurse Managers reinforcing expectations for reviewing ICAREs along with a copy of the newly developed ICARE report guidelines with instructions for use. Part of the expectations included what constitutes a timely investigation and response to ICAREs: Managers are expected to initiate investigation of their ICAREs within 72 hours of receipt and complete their investigation as soon as possible or no later than two weeks after receipt, depending on the severity and complexity of the case.
Responsible Party: Unity Director of Patient Care Services

MONITORING AND TRACKING PROCEDURES

20 ICAREs will be audited each week for 12 weeks to ensure all elements of the ICAREs are completed and allegations and cases of abuse or neglect are investigated and documented per standard process. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, the Unity Director of Patient Care Services will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 ICAREs will be audited each month for 3 months to ensure all elements of the ICAREs are completed and allegations and cases of abuse or neglect are investigated and documented per standard process. The target for compliance is 95%. If 95% is not achieved, Unity Director of Patient Care Services will conduct an analysis to assess areas of non-compliance. Unity Director of Patient Care Services will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

Upon hire, all direct care staff, including Registered Nurses, Behavioral Health Assistants, Behavioral Health Therapists, Counseling and Therapy staff, Care Management staff, Security staff, and contractors with direct patient contact receive education on safety

event reporting in the ICARE system and the types of incidents and events that should be reported and identification of cases of abuse and neglect.

To ensure sustainment of the ICARE and abuse or neglect investigation processes, the Unity Director of Patient Care Services will conduct ongoing audits of 30 ICAREs per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

3. RESTRAINT/SECLUSION ASSESSMENT AND MONITORING (A175)

PROCEDURE/PROCESS FOR IMPLEMENTATION

Registered Nurses, Behavioral Health Assistants, Behavioral Health Therapists, Counseling and Therapy staff, and Security staff will complete restraint/seclusion education, including restraint policy and all restraint types, by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete restraint and seclusion education at the beginning of their next shift.
Responsible Party: Unity Vice President

Legacy's policy #900.5274 "Restraint and Seclusion for Patient Safety" will be revised to include which role may complete every 2-hour assessments and every 15-minute monitoring for patients with violent or self-destructive behaviors. Additionally, the required elements of the every 2-hour nursing assessments will be specified in the policy.
Responsible Party: Clinical Nurse Specialist

MONITORING AND TRACKING PROCEDURES

Beginning on 8/3/2018, all restraint and seclusion events will be audited each week for 12 weeks (concluding on 11/3/2018) to assess compliance with restraint/seclusion documentation requirements. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, the Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved but not before 11/3/2018, 30 restraint and seclusion events per unit will be audited each month for 3 months to assess compliance with restraint/seclusion documentation requirements. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

Legacy's policy #900.5274 "Restraint and Seclusion for Patient Safety" will be reviewed at least every 3 years and with changes in regulatory guidelines.

Legacy's standard of care 900.1012 "Use of Restraint and Seclusion" will be reviewed at least every 3 years and with changes in regulatory guidelines.

Restraint/seclusion requirements are included in direct care staff, who are involved in restraint/seclusion events, orientation and annual education.

To ensure long-term, continued compliance with c restraint/seclusion requirements is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 restraint and seclusion events per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

4. RESTRAINT/SECLUSION TRAINING (A202)

PROCEDURE/PROCESS FOR IMPLEMENTATION

Legacy's policy #900.5274 "Restraint and Seclusion for Patient Safety" will be updated to include a list of specific restraint types that are utilized at Unity. Unity does not use nonviolent restraints.
Responsible Party: Unity Director of Patient Care Services

The restraint and seclusion education and return demonstration will be updated to reflect the specific restraint types that are utilized at Unity.
Responsible Party: Unity Director of Patient Care Services

Registered Nurses, Behavioral Health Assistants, Behavioral Health Therapists, Counseling and Therapy staff, and Security staff will complete restraint/seclusion education, including restraint policy and all restraint types, by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete restraint and seclusion education at the beginning of their next shift.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

Each staff person's education record (including Registered Nurses, Behavioral Health Assistants, Behavioral Health Therapists, Counseling and Therapy staff, and Security staff) will be audited by 9/11/2018 to ensure completion of required restraint/seclusion training, education, and competencies.
Responsible Party: Department Leadership

QAPI INTEGRATION

Legacy's policy #900.5274 "Restraint and Seclusion for Patient Safety" will be reviewed at least every 3 years and with changes in regulatory guidelines.

Legacy's standard of care 900.1012 "Use of Restraint and Seclusion" will be reviewed at least every 3 years and with changes in regulatory guidelines.

Restraint/seclusion requirements are included in direct care staff, who are involved in restraint/seclusion events orientation, and annual education.

A144 STANDARD | PATIENT RIGHTS: CARE IN SAFE SETTING

PLAN OF CORRECTION

To ensure compliance with tag A144, the following corrective actions will be implemented by 9/11/2018.

OBSERVATION PLAN/PATIENT MONITORING AND SAFETY ROUNDING

PROCEDURE/PROCESS FOR IMPLEMENTATION

A revised patient monitoring process will be implemented. In-person observation and engagement of patients in the performance of assigned patient observation checks will be the primary means of monitoring patients. Closed circuit video surveillance will only be utilized as an additional tool for unit safety; it will not be utilized in place of in-person monitoring. Upon admission, all patients will be placed on every 15-minute, in-person observation. Observation frequency level may be modified from every 15-minutes to hourly purposeful rounding only after all the following conditions have been met: patient admitted to an inpatient unit for at least 24 hours, 2 separate assessments by a licensed independent practitioner (LIP), and treatment team discussion of observation plan. The LIP will document the rationale to modify the level of observation. The level of observation will be documented by LIP order. At any time, a registered nurse (RN) may immediately increase the level of observation based on medical or behavioral conditions that create a potential risk to patient safety.
Responsible Party: Unity Vice President

LH policy #902.5201 “Guideline for Close Supervision” will be updated to “Routine and Special Observation for Patient Safety”. This updated policy will reflect the revised patient observation process. The following Unity inpatient standards of care and scope of service policies will also be revised to reflect the revised patient observation process: 902.7002, 902.1211, 902.1000, 902.7100.
Responsible Party: Unity Director of Patient Care Services

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers will receive education on the new patient monitoring policy and process by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete the education at the beginning of their next shift.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

Beginning on 8/3/2018, all admitted patients will be audited daily for 12 weeks (concluding on 11/3/2018) to assess compliance with the patient observation process and documentation. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/3/2018, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with the patient observation process and documentation. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with the patient observation process and documentation. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

Upon implementation of the revised patient observation policy, all admitted patients will be audited daily for 12 weeks to assess compliance with documentation of observation level modification process (patient admitted for 24 hours or greater, 2 separate assessments by an LIP, and treatment team discussion of observation plan). During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the LIP involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Medical Directors will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with documentation of observation level modification process. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Medical Directors will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with documentation of observation level modification process. The target for compliance is 95%. If 95% is not achieved, Medical Directors will conduct an analysis to assess areas of non-compliance. Medical Directors will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Chief Medical Officer

QAPI INTEGRATION

LH policy #902.5201 “Routine and Special Observation for Patient Safety” will be reviewed at least every three years and with changes in regulatory guidelines.

Education on patient monitoring policy and process will be included in the Unity staff and provider orientation and annual education for Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers.

To ensure long-term, continued compliance with the patient observation process and documentation is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

To ensure long-term, continued compliance with the documentation of observation level modification process is achieved, the Medical Directors will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

SUICIDE SCREENING AND ASSESSMENT AND SUICIDE PRECAUTIONS

PROCEDURE/PROCESS FOR IMPLEMENTATION

All patients presenting to the psychiatric emergency department (PES) and upon admission to inpatient units will be screened by a registered nurse (RN) for level of suicide risk using an evidence-based risk tool. Patients admitted to inpatient units will be rescreened twice daily by an RN for ongoing suicide risk. All patients presenting to the psychiatric emergency department (PES) and upon admission to inpatient units will be assessed by an LIP for suicidal risk. Daily and with change of condition, LIPs will reassess patients and place/review/modify orders for patient observation and level of suicide precautions. Patients who are assessed as at risk of suicidal behavior while hospitalized will be observed at a minimum of every 15-minutes in-person. Patients assessed as at imminent risk of suicidal behavior while hospitalized will be monitored by 1:1 in-person observation. Frequency level of patient observation will be determined by individual patient behaviors, risk factors, and protective factors. As part of the safety plan for patients at risk for suicide while hospitalized, patients on suicide precautions may have patient activities or items restricted for further protection from self-harm. For patients exhibiting an increase in self-injurious thoughts or behavior and for those whose suicide risk screen indicate an increase in suicide risk from the previous screening, staff will initiate an increase in patient observation and notify the LIP. Decreasing patient observation level may only be done with documented LIP assessment and order.
Responsible Party: Unity Vice President

LH policy #902.3108 “Suicide Precautions” will be updated to reflect the revised screening, assessment, and intervention process for patients at risk for suicide.
Responsible Party: Unity Director of Patient Care Services and Unity Chief Medical Officer

Suicide precaution order choices in the electronic health record (EHR) will be updated to be consistent with the revised patient observation and suicide precautions policy.
Responsible Party: Unity Chief Medical Officer

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers will receive education on the revised suicide precautions policy by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete the education at the beginning of their next shift.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

Beginning on 8/3/2018, all admitted patients will be audited daily for 12 weeks (concluding on 11/3/2018) to assess compliance with documentation of suicide risk screening. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/3/2018, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with documentation of suicide risk screening. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with documentation of suicide risk screening. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse

Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

Beginning on 8/3/2018, all admitted patients will be audited daily for 12 weeks (concluding on 11/3/2018) to assess compliance with provider suicide risk assessment documentation. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the LIP involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Medical Directors will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/3/2018, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with provide suicide risk assessment documentation. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Medical Directors will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with provide suicide risk assessment documentation. The target for compliance is 95%. If 95% is not achieved, Medical Directors will conduct an analysis to assess areas of non-compliance. Medical Directors will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Chief Medical Officer

QAPI INTEGRATION

LH policy #902.3108 “Suicide Precautions” will be reviewed at least every three years and with changes in regulatory guidelines.

Education on suicide precautions policy and process will be included in the Unity staff and provider orientation and annual education for Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers.

To ensure long-term, continued compliance with documentation of suicide risk screening is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

To ensure long-term, continued compliance with provide suicide risk assessment documentation is achieved, the Medical Directors will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

PATIENT BELONGINGS

PROCEDURE/PROCESS FOR IMPLEMENTATION

A revised process for managing patient belongings will be implemented. During inpatient intake process, patients may select personal items to keep with them. All items selected by patient will be inspected for safety and appropriateness and documented on the personal belongings form. The number of clothing items the patient will be allowed to have will be limited to 12. All other patient belongings will be put into sealed bags and placed in secure belongings storage. If a patient requests a personal item from secure storage, staff will retrieve and inspect the item for safety and appropriateness before giving to patient. Retrieval will be documented on the personal belongings form. This process will also apply to currently admitted patients.
Responsible Party: Unity Director of Patient Care Services

Legacy policy #902.3107 “Personal Belongings and Unsafe Items on Inpatient Psychiatric Units” was revised on 5/20/18 to categorize potentially unsafe items into four categories: never allowed, used during group, used with staff supervision, and allowed unmonitored unless an extreme risk. Items used during group or requiring staff supervision will be secured unless in use by patients. Staff will assess patients twice a day for safety regarding items in the unmonitored unless an extreme risk category and document in the EHR changes to unsafe item management.
Responsible Party: Unity Director of Patient Care Services

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, and Clerical staff will receive education on the new patient belongings policy and process by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete the education at the beginning of their next shift.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

In-room belongings will be inspected for safety and appropriateness for 30 patients per unit per month for 3 months to assess staff compliance with patient belongings policy, process, and documentation. The target for compliance is 95%. If 95% compliance is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an additional analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care Services

QAPI INTEGRATION

LH policy #902.3107 “Personal Belongings and Unsafe items on Inpatient Psychiatric Unit” will be reviewed at least every three years and with changes in regulatory guidelines.

Education on patient belongings policy and process will be included in the Unity orientation and annual education for Registered Nurses, Behavioral Health Assistants, Behavioral Health Therapists and Clerical staff.

