Unity Center Plan of Correction from July 2018 revisit. Revised plan accepted by the Oregon Health Authority September 24, 2018.

A043 CONDITION | GOVERNING BODY

PLAN OF CORRECTION

To ensure compliance with Tag A043, the following corrective actions were implemented by 9/11/2018 unless otherwise indicated.

Please refer to corrective action plans at Tag A263, Tag A385, and Tag A700 along with the corrective actions referred to below.

1. CARE OF PATIENTS AT RISK FOR SELF-HARM OR SUICIDE

Refer to corrective action plans detailed under Tag A144, Item 1.

2. LIGATURE RISKS IN THE PHYSICAL ENVIRONMENT

Refer to corrective action plans detailed under Tag A144, Item 2.

3. UNSAFE ITEMS IN THE PHYSICAL ENVIRONMENT

Refer to corrective action plans detailed under Tag A144, Item 3.

4. CAMERA BLIND SPOTS

Refer to corrective action plans detailed under Tag A144, Item 4.

5. COMMUNICATION SAFETY DEVICES

Refer to corrective action plans detailed under Tag A144, Item 5.

6. ELOPEMENT PREVENTION AND STAFF AWARENESS AND ALERTNESS TO POTENTIAL HAZARDS AND RISKS

Refer to corrective action plans detailed under Tag A144, Item 6.

7. EQUIPMENT AND SUPPLIES NECESSARY TO RESPONSE TO URGENT AND EMERGENT MEDICAL CONDITIONS

Refer to corrective action plans detailed under Tag A144, Item 7.

8. MEDICATION ERROR PREVENTION

Refer to corrective action plans detailed under Tag A405.

9. RESTRAINT AND SECLUSION REQUIREMENTS

Refer to corrective action plans detailed under Tag A175.

10. RESTRAINT AND SECLUSION TRAINING

Refer to corrective action plans detailed under Tag A202.

11. INVESTIGATION OF AND RESPONSE TO PATIENT INCIDENTS/EVENTS

Refer to corrective action plans detailed under Tag A145.

Unity Center Plan of Correction from July 2018 revisit. Revised plan accepted by the Oregon Health Authority September 24, 2018.

A115 CONDITION | PATIENT RIGHTS

PLAN OF CORRECTION

To ensure compliance with Tag A115, the following corrective actions were implemented by 9/11/2018 unless otherwise indicated.

1. CARE OF PATIENTS AT RISK FOR SELF-HARM OR SUICIDE

Refer to corrective action plans detailed under Tag A144, Item 1.

2. LIGATURE RISKS IN THE PHYSICAL ENVIRONMENT

Refer to corrective action plans detailed under Tag A144, Item 2.

3. UNSAFE ITEMS IN THE PHYSICAL ENVIRONMENT

Refer to corrective action plans detailed under Tag A144, Item 3.

4. CAMERA BLIND SPOTS

Refer to corrective action plans detailed under Tag A144, Item 4.

5. COMMUNICATION SAFETY DEVICES

Refer to corrective action plans detailed under Tag A144, Item 5.

6. ELOPEMENT PREVENTION AND STAFF AWARENESS AND ALERTNESS TO POTENTIAL HAZARDS AND RISKS

Refer to corrective action plans detailed under Tag A144, Item 6.

7. EQUIPMENT AND SUPPLIES NECESSARY TO RESPONSE TO URGENT AND EMERGENT MEDICAL CONDITIONS

Refer to corrective action plans detailed under Tag A144, Item 7.

8. MEDICATION ERROR PREVENTION

Refer to corrective action plans detailed under Tag A144, Item 8.

9. RESTRAINT AND SECLUSION REQUIREMENTS

Refer to corrective action plans detailed under Tag A175.

10. RESTRAINT AND SECLUSION TRAINING

Refer to corrective action plans detailed under Tag A202.

11. INVESTIGATION OF AND RESPONSE TO PATIENT INCIDENTS/EVENTS

Refer to corrective action plans detailed under Tag A145.

Unity Center Plan of Correction from July 2018 revisit. Revised plan accepted by the Oregon Health Authority September 24, 2018.

A144 STANDARD | PATIENT RIGHTS: CARE IN SAFE SETTING

PLAN OF CORRECTION

To ensure compliance with Tag A144, the following corrective actions were implemented by 9/11/2018 unless otherwise indicated.

1. CARE OF PATIENTS AT RISK FOR SELF-HARM OR SUICIDE

PROCEDURE/PROCESS FOR IMPLEMENTATION

A revised patient monitoring process was implemented on 9/10/2018. Patient observation and monitoring will be done in-person. Standard safety monitoring in the PES includes staff presence in the milieu and every 15-minute, in-person observation for all patients. This standard is applied from PES admission to discharge.

Patients in seclusion are monitored every 15-minutes, in-person.

