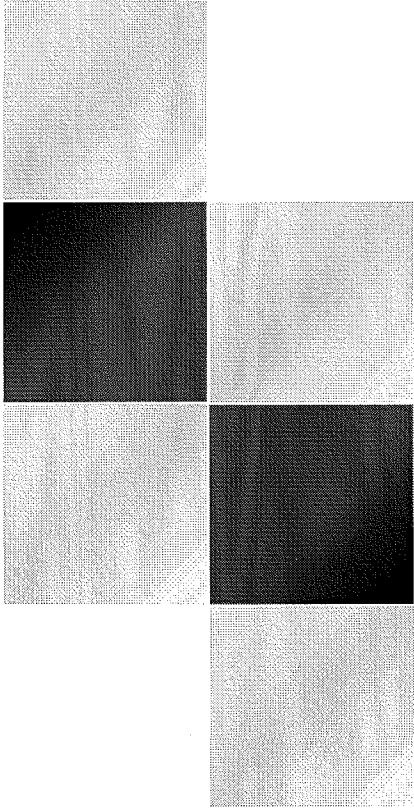


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**REPORT AND ROOT CAUSE
ANALYSIS
TO THE
STATE OF WASHINGTON
REGARDING
WESTERN STATE HOSPITAL**

August 8, 2016

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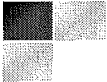


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REPORT TO THE STATE OF WASHINGTON REGARDING WESTERN STATE HOSPITAL LAKEWOOD, WASHINGTON

I. INTRODUCTION AND OVERVIEW

A. SALIENT BACKGROUND OF PROJECT

Western State Hospital (WSH) located in Lakewood, Washington has experienced a series of critical events and troublesome Centers for Medicare and Medicaid Services (CMS) surveys over the last two years. Understaffing, patient related violence, and elopements are among the serious issues that have challenged the credibility of the organization and left patients and staff vulnerable. Significant internal efforts and resources are now being dedicated by the State of Washington to plan and implement systemic performance improvements. In support of these efforts, WSH requested that Clinical Services Management, PC (CSM) perform a comprehensive Functional Assessment to identify deficiencies and recommend a plan for interventions to address critical concerns and ensure regulatory compliance. The scope of this review and planning process expanded as CMS and Western State Hospital (WSH) entered into a System Improvement Agreement (SIA) to “facilitate the delivery of quality hospital services to the community served by WSH and to promote WSH’s consistent compliance with the Medicare Conditions of Participation (CoPs).”

B. DESCRIPTION OF THE CLINICAL SERVICES MANAGEMENT PROJECT TEAMS

A Functional Assessment review was performed by CSM with the additional contributions of two contracted colleague organizations. A brief description of CSM, NRI, and Fields and Associates is included below. CSM served as the Lead Consultant coordinating the activities of the extended review team. A total of 11 (eleven) senior level consultants participated in the review process onsite at Western State Hospital.

The team included:

- A Psychiatrist/Compliance Medical Director
- Three PhD-level professionals with a focus on Psychology, Quality Improvement, and Nursing
- Two Masters-level social workers
- A Certified Healthcare Facilities Manager
- A Masters-level Senior Research Analyst
- Three Masters-level administrators

1. CSM

Clinical Services Management is a behavioral healthcare consulting and management organization with extensive experience in contract management, regulatory compliance, strategic planning, and systems analysis for public and private psychiatric hospitals and community-based behavioral healthcare services. Formed in 1997 CSM, and/or its principals and employees have designed, implemented, led and/or evaluated turnaround efforts and corrective action plans in Psychiatric facilities and Developmental Centers in more than 10 states. CSM team members have been responsible for assessing and managing a range of disability-related services throughout the continuum of care, including:

- Voluntary/Involuntary, Adult, Adolescent and Child Inpatient Units
- Psychiatric Emergency/Screening and Mobile Outreach Services
- Adult and Adolescent Residential Services
- Acute and Rehabilitative Partial Hospital Programs
- Traditional and Managed Care-Focused Outpatient Services
- Case Management and Navigator Services

Employees, associates, and principals of the CSM Team assigned to the WSH project possess specific expertise with direct relevance to many of the key issues and decisions being considered by Western State Hospital. Staff experience includes:

- Senior Executives of large hospital-based systems of care (medical and mental health)
- Medical and Clinical Directors of behavioral health facilities/programs
- Project managers for comprehensive planning and corrective action for state, county and private healthcare facilities
- Former Joint Commission and CMS Surveyors

CSM has led or participated in the performance of multiple program evaluations and needs assessments for individuals with mental illness, substance abuse, developmental disabilities, and acquired brain injuries. This experience and expertise is specifically relevant to the issues, challenges, and decisions currently being considered by Western State Hospital (WSH). Information regarding key project personnel is included in this project overview.

2. NRI

NRI was formed in 1987 as the research ally of the National Association of State Mental Health Program Directors (NASMHPD), the organization representing state mental health commissioners/directors and their agencies. NRI is a not-for-profit 501(c)(3) organization dedicated to sharing information, data, statistics, performance measures, and knowledge about public and private mental health service delivery systems and mental health services.

NRI's Behavioral Healthcare Performance Measurement System (BHPMS) provides robust and relevant benchmarking capabilities to psychiatric facilities to meet the ORYX® reporting requirements of The Joint Commission and CMS's Inpatient Psychiatric Facility Quality Reporting Program. NRI helps organizations establish and conduct a planned, systematic, organization-wide approach to process design and performance improvement. NRI focuses on the implementation of policies and procedures aimed at improving the quality of patient care and safety and/or achieving and maintaining accreditation/certification. Most importantly, key factors contributing to process sustainability are identified along with methods to embed a process of continual process improvement system-wide.

3. Fields & Associates

Fields & Associates, Inc. provided an exceptional cadre of consultants who are senior behavioral healthcare professionals with formal training and experience as clinicians, hospital managers, administrators, and former surveyors for agencies such as the Centers for Medicare & Medicaid Services (CMS), The Joint Commission, Joint Commission Resources, and The Joint Commission International. Their extensive hands-on experience and proven track records have helped successfully guide inpatient psychiatric hospitals in more than 26 states to improved standards compliance and better survey management for CMS Certification and Joint Commission Accreditation.