To ensure, long-term continued compliance with patient belongings policy, process, and documentation is achieved, Nurse Managers/Assistant Nurse Managers will conduct ongoing auditing of 30 patients per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

ENVIRONMENT OF CARE: LIGATURE RISKS, UNSAFE ITEMS, AND BLIND SPOTS

PROCEDURE/PROCESS FOR IMPLEMENTATION

A comprehensive environmental risk assessment, including identification of ligature risks and unsafe items, was completed on 5/20/18 by nursing leadership for all areas where patients receive care and services. The Unity Vice President is completing another comprehensive environmental risk assessment 8/14/2018-8/24/2018 to identify additional ligature risks and unsafe items. On 8/24/2018, external subject matter experts from Oregon State Hospital are visiting Unity to tour all patient care areas to offer observations on the environment of care. The comprehensive risk assessment will be updated with additional environmental risks.
Responsible Party: Unity Vice President

To mitigate the risk associated with the camera blind spots, in-person observation and engagement of patients in the performance of assigned patient observation checks will be the primary means of monitoring patients. Closed circuit video surveillance will only be utilized as an additional tool for unit safety; it will not be utilized in place of in-person monitoring.
Responsible Party: Unity Vice President

Recliners in the PES calming rooms were removed and replaced with heavy chairs and ottomans that are ligature-resistant on 7/26/2018.
Responsible Party: PES Nurse Manager

Metal rings in seclusion rooms will be removed and replaced with a round metal rod by 8/22/2018.
Responsible Party: Facilities Manager

All patient bathroom doors (with limited exception 201, 202, 203, 204, 205, 501, 502, 521, 522, 601, 602, 603, 608, 620) were removed on 7/20/2018 and replaced with Velcro curtains. Bathroom doors were kept in place in all hardened rooms and three patient rooms on Unit 6 to meet patient care needs for patients with eating disorders. The curtains were assessed in April 2017 and reassessed on 7/20/2018 for safety. Unity Leadership Council and Director of Environmental Services determined these are safe and do not pose a suffocation risk. The Velcro consists of small strips (approximately 1 inch by 1 inch) to mitigate Velcro being used as a ligature. The Velcro mounting system was assessed to be low weight-bearing and cannot be used as a ligature point. For those patient rooms that have bathroom doors, the bathroom door will be locked at all times, and the patient will be supervised by staff when in use. If the patient is assessed to not be at risk for suicide while hospitalized, the bathroom door may be unlocked, and the patient will be observed every 15-minutes in-person.
Responsible Party: Unity Director of Patient Care Services

Hinges on the window access panels in all patient rooms will be filled with pick-proof caulk to eliminate the ligature risk. This will be completed by 8/31/2018.
Responsible Party: Facilities Manager

Cabinet doors will be removed on all patient belongings cabinets in patient rooms. The following items located within the patient cabinets will have ligature and other safety risks mitigated: internal shelf, vent, clock, and outlet. The shelf will be removed and used to cover the vent. The clocks will be covered with a protective case. This will be completed by 8/31/2018.The outlet inside the cabinet is a safety outlet and does not require further safety mitigation.
Responsible Party: Facilities Manager

The correct version of LH policy #902.5111 “Counseling and Therapy Therapeutic Guideline” was posted to the Legacy intranet site on 7/30/2018. This version explicitly states that there will always be two staff members present in the garden, and no staff will be alone in the garden while patients are using the garden.
Responsible Party: Unity Vice President

The garden environmental risk assessment was updated to include the emergency poles, gazebos, and basketball hoops on 7/30/2018. To mitigate the environmental risks in the garden, the staffing ratio is 1 staff for 5 patients, and a minimum of two staff members must be in the garden with patients at all times regardless of number of patients. All patients that attend garden group must have an order from the LIP to attend.
Responsible Party: Unity Vice President

Linen carts were removed from general milieu and secured in non-patient care areas on 7/28/2018. Soiled linen hampers will be kept in a secure area when not in use.
Responsible Party: Unity Director of Patient Care Services

The coffee stirrers identified during survey are thin black straws. The straws were reviewed on 8/3/2018 by Unity Director of Patient Care Services and Unity Vice President and determined to be safe for patient use due to flexibility. This item has been added to the comprehensive environmental risk assessment.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

High risk issues identified during the leadership safety huddle will be added to the action plan template. Action items will be reviewed at the leadership safety huddle, and the action plan will be added as a standing agenda item at Leadership Council. Action items related to the environment of care will be added to the environmental risk assessment along with a mitigation plan.
Responsible Party: Unity Vice President

All safety event reports (ICAREs) related to ligature risk or unsafe items, attempted suicide or self-harm, patient elopements or attempted elopements will be investigated, and a mitigation plan will be implemented for any ongoing risks. Response to ICAREs includes these immediate steps: ensure the patient is safe, creation of an immediate safety plan, notification of leadership up through chain of command, documentation of the event, and investigation. Investigations will be initiated within 72 hours of receipt and completed as soon as possible or no later than two weeks after receipt, depending on the severity and complexity of the event.
Responsible Party: Unity Vice President

QAPI INTEGRATION

Legacy's Hazard Surveillance Rounds and Analyses tool was updated on 7/18/2018 to include ligature risks and unsafe items. These rounds are conducted quarterly.
Responsible Party: Environment of Care Manager

Environmental safety rounds to identify potential ligature risks and unsafe items began on 5/20/18 in accordance with revised policy #902.3107. Nursing staff will conduct environmental safety rounds twice a day in all areas where patients receive care and services.
Responsible Party: Unity Director of Patient Care Services

Prospectively, a comprehensive environmental risk assessment will be completed and reviewed for all areas where patients receive care and services, on a quarterly basis, by unit leadership or designee.
Responsible Party: Unity Vice President

RESPONSE TO URGENT AND EMERGENCY MEDICAL CONDITIONS

PROCEDURE/PROCESS FOR IMPLEMENTATION

All suction machines on Code M carts were enrolled in the Legacy preventive maintenance program in accordance with the LH policy #300.12 "Medical Equipment Management Plan" on 8/3/2018.
Responsible Party: Legacy Director of Clinical Engineering

To ensure that equipment and supplies for urgent and emergent medical response are available, the Code M carts are checked daily to ensure required cart elements are present and unexpired.
Responsible Party: Unity Director of Patient Care Services

MONITORING/TRACKING PROCEDURES

Per LH policy #300.12 "Medical Equipment Management Plan", the Director of Clinical Engineering assures that scheduled testing of all non-life support medical equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Safety Committee each quarter. If any monthly rate of completion falls below 90%, the Director of Clinical Engineering will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.
Responsible Party: Legacy Director of Clinical Engineering

All Code M carts daily checks will be audited each week for 12 weeks to assess compliance with completion and documentation of daily cart checks. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared

with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 Code M cart daily checks per unit will be audited each month for 3 months to assess compliance with completion and documentation of daily cart checks. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

The Code M carts are checked daily to ensure required cart elements are present and unexpired.

The Director of Clinical Engineering maintains the medical equipment inventory, which includes information on required scheduled maintenance for all equipment. This ensures all inventoried equipment receives timely preventive maintenance.

To ensure long-term, continued compliance with completion and documentation of daily cart checks is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 Code M cart daily checks per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

ELOPEMENT AND COMMUNICATION SAFETY DEVICES

PROCEDURE/PROCESS FOR IMPLEMENTATION

To mitigate elopement risk, a revised patient monitoring process will be implemented. In-person observation and engagement of patients in the performance of assigned patient observation checks will be the primary means of monitoring patients. Closed circuit video surveillance will only be utilized as an additional tool for unit safety; it will not be utilized in place of in-person monitoring. Upon admission, patients will be placed on every 15-minute, in-person observation. Observation frequency level may be modified from every 15-minutes to hourly purposeful rounding only after the following conditions have been met: patient admitted to an inpatient unit for at least 24 hours, 2 separate assessments by a licensed independent practitioner (LIP), and treatment team discussion of observation plan. The LIP will document the rationale to modify the level of observation. The level of observation will be documented by LIP order. At any time, a registered nurse (RN) may immediately increase the level of observation based on medical or behavioral conditions that create a potential risk to patient safety.
Responsible Party: Unity Vice President

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, providers, and contractors with direct patient contact will receive education on alertness to potential hazards and environmental risks by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete the education at the beginning of their next shift.
Responsible Party: Unity Vice President

30 additional Voceras (communication safety devices) were ordered on 8/20/2018 . A revised Vocera inventory process will be instituted. The revised process will include a check-in/check-out process to be conducted every shift to ensure that devices are returned from off-going shift staff and devices are allocated to all oncoming shift staff. Nurse Manager/Assistant Nurse Manager will review the Vocera report to identify and follow-up on lost or misplaced devices.
Responsible Party: Unity Director of Patient Care Services

MONITORING AND TRACKING PROCEDURES

Beginning on 8/3/2018, all admitted patients will be audited daily for 12 weeks (concluding on 11/3/2018) to assess compliance with the patient observation process and documentation. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/3/2018, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with the patient observation process and documentation. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with the patient observation process and documentation. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

LH policy #902.5201 “Routine and Special Observation for Patient Safety” will be reviewed at least every three years and with changes in regulatory guidelines.

To ensure long-term, continued compliance with the patient observation process and documentation is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

MEDICATION ADMINISTRATION (A405)

PROCEDURE/PROCESS FOR IMPLEMENTATION

Medication administration education was completed by all nurses by 7/26/2018.
Responsible Party: Unity Director of Patient Care Services

Starting on 7/28/2018 and ending 8/14/2018, medication administrations were audited in real-time by a second RN observing the medication administration process. All nurses were educated on how to use the audit tool, which includes all steps required for safe medication administration. When any instances of non-compliance were analyzed using the Just Culture Algorithm and non-compliance was addressed with the staff member involved.
Responsible Party: Unity Director of Patient Care Services

Medication administration education was completed by all nurses by 7/26/2018.
Responsible Party: Unity Director of Patient Care Services

New ICARE follow-up guidelines were developed to provide the Nurse Managers/Assistant Nurse Managers with additional guidance on what to include in their investigation of safety event reports on their units. The guidelines include a template for investigating distinct categories of safety event reports, including medication errors as previously described. Nurse Managers/Assistant Nurse Managers are to choose the appropriate category and template and input it into the ICARE system to document findings from their investigation. The template includes sections to list contributing factors, patient condition/outcome, mitigation plan, and just culture findings.
Responsible Party: Unity Director of Patient Care Services

MONITORING AND TRACKING PROCEDURES

After confirming adoption of the barcode medication administration process, as validated by improvement in barcode scanning percentages and daily audit results, beginning on 8/14/2018, 30 medication administration on each adult inpatient unit and PES and 20 medication administrations on the adolescent inpatient unit (approximately 50%) will be audited daily for 12 weeks (concluding on 11/14/2018) to assess compliance with the medication administration process. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/14/2018, 30 medication administrations on each adult inpatient unit and PES and 20 medication administrations on the adolescent inpatient unit will be audited each week for 12 weeks to assess compliance with the medication administration process. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 medication administrations will be audited each month for 3 months to assess compliance with the medication administration process. The target for compliance is 95% If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.

To ensure long-term, continued compliance with the medication administration process is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

All Nurse Managers/Assistant Nurse Managers will review individual nurse barcode medication administration scanning compliance percentages monthly. For any nurse that does not meet scanning expectations, the Nurse Manager/Assistant Nurse Manager will investigate and determine if correct medication administration process was followed. If it is determined the nurse did not follow correct medication administration process, the Nurse Manager/Assistant Nurse Manager will provide coaching on correct medication administration process and expectations.

A145 STANDARD | PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT

PLAN OF CORRECTION

To ensure compliance with tag A145, the following corrective actions will be implemented by 9/11/2018.

PROCEDURE/PROCESS FOR IMPLEMENTATION

Reeducation on safety event reporting (ICARE) was provided to all direct care staff, including Registered Nurses, Behavioral Health Assistants, Behavioral Health Therapists, Counseling and Therapy staff, Care Management staff, Security staff, and Contractors with direct patient contact on 7/20/2018. This education included information on types of incidents and events that should be reported along with what constitutes abuse and neglect. Staff that have not completed the education will complete the education prior to their next work shift.
Responsible Party: Unity Vice President

New ICARE follow-up guidelines were developed to provide the Nurse Managers/Assistant Nurse Managers with additional guidance on what to include in their investigation of safety event reports on their units. The guidelines include a template for investigating distinct categories of ICAREs, including ligature risks, elopements (attempted or actual), cheeking medications, medication errors, unsafe items, Code M (medical emergency), self-harm or suicide attempts, restraint and seclusion, abuse or assault allegations from patients (including neglect), falls, and abuse or assault allegations from staff. Nurse Managers/Assistant Nurse Managers verify that the appropriate event category is documented. The Nurse Managers/Assistant Nurse Managers use a follow-up template and input the template into the ICARE system along with the investigation findings. The template includes sections to list contributing factors, patient condition/outcome, mitigation plan, and just culture findings.
Responsible Party: Unity Director of Patient Care Services

Abuse and neglect allegations are investigated immediately. Response to abuse or neglect allegations includes these immediate steps: ensure the patient is safe, creation of an immediate safety plan, notification of leadership up through chain of command, documentation of the alleged or suspected abuse or neglect, and investigation of all allegations. Cases of abuse and neglect will be escalated to Risk Management for additional investigation per the department's established abuse investigation process. Investigation findings are reviewed by senior leadership and risk management. This group determines if the allegation of abuse or neglect is substantiated. If the allegation is substantiated, mandatory reporting processes will be followed. After the investigation is complete, the Nurse Managers/Assistant Nurse Managers will document the outcome of the investigation and whether the allegation of abuse or neglect is substantiated.
Responsible Party: Manager of Risk Management

Communication was provided in-person and reiterated in writing on 7/5/2018 to Nurse Managers and Assistant Nurse Managers reinforcing expectations for reviewing ICAREs along with a copy of the newly developed ICARE report guidelines with instructions for use. Part of the expectations included what constitutes a timely investigation and response to ICAREs: Managers are expected to initiate investigation of their ICAREs within 72 hours of receipt and complete their investigation as soon as possible or no later than two weeks after receipt, depending on the severity and complexity of the case.
Responsible Party: Unity Director of Patient Care Services

MONITORING AND TRACKING PROCEDURES

20 ICAREs will be audited each week for 12 weeks to ensure all elements of the ICAREs are completed and allegations and cases of abuse or neglect are investigated and documented per standard process. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, the Unity Director of Patient Care Services will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean

additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 ICAREs will be audited each month for 3 months to ensure all elements of the ICAREs are completed and allegations and cases of abuse or neglect are investigated and documented per standard process. The target for compliance is 95%. If 95% is not achieved, Unity Director of Patient Care Services will conduct an analysis to assess areas of non-compliance. Unity Director of Patient Care Services will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

Upon hire, all direct care staff, including Registered Nurses, Behavioral Health Assistants, Behavioral Health Therapists, Counseling and Therapy staff, Care Management staff, Security staff, and contractors with direct patient contact receive education on safety event reporting in the ICARE system and the types of incidents and events that should be reported and identification of cases of abuse and neglect.