Upon admission to the inpatient units, 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” was updated to “Routine and Special Observation for Patient Safety”. This updated policy reflects the revised patient observation process. The following Unity inpatient standards of care and scope of service policies were also revised to reflect the revised patient observation process: 902.1000 “Unity Adult Inpatient Psychiatric Service Standard of Care”, 902.1210 “Psychiatric Emergency Services Standard of Care”, 902.1211 “Adolescent Psychiatric Inpatient Standard of Care”, 902.7100 “Unity Center for Behavioral Health: Scope of Service for Adult Inpatient Units”, 902.7102 “Unity Center for Behavioral Health: Scope of Service for Psychiatric Emergency Services”, and 902.7002 “Unity Center for Behavioral Health: Scope of Service for Adolescent Inpatient Unit”.
Responsible Party: Unity Director of Patient Care Services

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and LIPs received 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. The training content and competency validation is the same regardless of education completion date. For staff completing education after 9/11/18 (at the beginning of their next shift), staff will be released from work duties to complete the training including the competency validation.
Responsible Party: Unity Vice President

The revised process for suicide screening, assessment, and precautions was implemented on 9/10/2018. 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. The LIP assessment will include review of modifiable and non-modifiable risk factors, protective factors, and the patient’s access to means. The LIP risk assessment incorporates the SAFE-T Protocol, C-SSRS screening results, and clinical judgment

to assign a formal level of risk of low, elevated, or extreme. Only LIPs make the risk level determination. 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 elevated risk of suicidal behavior while hospitalized will be observed at a minimum of every 15-minutes in-person. Patients assessed as at extreme 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. Required interventions for patients assessed as at elevated risk of suicidal behavior while hospitalized: Limit clothing to clothing worn and one extra set of clothing. No extra linen kept in room. Optional interventions for patients assessed as at elevated risk of suicidal behavior while hospitalized: Not allowed to have brassiere(s), finger foods with no utensils, writing tool use only with supervision, no use of sharps of any kind during any activity, remove all linen and use safety blanket, full room search every shift, patient must remain in common areas during waking hours.

Required interventions for patients assessed as at extreme risk of suicidal behavior while hospitalized: No use of sharps of any kind during any activity, remove all linen and use safety blanket, writing tool use only with supervision, full room search every shift. Monitor use of the following items: hot beverages, plastic chairs/stool, hardback books, toothbrushes, hair picks, toothpaste, radio/DVD player, cordless phones, computers, and cell phones. Optional interventions for patients assessed as at extreme risk of suicidal behavior while hospitalized: Finger foods with no utensils, no writing tools, may not attend group.

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, the Registered Nurse will initiate an increase to every 15-minute in-person observation or 1:1 patient observation and notify the LIP. Upon change in condition, the LIP will assess and determine risk level. Decreasing patient observation level may only be done with documented LIP assessment and order.
Responsible Party: Unity Vice President

LH policy #902.3108 “Suicide Risk Assessment and Safety Management Plan” was updated to reflect the revised screening, assessment, and intervention process for patients at risk for suicide.
Responsible Party: Unity Vice President

Suicide precaution order interventions in the electronic health record (EHR) have been 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 LIPs received 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. The training content and competency validation is the same regardless of education completion date. For staff completing education after 9/11/18 (at the beginning of their next shift), staff will be released from work duties to complete the training including the competency validation.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

Upon acceptance of the Plan of Correction, all admitted patients will be audited daily for 12 weeks to assess compliance with the patient observation process and documentation. Compliance is defined as all documentation elements being completed within required timeframes (partial compliance is considered non-compliant). During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared

with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee. 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 the patient observation process and documentation. During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee. 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. During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee. Monthly monitoring will continue until 95% compliance is achieved for 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

Upon acceptance of the Plan of Correction, 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). Compliance is defined as all documentation elements being completed within required timeframes (partial compliance is considered non-compliant). During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all LIPs to prevent recurrence. LIP behavior issues that contributed to noncompliance will be addressed with the individual LIP. 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. During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all LIPs to prevent recurrence. LIP behavior issues that contributed to noncompliance will be addressed with the individual LIP. 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. During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all LIPs to prevent recurrence. LIP behavior issues that contributed to noncompliance will be addressed with the individual LIP. Monthly monitoring will continue until 95% compliance is achieved for 3 consecutive months.
Responsible Party: Unity Chief Medical Officer

Upon acceptance of the Plan of Correction, all admitted patients will be audited daily for 12 weeks to assess compliance with documentation of suicide risk screening. Compliance is defined as all documentation elements being completed within required timeframes (partial compliance is considered non-compliant). During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee. 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 suicide risk screening. During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff

to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee. 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. During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee. Monthly monitoring will continue until 95% compliance is achieved for 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

Upon acceptance of the Plan of Correction, all admitted patients will be audited daily for 12 weeks to assess compliance with LIP suicide risk assessment documentation. Compliance is defined as all documentation elements being completed within required timeframes (partial compliance is considered non-compliant). During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all LIPs to prevent recurrence. LIP behavior issues that contributed to noncompliance will be addressed with the individual LIP. 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 provide suicide risk assessment documentation. During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all LIPs to prevent recurrence. LIP behavior issues that contributed to noncompliance will be addressed with the individual LIP. 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 LIP suicide risk assessment documentation. During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all LIPs to prevent recurrence. LIP behavior issues that contributed to noncompliance will be addressed with the individual LIP. Monthly monitoring will continue until 95% compliance is achieved for 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.

Beginning on 9/11/2018, education on patient monitoring policy and process will be included in the Unity orientation and annual education for Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and LIPs.

Once the compliance goal for the monthly audit is achieved, 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. During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee.

Once the compliance goal for the monthly audit is achieved, 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. During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design

issues that contributed to noncompliance will be addressed and shared with all LIPs to prevent recurrence. LIP behavior issues that contributed to noncompliance will be addressed with the individual LIP.

LH policy #902.3108 "Suicide Risk Assessment and Safety Management Plan" will be reviewed at least every three years and with changes in regulatory guidelines.

Beginning on 9/11/2018, education on suicide precautions policy and process will be included in the Unity staff and LIP orientation and annual education for Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, and LIPs.

Once the compliance goal for the monthly audit is achieved, 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. During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee.