4. Review Team Members

The following list provides a brief overview of CSM staff and consultants who were involved in the assessment of WSH. The table below outlines the roles/responsibilities of the team members.

Project Staff /Areas of Responsibility

Role and Title	Project Responsibilities
Peter Pastras, LCSW CSM Project Coordinator, Community Integration and Social Work	Overall project coordination; review of discharge planning and integration with community resources
Charles Higgins, M.Div. Field Analyst	Overall project coordination; Integration of discipline-specific findings into consolidated report
Craig R. Blum, PhD CSM Project Coordinator Psychologist/Training	Overall project coordination Evaluation of training efforts, Review of psychology practices; review of QAPI
Lou Cassaro MAS Operations Analyst	Patient and Staff Focus Group coordinator; Leadership assessment
Thomas Rosamilia, MA Quality/Administration	Review of Quality Improvement, Leadership assessment; Review of QAPI

Ira Hammer, MSW, MBA Project Management Planner	Coordination of performance improvement recommendations and development of project management tracking
Richard A. Fields, Sr., MD Medical Director/ Psychiatrist; Leader Compliance Evaluation Team	Overall quality and appropriateness of patient care, medical staff and psychology related documents, policies/procedures, practices and relevant standards of CMS/TJC compliance
Joseph J. Gigliotti, MSW Psychiatric Social Worker; Compliance Evaluation Team	Overall quality and appropriateness of social work and rehabilitation staff, related documents, policies/procedures, practices and relevant standards of CMS/TJC
Anne S. Menz, RN, PhD Psychiatric Nurse; Compliance Evaluation Team	Overall quality and appropriateness of nurse staffing/services, related documents, policies/procedures, practices and relevant standards of CMS/TJC
Barbara G. Pankoski, CHFM, CHSP Engineer, Life Safety Code Specialist; Compliance Evaluation Team	Overall quality, appropriateness and safety of the buildings/environment, related documents, policies/procedures, practices and relevant standards of CMS/TJC
Lucille Schacht, PhD, Senior Director of Performance & Quality Improvement	NRI Analytics coordination; Data Integrity review
Vera Hollen, MA, Senior Research Analyst	Data Integrity review

5. Review Team Activities

Beginning in May 2016 the CSM Team spent several days of time identifying and analyzing past survey results, plans of correction, and other relevant information. The CSM, NRI, and the Fields group then collaboratively designed an intensive review process that employed the strengths and experiences of each group into an integrated assessment. Following the preparatory activities, the implementation of the review was coordinated with WSH personnel and Carla Reyes, Assistant Secretary of Behavioral Health. The review process was designed to gather information about the quality of leadership, operations, and patient care. The initiation of CSM's onsite activities coincided with the establishment of the SIA on June 2, 2016. The agreement between CMS and WSH expanded the scope of the review process. The resulting report utilizes the outline provided by the SIA in Section 5.a as structure through which the substantial CSM findings and recommendations are organized

CSM utilized a comprehensive review process to assess the deficits and vulnerabilities of WSH. The consulting team members performed the following:

- Eleven team members provided approximately 64 days of onsite analysis (including consultants from CSM, NRI, and Fields & Associates).

Team	From To	Total Days
CSM Team toured	6/2/16 - 6/10/16	44 days onsite
NRI Team toured	7/7/16 - 7/8/16	4 days onsite
Fields & Associates toured	6/6/16 – 6/10/16	20 days onsite

- Members of the combined consulting teams had the opportunity to meet (often repeatedly) with the vast majority of key players and stakeholders. Interviews were held individually, in groups, and/or through observation of “natural setting” scheduled meetings. Participants included:
 - Central Office Leadership (Acting Secretary, Assistant Secretary, Behavioral Health and Deputy Assistant Secretary)
 - WSH new CEO and all members of the WSH leadership team
 - All discipline leaders (psychiatry, psychology, nursing, social work, rehabilitation services, physical medicine, pharmacy)
 - All treatment Center Directors
 - Union Leadership (Labor Partners, WFSE, SEIU and UPA/AWP)
 - Treatment teams and unit staff, (nursing, social work, psychiatry)

- The CSM review process was structured to allow the consultants access to all levels of staff, all treatment environments, and a sampling of patients residing in one of the 30 wards at WSH. (Patients were approached respectfully by staff. They were invited to meet with the consultants gathering information and asked for suggestions on improving the hospital. Participation was entirely voluntary). Individual structured interviews were performed with patients and line staff. Structured Focus Groups were held with patients in each center. Focus Groups were also held with staff within each of the individual disciplines.
 - Five (5) patient Focus Groups were held with more than 60 patients attending
 - Eight (9) discipline-centered Focus Groups were held with more than 135 staff. Groups included, Discharge Planning Team, MHT, Social Work, Rehab, Medical Doctor, Psychiatry, Pharmacy, Psychology and Nursing
 - In excess of 20 individual line staff members and 12 patients were interviewed individually.
 - Tours of the treatment malls were completed in each of the three Centers and in the Intellectual Disabilities program

C. OVERVIEW OF PROJECT

CSM was initially contracted to complete an assessment and consultation with Western State Hospital. The goal was to help the State of Washington address a wide range of problems identified in multiple CMS surveys from 2015 into early 2016. As conceived, this process had three major components:

- Functional Assessment;
- Regulatory Compliance Evaluation; and
- Customized Analytics from the NRI Behavioral Healthcare Performance Measurement System

Functional Analysis is CSM's term for a process that evaluates the entire operation of an organization to identify gaps, strengths, and weaknesses. This review is informed by accreditation and regulatory oversight guidelines, as well as other evidence-based and industry-standards of care. The information derived from the comprehensive operational review allows CSM to identify the root causes and themes of identified problems. This process provides the foundation for the development of a comprehensive plan of program improvement and/or corrective action.

Compliance Evaluation, the second component of the CSM review is a thorough review process. Utilizing a survey methodology the Compliance Evaluation is implemented to provide insight into the findings of recent CMS surveys. An intensive review is performed to identify progress achieved and provide a baseline for areas requiring continuing improvement. The information generated through this process is aggregated into a detailed outline of deficiencies and areas of potential improvements.