To ensure sustainment of the ICARE and abuse or neglect investigation processes, the Unity Director of Patient Care Services will conduct ongoing audits of 30 ICAREs per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

A175 STANDARD | PATIENT RIGHTS: RESTRAINT OR SECLUSION

PLAN OF CORRECTION

To ensure compliance with tag A175, the following corrective actions will be implemented by 9/11/2018.

PROCEDURE/PROCESS FOR IMPLEMENTATION

Registered Nurses, Behavioral Health Assistants, Behavioral Health Therapists, Counseling and Therapy staff, and Security staff will complete restraint/seclusion education, including restraint policy and all restraint types, by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete restraint and seclusion education at the beginning of their next shift.
Responsible Party: Unity Vice President

Legacy's policy #900.5274 "Restraint and Seclusion for Patient Safety" will be revised to include which role may complete every 2-hour assessments and every 15-minute monitoring for patients with violent or self-destructive behaviors. Additionally, the required elements of the every 2-hour nursing assessments will be specified in the policy.
Responsible Party: Clinical Nurse Specialist

MONITORING AND TRACKING PROCEDURES

Beginning on 8/3/2018, all restraint and seclusion events will be audited each week for 12 weeks (concluding on 11/3/2018) to assess compliance with restraint/seclusion documentation requirements. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, the Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved but not before 11/3/2018, 30 restraint and seclusion events per unit will be audited each month for 3 months to assess compliance with restraint/seclusion documentation requirements. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

Legacy's policy #900.5274 "Restraint and Seclusion for Patient Safety" will be reviewed at least every 3 years and with changes in regulatory guidelines.

Legacy's standard of care 900.1012 "Use of Restraint and Seclusion" will be reviewed at least every 3 years and with changes in regulatory guidelines.

Restraint/seclusion requirements are included in direct care staff, who are involved in restraint/seclusion events, orientation and annual education.

To ensure long-term, continued compliance with c restraint/seclusion requirements is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 restraint and seclusion events per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

A202 STANDARD | PATIENT RIGHTS: RESTRAINT OR SECLUSION

PLAN OF CORRECTION

To ensure compliance with tag A202, the following corrective actions will be implemented by 9/11/2018.

PROCEDURE/PROCESS FOR IMPLEMENTATION

Legacy's policy #900.5274 "Restraint and Seclusion for Patient Safety" will be updated to include a list of specific restraint types that are utilized at Unity. Unity does not use nonviolent restraints.
Responsible Party: Unity Director of Patient Care Services

The restraint and seclusion education and return demonstration will be updated to reflect the specific restraint types that are utilized at Unity.
Responsible Party: Unity Director of Patient Care Services

Registered Nurses, Behavioral Health Assistants, Behavioral Health Therapists, Counseling and Therapy staff, and Security staff will complete restraint/seclusion education, including restraint policy and all restraint types, by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete restraint and seclusion education at the beginning of their next shift.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

Each staff person's education record (including Registered Nurses, Behavioral Health Assistants, Behavioral Health Therapists, Counseling and Therapy staff, and Security staff) will be audited by 9/11/2018 to ensure completion of required restraint/seclusion training, education, and competencies.
Responsible Party: Department Leadership

QAPI INTEGRATION

Legacy's policy #900.5274 "Restraint and Seclusion for Patient Safety" will be reviewed at least every 3 years and with changes in regulatory guidelines.

Legacy's standard of care 900.1012 "Use of Restraint and Seclusion" will be reviewed at least every 3 years and with changes in regulatory guidelines.

Restraint/seclusion requirements are included in direct care staff, who are involved in restraint/seclusion events orientation, and annual education.

A263 CONDITION | QAPI

PLAN OF CORRECTION

To ensure compliance with tag A263, the following corrective actions will be implemented by 9/11/2018.

A115

1. PROVISION OF CARE IN A SAFE SETTING (A144)

OBSERVATION PLAN/PATIENT MONITORING AND SAFETY ROUNDING

PROCEDURE/PROCESS FOR IMPLEMENTATION

A revised patient monitoring process will be implemented. In-person observation and engagement of patients in the performance of assigned patient observation checks will be the primary means of monitoring patients. Closed circuit video surveillance will only be utilized as an additional tool for unit safety; it will not be utilized in place of in-person monitoring. Upon admission, all patients will be placed on every 15-minute, in-person observation. Observation frequency level may be modified from every 15-minutes to hourly purposeful rounding only after all the following conditions have been met: patient admitted to an inpatient unit for at least 24 hours, 2 separate assessments by a licensed independent practitioner (LIP), and treatment team discussion of observation plan. The LIP will document the rationale to modify the level of observation. The level of observation will be documented by LIP order. At any time, a registered nurse (RN) may immediately increase the level of observation based on medical or behavioral conditions that create a potential risk to patient safety.
Responsible Party: Unity Vice President

LH policy #902.5201 “Guideline for Close Supervision” will be updated to “Routine and Special Observation for Patient Safety”. This updated policy will reflect the revised patient observation process. The following Unity inpatient standards of care and scope of service policies will also be revised to reflect the revised patient observation process: 902.7002, 902.1211, 902.1000, 902.7100.
Responsible Party: Unity Director of Patient Care Services

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers will receive education on the new patient monitoring policy and process by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete the education at the beginning of their next shift.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

Beginning on 8/3/2018, all admitted patients will be audited daily for 12 weeks (concluding on 11/3/2018) to assess compliance with the patient observation process and documentation. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/3/2018, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with the patient observation process and documentation. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify

themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with the patient observation process and documentation. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

Upon implementation of the revised patient observation policy, all admitted patients will be audited daily for 12 weeks to assess compliance with documentation of observation level modification process (patient admitted for 24 hours or greater, 2 separate assessments by an LIP, and treatment team discussion of observation plan). During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the LIP involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Medical Directors will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with documentation of observation level modification process. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Medical Directors will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with documentation of observation level modification process. The target for compliance is 95%. If 95% is not achieved, Medical Directors will conduct an analysis to assess areas of non-compliance. Medical Directors will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Chief Medical Officer

QAPI INTEGRATION

LH policy #902.5201 “Routine and Special Observation for Patient Safety” will be reviewed at least every three years and with changes in regulatory guidelines.

Education on patient monitoring policy and process will be included in the Unity staff and provider orientation and annual education for Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers.

To ensure long-term, continued compliance with the patient observation process and documentation is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

To ensure long-term, continued compliance with the documentation of observation level modification process is achieved, the Medical Directors will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

SUICIDE SCREENING AND ASSESSMENT AND SUICIDE PRECAUTIONS

PROCEDURE/PROCESS FOR IMPLEMENTATION

All patients presenting to the psychiatric emergency department (PES) and upon admission to inpatient units will be screened by a registered nurse (RN) for level of suicide risk using an evidence-based risk tool. Patients admitted to inpatient units will be rescreened twice daily by an RN for ongoing suicide risk. All patients presenting to the psychiatric emergency department (PES) and upon admission to inpatient units will be assessed by an LIP for suicidal risk. Daily and with change of condition, LIPs will reassess patients and place/review/modify orders for patient observation and level of suicide precautions. Patients who are assessed as at risk of suicidal behavior while hospitalized will be observed at a minimum of every 15-minutes in-person. Patients assessed as at imminent risk of suicidal behavior while hospitalized will be monitored by 1:1 in-person observation. Frequency level of patient observation will be determined by individual patient behaviors, risk factors, and protective factors. As part of the safety plan for patients at risk for suicide while hospitalized, patients on suicide precautions may have patient activities or items restricted for further protection from self-harm. For patients exhibiting an increase in self-injurious thoughts or behavior and for those whose suicide risk screen indicate an increase in suicide risk from the previous screening, staff will initiate an increase in patient observation and notify the LIP. Decreasing patient observation level may only be done with documented LIP assessment and order.
Responsible Party: Unity Vice President

LH policy #902.3108 “Suicide Precautions” will be updated to reflect the revised screening, assessment, and intervention process for patients at risk for suicide.
Responsible Party: Unity Director of Patient Care Services and Unity Chief Medical Officer

Suicide precaution order choices in the electronic health record (EHR) will be updated to be consistent with the revised patient observation and suicide precautions policy.
Responsible Party: Unity Chief Medical Officer

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers will receive education on the revised suicide precautions policy by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete the education at the beginning of their next shift.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

Beginning on 8/3/2018, all admitted patients will be audited daily for 12 weeks (concluding on 11/3/2018) to assess compliance with documentation of suicide risk screening. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/3/2018, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with documentation of suicide risk screening. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with documentation of suicide risk screening. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

Beginning on 8/3/2018, all admitted patients will be audited daily for 12 weeks (concluding on 11/3/2018) to assess compliance with provider suicide risk assessment documentation. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the LIP involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Medical Directors will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/3/2018, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with provide suicide risk assessment documentation. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Medical Directors will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with provide suicide risk assessment documentation. The target for compliance is 95%. If 95% is not achieved, Medical Directors will conduct an analysis to assess areas of non-compliance. Medical Directors will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Chief Medical Officer

QAPI INTEGRATION

LH policy #902.3108 “Suicide Precautions” will be reviewed at least every three years and with changes in regulatory guidelines.

Education on suicide precautions policy and process will be included in the Unity staff and provider orientation and annual education for Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers.

To ensure long-term, continued compliance with documentation of suicide risk screening is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

To ensure long-term, continued compliance with provide suicide risk assessment documentation is achieved, the Medical Directors will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

PATIENT BELONGINGS

PROCEDURE/PROCESS FOR IMPLEMENTATION

A revised process for managing patient belongings will be implemented. During inpatient intake process, patients may select personal items to keep with them. All items selected by patient will be inspected for safety and appropriateness and documented on the personal belongings form. The number of clothing items the patient will be allowed to have will be limited to 12. All other patient belongings will be put into sealed bags and placed in secure belongings storage. If a patient requests a personal item from secure storage, staff will retrieve and inspect the item for safety and appropriateness before giving to patient. Retrieval will be documented on the personal belongings form. This process will also apply to currently admitted patients.
Responsible Party: Unity Director of Patient Care Services

Legacy policy #902.3107 “Personal Belongings and Unsafe Items on Inpatient Psychiatric Units” was revised on 5/20/18 to categorize potentially unsafe items into four categories: never allowed, used during group, used with staff supervision, and allowed unmonitored unless an extreme risk. Items used during group or requiring staff supervision will be secured unless in use by patients.

Staff will assess patients twice a day for safety regarding items in the unmonitored unless an extreme risk category and document in the EHR changes to unsafe item management.
Responsible Party: Unity Director of Patient Care Services

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, and Clerical staff will receive education on the new patient belongings policy and process by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete the education at the beginning of their next shift.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

In-room belongings will be inspected for safety and appropriateness for 30 patients per unit per month for 3 months to assess staff compliance with patient belongings policy, process, and documentation. The target for compliance is 95%. If 95% compliance is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an additional analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care Services

QAPI INTEGRATION

LH policy #902.3107 “Personal Belongings and Unsafe items on Inpatient Psychiatric Unit” will be reviewed at least every three years and with changes in regulatory guidelines.

Education on patient belongings policy and process will be included in the Unity orientation and annual education for Registered Nurses, Behavioral Health Assistants, Behavioral Health Therapists and Clerical staff.