Once the compliance goal for the monthly audit is achieved, 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. During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all LIPs to prevent recurrence. LIP behavior issues that contributed to noncompliance will be addressed with the individual LIP.

2. LIGATURE RISKS IN THE PHYSICAL ENVIRONMENT

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 completed 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 visited Unity to tour all patient care areas to offer observations on the environment of care. The comprehensive risk assessment was updated with all currently identified environmental risks. Any future environmental risks will be added to the comprehensive environmental risk assessment.
Responsible Party: Unity Vice President

LH policy #300.06 "Security Management Plan" was updated in June 2018 to include the process to conduct quarterly comprehensive environmental risk assessments. The assessments include identification of potential elopement risk, blind spots, high-risk areas and activities, ligature risks, unsafe items, and other safety risks. Any identified environmental risk will be documented on the comprehensive environmental risk assessment document. Identified risks and mitigation plans are reviewed at the Unity Leadership Council. Department leadership is responsible for sharing mitigation plans with staff.

As of 9/11/2018, all risks listed below were assessed and mitigated per policy and documented on the comprehensive environmental risk assessment.
Responsible Party: Unity Vice President

Recliner chair arms in the PES calming rooms were identified as a safety risk and added to the comprehensive environmental risk assessment on 7/26/2018. The recliners 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 were identified as a safety risk and added to the comprehensive environmental risk assessment on 7/24/2018. To mitigate the risk, the rings were removed and replaced with a round metal rod by 8/29/2018.
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 and that the ligature risk for the shower curtains is the same as other linen. 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 were identified as a safety risk and added to the comprehensive environmental risk assessment on 8/31/2018. The hinges were filled with pick-proof caulk to eliminate the ligature risk. This was completed by 9/5/2018.
Responsible Party: Facilities Manager

Cabinet door hinges were identified as a safety risk and added to the comprehensive environmental risk assessment on 7/24/2018. To mitigate the risk, cabinet doors were removed on all patient belongings cabinets in patient rooms. The following items located within the patient cabinets had ligature and other safety risks mitigated: internal shelf, vent, clock, and outlet. The shelf was removed and used to cover the vent. The clocks were covered with a protective case. This was completed by 9/7/2018. The outlet inside the cabinet is a safety outlet and does not require further safety mitigation.
Responsible Party: Facilities Manager

The comprehensive environmental risk assessment was updated to include garden risks, including 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.

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

Linen carts were identified as a safety risk and added to the comprehensive environmental risk assessment on 7/28/2018. The linen carts removed from general milieu and secured in non-patient care areas on 7/28/2018.

Soiled linen hampers were identified as a safety risk, removed from the general milieu, and added to the comprehensive environmental risk assessment on 9/7/2018. Soiled linen hampers will be kept in a secure area when not in use.

Patients do not have unsupervised access to clothing, linens, or scrubs. Staff provide clothing, linens, and scrubs to patients. For patients who have unmonitored item restrictions, prevention of access to those items is achieved through patient monitoring, twice daily environment of care rounds (which include all patient rooms), and room searches per LIP orders.
Responsible Party: Unity Director of Patient Care Services

The coffee stirrers identified during the revisit survey are thin black straws. The straws were reviewed and added to the comprehensive environmental risk assessment 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.
Responsible Party: Unity Vice President

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, LIPs, and contractors with direct patient contact received education on ligature risks in the environment of care 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. The training content and competency validation is the same regardless of education completion date. For staff completing education after 9/11/18 (at the beginning of their next shift), staff will be released from work duties to complete the training including the competency validation.
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: assess the patient, 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

Beginning 8/24/2018, 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

Beginning on 9/11/2018, education on ligature risks, unsafe items, and blind spots in the environment of care will be included in the Unity orientation and annual education for Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, contractors with direct patient contact, and LIPs.

3. UNSAFE ITEMS IN THE PHYSICAL ENVIRONMENT

Unity Center Plan of Correction from July 2018 revisit. Revised plan accepted by the Oregon Health Authority September 24, 2018.

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 completed 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 visited Unity to tour all patient care areas to offer observations on the environment of care. The comprehensive risk assessment was updated with all currently identified environmental risks. Any future environmental risks will be added to the comprehensive environmental risk assessment.
Responsible Party: Unity Vice President

LH policy #300.06 "Security Management Plan" was updated in June 2018 to include the process to conduct quarterly comprehensive environmental risk assessments. The assessments include identification of potential elopement risk, blind spots, high-risk areas and activities, ligature risks, unsafe items, and other safety risks. Any identified environmental risk will be documented on the comprehensive environmental risk assessment document. Identified risks and mitigation plans are reviewed at the Unity Leadership Council. Department leadership is responsible for sharing mitigation plans with staff.

As of 9/11/2018, all risks listed below were assessed and mitigated per policy and documented on the comprehensive environmental risk assessment.
Responsible Party: Unity Vice President

Recliner chair arms in the PES calming rooms were identified as a safety risk and added to the comprehensive environmental risk assessment on 7/26/2018. The recliners 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 were identified as a safety risk and added to the comprehensive environmental risk assessment on 7/24/2018. To mitigate the risk, the rings were removed and replaced with a round metal rod by 8/29/2018.
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 and that the ligature risk for the shower curtains is the same as other linen. 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 were identified as a safety risk and added to the comprehensive environmental risk assessment on 8/31/2018. The hingers were filled with pick-proof caulk to eliminate the ligature risk. This was completed by 9/5/2018.
Responsible Party: Facilities Manager

Cabinet door hinges were identified as a safety risk and added to the comprehensive environmental risk assessment on 7/24/2018. To mitigate the risk, cabinet doors were removed on all patient belongings cabinets in patient rooms. The following items located within the patient cabinets had 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 was completed by 9/7/2018.The outlet inside the cabinet is a safety outlet and does not require further safety mitigation.
Responsible Party: Facilities Manager

The comprehensive environmental risk assessment was updated to include garden risks, including 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.