The Advanced Analytics review is an analysis provided by NRI utilizing Behavioral Healthcare Performance Measurement system (BHPMS). This process was individually adapted by NRI utilizing data that has been submitted monthly by WSH for the past 16 years. This information was used to provide insight into the hospital's quality of care. Although this data is generally held confidential, WSH provided specific written permission for NRI to utilize it in a series of specialized analyses of Assaults/Patient injuries and Elopement events.

II. REVIEW OUTLINE

CSM was initially contracted to complete an assessment and consultation with Western State Hospital. The goal was to help the State of Washington address a wide range of problems identified in several CMS surveys from 2015 into early 2016. During CSM's first week of onsite work at WSH in early June 2016, this project was superseded by the System Improvement Agreement. The SIA (as previously described) specifically required that "Within 30 days after signing this Agreement, WSH will provide CMS a roster of the Independent Expert Consultant team(s) it proposes to utilize." WSH submitted Clinical Services Management (CSM) as the team, and CMS subsequently sent a letter dated June 9, 2016 accepting this team to provide the Independent Consultant services.

As prescribed within the SIA, the following sections "analyze the structure and performance of WSH's key systems and operations and identify material gaps between its operations, industry accepted standards of practice and compliance with Medicare CoPs." Based upon the SIA, the areas that the Gap Analysis will address include:

1. **Leadership/management and accountability mechanisms.**
2. **Quality and appropriateness of services;**
3. **Patient's rights protections;**
4. **Qualified and supportive staffing resources;**
5. **Staff training and education; and**
6. **WSH's Quality Assessment and Performance Improvement Program (QAPI)**
including but not limited to determining whether the program:
 - a. continually operates and has adequate resources;
 - b. effectively increases patient safety and improves quality of care;
 - c. sufficiently demonstrates involvement by hospital leadership (including the governing body);
 - d. widely disperses its activities throughout the hospital;
 - e. adequately collects and analyzes data;
 - f. diligently uses data to drive its decision making, including in its processes for determining the selection of tracking measures that comply with 42 C.F.R. § 482.21 concerning tracking, measuring and analyzing adverse patient events; and
 - g. clearly demonstrates the program has a process for developing, implementing and evaluating its performance improvement projects and activities.

Section 5.2 of the SIA requires that, “(f)or each gap that the Independent Expert Consultant Team identifies, the Independent Expert Consultant will analyze the Root Causes of these gaps, meaning the obstacles and system failures that are preventing or impeding WSH from achieving and sustaining safe and acceptable practices for providing hospital services that are in compliance with the Medicare CoPs. As part of the Root Cause Analysis, the Independent Expert Consultant will:

- identify and define problems;
- investigate and collect supporting information; and
- analyze and identify the root causes.

Report and List of Recommendations: The Independent Expert Consultant will provide a Report on the results of the analyses required under this provision. The Report must include a list of recommendations for changes and improvements that are necessary for WSH to achieve substantial compliance with all Medicare CoPs. These recommendations are reviewed in the report and also abstracted in table form at the end of the document. The recommendations shall be utilized by WSH to form the basis for a comprehensive Corrective Action Plan.

A. THE CSM REPORT: REVIEW, FINDINGS AND RECOMMENDATIONS

CSM was in active planning and preparation contact with WSH for a month prior to arriving onsite on June 2, 2016. During this pre-visit phase, many documents were requested to plan for

the onsite visit, in order to be best prepared for the intensive review process that was completed from June 2, 2016 through June 10, 2016. The onsite time was planned to allow for observations a wide range of activities including change of shift and weekend meetings and treatment. The functional analysis team consisted of five (5) members (see above under CSM) who were on campus throughout the visit, except for Tom Rosamilia who was there until noon on June 7th and Charles Higgins who was there until the end of the day on June 8th. Following the onsite visit, CSM has had consistent communication with WSH to request additional documents, as needed, as well as to participate in regular meetings with the Quality Improvement Team (QIT) to keep abreast of any facility or operational issues. CSM has been copied on incident reports sent to CMS, and met telephonically with the CEO, Cheryl Strange, on approximately a weekly basis for updates. Members of the CSM team have consulted with the Leadership Team in there weekly three hour management meetings.

The onsite meetings and observations performed in early June were directed at communicating with as many stakeholders as possible, to observe various treatment teams and treatment settings, participate in various committees, and meet with as many other individuals and groups as possible. As described, CSM was able to meet with:

- A sample of patients from different wards (individually during unit visits and in larger focus groups),
- All senior leadership staff (most were met with individually and during various normally functioning meetings),
- A number of state agency leaders from the behavioral health hierarchy,
- All clinical disciplines (during unit tours and in larger focus groups),
- Numerous line staff of varied roles (during unit visits, team meetings, focus groups, etc.)
- CSM was also able to observe operations during off-shift times; specifically, during weekend visits on both Saturday and Sunday and at various change of shift times throughout the visit, and
- external Behavioral Health Organizations (BHOs) that send patients to WSH and coordinate services for them upon discharge.

We were unable to arrange to talk with any judges, advocacy/family groups, or other community stakeholders during this time, although their perceptions would be useful in future efforts to improve services at WSH and in the overall system.

1. Leadership/Management and Accountability Mechanisms

In recent failed CMS surveys numerous findings were made with regard to leadership and management connected to 42 CFR 482.12 Governing Body. This regulation is defined as "...an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body." As is common, most of these findings are what are often termed "roll-up findings," which means that leadership is held accountable for all operations and responsible for any

deficiencies, especially of a chronic nature. As such, correcting of the specific findings in other required areas will often lift most of the findings under Governing Body. There are a number of components delineated in the A-tags and Interpretive Guidelines outlined in the CMS State Operations Manuals; much of this is of a general nature that can be complied with in a variety of organizationally individualized ways. However, the inability of WSH leadership to address deficiencies or develop effective corrective action is an indication that the organization is lacking adequate management and/or staff resources to achieve success.