To ensure, long-term continued compliance with patient belongings policy, process, and documentation is achieved, Nurse Managers/Assistant Nurse Managers will conduct ongoing auditing of 30 patients per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

ENVIRONMENT OF CARE: LIGATURE RISKS, UNSAFE ITEMS, AND BLIND SPOTS

PROCEDURE/PROCESS FOR IMPLEMENTATION

A comprehensive environmental risk assessment, including identification of ligature risks and unsafe items, was completed on 5/20/18 by nursing leadership for all areas where patients receive care and services. The Unity Vice President is completing another comprehensive environmental risk assessment 8/14/2018-8/24/2018 to identify additional ligature risks and unsafe items. On 8/24/2018, external subject matter experts from Oregon State Hospital are visiting Unity to tour all patient care areas to offer observations on the environment of care. The comprehensive risk assessment will be updated with additional environmental risks.
Responsible Party: Unity Vice President

To mitigate the risk associated with the camera blind spots, in-person observation and engagement of patients in the performance of assigned patient observation checks will be the primary means of monitoring patients. Closed circuit video surveillance will only be utilized as an additional tool for unit safety; it will not be utilized in place of in-person monitoring.
Responsible Party: Unity Vice President

Recliners in the PES calming rooms were removed and replaced with heavy chairs and ottomans that are ligature-resistant on 7/26/2018.
Responsible Party: PES Nurse Manager

Metal rings in seclusion rooms will be removed and replaced with a round metal rod by 8/22/2018.
Responsible Party: Facilities Manager

All patient bathroom doors (with limited exception 201, 202, 203, 204, 205, 501, 502, 521, 522, 601, 602, 603, 608, 620) were removed on 7/20/2018 and replaced with Velcro curtains. Bathroom doors were kept in place in all hardened rooms and three patient rooms on Unit 6 to meet patient care needs for patients with eating disorders. The curtains were assessed in April 2017 and reassessed on 7/20/2018 for safety. Unity Leadership Council and Director of Environmental Services determined these are safe and do not pose a suffocation risk. The Velcro consists of small strips (approximately 1 inch by 1 inch) to mitigate Velcro being used as a ligature. The Velcro mounting system was assessed to be low weight-bearing and cannot be used as a ligature point. For those patient rooms that have bathroom doors, the bathroom door will be locked at all times, and the patient will be supervised by staff when in use. If the patient is assessed to not be at risk for suicide while hospitalized, the bathroom door may be unlocked, and the patient will be observed every 15-minutes in-person.
Responsible Party: Unity Director of Patient Care Services

Hinges on the window access panels in all patient rooms will be filled with pick-proof caulk to eliminate the ligature risk. This will be completed by 8/31/2018.
Responsible Party: Facilities Manager

Cabinet doors will be removed on all patient belongings cabinets in patient rooms. The following items located within the patient cabinets will have ligature and other safety risks mitigated: internal shelf, vent, clock, and outlet. The shelf will be removed and used to cover the vent. The clocks will be covered with a protective case. This will be completed by 8/31/2018.The outlet inside the cabinet is a safety outlet and does not require further safety mitigation.
Responsible Party: Facilities Manager

The correct version of LH policy #902.5111 “Counseling and Therapy Therapeutic Guideline” was posted to the Legacy intranet site on 7/30/2018. This version explicitly states that there will always be two staff members present in the garden, and no staff will be alone in the garden while patients are using the garden.
Responsible Party: Unity Vice President

The garden environmental risk assessment was updated to include the emergency poles, gazebos, and basketball hoops on 7/30/2018. To mitigate the environmental risks in the garden, the staffing ratio is 1 staff for 5 patients, and a minimum of two staff members must be in the garden with patients at all times regardless of number of patients. All patients that attend garden group must have an order from the LIP to attend.
Responsible Party: Unity Vice President

Linen carts were removed from general milieu and secured in non-patient care areas on 7/28/2018. Soiled linen hampers will be kept in a secure area when not in use.
Responsible Party: Unity Director of Patient Care Services

The coffee stirrers identified during survey are thin black straws. The straws were reviewed on 8/3/2018 by Unity Director of Patient Care Services and Unity Vice President and determined to be safe for patient use due to flexibility. This item has been added to the comprehensive environmental risk assessment.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

High risk issues identified during the leadership safety huddle will be added to the action plan template. Action items will be reviewed at the leadership safety huddle, and the action plan will be added as a standing agenda item at Leadership Council. Action items related to the environment of care will be added to the environmental risk assessment along with a mitigation plan.
Responsible Party: Unity Vice President

All safety event reports (ICAREs) related to ligature risk or unsafe items, attempted suicide or self-harm, patient elopements or attempted elopements will be investigated, and a mitigation plan will be implemented for any ongoing risks. Response to ICAREs

includes these immediate steps: ensure the patient is safe, creation of an immediate safety plan, notification of leadership up through chain of command, documentation of the event, and investigation. Investigations will be initiated within 72 hours of receipt and completed as soon as possible or no later than two weeks after receipt, depending on the severity and complexity of the event.
Responsible Party: Unity Vice President

QAPI INTEGRATION

Legacy's Hazard Surveillance Rounds and Analyses tool was updated on 7/18/2018 to include ligature risks and unsafe items. These rounds are conducted quarterly.
Responsible Party: Environment of Care Manager

Environmental safety rounds to identify potential ligature risks and unsafe items began on 5/20/18 in accordance with revised policy #902.3107. Nursing staff will conduct environmental safety rounds twice a day in all areas where patients receive care and services.
Responsible Party: Unity Director of Patient Care Services

Prospectively, a comprehensive environmental risk assessment will be completed and reviewed for all areas where patients receive care and services, on a quarterly basis, by unit leadership or designee.
Responsible Party: Unity Vice President

RESPONSE TO URGENT AND EMERGENCY MEDICAL CONDITIONS

PROCEDURE/PROCESS FOR IMPLEMENTATION

All suction machines on Code M carts were enrolled in the Legacy preventive maintenance program in accordance with the LH policy #300.12 "Medical Equipment Management Plan" on 8/3/2018.
Responsible Party: Legacy Director of Clinical Engineering

To ensure that equipment and supplies for urgent and emergent medical response are available, the Code M carts are checked daily to ensure required cart elements are present and unexpired.
Responsible Party: Unity Director of Patient Care Services

MONITORING/TRACKING PROCEDURES

Per LH policy #300.12 "Medical Equipment Management Plan", the Director of Clinical Engineering assures that scheduled testing of all non-life support medical equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Safety Committee each quarter. If any monthly rate of completion falls below 90%, the Director of Clinical Engineering will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.
Responsible Party: Legacy Director of Clinical Engineering

All Code M carts daily checks will be audited each week for 12 weeks to assess compliance with completion and documentation of daily cart checks. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 Code M cart daily checks per unit will be audited each month for 3 months to assess compliance with completion and documentation of daily cart checks. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3

consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

The Code M carts are checked daily to ensure required cart elements are present and unexpired.

The Director of Clinical Engineering maintains the medical equipment inventory, which includes information on required scheduled maintenance for all equipment. This ensures all inventoried equipment receives timely preventive maintenance.

To ensure long-term, continued compliance with completion and documentation of daily cart checks is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 Code M cart daily checks per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

ELOPEMENT AND COMMUNICATION SAFETY DEVICES

PROCEDURE/PROCESS FOR IMPLEMENTATION

To mitigate elopement risk, a revised patient monitoring process will be implemented. In-person observation and engagement of patients in the performance of assigned patient observation checks will be the primary means of monitoring patients. Closed circuit video surveillance will only be utilized as an additional tool for unit safety; it will not be utilized in place of in-person monitoring. Upon admission, patients will be placed on every 15-minute, in-person observation. Observation frequency level may be modified from every 15-minutes to hourly purposeful rounding only after the following conditions have been met: patient admitted to an inpatient unit for at least 24 hours, 2 separate assessments by a licensed independent practitioner (LIP), and treatment team discussion of observation plan. The LIP will document the rationale to modify the level of observation. The level of observation will be documented by LIP order. At any time, a registered nurse (RN) may immediately increase the level of observation based on medical or behavioral conditions that create a potential risk to patient safety.
Responsible Party: Unity Vice President

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, providers, and contractors with direct patient contact will receive education on alertness to potential hazards and environmental risks by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete the education at the beginning of their next shift.
Responsible Party: Unity Vice President

30 additional Voceras (communication safety devices) were ordered on 8/20/2018 . A revised Vocera inventory process will be instituted. The revised process will include a check-in/check-out process to be conducted every shift to ensure that devices are returned from off-going shift staff and devices are allocated to all oncoming shift staff. Nurse Manager/Assistant Nurse Manager will review the Vocera report to identify and follow-up on lost or misplaced devices.
Responsible Party: Unity Director of Patient Care Services

MONITORING AND TRACKING PROCEDURES

Beginning on 8/3/2018, all admitted patients will be audited daily for 12 weeks (concluding on 11/3/2018) to assess compliance with the patient observation process and documentation. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/3/2018, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with the patient observation process and documentation. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with the patient observation process and documentation. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

LH policy #902.5201 “Routine and Special Observation for Patient Safety” will be reviewed at least every three years and with changes in regulatory guidelines.

To ensure long-term, continued compliance with the patient observation process and documentation is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

MEDICATION ADMINISTRATION (A405)

PROCEDURE/PROCESS FOR IMPLEMENTATION

Medication administration education was completed by all nurses by 7/26/2018.
Responsible Party: Unity Director of Patient Care Services

Starting on 7/28/2018 and ending 8/14/2018, medication administrations were audited in real-time by a second RN observing the medication administration process. All nurses were educated on how to use the audit tool, which includes all steps required for safe medication administration. When any instances of non-compliance were analyzed using the Just Culture Algorithm and non-compliance was addressed with the staff member involved.
Responsible Party: Unity Director of Patient Care Services

Medication administration education was completed by all nurses by 7/26/2018.
Responsible Party: Unity Director of Patient Care Services

New ICARE follow-up guidelines were developed to provide the Nurse Managers/Assistant Nurse Managers with additional guidance on what to include in their investigation of safety event reports on their units. The guidelines include a template for investigating distinct categories of safety event reports, including medication errors as previously described. Nurse Managers/Assistant Nurse Managers are to choose the appropriate category and template and input it into the ICARE system to document findings from their investigation. The template includes sections to list contributing factors, patient condition/outcome, mitigation plan, and just culture findings.
Responsible Party: Unity Director of Patient Care Services

MONITORING AND TRACKING PROCEDURES

After confirming adoption of the barcode medication administration process, as validated by improvement in barcode scanning percentages and daily audit results, beginning on 8/14/2018, 30 medication administration on each adult inpatient unit and PES and 20 medication administrations on the adolescent inpatient unit (approximately 50%) will be audited daily for 12 weeks (concluding on 11/14/2018) to assess compliance with the medication administration process. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/14/2018, 30 medication administrations on each adult inpatient unit and PES and 20 medication administrations on the adolescent inpatient unit will be audited each week for 12 weeks to assess compliance with the medication administration process. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 medication administrations will be audited each month for 3 months to assess compliance with the medication administration process. The target for compliance is 95% If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.

To ensure long-term, continued compliance with the medication administration process is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

All Nurse Managers/Assistant Nurse Managers will review individual nurse barcode medication administration scanning compliance percentages monthly. For any nurse that does not meet scanning expectations, the Nurse Manager/Assistant Nurse Manager will investigate and determine if correct medication administration process was followed. If it is determined the nurse did not follow correct medication administration process, the Nurse Manager/Assistant Nurse Manager will provide coaching on correct medication administration process and expectations.

2. TIMELY AND COMPLETE INVESTIGATION OF EVENTS (A145)

PROCEDURE/PROCESS FOR IMPLEMENTATION

Reeducation on safety event reporting (ICARE) was provided to all direct care staff, including Registered Nurses, Behavioral Health Assistants, Behavioral Health Therapists, Counseling and Therapy staff, Care Management staff, Security staff, and Contractors with direct patient contact on 7/20/2018. This education included information on types of incidents and events that should be reported along with what constitutes abuse and neglect. Staff that have not completed the education will complete the education prior to their next work shift.
Responsible Party: Unity Vice President

New ICARE follow-up guidelines were developed to provide the Nurse Managers/Assistant Nurse Managers with additional guidance on what to include in their investigation of safety event reports on their units. The guidelines include a template for investigating distinct categories of ICAREs, including ligature risks, elopements (attempted or actual), cheeking medications, medication errors,

unsafe items, Code M (medical emergency), self-harm or suicide attempts, restraint and seclusion, abuse or assault allegations from patients (including neglect), falls, and abuse or assault allegations from staff. Nurse Managers/Assistant Nurse Managers verify that the appropriate event category is documented. The Nurse Managers/Assistant Nurse Managers use a follow-up template and input the template into the ICARE system along with the investigation findings. The template includes sections to list contributing factors, patient condition/outcome, mitigation plan, and just culture findings.
Responsible Party: Unity Director of Patient Care Services

Abuse and neglect allegations are investigated immediately. Response to abuse or neglect allegations includes these immediate steps: ensure the patient is safe, creation of an immediate safety plan, notification of leadership up through chain of command, documentation of the alleged or suspected abuse or neglect, and investigation of all allegations. Cases of abuse and neglect will be escalated to Risk Management for additional investigation per the department's established abuse investigation process. Investigation findings are reviewed by senior leadership and risk management. This group determines if the allegation of abuse or neglect is substantiated. If the allegation is substantiated, mandatory reporting processes will be followed. After the investigation is complete, the Nurse Managers/Assistant Nurse Managers will document the outcome of the investigation and whether the allegation of abuse or neglect is substantiated.
Responsible Party: Manager of Risk Management

Communication was provided in-person and reiterated in writing on 7/5/2018 to Nurse Managers and Assistant Nurse Managers reinforcing expectations for reviewing ICAREs along with a copy of the newly developed ICARE report guidelines with instructions for use. Part of the expectations included what constitutes a timely investigation and response to ICAREs: Managers are expected to initiate investigation of their ICAREs within 72 hours of receipt and complete their investigation as soon as possible or no later than two weeks after receipt, depending on the severity and complexity of the case.
Responsible Party: Unity Director of Patient Care Services

MONITORING AND TRACKING PROCEDURES

20 ICAREs will be audited each week for 12 weeks to ensure all elements of the ICAREs are completed and allegations and cases of abuse or neglect are investigated and documented per standard process. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, the Unity Director of Patient Care Services will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 ICAREs will be audited each month for 3 months to ensure all elements of the ICAREs are completed and allegations and cases of abuse or neglect are investigated and documented per standard process. The target for compliance is 95%. If 95% is not achieved, Unity Director of Patient Care Services will conduct an analysis to assess areas of non-compliance. Unity Director of Patient Care Services will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

Upon hire, all direct care staff, including Registered Nurses, Behavioral Health Assistants, Behavioral Health Therapists, Counseling and Therapy staff, Care Management staff, Security staff, and contractors with direct patient contact receive education on safety event reporting in the ICARE system and the types of incidents and events that should be reported and identification of cases of abuse and neglect.