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

Linen carts were identified as a safety risk and added to the comprehensive environmental risk assessment on 7/28/2018. The linen carts removed from general milieu and secured in non-patient care areas on 7/28/2018.

Soiled linen hampers were identified as a safety risk, removed from the general milieu, and added to the comprehensive environmental risk assessment on 9/7/2018. All soiled linen hampers will be kept in a secure area when not in use.

Patients do not have unsupervised access to clothing, linens, or scrubs. Staff provide clothing, linens, and scrubs to patients. For patients who have unmonitored item restrictions, prevention of access to those items is achieved through patient monitoring, twice daily environment of care rounds (which includes all patient rooms), and room searches per LIP orders.
Responsible Party: Unity Director of Patient Care Services

The coffee stirrers identified during survey are thin black straws. The straws were reviewed and added to the comprehensive environmental risk assessment 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.
Responsible Party: Unity Vice President

A revised process for managing patient belongings was implemented on 9/6/2018 and 9/7/2018. Upon presentation to the PES, patients and the clothing they are wearing will be screened for safety and secured. In rare circumstances, patients may have access to personal belongings, which will be supervised by staff. Personal belongings will be secured after patient use. Registered Nurses, Behavioral Health Therapists, and Behavioral Health Assistants will be document patient belongings upon admission, transfer, and discharge.

For adult or adolescent patients directly admitted to the nursing unit from outside facilities, staff will screen patients and the patients clothing for safety. Patients may be allowed to wear their own clothing and to retain possession of personal items except when items pose a threat to safety. Number of personal belongings that a patient may have in their possession will be limited. All other patient belongings will be secured. All personal belongings provided to the patient (during admission or throughout the patient's stay) will be searched and evaluated for safety prior to giving the personal belonging to the patient. Registered Nurses, Behavioral Health Therapists, and Behavioral Health Assistants will be document patient belongings upon admission, transfer, and discharge.
Responsible Party: Unity Director of Patient Care Services

Legacy policy #902.3107 "Personal Belongings and Unsafe Items on Inpatient Psychiatric Units" will be revised on 9/17/2018 to categorize items into four categories: never allowed, used during group, used with staff supervision, and allowed unmonitored. Items used during group or requiring staff supervision will be secured unless in use by patients. For all patients, staff will assess

patients twice a day for safety regarding items in the unmonitored category and document in the EHR. For patients at elevated or extreme risk of suicidal behaviors while hospitalized, items may be restricted that are in the unmonitored category. For patients who have unmonitored item restrictions, prevention of access to those items is achieved through patient monitoring, twice daily environment of care rounds (which includes all patient rooms), and room searches per LIP orders.
Responsible Party: Unity Director of Patient Care Services

To ensure compliance with the revised patient belongings policy and process, on 9/6/18 and 9/7/18, all patient rooms and belongings were searched and brought into compliance with revised patient belongings policy and process.
Responsible Party: Unity Director of Patient Care Services

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, and Clerical staff received 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. The training content and competency validation is the same regardless of education completion date. For staff completing education after 9/11/18 (at the beginning of their next shift), staff will be released from work duties to complete the training including the competency validation.
Responsible Party: Unity Vice President

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, LIPs, and contractors with direct patient contact received education on unsafe items in the environment of care 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. The training content and competency validation is the same regardless of education completion date. For staff completing education after 9/11/18 (at the beginning of their next shift), staff will be released from work duties to complete the training including the competency validation.
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: assess the patient, ensure the patient is safe, creation of an immediate safety plan, notification of leadership up through the 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

Upon acceptance of the Plan of Correction, in-room belongings will be inspected for safety and appropriateness for 10 patients per unit per week for 12 weeks to assess staff compliance with patient belongings policy, process, and documentation. Compliance is defined as staff following all elements of the patient belongings policy. During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Unity Center Plan of Correction from July 2018 revisit. Revised plan accepted by the Oregon Health Authority September 24, 2018.

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. During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee. Monthly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.
Responsible Party: Unity Director of Patient Care Services

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

A comprehensive environmental risk assessment was completed on 8/24/2018 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

Beginning on 9/11/2018, education on ligature risks, unsafe items, and blind spots in the environment of care will be included in the Unity staff and LIP orientation and annual education for Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, contractors with direct patient contact, and LIPs.
Responsible Party: Unity Vice President

LH policy #902.3107 "Management of Personal Belongings and Potentially Unsafe Items" will be reviewed at least every three years and with changes in regulatory guidelines.
Responsible Party: Unity Director of Patient Care Services

Beginning on 9/11/2018, 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.
Responsible Party: Unity Director of Patient Care Services

Once the compliance goal for the monthly audit is achieved, 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. During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee.
Responsible Party: Unity Director of Patient Care Services

4. CAMERA BLIND SPOTS

PROCEDURE/PROCESS FOR IMPLEMENTATION

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 means of monitoring patients. LH policy #902.5201 "Guideline for Close Supervision" was updated to "Routine and Special Observation for Patient Safety". This updated policy reflects the revised patient

observation process. The following Unity inpatient standards of care and scope of service policies were also revised to reflect the revised patient observation process: 902.1000 "Unity Adult Inpatient Psychiatric Service Standard of Care", 902.1210 "Psychiatric Emergency Services Standard of Care", 902.1211 "Adolescent Psychiatric Inpatient Standard of Care", 902.7100 "Unity Center for Behavioral Health: Scope of Service for Adult Inpatient Units", 902.7102 "Unity Center for Behavioral Health: Scope of Service for Psychiatric Emergency Services", and 902.7002 "Unity Center for Behavioral Health: Scope of Service for Adolescent Inpatient Unit".
Responsible Party: Unity Vice President