Significant changes in leadership and management are required to address the underlying issues that have led to frequent findings and chronic non-compliance with CMS requirements. Within this area, the SIA requires a focus on: “conducting an in-depth evaluation of WSH’s governing body, leadership team and management structure and their ability to oversee a Corrective Action Plan (see below) and recommending changes to WSH’s governing body membership, management or operations.”

a. The State of Leadership at Western State Hospital

A brief summary overview of the history of services and funding in the State of Washington will be provided here to provide context for the problems at WSH. Additionally, a brief review of the last few years of leadership will be provided to further explore the findings and recommendations to follow. This history is not meant to be definitive nor detailed, but it provides some understanding for how conditions deteriorated and led to the SIA. The year 2008 was mentioned by many individuals as the starting point for the decline of quality at WSH. Adverse fiscal conditions in the State led to substantial budget cuts throughout the public sector, and WSH was impacted significantly by these across-the-board reductions. Over the course of several years there was a progressive phasing down of staff and leadership/management positions at the hospital. The shrinking financial support challenged the organization and exposed its core vulnerabilities.

GOVERNING BODY

This review and analysis will proceed in a top-down fashion starting with the Governing Body. The Governing Body at the time of CSM’s visit consisted only of the following members:

- Deputy Assistant Secretary, Behavioral Health and Service Integration Administration;
- Chief Executive Officer, WSH;
- Medical Director, WSH; and
- Chief Medical Officer, WSH.

Various WSH senior leaders and staff are routinely present or invited to attend governing body meetings in order to provide reports information and details on organizational functioning. This is not an atypical structure from what is seen in other state hospitals, and it meets regulatory requirements. That said, there are a number of issues that are clearly

problematic when reviewing minutes and in discussions with various key constituents. First, when asked for the last six months of minutes there were none available. The most recent documented meeting with minutes available was from December 22, 2015 despite the normal pattern being monthly meetings in the past. Second, looking back over the performance of the Governing Body, the number of excused staff was quite large and this was reportedly a common occurrence. Finally, the range and level of detail in reviewing topics seems shallow and inadequate to allow for proper oversight. The minutes reviewed were primarily focused on recent CMS visits and findings and state government initiatives to deal with staffing and retention issues. The higher level functions of management, such as strategic planning, facility planning, and new program development were largely absent.

SENIOR LEADERSHIP TEAM

Based on experience with many other facilities and the feedback provided during our interviews with staff and leaders at the hospital, there are many concerns that CSM had during its review of the leadership structure at WSH. In example, the number of positions reporting directly to the prior CEO (as of the beginning of our onsite visit) was 18. Leadership meetings actually included many other individuals that led to an unwieldy group of over 20 participants. On June 2, 2016, the reporting structure was changed by Cheryl Strange, the new CEO. She reduced her direct reports to 8 senior managers, which is more consistent with common theory and practice. Ms. Strange developed a new “CEO Direct Reports” table of organization that included the following senior managers reporting to the CEO:

- Chief of Safety and Security,
- Chief Quality Officer,
- Chief Operating Officer,
- Chief Administrative Officer,
- Chief Financial Officer,
- Chief Medical Officer,
- Nurse Executive, and
- Chief Clinical Officer.

In the leadership interviews conducted by CSM, the senior managers generally agreed that the previous structure was neither efficient nor effective. By the report of many, the past CEOs struggled under the burden of a broadening span of control. In response to an unmanageable set of responsibilities, senior leadership became increasingly autocratic and micromanaging. There were numerous challenges that had a negative impact on the WSH management staff:

- the history of significant state budget cuts;
- anachronistic issues with the excessive size of WSH;
- a lack of adequate range and extent of community-based programs and services to facilitate prompt discharges;

- poorly designed and implemented legal requirements around civil and forensic admissions and review processes; and
- Loss of qualified staff; inability to train/develop competent replacements

These and other factors combined to make it an extreme challenge to properly manage and administer services at WSH no matter who was in charge. All of these issues need to be addressed with changes to WSH to allow for it to become a properly functioning organization. The change in the Table of Organization provides an example of a more responsive and easier to manage senior leadership process. There is no definitive literature on the exact best ratio. The classic ideas of Gulick (1937)¹, reviewed by Meier and Bohte (2003)² for public organizations, suggests that beyond personal preferences and abilities that three organizational variables are paramount: diversification of function, time, and space. In other words, an organization or area that has diverse functions will require a smaller span of control (or less direct reports), since the work performed is not the same or is very complex. Time relates to stability, so in times that are unstable and requiring great change, a shorter span is needed. Finally, space refers to the number of places, buildings, and amount of direct face-to-face contact that is needed. In many ways it relates to size. This would also involve different shifts as an additional complication. On all three variables, WSH's structure, size, complexity, and need for rapid change demands shorter spans than might be typical.

MANAGEMENT

At the Hospital, much of middle management was lost to attrition and layoffs. This constant turnover of leaders throughout all levels of the organization often required managers and supervisory staff to take on a broader scope of responsibility. In example, the Social Work and Psychology Directors were assigned operational oversight of Treatment Centers in addition to their Discipline-specific roles. Similar to other parts of the organizational chart, these Center Directors do not have authority over the building and wards that they are accountable for managing. They are required to negotiate with staff and supervisors instead of having the authority to direct them to address deficiencies. The Center Directors are required to manage through a structure where they have responsibility for supervising the Social Workers, Psychologists and Rehabilitation Therapists while they are also operationally responsible for the Centers. This awkward matrix model presents significant issues. The span of control and complexity of patient issues and demands makes for it especially challenging to manage change processes (e.g., a plan of correction).

Beneath the Center Directors, there are numerous wards. At the present time, there are no unit or program directors or managers. Historically, there were Ward Managers who were responsible (and accountable) for the operations of a specific unit. These Ward Managers

¹ Gulick, L. (1937). Notes on the theory of organization. In *Papers on the science of administration*, edited by Luther Gulick and Lydal Urwick. New York: Institute of Public Administration, Columbia University.

² Meier, K. J., & Bohte, J. (2003). Span of control and public organizations: Implementing Luther Gulick's research design, *Public Administration Review*, 63(1), 61-70.

covered one or two units (depending on size and complexity). However, this model was dismantled due to the various budget cuts outlined above. Thus, the organization has been left with little clear and/or reasonably appropriate oversight of units, program areas, or disciplines. Ultimately, it is a tenuous and cobbled together structure where clear lines of authority are absent, stretched too thin or dependent upon personal influence and not designated responsibility. The diffuse nature of management authority is compounded by a lack of budgetary and hiring/firing authority that leaves everyone uncertain and unclear regarding who is in charge and what authority there is to affect needed oversight and change.