To ensure sustainment of the ICARE and abuse or neglect investigation processes, the Unity Director of Patient Care Services will conduct ongoing audits of 30 ICAREs per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

3. RESTRAINT/SECLUSION ASSESSMENT AND MONITORING (A175)

PROCEDURE/PROCESS FOR IMPLEMENTATION

Registered Nurses, Behavioral Health Assistants, Behavioral Health Therapists, Counseling and Therapy staff, and Security staff will complete restraint/seclusion education, including restraint policy and all restraint types, by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete restraint and seclusion education at the beginning of their next shift.
Responsible Party: Unity Vice President

Legacy's policy #900.5274 "Restraint and Seclusion for Patient Safety" will be revised to include which role may complete every 2-hour assessments and every 15-minute monitoring for patients with violent or self-destructive behaviors. Additionally, the required elements of the every 2-hour nursing assessments will be specified in the policy.
Responsible Party: Clinical Nurse Specialist

MONITORING AND TRACKING PROCEDURES

Beginning on 8/3/2018, all restraint and seclusion events will be audited each week for 12 weeks (concluding on 11/3/2018) to assess compliance with restraint/seclusion documentation requirements. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, the Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved but not before 11/3/2018, 30 restraint and seclusion events per unit will be audited each month for 3 months to assess compliance with restraint/seclusion documentation requirements. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

Legacy's policy #900.5274 "Restraint and Seclusion for Patient Safety" will be reviewed at least every 3 years and with changes in regulatory guidelines.

Legacy's standard of care 900.1012 "Use of Restraint and Seclusion" will be reviewed at least every 3 years and with changes in regulatory guidelines.

Restraint/seclusion requirements are included in direct care staff, who are involved in restraint/seclusion events, orientation and annual education.

To ensure long-term, continued compliance with c restraint/seclusion requirements is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 restraint and seclusion events per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

4. RESTRAINT/SECLUSION TRAINING (A202)

PROCEDURE/PROCESS FOR IMPLEMENTATION

Legacy's policy #900.5274 "Restraint and Seclusion for Patient Safety" will be updated to include a list of specific restraint types that are utilized at Unity. Unity does not use nonviolent restraints.
Responsible Party: Unity Director of Patient Care Services

The restraint and seclusion education and return demonstration will be updated to reflect the specific restraint types that are utilized at Unity.
Responsible Party: Unity Director of Patient Care Services

Registered Nurses, Behavioral Health Assistants, Behavioral Health Therapists, Counseling and Therapy staff, and Security staff will complete restraint/seclusion education, including restraint policy and all restraint types, by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete restraint and seclusion education at the beginning of their next shift.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

Each staff person's education record (including Registered Nurses, Behavioral Health Assistants, Behavioral Health Therapists, Counseling and Therapy staff, and Security staff) will be audited by 9/11/2018 to ensure completion of required restraint/seclusion training, education, and competencies.
Responsible Party: Department Leadership

QAPI INTEGRATION

Legacy's policy #900.5274 "Restraint and Seclusion for Patient Safety" will be reviewed at least every 3 years and with changes in regulatory guidelines.

Legacy's standard of care 900.1012 "Use of Restraint and Seclusion" will be reviewed at least every 3 years and with changes in regulatory guidelines.

Restraint/seclusion requirements are included in direct care staff, who are involved in restraint/seclusion events orientation, and annual education.

A385

1. RN ASSESSMENT, MONITORING, AND OBSERVATION (A395)

OBSERVATION PLAN/PATIENT MONITORING AND SAFETY ROUNDING

PROCEDURE/PROCESS FOR IMPLEMENTATION

A revised patient monitoring process will be implemented. In-person observation and engagement of patients in the performance of assigned patient observation checks will be the primary means of monitoring patients. Closed circuit video surveillance will only be utilized as an additional tool for unit safety; it will not be utilized in place of in-person monitoring. Upon admission, all patients will be placed on every 15-minute, in-person observation. Observation frequency level may be modified from every 15-minutes to hourly purposeful rounding only after all the following conditions have been met: patient admitted to an inpatient unit for at least 24 hours, 2 separate assessments by a licensed independent practitioner (LIP), and treatment team discussion of observation plan. The LIP will document the rationale to modify the level of observation. The level of observation will be documented by LIP order. At any

time, a registered nurse (RN) may immediately increase the level of observation based on medical or behavioral conditions that create a potential risk to patient safety.
Responsible Party: Unity Vice President

LH policy #902.5201 "Guideline for Close Supervision" will be updated to "Routine and Special Observation for Patient Safety". This updated policy will reflect the revised patient observation process. The following Unity inpatient standards of care and scope of service policies will also be revised to reflect the revised patient observation process: 902.7002, 902.1211, 902.1000, 902.7100.
Responsible Party: Unity Director of Patient Care Services

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers will receive education on the new patient monitoring policy and process by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete the education at the beginning of their next shift.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

Beginning on 8/3/2018, all admitted patients will be audited daily for 12 weeks (concluding on 11/3/2018) to assess compliance with the patient observation process and documentation. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/3/2018, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with the patient observation process and documentation. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with the patient observation process and documentation. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

LH policy #902.5201 "Routine and Special Observation for Patient Safety" will be reviewed at least every three years and with changes in regulatory guidelines.

Education on patient monitoring policy and process will be included in the Unity staff and provider orientation and annual education for Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers.

To ensure long-term, continued compliance with the patient observation process and documentation is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

SUICIDE SCREENING AND ASSESSMENT AND SUICIDE PRECAUTIONS

PROCEDURE/PROCESS FOR IMPLEMENTATION

All patients presenting to the psychiatric emergency department (PES) and upon admission to inpatient units will be screened by a registered nurse (RN) for level of suicide risk using an evidence-based risk tool. Patients admitted to inpatient units will be rescreened twice daily by an RN for ongoing suicide risk. All patients presenting to the psychiatric emergency department (PES) and upon admission to inpatient units will be assessed by an LIP for suicidal risk. Daily and with change of condition, LIPs will reassess patients and place/review/modify orders for patient observation and level of suicide precautions. Patients who are assessed as at risk of suicidal behavior while hospitalized will be observed at a minimum of every 15-minutes in-person. Patients assessed as at imminent risk of suicidal behavior while hospitalized will be monitored by 1:1 in-person observation. Frequency level of patient observation will be determined by individual patient behaviors, risk factors, and protective factors. As part of the safety plan for patients at risk for suicide while hospitalized, patients on suicide precautions may have patient activities or items restricted for further protection from self-harm. For patients exhibiting an increase in self-injurious thoughts or behavior and for those whose suicide risk screen indicate an increase in suicide risk from the previous screening, staff will initiate an increase in patient observation and notify the LIP. Decreasing patient observation level may only be done with documented LIP assessment and order.
Responsible Party: Unity Vice President

LH policy #902.3108 “Suicide Precautions” will be updated to reflect the revised screening, assessment, and intervention process for patients at risk for suicide.
Responsible Party: Unity Vice President

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers will receive education on the revised suicide precautions policy by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete the education at the beginning of their next shift.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

Beginning on 8/3/2018, all admitted patients will be audited daily for 12 weeks (concluding on 11/3/2018) to assess compliance with documentation of suicide risk screening. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/3/2018, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with documentation of suicide risk screening. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with documentation of suicide risk screening. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

LH policy #902.3108 “Suicide Precautions” will be reviewed at least every three years and with changes in regulatory guidelines.

Education on suicide precautions policy and process will be included in the Unity staff and provider orientation and annual education for Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers.

To ensure long-term, continued compliance with documentation of suicide risk screening is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

2. MEDICATION ADMINISTRATION (A405)

PROCEDURE/PROCESS FOR IMPLEMENTATION

Medication administration education was completed by all nurses by 7/26/2018.
Responsible Party: Unity Director of Patient Care Services

Starting on 7/28/2018 and ending 8/14/2018, medication administrations were audited in real-time by a second RN observing the medication administration process. All nurses were educated on how to use the audit tool, which includes all steps required for safe medication administration. When any instances of non-compliance were analyzed using the Just Culture Algorithm and non-compliance was addressed with the staff member involved.
Responsible Party: Unity Director of Patient Care Services

Medication administration education was completed by all nurses by 7/26/2018.
Responsible Party: Unity Director of Patient Care Services

New ICARE follow-up guidelines were developed to provide the Nurse Managers/Assistant Nurse Managers with additional guidance on what to include in their investigation of safety event reports on their units. The guidelines include a template for investigating distinct categories of safety event reports, including medication errors as previously described. Nurse Managers/Assistant Nurse Managers are to choose the appropriate category and template and input it into the ICARE system to document findings from their investigation. The template includes sections to list contributing factors, patient condition/outcome, mitigation plan, and just culture findings.
Responsible Party: Unity Director of Patient Care Services

MONITORING AND TRACKING PROCEDURES

After confirming adoption of the barcode medication administration process, as validated by improvement in barcode scanning percentages and daily audit results, beginning on 8/14/2018, 30 medication administration on each adult inpatient unit and PES and 20 medication administrations on the adolescent inpatient unit (approximately 50%) will be audited daily for 12 weeks (concluding on 11/14/2018) to assess compliance with the medication administration process. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/14/2018, 30 medication administrations on each adult inpatient unit and PES and 20 medication administrations on the adolescent inpatient unit will be audited each week for 12 weeks to assess compliance with the medication administration process. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or

barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 medication administrations will be audited each month for 3 months to assess compliance with the medication administration process. The target for compliance is 95% If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.

To ensure long-term, continued compliance with the medication administration process is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

All Nurse Managers/Assistant Nurse Managers will review individual nurse barcode medication administration scanning compliance percentages monthly. For any nurse that does not meet scanning expectations, the Nurse Manager/Assistant Nurse Manager will investigate and determine if correct medication administration process was followed. If it is determined the nurse did not follow correct medication administration process, the Nurse Manager/Assistant Nurse Manager will provide coaching on correct medication administration process and expectations.

A700

PLAN OF CORRECTION

To ensure compliance with tag A700, the following corrective actions will be implemented by 9/11/2018.

ENVIRONMENT OF CARE: LIGATURE RISKS, UNSAFE ITEMS, AND BLIND SPOTS

PROCEDURE/PROCESS FOR IMPLEMENTATION

A comprehensive environmental risk assessment, including identification of ligature risks and unsafe items, was completed on 5/20/18 by nursing leadership for all areas where patients receive care and services. The Unity Vice President is completing another comprehensive environmental risk assessment 8/14/2018-8/24/2018 to identify additional ligature risks and unsafe items. On 8/24/2018, external subject matter experts from Oregon State Hospital are visiting Unity to tour all patient care areas to offer observations on the environment of care. The comprehensive risk assessment will be updated with additional environmental risks.
Responsible Party: Unity Vice President

To mitigate the risk associated with the camera blind spots, in-person observation and engagement of patients in the performance of assigned patient observation checks will be the primary means of monitoring patients. Closed circuit video surveillance will only be utilized as an additional tool for unit safety; it will not be utilized in place of in-person monitoring.
Responsible Party: Unity Vice President

Recliners in the PES calming rooms were removed and replaced with heavy chairs and ottomans that are ligature-resistant on 7/26/2018.
Responsible Party: PES Nurse Manager

Metal rings in seclusion rooms will be removed and replaced with a round metal rod by 8/22/2018.
Responsible Party: Facilities Manager

All patient bathroom doors (with limited exception 201, 202, 203, 204, 205, 501, 502, 521, 522, 601, 602, 603, 608, 620) were removed on 7/20/2018 and replaced with Velcro curtains. Bathroom doors were kept in place in all hardened rooms and three patient rooms on Unit 6 to meet patient care needs for patients with eating disorders. The curtains were assessed in April 2017 and reassessed on 7/20/2018 for safety. Unity Leadership Council and Director of Environmental Services determined these are safe and do not pose a suffocation risk. The Velcro consists of small strips (approximately 1 inch by 1 inch) to mitigate Velcro being used as a ligature. The Velcro mounting system was assessed to be low weight-bearing and cannot be used as a ligature point. For those patient rooms that have bathroom doors, the bathroom door will be locked at all times, and the patient will be supervised by staff when in use. If the patient is assessed to not be at risk for suicide while hospitalized, the bathroom door may be unlocked, and the patient will be observed every 15-minutes in-person.
Responsible Party: Unity Director of Patient Care Services

Hinges on the window access panels in all patient rooms will be filled with pick-proof caulk to eliminate the ligature risk. This will be completed by 8/31/2018.
Responsible Party: Facilities Manager

Cabinet doors will be removed on all patient belongings cabinets in patient rooms. The following items located within the patient cabinets will have ligature and other safety risks mitigated: internal shelf, vent, clock, and outlet. The shelf will be removed and used to cover the vent. The clocks will be covered with a protective case. This will be completed by 8/31/2018.The outlet inside the cabinet is a safety outlet and does not require further safety mitigation.
Responsible Party: Facilities Manager

The correct version of LH policy #902.5111 “Counseling and Therapy Therapeutic Guideline” was posted to the Legacy intranet site on 7/30/2018. This version explicitly states that there will always be two staff members present in the garden, and no staff will be alone in the garden while patients are using the garden.
Responsible Party: Unity Vice President

The garden environmental risk assessment was updated to include the emergency poles, gazebos, and basketball hoops on 7/30/2018. To mitigate the environmental risks in the garden, the staffing ratio is 1 staff for 5 patients, and a minimum of two staff members must be in the garden with patients at all times regardless of number of patients. All patients that attend garden group must have an order from the LIP to attend.
Responsible Party: Unity Vice President

Linen carts were removed from general milieu and secured in non-patient care areas on 7/28/2018. Soiled linen hampers will be kept in a secure area when not in use.
Responsible Party: Unity Director of Patient Care Services