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, LIPs, and contractors with direct patient contact received education on camera blind spots in the environment of care 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. The training content and competency validation is the same regardless of education completion date. For staff completing education after 9/11/18 (at the beginning of their next shift), staff will be released from work duties to complete the training including the competency validation.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

Upon acceptance of the Plan of Correction, all admitted patients will be audited daily for 12 weeks to assess compliance with the patient observation process and documentation. Compliance is defined as all documentation elements being completed within required timeframes (partial compliance is considered non-compliant). During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee. 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 the patient observation process and documentation. During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee. 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. During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee. Monthly monitoring will continue until 95% compliance is achieved for 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.

Once the compliance goal for the monthly audit is achieved, 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. defined as all documentation elements being completed within required timeframes (partial compliance is considered non-compliant). During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee.

Unity Center Plan of Correction from July 2018 revisit. Revised plan accepted by the Oregon Health Authority September 24, 2018.

5. COMMUNICATION SAFETY DEVICES

PROCEDURE/PROCESS FOR IMPLEMENTATION

30 additional Voceras (communication safety devices) were ordered on 8/20/2018 and received on 9/5/2018. A revised Vocera inventory process was 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

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Social Work, Crisis Intervention Specialist, Counseling and Therapy, and LIPs receive Vocera use training as part of the orientation process. Beginning on 9/17/2018, reeducation on Vocera use and inventory will be provided by department managers.
Responsible Party: Unity Director of Patient Care Services

MONITORING AND TRACKING PROCEDURES

Upon acceptance of the Plan of Correction, Vocera inventory will be audited each week for 12 weeks to assess compliance with inventory process and documentation. During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

Once the compliance goal for the weekly audit is achieved, to ensure long-term, continued compliance with the Vocera inventory process and documentation is achieved, the Nurse Managers/Assistant Nurse Managers will inventory Voceras and conduct ongoing audits of the Vocera inventory process each month. During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee.
Responsible Party: Unity Director of Patient Care Services

6. ELOPEMENT PREVENTION AND STAFF AWARENESS AND ALERTNESS TO POTENTIAL HAZARDS AND RISKS

PROCEDURE/PROCESS FOR IMPLEMENTATION

To mitigate elopement risk, a revised patient monitoring process was implemented on 9/10/2018. In-person observation and engagement of patients in the performance of assigned patient observation checks will be the means of monitoring patients. 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

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To mitigate elopement risk during garden visits, there are patient counts at defined points during the walk to and from 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. 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

To mitigate elopement risk, per LH policy #902.3200 "Safe Transportation of Patient and Prevention of Elopement", a minimum of one staff must accompany patients through the facility upon admission. Upon discharge, a minimum of one staff must accompany patients out of the secure areas. Adolescent patients will be escorted to lobby and outside of the building by parent/guardian/secure transport. In the absence of parent/guardian/secure transport, adolescent patients will be escorted by at least one staff member. To prevent elopement, all staff and service providers with badge access will ensure doors are clear of patients prior to opening and observe the area near the door until it is completely closed.
Responsible Party: Unity Vice President

The list of Legacy staff and contracted staff at Unity will be evaluated by Unity leadership to determine who should have badge access and who should not. Contracted staff who are determined to not need badge access will have their badges deactivated by 9/30/2018. All Legacy staff and contracted staff who have badge access at Unity will receive education on elopement prevention by 10/21/2018. Staff on an approved absence and unable to complete education by 10/21/18 will complete the education at the beginning of their next shift at Unity. The training content and competency validation is the same regardless of education completion date. For staff completing education after 10/21/18 (at the beginning of their next shift), staff will be released from work duties to complete the training including the competency validation.
Responsible Party: Unity Vice President

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, LIPs, and contractors with direct patient contact received 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. The training content and competency validation is the same regardless of education completion date. For staff completing education after 9/11/18 (at the beginning of their next shift), staff will be released from work duties to complete the training including the competency validation.
Responsible Party: Unity Vice President

Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, LIPs, and contractors with direct patient contact received education on elopement prevention 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. The training content and competency validation is the same regardless of education completion date. For staff completing education after 9/11/18 (at the beginning of their next shift), staff will be released from work duties to complete the training including the competency validation.
Responsible Party: Unity Vice President

MONITORING AND TRACKING PROCEDURES

Upon acceptance of the Plan of Correction, elopement drills will be conducted once per month per shift. Elopement drills will be unannounced. These drills will be witnessed, documented, and evaluated to ensure compliance with elopement prevention policy. Compliance is defined as staff following all elopement prevention policy elements (partial compliance is considered non-compliant). During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that

contributed to noncompliance will be addressed with the individual employee. Monthly monitoring will continue until 95% compliance is achieved for 3 consecutive months.
Responsible Party: Unity Director of Patient Care Services

Upon acceptance of the Plan of Correction, all admitted patients will be audited daily for 12 weeks to assess compliance with the patient observation process and documentation. Compliance is defined as all documentation elements being completed within required timeframes (partial compliance is considered non-compliant). During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee. 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 the patient observation process and documentation. During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee. 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. During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee. Monthly monitoring will continue until 95% compliance is achieved for 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

Beginning 9/24/2018, to be granted badge access at Unity, all staff and contracted staff will complete education on elopement prevention. To maintain badge access at Unity, all staff and contracted will complete education on an annual basis.