Over time, the quality and consistency of services degraded. The competency of direct care and management staff eroded as well. However, the census and complexity of patients at WSH remained difficult and by many accounts the overall nature of patient problems became more difficult due to highly challenging forensic patients becoming more commonly admitted. During this time, the discrepancy between hospital (and state) salary and benefits and private sector jobs diverged significantly with the private sector paying more with better benefits (including signing bonuses, etc.). The inability to retain and recruit qualified staff was compounded by the reductions in force. The Hospital was viewed by potential candidates as understaffed, unsafe and unstable.

The concept of accountability is also a key element in the effectiveness of management. Repeatedly managers, staff and patients expressed frustration about the continuous lack of competence the organization has demonstrated in planning and completing key projects. Incapacity is a key characteristic in failing organizations. WSH has demonstrated a lack of competence in numerous key areas. These include (among other goals) the inability to:

- maintain substantial compliance with standards and regulations;
- develop and implement critical plans of correction;
- provide a safe environment for patients, staff and the neighboring community;

These inadequacies are the culmination of constant change in key management positions. Instability of leadership undermines the performance of organizations. The approach of past leadership was consistently described by key managers as reactive and punitive. Staff and middle level managers also indicated that the culture encouraged caution and blame.

Successful behavioral health organizations employ a clearly articulated mission to serve as the guiding principles of a therapeutic milieu. Compliance, competence and adequacy are not goals to be pursued but minimal standards which should be achieved as building blocks in the process of serving individuals with serious mental illness. The culture of WSH has been diluted through the loss of leaders among the organization's management and staff. WSH has ceased to aim at excellence. In the interviews that CSM held with staff and patients it became clear that the organization is not adequately committed to patient centered care. Planning of major projects (like the fencing of the Quadrangle and subsequent restriction of patient rights) does not prioritize inclusion of the key stakeholders, those living at WSH and dependent upon it for their opportunity to recover and live a more healthy life. The principles of wellness and recovery are seldom acknowledged. Evidence based practices are minimally utilized and without consistency.

Active treatment is provided minimally with patients left frustrated or apathetic on weekends, evenings and times that they are unable to attend mall services. The staff struggles to maintain a safe environment for their patients and themselves. In the past years leadership at WSH has governed more restrictively than therapeutically. The concept of all patients being entitled to the right of living in the least restrictive environment clinically necessary has been deemphasized.

b. Recommendations

- Create a management structure that assigns authority and accountability
- Improve span of control structure; implement across all levels of the organization including ward based management
- Change the culture; adopt a mission driven patient focused approach to service delivery
- Review meeting and reporting structures; utilize consistent project tracking/documentation across all committees and meetings

2. Quality and Appropriateness of Services

Western State Hospital, like most state institutions responsible for both acute and long term behavioral healthcare service delivery, is tasked with caring for the most difficult and multiply challenged individuals. Acuity and behavioral manifestations of mental illness are the most extreme in such settings. Often, these individuals have dual diagnostic issues including mental illness and substance abuse and/or developmental/intellectual issues. These are often compounded by chronic physical ailments that have often been undertreated, if cared for at all. It is typical that many of the individuals who become patients at this and similar facilities have experienced socioeconomic deterioration due to unemployment, homelessness, and lack of family/community supports. The challenge for WSH is further complicated due to its role as the Forensic Evaluation and Treatment Center for the State, adding a significant population (approximately 275 or one-third of the total patient population) of criminal justice system mandated individuals for competency assessments and due to NGRI determinations. These individuals are frequently not as easily moved back into the community, and they present additional behavioral and treatment challenges.

Oftentimes, the state hospital is seen as the treatment center of last resort, after all less intensive community options have failed. This places a unique burden upon any state institution serving those with mental illness, and this is no different for WSH. There is the continuous demand to admit and assess a steady stream of legally- and civilly-committed individuals, determine treatment needs and provide care, prepare patients for their return to the community, and successfully place these individuals who have often not been successfully placed prior to their arrival at the hospital. This is all done under steady volume pressure with people being referred through the “front door,” while options to move people out appropriately through the “back door” are limited and difficult to access.

Under optimal conditions, the above process is extraordinarily complex and difficult to achieve consistently. It is not unusual for states to see backups for placements in their state facilities, causing local facilities to hold and treat these complex and often most severe patients. In the

most successful situations, the larger system of care is designed to facilitate ready access to the necessary community services upon determination of readiness for discharge. This allows the hospital to focus on providing the comprehensive assessments and treatment along with habilitative/rehabilitative services that properly prepare individuals for their return to the community where the next steps in the rehabilitative process can occur.

a. The Current State of Services at Western State Hospital

WSH is a facility that has experienced a dual crisis of quality of care issues that have been complicated by a state system of care limiting its ability to have significant control over patient movement into and out of the hospital. It is a very large facility by current standards with over 800 beds and a full-fledged forensic hospital as part of its array of services. The scale and scope of the hospital's responsibility makes management and service delivery difficult from the outset. Limited patient movement and difficulty in placement and discharge, compounded by endless pressures to admit new patients determined solely by community organizations and the courts, have combined with notable deficits in care and treatment processes to produce a situation where daily milieu experiences can become chaotic and counter-therapeutic. These problems are exacerbated by the loss of staff positions, vacancies, and frequent turnover across many disciplines. Staff are stretched to the maximum, covering vacancies each day and shift, often working on units treating unfamiliar patients. Tired and overworked staff, stretched to the limit with coverage, are more apt to miss assignments, take shortcuts in completing duties, and just make simple, technical errors. This all contributes to a deterioration in treatment services, and results is a "culture of helplessness" experienced by frustrated staff seeing limited success and having little belief in positive change. This is mirrored by patients feeling they are being neglected within the hospital and by the community that limits their ability to be discharged. As processes deteriorated, increased tensions have compounded the situation adding an element of fear and insecurity to the experiences of both patients and staff as conditions have worsened over the years. These were expected to be found and were reported in our many patient and staff Focus Groups, and during individual meetings with both groups.