The coffee stirrers identified during survey are thin black straws. The straws were reviewed on 8/3/2018 by Unity Director of Patient Care Services and Unity Vice President and determined to be safe for patient use due to flexibility. This item has been added to the comprehensive environmental risk assessment.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

High risk issues identified during the leadership safety huddle will be added to the action plan template. Action items will be reviewed at the leadership safety huddle, and the action plan will be added as a standing agenda item at Leadership Council. Action items related to the environment of care will be added to the environmental risk assessment along with a mitigation plan.
Responsible Party: Unity Vice President

All safety event reports (ICAREs) related to ligature risk or unsafe items, attempted suicide or self-harm, patient elopements or attempted elopements will be investigated, and a mitigation plan will be implemented for any ongoing risks. Response to ICAREs

includes these immediate steps: ensure the patient is safe, creation of an immediate safety plan, notification of leadership up through chain of command, documentation of the event, and investigation. Investigations will be initiated within 72 hours of receipt and completed as soon as possible or no later than two weeks after receipt, depending on the severity and complexity of the event.
Responsible Party: Unity Vice President

QAPI INTEGRATION

Legacy's Hazard Surveillance Rounds and Analyses tool was updated on 7/18/2018 to include ligature risks and unsafe items. These rounds are conducted quarterly.
Responsible Party: Environment of Care Manager

Environmental safety rounds to identify potential ligature risks and unsafe items began on 5/20/18 in accordance with revised policy #902.3107. Nursing staff will conduct environmental safety rounds twice a day in all areas where patients receive care and services.
Responsible Party: Unity Director of Patient Care Services

Prospectively, a comprehensive environmental risk assessment will be completed and reviewed for all areas where patients receive care and services, on a quarterly basis, by unit leadership or designee.
Responsible Party: Unity Vice President

RESPONSE TO URGENT AND EMERGENCY MEDICAL CONDITIONS

PROCEDURE/PROCESS FOR IMPLEMENTATION

All suction machines on Code M carts were enrolled in the Legacy preventive maintenance program in accordance with the LH policy #300.12 "Medical Equipment Management Plan" on 8/3/2018.
Responsible Party: Legacy Director of Clinical Engineering

To ensure that equipment and supplies for urgent and emergent medical response are available, the Code M carts are checked daily to ensure required cart elements are present and unexpired.
Responsible Party: Unity Director of Patient Care Services

MONITORING/TRACKING PROCEDURES

Per LH policy #300.12 "Medical Equipment Management Plan", the Director of Clinical Engineering assures that scheduled testing of all non-life support medical equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Safety Committee each quarter. If any monthly rate of completion falls below 90%, the Director of Clinical Engineering will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.
Responsible Party: Legacy Director of Clinical Engineering

All Code M carts daily checks will be audited each week for 12 weeks to assess compliance with completion and documentation of daily cart checks. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 Code M cart daily checks per unit will be audited each month for 3 months to assess compliance with completion and documentation of daily cart checks. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3

consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

The Code M carts are checked daily to ensure required cart elements are present and unexpired.

The Director of Clinical Engineering maintains the medical equipment inventory, which includes information on required scheduled maintenance for all equipment. This ensures all inventoried equipment receives timely preventive maintenance.

To ensure long-term, continued compliance with completion and documentation of daily cart checks is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 Code M cart daily checks per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

ELOPEMENT AND COMMUNICATION SAFETY DEVICES

PROCEDURE/PROCESS FOR IMPLEMENTATION

To mitigate elopement risk, a revised patient monitoring process will be implemented. In-person observation and engagement of patients in the performance of assigned patient observation checks will be the primary means of monitoring patients. Closed circuit video surveillance will only be utilized as an additional tool for unit safety; it will not be utilized in place of in-person monitoring. Upon admission, patients will be placed on every 15-minute, in-person observation. Observation frequency level may be modified from every 15-minutes to hourly purposeful rounding only after the following conditions have been met: patient admitted to an inpatient unit for at least 24 hours, 2 separate assessments by a licensed independent practitioner (LIP), and treatment team discussion of observation plan. The LIP will document the rationale to modify the level of observation. The level of observation will be documented by LIP order. At any time, a registered nurse (RN) may immediately increase the level of observation based on medical or behavioral conditions that create a potential risk to patient safety.
Responsible Party: Unity Vice President

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, providers, and contractors with direct patient contact will receive education on alertness to potential hazards and environmental risks by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete the education at the beginning of their next shift.
Responsible Party: Unity Vice President

30 additional Voceras (communication safety devices) were ordered on 8/20/2018 . A revised Vocera inventory process will be instituted. The revised process will include a check-in/check-out process to be conducted every shift to ensure that devices are returned from off-going shift staff and devices are allocated to all oncoming shift staff. Nurse Manager/Assistant Nurse Manager will review the Vocera report to identify and follow-up on lost or misplaced devices.
Responsible Party: Unity Director of Patient Care Services

MONITORING AND TRACKING PROCEDURES

Beginning on 8/3/2018, all admitted patients will be audited daily for 12 weeks (concluding on 11/3/2018) to assess compliance with the patient observation process and documentation. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/3/2018, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with the patient observation process and documentation. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with the patient observation process and documentation. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

LH policy #902.5201 “Routine and Special Observation for Patient Safety” will be reviewed at least every three years and with changes in regulatory guidelines.

To ensure long-term, continued compliance with the patient observation process and documentation is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

A385 CONDITION | NURSING SERVICES

PLAN OF CORRECTION

To ensure compliance with tag A385, the following corrective actions will be implemented by 9/11/2018.

1. RN ASSESSMENT, MONITORING, AND OBSERVATION (A395)

OBSERVATION PLAN/PATIENT MONITORING AND SAFETY ROUNDING

PROCEDURE/PROCESS FOR IMPLEMENTATION

A revised patient monitoring process will be implemented. In-person observation and engagement of patients in the performance of assigned patient observation checks will be the primary means of monitoring patients. Closed circuit video surveillance will only be utilized as an additional tool for unit safety; it will not be utilized in place of in-person monitoring. Upon admission, all patients will be placed on every 15-minute, in-person observation. Observation frequency level may be modified from every 15-minutes to hourly purposeful rounding only after all the following conditions have been met: patient admitted to an inpatient unit for at least 24 hours, 2 separate assessments by a licensed independent practitioner (LIP), and treatment team discussion of observation plan. The LIP will document the rationale to modify the level of observation. The level of observation will be documented by LIP order. At any time, a registered nurse (RN) may immediately increase the level of observation based on medical or behavioral conditions that create a potential risk to patient safety.
Responsible Party: Unity Vice President

LH policy #902.5201 “Guideline for Close Supervision” will be updated to “Routine and Special Observation for Patient Safety”. This updated policy will reflect the revised patient observation process. The following Unity inpatient standards of care and scope of service policies will also be revised to reflect the revised patient observation process: 902.7002, 902.1211, 902.1000, 902.7100.
Responsible Party: Unity Director of Patient Care Services

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers will receive education on the new patient monitoring policy and process by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete the education at the beginning of their next shift.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

Beginning on 8/3/2018, all admitted patients will be audited daily for 12 weeks (concluding on 11/3/2018) to assess compliance with the patient observation process and documentation. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/3/2018, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with the patient observation process and documentation. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with the patient observation process and documentation. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

LH policy #902.5201 “Routine and Special Observation for Patient Safety” will be reviewed at least every three years and with changes in regulatory guidelines.

Education on patient monitoring policy and process will be included in the Unity staff and provider orientation and annual education for Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers.

To ensure long-term, continued compliance with the patient observation process and documentation is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

SUICIDE SCREENING AND ASSESSMENT AND SUICIDE PRECAUTIONS

PROCEDURE/PROCESS FOR IMPLEMENTATION

All patients presenting to the psychiatric emergency department (PES) and upon admission to inpatient units will be screened by a registered nurse (RN) for level of suicide risk using an evidence-based risk tool. Patients admitted to inpatient units will be rescreened twice daily by an RN for ongoing suicide risk. All patients presenting to the psychiatric emergency department (PES) and upon admission to inpatient units will be assessed by an LIP for suicidal risk. Daily and with change of condition, LIPs will reassess patients and place/review/modify orders for patient observation and level of suicide precautions. Patients who are assessed as at risk of suicidal behavior while hospitalized will be observed at a minimum of every 15-minutes in-person. Patients assessed as at imminent risk of suicidal behavior while hospitalized will be monitored by 1:1 in-person observation. Frequency level of patient observation will be determined by individual patient behaviors, risk factors, and protective factors. As part of the safety plan for patients at risk for suicide while hospitalized, patients on suicide precautions may have patient activities or items restricted for further protection from self-harm. For patients exhibiting an increase in self-injurious thoughts or behavior and for those whose suicide risk screen indicate an increase in suicide risk from the previous screening, staff will initiate an increase in patient observation and notify the LIP. Decreasing patient observation level may only be done with documented LIP assessment and order.
Responsible Party: Unity Vice President

LH policy #902.3108 “Suicide Precautions” will be updated to reflect the revised screening, assessment, and intervention process for patients at risk for suicide.
Responsible Party: Unity Vice President

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers will receive education on the revised suicide precautions policy by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete the education at the beginning of their next shift.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

Beginning on 8/3/2018, all admitted patients will be audited daily for 12 weeks (concluding on 11/3/2018) to assess compliance with documentation of suicide risk screening. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff

member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/3/2018, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with documentation of suicide risk screening. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with documentation of suicide risk screening. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

LH policy #902.3108 “Suicide Precautions” will be reviewed at least every three years and with changes in regulatory guidelines.

Education on suicide precautions policy and process will be included in the Unity staff and provider orientation and annual education for Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers.

To ensure long-term, continued compliance with documentation of suicide risk screening is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

2. MEDICATION ADMINISTRATION (A405)

PROCEDURE/PROCESS FOR IMPLEMENTATION

Medication administration education was completed by all nurses by 7/26/2018.
Responsible Party: Unity Director of Patient Care Services

Starting on 7/28/2018 and ending 8/14/2018, medication administrations were audited in real-time by a second RN observing the medication administration process. All nurses were educated on how to use the audit tool, which includes all steps required for safe medication administration. When any instances of non-compliance were analyzed using the Just Culture Algorithm and non-compliance was addressed with the staff member involved.
Responsible Party: Unity Director of Patient Care Services

Medication administration education was completed by all nurses by 7/26/2018.
Responsible Party: Unity Director of Patient Care Services

New ICARE follow-up guidelines were developed to provide the Nurse Managers/Assistant Nurse Managers with additional guidance on what to include in their investigation of safety event reports on their units. The guidelines include a template for investigating distinct categories of safety event reports, including medication errors as previously described. Nurse Managers/Assistant Nurse Managers are to choose the appropriate category and template and input it into the ICARE system to document findings from their

investigation. The template includes sections to list contributing factors, patient condition/outcome, mitigation plan, and just culture findings.
Responsible Party: Unity Director of Patient Care Services

MONITORING AND TRACKING PROCEDURES

After confirming adoption of the barcode medication administration process, as validated by improvement in barcode scanning percentages and daily audit results, beginning on 8/14/2018, 30 medication administration on each adult inpatient unit and PES and 20 medication administrations on the adolescent inpatient unit (approximately 50%) will be audited daily for 12 weeks (concluding on 11/14/2018) to assess compliance with the medication administration process. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

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To ensure long-term, continued compliance with the medication administration process is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

All Nurse Managers/Assistant Nurse Managers will review individual nurse barcode medication administration scanning compliance percentages monthly. For any nurse that does not meet scanning expectations, the Nurse Manager/Assistant Nurse Manager will investigate and determine if correct medication administration process was followed. If it is determined the nurse did not follow correct medication administration process, the Nurse Manager/Assistant Nurse Manager will provide coaching on correct medication administration process and expectations.

A395 STANDARD | RN SUPERVISION OF NURSING CARE

PLAN OF CORRECTION

To ensure compliance with tag A395, the following corrective actions will be implemented by 9/11/2018.

1. RN ASSESSMENT, MONITORING, AND OBSERVATION (A115)

OBSERVATION PLAN/PATIENT MONITORING AND SAFETY ROUNDING

PROCEDURE/PROCESS FOR IMPLEMENTATION

A revised patient monitoring process will be implemented. In-person observation and engagement of patients in the performance of assigned patient observation checks will be the primary means of monitoring patients. Closed circuit video surveillance will only be utilized as an additional tool for unit safety; it will not be utilized in place of in-person monitoring. Upon admission, all patients will be placed on every 15-minute, in-person observation. Observation frequency level may be modified from every 15-minutes to hourly purposeful rounding only after all the following conditions have been met: patient admitted to an inpatient unit for at least 24 hours, 2 separate assessments by a licensed independent practitioner (LIP), and treatment team discussion of observation plan. The LIP will document the rationale to modify the level of observation. The level of observation will be documented by LIP order. At any time, a registered nurse (RN) may immediately increase the level of observation based on medical or behavioral conditions that create a potential risk to patient safety.
Responsible Party: Unity Vice President

LH policy #902.5201 “Guideline for Close Supervision” will be updated to “Routine and Special Observation for Patient Safety”. This updated policy will reflect the revised patient observation process. The following Unity inpatient standards of care and scope of service policies will also be revised to reflect the revised patient observation process: 902.7002, 902.1211, 902.1000, 902.7100.
Responsible Party: Unity Director of Patient Care Services

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers will receive education on the new patient monitoring policy and process by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete the education at the beginning of their next shift.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

Beginning on 8/3/2018, all admitted patients will be audited daily for 12 weeks (concluding on 11/3/2018) to assess compliance with the patient observation process and documentation. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/3/2018, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with the patient observation process and documentation. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with the patient observation process and documentation. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

LH policy #902.5201 “Routine and Special Observation for Patient Safety” will be reviewed at least every three years and with changes in regulatory guidelines.