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.

Once the compliance goal for the monthly elopement drills is achieved, to ensure long-term, continued compliance with the elopement prevention policy, elopement drills will be conducted once per quarter per shift. Elopement drills will be unannounced. These drills will be witnessed, documented, and evaluated to ensure compliance with elopement prevention policy. During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee.

Once the compliance goal for the monthly patient observation audit is achieved, 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. During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee.

Beginning on 9/11/2018, education on alertness to potential hazards and environmental risks is included in the Unity orientation and annual education for Registered Nurses, Behavioral Health Therapists, Behavioral Health Assistants, Counseling and Therapy staff, contractors with direct patient contact, and LIPs.

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7. EQUIPMENT AND SUPPLIES NECESSARY TO RESPONSE TO URGENT AND EMERGENT MEDICAL CONDITIONS

PROCEDURE/PROCESS FOR IMPLEMENTATION

All suction machines on Code M carts were enrolled, including initial preventive maintenance, 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

A Code M cart daily checklist was developed and implemented on 5/21/18 to ensure required supplies such as suction device, O2 tubing, Ambu bags, masks, protective personal equipment, manual blood pressure, and stethoscope are in the cart and not expired. The checklist also requires staff to check that all blood glucose supplies are available, labeled appropriately, and not expired. Registered Nurses, Behavioral Health Therapists, and Behavioral Health Assistants completed education regarding the Code M cart by 6/30/2018.

To reinforce Code M cart education, beginning on 8/3/2018, all Code M cart daily checks have been audited to assess compliance with completion and documentation of daily cart checks. During all monitoring, any instances of noncompliance were analyzed using the Just Culture algorithm. System design issues that contributed to noncompliance were addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance were addressed with the individual employee.
Responsible Party: Unity Director of Patient Care Services

MONITORING/TRACKING PROCEDURES

Upon acceptance of the Plan of Correction, 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. Compliance is defined as all documentation elements being completed within required timeframes (partial compliance is considered non-compliant). During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee. 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. During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee. Monthly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

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.

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Responsible Party: Legacy Director of Clinical Engineering

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.

Once the compliance goal for the monthly Code M cart daily check audit is achieved, 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. During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee.

8. MEDICATION ERROR PREVENTION

Refer to corrective action plans detailed under Tag A405.

Unity Center Plan of Correction from July 2018 revisit. Revised plan accepted by the Oregon Health Authority September 24, 2018.

A145 STANDARD | PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT

PLAN OF CORRECTION

To ensure compliance with Tag A145, the following corrective actions were implemented by 9/11/2018 unless otherwise indicated.

PROCEDURE/PROCESS FOR IMPLEMENTATION

New ICARE follow-up guidelines were developed and implemented on 7/5/2018 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: assess the patient, 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

Initial education regarding expectations for reviewing ICAREs and the new ICARE response template was provided in-person on 7/5/2018 and reiterated in writing on 7/14/2018 to Nurse Managers and Assistant Nurse Managers. Reinforcement of ICARE response expectations will be provided to Nurse Managers and Assistant Nurse Managers on 9/17/2018. When instances of noncompliance are found with ICARE response expectations, the Nurse Manager or Assistant Nurse Manager will be provided coaching to reinforce education. Part of the expectations include 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

Upon acceptance of the Plan of Correction, 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. Compliance is defined as all documentation elements being completed within required timeframes (partial compliance is considered non-compliant). During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee. 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. During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee. Monthly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

Beginning on 9/11/2018, upon hire and annually thereafter, 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.

Beginning on 9/11/2018, training on investigation of ICAREs is included in the Unity orientation and annual education for Nurse Managers and Assistant Nurse Managers.

Once the compliance goal for the monthly ICARE audit is achieved, 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. During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee.
Responsible Party: Unity Director of Patient Care Services

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A175 STANDARD | PATIENT RIGHTS: RESTRAINT OR SECLUSION

PLAN OF CORRECTION

To ensure compliance with Tag A175, the following corrective actions were implemented by 9/11/2018 unless otherwise indicated.

PROCEDURE/PROCESS FOR IMPLEMENTATION

Registered Nurses, Behavioral Health Assistants, Behavioral Health Therapists, Counseling and Therapy staff, and Security staff completed 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. The training content and competency validation is the same regardless of education completion date. For staff completing education after 9/11/18 (at the beginning of their next shift), staff will be released from work duties to complete the training including the competency validation.
Responsible Party: Unity Vice President

Legacy's policy #900.5274 "Restraint and Seclusion for Patient Safety" was 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 are specified in the policy.
Responsible Party: Clinical Nurse Specialist

MONITORING AND TRACKING PROCEDURES

Upon acceptance of the Plan of Correction, all restraint and seclusion events will be audited each week for 12 weeks to assess compliance with restraint/seclusion documentation requirements. Compliance is defined as all documentation elements being completed within required timeframes (partial compliance is considered non-compliant). During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee. Weekly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the weekly audit is achieved, 30 restraint and seclusion events per unit will be audited each month for 3 months to assess compliance with restraint/seclusion documentation requirements. Compliance is defined as all documentation elements being completed within required timeframes (partial compliance is considered non-compliant). During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee. Monthly monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.
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.

Unity Center Plan of Correction from July 2018 revisit. Revised plan accepted by the Oregon Health Authority September 24, 2018.