The detail in the CMS citations was corroborated in our consultative meetings with leadership, staff, and patients at WSH. Services are delivered inconsistently, meetings are missed, planning does not translate into action, procedures are not adhered to reliably, and the environment has deteriorated both physically and psychologically. This has created a more dangerous and challenging workplace that further exacerbates problems in the delivery of quality service. As noted in the multiple oversight visits during 2015-2016, treatment performance has been impacted in multiple areas:

- **Treatment services (Tags B122, B125, and B158)** – Services are not delivered as scheduled or determined to be necessary for individuals under the hospital's care. It was cited that notes documenting psychiatric visits with patients were missing on multiple days for various patients. This was reflected in our patient interviews where a number of patients stated they rarely saw their doctor or "my doctor doesn't know who I am." During visits to the Treatment Recovery Centers (i.e., treatment malls),

we saw patients sitting in the hall when their group was not being held as scheduled due to staff absences or coverage issues. There was no communication from the unit to the Recovery Center Coordinator that would have addressed this issue. While this can happen occasionally in a dynamic and complex environment, it was reported by patients and staff that this occurrence was fairly common. Patients reported their individual contacts with other professional staff were also infrequent and truncated at times. Service delivery is hindered by lack of space, group sessions being held in adjacent cubicles without full walls, causing interference in communications and impacting privacy. Many service decisions are made based on availability, not based upon individual patient needs. Specifically, many patients are initially put into the first available group. This can be changed over time, but this is not therapeutically sound. Patients can become discouraged with not getting what they want and need, and it does not clearly connect with treatment planning. We heard repeatedly from staff that the objectives and notes for treatment mall groups were written to try to accommodate what has been put into the formal treatment plan, instead of the other way around with treatment planning dictating what interventions and groups should be provided to meet patient needs. Shortages of professional staff leads to gaps in the delivery of counseling services, lack of specialized programming or evidenced-based practices such as cognitive behavior therapy, dialectical behavioral therapy, or substance abuse treatment. When patients do not participate in the Recovery Center activities, there are limited or no unit-based alternatives. This fosters too much time in patient rooms and no expectation of “normalcy” in daily life activity. The dearth of activities during the day is compounded on evenings and weekends. Patient interviews highlighted a lack of access to the gym, library, computer areas, and general outdoor time, stating access had typically been greater in the past but was reduced due to coverage and security issues. The team observed these problems during our weekend and offshift visits. Patients reported “we currently feel warehoused” with all the former privileges that have been revoked. Their feeling is many of the events leading to this removal of freedoms were a result of poor staff supervision based upon short staffing or people being neglectful in doing their jobs resulting in loss of patient rights. There was a general feeling that the loss of options and increase in inactivity perpetuates more trouble and loss of motivation on the part of many patients. The increased restrictions on patient movement and freedoms also impacts upon staff in that they are tied up with more patient escort duties, for example taking patients on smoking breaks or escorting them between buildings that did not require staff supervision in the past.

- **Treatment Planning (Tags B122, B125, B144, B148, and B158)** – The most common finding is treatment plans containing more general, basic activities (monitoring, encouraging, supporting, etc.) instead of more unique, patient-centered goals and objectives that are measurable and allow for assessing patient change and progress. The plans were noted to frequently be missing reference to specific treatment modalities being offered and to what end they are meant to achieve. Quite often, activities of the Recovery Center/Mall are not integrated into the plan. Considering the amount of scheduled time patients are meant to be in the Recovery

Centers, the Rehab staff are not involved in the development of the multidisciplinary plan. As noted above, staff reported that they usually modified group objectives and wrote notes to try to address what was in the patient's plan versus having the plans specify what groups were needed to meet certain objectives in the plan. In other words, instead of having clear and specific treatment plans with measurable goals and objectives with identified treatments or interventions to meet the goals/objectives the process is more that rather general goals and objectives are written with general interventions specified in treatment plans. The patients are put into groups that often are not specified in the plan or that are not requested by the patient and then the treatment staff write in their notes after the groups have been attended and in their description of the objectives of the group they try to show how they met the treatment plan requirements. It was clear that they were doing this in good faith and trying to show how what happened in groups might have been consistent with the treatment plans, but the fidelity to the plans and the specificity and usefulness of this are questionable in many cases. Additionally, treatment plan updates are haphazard at times, with staffing coverage and other demands taking precedence. On a number of occasions our site visit team went to units to observe the treatment planning conference only to find it was not held as scheduled. Staff reported that staff absences impact scheduled treatment team conferences and patients reported varying degrees of personal involvement in their plans, often based upon the unit they occupy. At best, patients report a staff member meeting with them in advance to discuss goals and give the patient time to prepare ideas. In other units, patients reported they just came in to "confirm and sign" the plan put forward by the team. In yet other cases, patients reported little or no involvement in the process.

- **Staffing issues (Tag B158)** – Staffing issues have been pervasive and growing more problematic over recent years with impacts on the above two areas and others. For example, psychiatric staffing showed 11 of 48 positions were vacant at the time of our site visit. This leads to staff covering in multiple areas and being clinically responsible for more patients. Social Work is another area that has been chronically impacted by vacancies. While they have been able to recruit mostly new, inexperienced staff to fill the vacancies, retention has been a major problem as other community positions paid better and the clinical environment has been perceived to be much safer and preferable. Patients supported this finding with such feedback as, "I have had four social workers in seven months" and "three since September (in June)." Vacancies and loss of positions have impacted multiple areas such as Quality Improvement, psychology, rehab, and tech staff, leading to a deterioration in service delivery. The recruitment process has typically been described as ponderous and remote, with Human Resource functions being directed from the State Central Office, even though a representative is onsite. Shortages in staff lead to overuse of full-time staff through overtime and on-call staff who are called in as replacements and assigned to various units depending upon the location of staff vacancies that shift. Interviews with such staff and those assigned full-time to one ward all indicated the float concept leads to staff unfamiliarity with the patients when covering and even ignorance of specific unit protocols or treatment plans.