Education on patient monitoring policy and process will be included in the Unity staff and provider orientation and annual education for Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers.

To ensure long-term, continued compliance with the patient observation process and documentation is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

SUICIDE SCREENING AND ASSESSMENT AND SUICIDE PRECAUTIONS

PROCEDURE/PROCESS FOR IMPLEMENTATION

All patients presenting to the psychiatric emergency department (PES) and upon admission to inpatient units will be screened by a registered nurse (RN) for level of suicide risk using an evidence-based risk tool. Patients admitted to inpatient units will be rescreened twice daily by an RN for ongoing suicide risk. All patients presenting to the psychiatric emergency department (PES) and upon admission to inpatient units will be assessed by an LIP for suicidal risk. Daily and with change of condition, LIPs will reassess patients and place/review/modify orders for patient observation and level of suicide precautions. Patients who are assessed as at risk of suicidal behavior while hospitalized will be observed at a minimum of every 15-minutes in-person. Patients assessed as at imminent risk of suicidal behavior while hospitalized will be monitored by 1:1 in-person observation. Frequency level of patient observation will be determined by individual patient behaviors, risk factors, and protective factors. As part of the safety plan for patients at risk for suicide while hospitalized, patients on suicide precautions may have patient activities or items restricted for further protection from self-harm. For patients exhibiting an increase in self-injurious thoughts or behavior and for those whose suicide risk screen indicate an increase in suicide risk from the previous screening, staff will initiate an increase in patient observation and notify the LIP. Decreasing patient observation level may only be done with documented LIP assessment and order.
Responsible Party: Unity Vice President

LH policy #902.3108 “Suicide Precautions” will be updated to reflect the revised screening, assessment, and intervention process for patients at risk for suicide.
Responsible Party: Unity Vice President

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers will receive education on the revised suicide precautions policy by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete the education at the beginning of their next shift.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

Beginning on 8/3/2018, all admitted patients will be audited daily for 12 weeks (concluding on 11/3/2018) to assess compliance with documentation of suicide risk screening. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff

member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/3/2018, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with documentation of suicide risk screening. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with documentation of suicide risk screening. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

LH policy #902.3108 “Suicide Precautions” will be reviewed at least every three years and with changes in regulatory guidelines.

Education on suicide precautions policy and process will be included in the Unity staff and provider orientation and annual education for Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and providers.

To ensure long-term, continued compliance with documentation of suicide risk screening is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

2. MEDICATION ADMINISTRATION (A405)

PROCEDURE/PROCESS FOR IMPLEMENTATION

Medication administration education was completed by all nurses by 7/26/2018.
Responsible Party: Unity Director of Patient Care Services

Starting on 7/28/2018 and ending 8/14/2018, medication administrations were audited in real-time by a second RN observing the medication administration process. All nurses were educated on how to use the audit tool, which includes all steps required for safe medication administration. When any instances of non-compliance were analyzed using the Just Culture Algorithm and non-compliance was addressed with the staff member involved.
Responsible Party: Unity Director of Patient Care Services

Medication administration education was completed by all nurses by 7/26/2018.
Responsible Party: Unity Director of Patient Care Services

New ICARE follow-up guidelines were developed to provide the Nurse Managers/Assistant Nurse Managers with additional guidance on what to include in their investigation of safety event reports on their units. The guidelines include a template for investigating distinct categories of safety event reports, including medication errors as previously described. Nurse Managers/Assistant Nurse Managers are to choose the appropriate category and template and input it into the ICARE system to document findings from their

investigation. The template includes sections to list contributing factors, patient condition/outcome, mitigation plan, and just culture findings.
Responsible Party: Unity Director of Patient Care Services

MONITORING AND TRACKING PROCEDURES

After confirming adoption of the barcode medication administration process, as validated by improvement in barcode scanning percentages and daily audit results, beginning on 8/14/2018, 30 medication administration on each adult inpatient unit and PES and 20 medication administrations on the adolescent inpatient unit (approximately 50%) will be audited daily for 12 weeks (concluding on 11/14/2018) to assess compliance with the medication administration process. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/14/2018, 30 medication administrations on each adult inpatient unit and PES and 20 medication administrations on the adolescent inpatient unit will be audited each week for 12 weeks to assess compliance with the medication administration process. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 medication administrations will be audited each month for 3 months to assess compliance with the medication administration process. The target for compliance is 95% If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.

To ensure long-term, continued compliance with the medication administration process is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

All Nurse Managers/Assistant Nurse Managers will review individual nurse barcode medication administration scanning compliance percentages monthly. For any nurse that does not meet scanning expectations, the Nurse Manager/Assistant Nurse Manager will investigate and determine if correct medication administration process was followed. If it is determined the nurse did not follow correct medication administration process, the Nurse Manager/Assistant Nurse Manager will provide coaching on correct medication administration process and expectations.

A405 STANDARD | ADMINISTRATION OF DRUGS

PLAN OF CORRECTION

To ensure compliance with tag A405, the following corrective actions will be implemented by 9/11/2018.

PROCEDURE/PROCESS FOR IMPLEMENTATION

Medication administration education was completed by all nurses by 7/26/2018.
Responsible Party: Unity Director of Patient Care Services

Starting on 7/28/2018 and ending 8/14/2018, medication administrations were audited in real-time by a second RN observing the medication administration process. All nurses were educated on how to use the audit tool, which includes all steps required for safe medication administration. When any instances of non-compliance were analyzed using the Just Culture Algorithm and non-compliance was addressed with the staff member involved.
Responsible Party: Unity Director of Patient Care Services

Medication administration education was completed by all nurses by 7/26/2018.
Responsible Party: Unity Director of Patient Care Services

New ICARE follow-up guidelines were developed to provide the Nurse Managers/Assistant Nurse Managers with additional guidance on what to include in their investigation of safety event reports on their units. The guidelines include a template for investigating distinct categories of safety event reports, including medication errors as previously described. Nurse Managers/Assistant Nurse Managers are to choose the appropriate category and template and input it into the ICARE system to document findings from their investigation. The template includes sections to list contributing factors, patient condition/outcome, mitigation plan, and just culture findings.
Responsible Party: Unity Director of Patient Care Services

MONITORING AND TRACKING PROCEDURES

After confirming adoption of the barcode medication administration process, as validated by improvement in barcode scanning percentages and daily audit results, beginning on 8/14/2018, 30 medication administration on each adult inpatient unit and PES and 20 medication administrations on the adolescent inpatient unit (approximately 50%) will be audited daily for 12 weeks (concluding on 11/14/2018) to assess compliance with the medication administration process. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/14/2018, 30 medication administrations on each adult inpatient unit and PES and 20 medication administrations on the adolescent inpatient unit will be audited each week for 12 weeks to assess compliance with the medication administration process. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 medication administrations will be audited each month for 3 months to assess compliance with the medication administration process. The target for compliance is 95% If 95% is not achieved, Nurse

Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.

To ensure long-term, continued compliance with the medication administration process is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

All Nurse Managers/Assistant Nurse Managers will review individual nurse barcode medication administration scanning compliance percentages monthly. For any nurse that does not meet scanning expectations, the Nurse Manager/Assistant Nurse Manager will investigate and determine if correct medication administration process was followed. If it is determined the nurse did not follow correct medication administration process, the Nurse Manager/Assistant Nurse Manager will provide coaching on correct medication administration process and expectations.

A700 CONDITION | PHYSICAL ENVIRONMENT | REFER TO A701

PLAN OF CORRECTION

To ensure compliance with tag A700, the following corrective actions will be implemented by 9/11/2018.

ENVIRONMENT OF CARE: LIGATURE RISKS, UNSAFE ITEMS, AND BLIND SPOTS

PROCEDURE/PROCESS FOR IMPLEMENTATION

A comprehensive environmental risk assessment, including identification of ligature risks and unsafe items, was completed on 5/20/18 by nursing leadership for all areas where patients receive care and services. The Unity Vice President is completing another comprehensive environmental risk assessment 8/14/2018-8/24/2018 to identify additional ligature risks and unsafe items. On 8/24/2018, external subject matter experts from Oregon State Hospital are visiting Unity to tour all patient care areas to offer observations on the environment of care. The comprehensive risk assessment will be updated with additional environmental risks.
Responsible Party: Unity Vice President

To mitigate the risk associated with the camera blind spots, in-person observation and engagement of patients in the performance of assigned patient observation checks will be the primary means of monitoring patients. Closed circuit video surveillance will only be utilized as an additional tool for unit safety; it will not be utilized in place of in-person monitoring.
Responsible Party: Unity Vice President

Recliners in the PES calming rooms were removed and replaced with heavy chairs and ottomans that are ligature-resistant on 7/26/2018.
Responsible Party: PES Nurse Manager

Metal rings in seclusion rooms will be removed and replaced with a round metal rod by 8/22/2018.
Responsible Party: Facilities Manager

All patient bathroom doors (with limited exception 201, 202, 203, 204, 205, 501, 502, 521, 522, 601, 602, 603, 608, 620) were removed on 7/20/2018 and replaced with Velcro curtains. Bathroom doors were kept in place in all hardened rooms and three patient rooms on Unit 6 to meet patient care needs for patients with eating disorders. The curtains were assessed in April 2017 and reassessed on 7/20/2018 for safety. Unity Leadership Council and Director of Environmental Services determined these are safe and do not pose a suffocation risk. The Velcro consists of small strips (approximately 1 inch by 1 inch) to mitigate Velcro being used as a ligature. The Velcro mounting system was assessed to be low weight-bearing and cannot be used as a ligature point. For those patient rooms that have bathroom doors, the bathroom door will be locked at all times, and the patient will be supervised by staff when in use. If the patient is assessed to not be at risk for suicide while hospitalized, the bathroom door may be unlocked, and the patient will be observed every 15-minutes in-person.
Responsible Party: Unity Director of Patient Care Services

Hinges on the window access panels in all patient rooms will be filled with pick-proof caulk to eliminate the ligature risk. This will be completed by 8/31/2018.
Responsible Party: Facilities Manager

Cabinet doors will be removed on all patient belongings cabinets in patient rooms. The following items located within the patient cabinets will have ligature and other safety risks mitigated: internal shelf, vent, clock, and outlet. The shelf will be removed and used to cover the vent. The clocks will be covered with a protective case. This will be completed by 8/31/2018.The outlet inside the cabinet is a safety outlet and does not require further safety mitigation.
Responsible Party: Facilities Manager

The correct version of LH policy #902.5111 “Counseling and Therapy Therapeutic Guideline” was posted to the Legacy intranet site on 7/30/2018. This version explicitly states that there will always be two staff members present in the garden, and no staff will be alone in the garden while patients are using the garden.
Responsible Party: Unity Vice President

The garden environmental risk assessment was updated to include the emergency poles, gazebos, and basketball hoops on 7/30/2018. To mitigate the environmental risks in the garden, the staffing ratio is 1 staff for 5 patients, and a minimum of two staff members must be in the garden with patients at all times regardless of number of patients. All patients that attend garden group must have an order from the LIP to attend.
Responsible Party: Unity Vice President

Linen carts were removed from general milieu and secured in non-patient care areas on 7/28/2018. Soiled linen hampers will be kept in a secure area when not in use.
Responsible Party: Unity Director of Patient Care Services

The coffee stirrers identified during survey are thin black straws. The straws were reviewed on 8/3/2018 by Unity Director of Patient Care Services and Unity Vice President and determined to be safe for patient use due to flexibility. This item has been added to the comprehensive environmental risk assessment.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

High risk issues identified during the leadership safety huddle will be added to the action plan template. Action items will be reviewed at the leadership safety huddle, and the action plan will be added as a standing agenda item at Leadership Council. Action items related to the environment of care will be added to the environmental risk assessment along with a mitigation plan.
Responsible Party: Unity Vice President

All safety event reports (ICAREs) related to ligature risk or unsafe items, attempted suicide or self-harm, patient elopements or attempted elopements will be investigated, and a mitigation plan will be implemented for any ongoing risks. Response to ICAREs includes these immediate steps: ensure the patient is safe, creation of an immediate safety plan, notification of leadership up through chain of command, documentation of the event, and investigation. Investigations will be initiated within 72 hours of receipt and completed as soon as possible or no later than two weeks after receipt, depending on the severity and complexity of the event.
Responsible Party: Unity Vice President

QAPI INTEGRATION

Legacy’s Hazard Surveillance Rounds and Analyses tool was updated on 7/18/2018 to include ligature risks and unsafe items. These rounds are conducted quarterly.
Responsible Party: Environment of Care Manager

Environmental safety rounds to identify potential ligature risks and unsafe items began on 5/20/18 in accordance with revised policy #902.3107. Nursing staff will conduct environmental safety rounds twice a day in all areas where patients receive care and services.
Responsible Party: Unity Director of Patient Care Services

Prospectively, a comprehensive environmental risk assessment will be completed and reviewed for all areas where patients receive care and services, on a quarterly basis, by unit leadership or designee.
Responsible Party: Unity Vice President

RESPONSE TO URGENT AND EMERGENCY MEDICAL CONDITIONS

PROCEDURE/PROCESS FOR IMPLEMENTATION

All suction machines on Code M carts were enrolled in the Legacy preventive maintenance program in accordance with the LH policy #300.12 “Medical Equipment Management Plan” on 8/3/2018.
Responsible Party: Legacy Director of Clinical Engineering

To ensure that equipment and supplies for urgent and emergent medical response are available, the Code M carts are checked daily to ensure required cart elements are present and unexpired.
Responsible Party: Unity Director of Patient Care Services

MONITORING/TRACKING PROCEDURES

Per LH policy #300.12 “Medical Equipment Management Plan”, the Director of Clinical Engineering assures that scheduled testing of all non-life support medical equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Safety Committee each quarter. If any monthly rate of completion falls below 90%, the Director of Clinical Engineering will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.
Responsible Party: Legacy Director of Clinical Engineering

All Code M carts daily checks will be audited each week for 12 weeks to assess compliance with completion and documentation of daily cart checks. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 Code M cart daily checks per unit will be audited each month for 3 months to assess compliance with completion and documentation of daily cart checks. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

The Code M carts are checked daily to ensure required cart elements are present and unexpired.