Once the compliance goal for the monthly restraint/seclusion audit is achieved, to ensure long-term, continued compliance with 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. During all monitoring, any instances of noncompliance will be analyzed using the Just Culture Algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee.

Unity Center Plan of Correction from July 2018 revisit. Revised plan accepted by the Oregon Health Authority September 24, 2018.

A202 STANDARD | PATIENT RIGHTS: RESTRAINT OR SECLUSION

PLAN OF CORRECTION

To ensure compliance with Tag A202, the following corrective actions were implemented by 9/11/2018 unless otherwise indicated.

PROCEDURE/PROCESS FOR IMPLEMENTATION

Legacy's policy #900.5274 "Restraint and Seclusion for Patient Safety" was 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 was 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 completed 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. The training content and competency validation is the same regardless of education completion date. For staff completing education after 9/11/18 (at the beginning of their next shift), staff will be released from work duties to complete the training including the competency validation.
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 9/17/2018 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.

Unity Center Plan of Correction from July 2018 revisit. Revised plan accepted by the Oregon Health Authority September 24, 2018.

A263 CONDITION | QAPI

PLAN OF CORRECTION

To ensure compliance with Tag A263, the following corrective actions were implemented by 9/11/2018 unless otherwise indicated.

Please refer to corrective action plans at Tag A043, Tag A385, and Tag A700 along with the corrective actions referred to below.

1. CARE OF PATIENTS AT RISK FOR SELF-HARM OR SUICIDE

Refer to corrective action plans detailed under Tag A144, Item 1.

2. LIGATURE RISKS IN THE PHYSICAL ENVIRONMENT

Refer to corrective action plans detailed under Tag A144, Item 2.

3. UNSAFE ITEMS IN THE PHYSICAL ENVIRONMENT

Refer to corrective action plans detailed under Tag A144, Item 3.

4. CAMERA BLIND SPOTS

Refer to corrective action plans detailed under Tag A144, Item 4.

5. COMMUNICATION SAFETY DEVICES

Refer to corrective action plans detailed under Tag A144, Item 5.

6. ELOPEMENT PREVENTION AND STAFF AWARENESS AND ALERTNESS TO POTENTIAL HAZARDS AND RISKS

Refer to corrective action plans detailed under Tag A144, Item 6.

7. EQUIPMENT AND SUPPLIES NECESSARY TO RESPONSE TO URGENT AND EMERGENT MEDICAL CONDITIONS

Refer to corrective action plans detailed under Tag A144, Item 7.

8. MEDICATION ERROR PREVENTION

Refer to corrective action plans detailed under Tag A144, Item 8.

9. RESTRAINT AND SECLUSION REQUIREMENTS

Refer to corrective action plans detailed under Tag A175.

10. RESTRAINT AND SECLUSION TRAINING

Refer to corrective action plans detailed under Tag A202.

11. INVESTIGATION OF AND RESPONSE TO PATIENT INCIDENTS/EVENTS

Refer to corrective action plans detailed under Tag A145.

Unity Center Plan of Correction from July 2018 revisit. Revised plan accepted by the Oregon Health Authority September 24, 2018.

A385 CONDITION | NURSING SERVICES

PLAN OF CORRECTION

To ensure compliance with Tag A385, the following corrective actions were implemented by 9/11/2018 unless otherwise indicated.

1. CARE OF PATIENTS AT RISK FOR SELF-HARM OR SUICIDE

Refer to corrective action plans detailed under Tag A144, Item 1.

2. COMMUNICATION SAFETY DEVICES

Refer to corrective action plans detailed under Tag A144, Item 5.

3. ELOPEMENT PREVENTION AND STAFF AWARENESS AND ALERTNESS TO POTENTIAL HAZARDS AND RISKS

Refer to corrective action plans detailed under Tag A144, Item 6.

4. EQUIPMENT AND SUPPLIES NECESSARY TO RESPONSE TO URGENT AND EMERGENT MEDICAL CONDITIONS

Refer to corrective action plans detailed under Tag A144, Item 7.

5. MEDICATION ERROR PREVENTION

Refer to corrective action plans detailed under Tag A405.

6. RESTRAINT AND SECLUSION REQUIREMENTS

Refer to corrective action plans detailed under Tag A175.

7. INVESTIGATION OF AND RESPONSE TO PATIENT INCIDENTS/EVENTS

Refer to corrective action plans detailed under Tag A145.

Unity Center Plan of Correction from July 2018 revisit. Revised plan accepted by the Oregon Health Authority September 24, 2018.

A395 STANDARD | RN SUPERVISION OF NURSING CARE

PLAN OF CORRECTION

To ensure compliance with Tag A395, the following corrective actions were implemented by 9/11/2018 unless otherwise indicated.

1. CARE OF PATIENTS AT RISK FOR SELF-HARM OR SUICIDE

Refer to corrective action plans detailed under Tag A144, Item 1.

2. COMMUNICATION SAFETY DEVICES

Refer to corrective action plans detailed under Tag A144, Item 5.

3. ELOPEMENT PREVENTION AND STAFF AWARENESS AND ALERTNESS TO POTENTIAL HAZARDS AND RISKS

Refer to corrective action plans detailed under Tag A144, Item 6.

4. EQUIPMENT AND SUPPLIES NECESSARY TO RESPONSE TO URGENT AND EMERGENT MEDICAL CONDITIONS

Refer to corrective action plans detailed under Tag A144, Item 7.

5. MEDICATION ERROR PREVENTION

Refer to corrective action plans detailed under Tag A405.