- **Safety issues (Tags A115, A143, A144, A168, A175, A286, A385, A405, A505, and A747-749)** – The impact of safety issues on quality of services is broad ranging. As part of the CMS findings and the initial WSH Plan of Correction, an updated survey was circulated to staff to garner feedback on their perceptions of the culture of safety. Of the 462 surveys completed by staff, notable issues included 54% of staff felt safe, down 9% from the previous survey. Satisfaction with staffing levels was perceived by only 39% of staff. Speaking to a disconnect with leadership, only 39% felt leadership promoted a culture of safety and only 37% felt safety was an area of consistent focus. 45% of staff felt there was good communication about changes being made for improvements and even ratings of staff-based performance reflected major issues of concern: Ratings of handoff communication were at 46%, general communication among staff (a critical element of safety) was seen as effective by only 40% of respondents, and staff accountability was seen as good by only 27% of the staff surveyed, down 14% from previous surveys. A summary of some of the typical current daily situations found during our visit show the following:
 - **Physical safety** – Patients and staff experience of physical danger and personal threat impacts both service delivery and the ability of the patients to fully benefit from the hospital environment. Interviews with both staff and patients provided evidence of this perception, often grounded in actual experience. Examples of staff experiences were common. One was an RN with three surgeries over the years as a result of assaults (wrist and knees). Another was an LPN with 6+ years at WSH who was attacked and punched until a male coworker rescued her. She also described a coworker who was beaten on a unit that had all female staff one shift. Even when these are singular and rare events, the impact can be long lasting and goes beyond the specific victim in terms of psychological impact on others. During a focus group in the Forensics area, the strong majority, 9 of 13 patients, reported being attacked at least once during their time in the hospital. One female patient reported 14 assaults, a dozen by the same female peer over the course of just beyond one year. Patients often felt interventions were minimal or led patients to become aggressive in order to reap rewards for modifying their behavior. Patients feel they have little ability to respond to being attacked, either physically or within the legal or program boundaries in which they are placed. This makes it difficult to gain closure and move forward emotionally and in treatment. The newly implemented Psychiatric Emergency Response Teams (PERT teams) developed in 2015 as a response to increasing violence have not had the desired impact on safety, instead creating a disconnect between direct care staff and Security. Physicians and nurses have reported feeling they were no longer in control of what is essentially a clinical situation. The impact upon patients has not been favorable either, especially for those witnessing interventions that have not been seen as therapeutic in any manner. Nor has the increased and unchecked use of 1:1 direct observation staff led to any measurable impact upon safety. While some 55-60

staff are being used for 1:1 care on any given shift, a full 7% or more of patients on 1:1, statistics on assaults over the last year have indicated a higher percentage of patients involved in assaults and a higher rate of assaults since the start of 2015 than in the preceding year.

- **Environmental safety** – Unit-based rounding for environmental safety, to be done daily, is haphazard and frequently ineffective. Broken fixtures or furniture, which can lead to pieces being used as weapons, have been allowed to remain in place for extended periods. The situation leading to an elopement through a loosened window is an example of a deteriorated physical plant issue not being caught and addressed. The very process of work orders within the facility has been, like the recruitment process, a cumbersome Central Office managed process whereby tracking of orders was inconsistent and many orders were never acted upon (see the findings by the Compliance Team on this for further details). Off-hours staffing was inadequate to address urgent or emergent needs arising in the many old buildings of the campus, particularly South Hall. In this building it was reported that elevators often break down creating an evacuation risk for elderly patients and those not able to ambulate.

A number of safety issues, while not directly observed by the CSM team, were noted in the original CMS findings. They were reviewed with staff and leadership. These included:

- **Restraint issues** – Lack of proper oversight of patients placed in restraints including missing physician orders, lack of monitoring of the patients' vital signs and other physical conditions/needs, not demonstrating efforts at using less restrictive means of behavioral control, poor debriefing processes and lack of treatment planning modifications to address the issues leading to restraint use. These were substantiated in the Compliance Team's results. Data from NRI reported later also showed problems here.
- **Safety of medication administration** – staff taking shortcuts that included preparing medications for patients ahead of time and keeping them out, thereby increasing the risk of mistakes in administration; not using two patient identifiers or using outdated information, leading to wrong patients receiving medication. The response to correcting this was to assign one of the ward staff to be present outside the medication room to announce and check of the patient next in line for medication. Although an effective process, it served to essentially remove one staff member from the unit to be involved with other patients and notice and be readily available for care and de-escalation of any developing issues. This could become a greater safety issue and is certainly a therapeutic issue.

- **Promptness of medical treatment** – Medical staff reported being spread too thin, not being able to join in treatment planning and being short on necessary equipment. Patients reported delays in getting medical needs cared for, and one patient noted that it “I broke my arm. It took me three days to get an X-ray and seventeen days to receive the result.”
- **Safety in other aspects of care delivery**, from proper reevaluation of patients deemed to be at-risk for self-harm, to general infection control processes like proper handwashing.

b. Target for the Plan of Correction for Quality and Appropriateness of Services at WSH

The goal of the Plan of Correction should be to resolve the citations through the creation of an environment of care that is both adequately staffed with the proper people in the correct places. It should create a structure whereby the organization is able to build a partnership between staff and leadership that enables a collective effort at developing solutions and carrying them through to successful completion. While in the past leadership has developed roadmaps to improvement, lack of support from staff has led to roadblocks and detours from which the organization never made it back onto the planned route. Ideally, there will be a better flow of communication both up and down through the organization. The State’s reported effort to add staffing and modify pay structures for better recruitment and retention will help to address the concrete resource gaps with which the organization has had to operate. It will likely take a great deal of time to fill the new positions as there are many current vacancies to fill as well. It was reported that there are presently over 140 vacancies. As staffing levels reach more acceptable numbers, it will create a workplace where adequate coverage is available and scheduling can be more consistently done, allowing for proper use of paid time off, thereby reducing stress and burnout. With more adequate fulltime staffing positions in place, it will be possible to have more unit-assigned staff, and less reliance on use of on-calls who float. This will create stronger teams and more consistent staff on each unit, thereby improving patient care through increased familiarity and stronger relationships between patients and staff.

The optimally functioning environment will provide for adequately trained staff who are knowledgeable regarding regulations, policies, and procedures; and have a scale and scope of duties that promotes attention to detail and compliance. A structure will be in place allowing for monitoring and oversight with initial interventions aimed at coaching and correction, not discipline, and thus consistent with general quality or performance improvement principles. This organizational structure will lead to enhanced performance in such areas as assessments, treatment planning, provision of treatment services, and improvements in safety and security.