The Director of Clinical Engineering maintains the medical equipment inventory, which includes information on required scheduled maintenance for all equipment. This ensures all inventoried equipment receives timely preventive maintenance.

To ensure long-term, continued compliance with completion and documentation of daily cart checks is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 Code M cart daily checks per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

ELOPEMENT AND COMMUNICATION SAFETY DEVICES

PROCEDURE/PROCESS FOR IMPLEMENTATION

To mitigate elopement risk, a revised patient monitoring process will be implemented. In-person observation and engagement of patients in the performance of assigned patient observation checks will be the primary means of monitoring patients. Closed circuit video surveillance will only be utilized as an additional tool for unit safety; it will not be utilized in place of in-person monitoring.

Upon admission, patients will be placed on every 15-minute, in-person observation. Observation frequency level may be modified from every 15-minutes to hourly purposeful rounding only after the following conditions have been met: patient admitted to an inpatient unit for at least 24 hours, 2 separate assessments by a licensed independent practitioner (LIP), and treatment team discussion of observation plan. The LIP will document the rationale to modify the level of observation. The level of observation will be documented by LIP order. At any time, a registered nurse (RN) may immediately increase the level of observation based on medical or behavioral conditions that create a potential risk to patient safety.
Responsible Party: Unity Vice President

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, providers, and contractors with direct patient contact will receive education on alertness to potential hazards and environmental risks by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete the education at the beginning of their next shift.
Responsible Party: Unity Vice President

30 additional Voceras (communication safety devices) were ordered on 8/20/2018 . A revised Vocera inventory process will be instituted. The revised process will include a check-in/check-out process to be conducted every shift to ensure that devices are returned from off-going shift staff and devices are allocated to all oncoming shift staff. Nurse Manager/Assistant Nurse Manager will review the Vocera report to identify and follow-up on lost or misplaced devices.
Responsible Party: Unity Director of Patient Care Services

MONITORING AND TRACKING PROCEDURES

Beginning on 8/3/2018, all admitted patients will be audited daily for 12 weeks (concluding on 11/3/2018) to assess compliance with the patient observation process and documentation. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/3/2018, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with the patient observation process and documentation. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with the patient observation process and documentation. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

LH policy #902.5201 “Routine and Special Observation for Patient Safety” will be reviewed at least every three years and with changes in regulatory guidelines.

To ensure long-term, continued compliance with the patient observation process and documentation is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

A701 STANDARD | MAINTENANCE OF PHYSICAL PLANT | REFER TO A115

PLAN OF CORRECTION

To ensure compliance with tag A701, the following corrective actions will be implemented by 9/11/2018.

ENVIRONMENT OF CARE: LIGATURE RISKS, UNSAFE ITEMS, AND BLIND SPOTS

PROCEDURE/PROCESS FOR IMPLEMENTATION

A comprehensive environmental risk assessment, including identification of ligature risks and unsafe items, was completed on 5/20/18 by nursing leadership for all areas where patients receive care and services. The Unity Vice President is completing another comprehensive environmental risk assessment 8/14/2018-8/24/2018 to identify additional ligature risks and unsafe items. On 8/24/2018, external subject matter experts from Oregon State Hospital are visiting Unity to tour all patient care areas to offer observations on the environment of care. The comprehensive risk assessment will be updated with additional environmental risks.
Responsible Party: Unity Vice President

To mitigate the risk associated with the camera blind spots, in-person observation and engagement of patients in the performance of assigned patient observation checks will be the primary means of monitoring patients. Closed circuit video surveillance will only be utilized as an additional tool for unit safety; it will not be utilized in place of in-person monitoring.
Responsible Party: Unity Vice President

Recliners in the PES calming rooms were removed and replaced with heavy chairs and ottomans that are ligature-resistant on 7/26/2018.
Responsible Party: PES Nurse Manager

Metal rings in seclusion rooms will be removed and replaced with a round metal rod by 8/22/2018.
Responsible Party: Facilities Manager

All patient bathroom doors (with limited exception 201, 202, 203, 204, 205, 501, 502, 521, 522, 601, 602, 603, 608, 620) were removed on 7/20/2018 and replaced with Velcro curtains. Bathroom doors were kept in place in all hardened rooms and three patient rooms on Unit 6 to meet patient care needs for patients with eating disorders. The curtains were assessed in April 2017 and reassessed on 7/20/2018 for safety. Unity Leadership Council and Director of Environmental Services determined these are safe and do not pose a suffocation risk. The Velcro consists of small strips (approximately 1 inch by 1 inch) to mitigate Velcro being used as a ligature. The Velcro mounting system was assessed to be low weight-bearing and cannot be used as a ligature point. For those patient rooms that have bathroom doors, the bathroom door will be locked at all times, and the patient will be supervised by staff when in use. If the patient is assessed to not be at risk for suicide while hospitalized, the bathroom door may be unlocked, and the patient will be observed every 15-minutes in-person.
Responsible Party: Unity Director of Patient Care Services

Hinges on the window access panels in all patient rooms will be filled with pick-proof caulk to eliminate the ligature risk. This will be completed by 8/31/2018.
Responsible Party: Facilities Manager

Cabinet doors will be removed on all patient belongings cabinets in patient rooms. The following items located within the patient cabinets will have ligature and other safety risks mitigated: internal shelf, vent, clock, and outlet. The shelf will be removed and used to cover the vent. The clocks will be covered with a protective case. This will be completed by 8/31/2018.The outlet inside the cabinet is a safety outlet and does not require further safety mitigation.
Responsible Party: Facilities Manager

The correct version of LH policy #902.5111 “Counseling and Therapy Therapeutic Guideline” was posted to the Legacy intranet site on 7/30/2018. This version explicitly states that there will always be two staff members present in the garden, and no staff will be alone in the garden while patients are using the garden.
Responsible Party: Unity Vice President

The garden environmental risk assessment was updated to include the emergency poles, gazebos, and basketball hoops on 7/30/2018. To mitigate the environmental risks in the garden, the staffing ratio is 1 staff for 5 patients, and a minimum of two staff members must be in the garden with patients at all times regardless of number of patients. All patients that attend garden group must have an order from the LIP to attend.
Responsible Party: Unity Vice President

Linen carts were removed from general milieu and secured in non-patient care areas on 7/28/2018. Soiled linen hampers will be kept in a secure area when not in use.
Responsible Party: Unity Director of Patient Care Services

The coffee stirrers identified during survey are thin black straws. The straws were reviewed on 8/3/2018 by Unity Director of Patient Care Services and Unity Vice President and determined to be safe for patient use due to flexibility. This item has been added to the comprehensive environmental risk assessment.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

High risk issues identified during the leadership safety huddle will be added to the action plan template. Action items will be reviewed at the leadership safety huddle, and the action plan will be added as a standing agenda item at Leadership Council. Action items related to the environment of care will be added to the environmental risk assessment along with a mitigation plan.
Responsible Party: Unity Vice President

All safety event reports (ICAREs) related to ligature risk or unsafe items, attempted suicide or self-harm, patient elopements or attempted elopements will be investigated, and a mitigation plan will be implemented for any ongoing risks. Response to ICAREs includes these immediate steps: ensure the patient is safe, creation of an immediate safety plan, notification of leadership up through chain of command, documentation of the event, and investigation. Investigations will be initiated within 72 hours of receipt and completed as soon as possible or no later than two weeks after receipt, depending on the severity and complexity of the event.
Responsible Party: Unity Vice President

QAPI INTEGRATION

Legacy’s Hazard Surveillance Rounds and Analyses tool was updated on 7/18/2018 to include ligature risks and unsafe items. These rounds are conducted quarterly.
Responsible Party: Environment of Care Manager

Environmental safety rounds to identify potential ligature risks and unsafe items began on 5/20/18 in accordance with revised policy #902.3107. Nursing staff will conduct environmental safety rounds twice a day in all areas where patients receive care and services.
Responsible Party: Unity Director of Patient Care Services

Prospectively, a comprehensive environmental risk assessment will be completed and reviewed for all areas where patients receive care and services, on a quarterly basis, by unit leadership or designee.
Responsible Party: Unity Vice President

RESPONSE TO URGENT AND EMERGENCY MEDICAL CONDITIONS

PROCEDURE/PROCESS FOR IMPLEMENTATION

All suction machines on Code M carts were enrolled in the Legacy preventive maintenance program in accordance with the LH policy #300.12 “Medical Equipment Management Plan” on 8/3/2018.
Responsible Party: Legacy Director of Clinical Engineering

To ensure that equipment and supplies for urgent and emergent medical response are available, the Code M carts are checked daily to ensure required cart elements are present and unexpired.
Responsible Party: Unity Director of Patient Care Services

MONITORING/TRACKING PROCEDURES

Per LH policy #300.12 “Medical Equipment Management Plan”, the Director of Clinical Engineering assures that scheduled testing of all non-life support medical equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Safety Committee each quarter. If any monthly rate of completion falls below 90%, the Director of Clinical Engineering will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.
Responsible Party: Legacy Director of Clinical Engineering

All Code M carts daily checks will be audited each week for 12 weeks to assess compliance with completion and documentation of daily cart checks. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 Code M cart daily checks per unit will be audited each month for 3 months to assess compliance with completion and documentation of daily cart checks. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

The Code M carts are checked daily to ensure required cart elements are present and unexpired.

The Director of Clinical Engineering maintains the medical equipment inventory, which includes information on required scheduled maintenance for all equipment. This ensures all inventoried equipment receives timely preventive maintenance.

To ensure long-term, continued compliance with completion and documentation of daily cart checks is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 Code M cart daily checks per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.

ELOPEMENT AND COMMUNICATION SAFETY DEVICES

PROCEDURE/PROCESS FOR IMPLEMENTATION

To mitigate elopement risk, a revised patient monitoring process will be implemented. In-person observation and engagement of patients in the performance of assigned patient observation checks will be the primary means of monitoring patients. Closed circuit video surveillance will only be utilized as an additional tool for unit safety; it will not be utilized in place of in-person monitoring.

Upon admission, patients will be placed on every 15-minute, in-person observation. Observation frequency level may be modified from every 15-minutes to hourly purposeful rounding only after the following conditions have been met: patient admitted to an inpatient unit for at least 24 hours, 2 separate assessments by a licensed independent practitioner (LIP), and treatment team discussion of observation plan. The LIP will document the rationale to modify the level of observation. The level of observation will be documented by LIP order. At any time, a registered nurse (RN) may immediately increase the level of observation based on medical or behavioral conditions that create a potential risk to patient safety.
Responsible Party: Unity Vice President

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, providers, and contractors with direct patient contact will receive education on alertness to potential hazards and environmental risks by 9/11/2018. Staff on an approved absence and unable to complete education by 9/11/18 will complete the education at the beginning of their next shift.
Responsible Party: Unity Vice President

30 additional Voceras (communication safety devices) were ordered on 8/20/2018 . A revised Vocera inventory process will be instituted. The revised process will include a check-in/check-out process to be conducted every shift to ensure that devices are returned from off-going shift staff and devices are allocated to all oncoming shift staff. Nurse Manager/Assistant Nurse Manager will review the Vocera report to identify and follow-up on lost or misplaced devices.
Responsible Party: Unity Director of Patient Care Services

MONITORING AND TRACKING PROCEDURES

Beginning on 8/3/2018, all admitted patients will be audited daily for 12 weeks (concluding on 11/3/2018) to assess compliance with the patient observation process and documentation. During daily auditing, any gaps will be addressed in real-time. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved but not before 11/3/2018, 10 patient charts per unit will be audited each week for 12 weeks to assess compliance with the patient observation process and documentation. When discovered, any instances of non-compliance will be analyzed using the Just Culture Algorithm and non-compliance will be addressed with the staff member involved. Any process related flaws or barriers will be addressed and shared with all staff to prevent recurrence. Monthly, Nurse Managers/Assistant Nurse Managers will conduct an analysis on the audit findings to assess all areas of non-compliance, identify themes, and glean additional opportunities for process improvement. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 patient charts per unit will be audited each month for 3 months to assess compliance with the patient observation process and documentation. The target for compliance is 95%. If 95% is not achieved, Nurse Managers/Assistant Nurse Managers will conduct an analysis to assess areas of non-compliance. Nurse Managers/Assistant Nurse Managers will address gaps and then re-audit until 95% compliance is achieved for a period of 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

LH policy #902.5201 “Routine and Special Observation for Patient Safety” will be reviewed at least every three years and with changes in regulatory guidelines.

To ensure long-term, continued compliance with the patient observation process and documentation is achieved, the Nurse Managers/Assistant Nurse Managers will conduct ongoing audits of 30 charts per unit per quarter. Any lessons learned and any process revisions from monitoring activities will be incorporated into education materials when applicable.