6. RESTRAINT AND SECLUSION REQUIREMENTS

Refer to corrective action plans detailed under Tag A175.

7. INVESTIGATION OF AND RESPONSE TO PATIENT INCIDENTS/EVENTS

Refer to corrective action plans detailed under Tag A145.

A405 STANDARD | ADMINISTRATION OF DRUGS

PLAN OF CORRECTION

To ensure compliance with Tag A405, the following corrective actions were implemented by 9/11/2018 unless otherwise indicated.

PROCEDURE/PROCESS FOR IMPLEMENTATION

Medication administration education was completed by all nurses by 7/26/2018. Medication administration education included verification of patient identification, adherence to LIP medication order including verification of right medication, dose, time, route, and reason, medication administration policies, and nursing medication administration standard of practice.

To reinforce medication administration education, 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. The audit assessed compliance with verification of patient identification, adherence to LIP medication order including verification of right medication, dose, time, route, and reason, medication administration policies, and nursing medication administration standard of practice. During all monitoring, any instances of noncompliance were analyzed using the Just Culture algorithm. System design issues that contributed to noncompliance were addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance were addressed with the individual employee.
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 through completion of the real-time medication administration audits mentioned above that started on 7/28/2018 and ended on 8/14/2018, as validated by improvement in barcode scanning percentages which indicate widespread adoption (>95% for 9 consecutive days), upon acceptance of the Plan of Correction, 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 to assess compliance with the medication administration process. The audit assesses compliance with verification of patient identification, adherence to LIP medication order including verification of right medication, dose, time, route, and reason, medication administration policies, and nursing medication administration standard of practice (partial compliance is considered noncompliance). During all monitoring, any instances of noncompliance will be analyzed using the Just Culture algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee. Daily monitoring will continue until 95% compliance is achieved for 6 consecutive weeks.

Once the compliance goal for the daily audit is achieved, 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. During all monitoring, any instances of noncompliance will be analyzed using the Just Culture algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent

recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee. 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. During all monitoring, any instances of noncompliance will be analyzed using the Just Culture algorithm. System design issues that contributed to noncompliance will be addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance will be addressed with the individual employee. Monthly monitoring will continue until 95% compliance is achieved for 3 consecutive months.
Responsible Party: Unity Director of Patient Care services

QAPI INTEGRATION

All Nurse Managers/Assistant Nurse Managers 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.

Beginning on 9/11/2018, education on medication administration policy and process will be included in the Unity RN staff orientation and annual education.
Responsible Party: Unity Director of Patient Care Services

Once the compliance goal for the monthly medication administration process audit is achieved, 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. During all monitoring, any instances of noncompliance were analyzed using the Just Culture algorithm. System design issues that contributed to noncompliance were addressed and shared with all staff to prevent recurrence. Employee behavior issues that contributed to noncompliance were addressed with the individual employee.
Responsible Party: Unity Director of Patient Care Services

A700 CONDITION | PHYSICAL ENVIRONMENT

PLAN OF CORRECTION

To ensure compliance with Tag A700, the following corrective actions were implemented by 9/11/2018 unless otherwise indicated.

1. CARE OF PATIENTS AT RISK FOR SELF-HARM OR SUICIDE

Refer to corrective action plans detailed under Tag A144, Item 1.

2. LIGATURE RISKS IN THE PHYSICAL ENVIRONMENT

Refer to corrective action plans detailed under Tag A144, Item 2.

3. UNSAFE ITEMS IN THE PHYSICAL ENVIRONMENT

Refer to corrective action plans detailed under Tag A144, Item 3.

4. CAMERA BLIND SPOTS

Refer to corrective action plans detailed under Tag A144, Item 4.

5. COMMUNICATION SAFETY DEVICES

Refer to corrective action plans detailed under Tag A144, Item 5.

6. ELOPEMENT PREVENTION AND STAFF AWARENESS AND ALERTNESS TO POTENTIAL HAZARDS AND RISKS

Refer to corrective action plans detailed under Tag A144, Item 6.

7. EQUIPMENT AND SUPPLIES NECESSARY TO RESPONSE TO URGENT AND EMERGENT MEDICAL CONDITIONS

Refer to corrective action plans detailed under Tag A144, Item 7.

A701 STANDARD | MAINTENANCE OF PHYSICAL PLANT

PLAN OF CORRECTION

To ensure compliance with Tag A701, the following corrective actions were implemented by 9/11/2018 unless otherwise indicated.

1. CARE OF PATIENTS AT RISK FOR SELF-HARM OR SUICIDE

Refer to corrective action plans detailed under Tag A144, Item 1.

2. LIGATURE RISKS IN THE PHYSICAL ENVIRONMENT

Refer to corrective action plans detailed under Tag A144, Item 2.

3. UNSAFE ITEMS IN THE PHYSICAL ENVIRONMENT

Refer to corrective action plans detailed under Tag A144, Item 3.

4. CAMERA BLIND SPOTS

Refer to corrective action plans detailed under Tag A144, Item 4.

5. COMMUNICATION SAFETY DEVICES

Refer to corrective action plans detailed under Tag A144, Item 5.

6. ELOPEMENT PREVENTION AND STAFF AWARENESS AND ALERTNESS TO POTENTIAL HAZARDS AND RISKS

Refer to corrective action plans detailed under Tag A144, Item 6.

7. EQUIPMENT AND SUPPLIES NECESSARY TO RESPONSE TO URGENT AND EMERGENT MEDICAL CONDITIONS

Refer to corrective action plans detailed under Tag A144, Item 7.