- Evaluation and Treatment Conferences (treatment planning meetings) will be held as scheduled and include representation from all relevant disciplines. Goals and objectives will be developed in a format that emphasizes specific, measureable outcomes that are attainable, relevant, and can be evaluated regularly and consistently.

- Increased individual counseling/therapy sessions will be delivered with increased productive activity alternatives both on-ward and in the Recovery Centers.
- Details of care delivery will be attended to properly and documented completely for such activities as restraint and seclusion, medication administration, daily progress notes, and ongoing assessment/reassessment processes.
- Staff will be engaged, knowledgeable, and active in performance improvement at the unit levels with dashboards, showing outcomes and revisions to processes, posted and discussed.
- Sufficient, well-trained and involved staff will enable the organization to provide safer care, with fewer incidents of violence and lower reliance on restraint and seclusion as a means to ensure safety.

WSH's internal efforts to provide an optimal level of patient care will need to be combined with an improved overall state system of care that will promote the safe and successful movement of stable, discharge-ready patients back to the community. In discussions with leadership staff, estimates ranged from 140-180 discharge ready individuals still residing at the hospital. The alleviation of this logjam will allow for a better flow through the institution, shorten length of stay, and allow for more admissions and discharges each year. This will reduce the state of hopelessness that impacts many patients, and some staff, in that their efforts to become well and ready to return to society are not met with the reward of discharge and a chance to move forward with their lives. On the opposite end of the flow, the hospital would ideally have some say in reviewing admission requests to the facility, especially pertaining to civil commitments. A joint Hospital – Community Behavioral Health Organization (BHO) review team exploring all appropriate options for patients and deciding on the least restrictive options available is envisioned.

c. Root Cause Analysis - Factors to consider in the current state of Quality in WSH Services

In the years since 2008, as state tax revenues declined across the nation and budgets were correspondingly reduced, WSH began a period of cutbacks that reduced staffing numbers and ultimately quality of care and services delivered at the hospital. Loss of direct clinical care staff and support personnel throughout the hospital were combined with cutbacks that eliminated much of the unit-based, middle-level management of the organization. The net result was an organization where staff in all clinical disciplines were stretched thin, resulting in care processes that become inconsistent at best, often with shortcuts aimed at getting the job done and surviving the shift. At the same time, the direct care leaders responsible for ensuring standards were met, were also eliminated from the organization. Thus, at the same time standards of care were slipping, there was no unit-based leadership to interrupt that process and steer staff back in the proper direction. Clinical support functions for performance improvement, staff education, and such basic healthcare oversight as infection control and environmental/facility services were also compromised, further impacting services and morale at the hospital. By the time of the complaints and issues driving the CMS site visits in the winter of 2015-2016, care at WSH was reaching its low point. During our interviews, we were told that these issues were compounded by changing leadership that did

not engage the hearts and minds of staff. The most recent top administration at the time of the surveys was described as hostile, intimidating, and blaming of staff.

Some of the efforts to right the ship during this period turned out to not have the desired impact. These included the creation of the on-call staff for coverage and the PERT teams for increased safety and violence reduction. They have only further deteriorated the strained relations between leadership and staff. At best, they had no significant impact on service delivery and at worst they contributed to further lapses in direct care processes and an increase in strained relations between patients and staff and staff and leaders.

Compounding the clinical/operational issues at WSH were the dynamics of the state system of care for behavioral health services. The community-based organizations, formerly Regional Service Networks and now Behavioral Health Organizations, are tasked with developing the mental health/substance abuse services for each designated state region. They basically determine the current system for patient movement into and out of the WSH. If a patient is court-ordered for civil commitment in the community, after a 72-hour screening period and 14-day treatment period, any continued commitment is directed to the state hospitals. To make this system functional, as many people must leave the hospital as the number being directed for admission. However, reports to CSM were that the BHOs do not readily accept patients back into community services, since they often determine that the proper resources are not available. Besides clinical treatment services, residential resources, largely out of the Aging and Long Term Supports Administration (AL TSA), another division of the state DSHS, are lacking and often not available to potential WSH discharges due to the patients being seen as too complex or difficult to manage. What is unclear is the total community residential capacity and the potential for growth. This problem of actual and/or determined lack of community resources needs to be addressed as part of any long-term solution to the problems at WSH.

The net result of the above bottlenecking is that patients ready for discharge remain at WSH, relegating discharge planning as a futile exercise and leading both patients and staff to become increasingly frustrated. A psychologist interviewed in the Recovery Center stated he feels the role of psychologists is just to complete the 180-day assessments to keep people in the hospital longer, impacting any ability to develop more therapeutic relationships with the patients. A 2014 Statute on conversion from Criminal to Civil Commitments for forensic patients where charges are dropped has served to complicate factors further. Without any process for Not Guilty by Reason of Insanity or Incapable of Standing Trial, patients are moved to civil commitment wards, increasing the logjam and having negative impacts on both safety and quality of treatment.

d. Recommendations for Improvement

As noted elsewhere, the state has responded to the problems at WSH with a proposed plan to increase staffing and enable better recruitment and retention. This will provide a foundation of resources that, if used wisely, can help set the hospital on the course back to being a quality provider of behavioral healthcare services to both acute and chronic mentally ill

populations. New leadership has arrived with a mandate and anticipated support to build a new team that will take a different direction in rebuilding the hospital's treatment services. Specific recommendations to consider in the plan to improve treatment services include:

- **Build bridges and a productive partnership with staff.** New leadership has already begun this effort with Senior Leaders "adopting units" and becoming more present. Meetings with supervisors from all shifts are now getting underway. First contacts need to lead to staff inclusion in problem solving efforts. It is possible that specific task-oriented teams can be created to tackle different aspects of treatment services that require improvement. It was stated by numerous staff and leadership during interviews that many grand plans have been developed, even in response to the initial CMS survey findings last November. However, the ability to put them into action has not materialized. Part of the problem is that leadership alone cannot resolve the problems occurring at the point of service delivery. The solutions have to be accepted by staff, integrated into practice and followed consistently. This is consistent with the Lean model of quality improvement. If staff are part of the solution finding, better ideas are generated, acceptance becomes easier, and then the resources for training and implementation need to be in place to make things happen.
- **Systems advocacy for change.** With an improved leadership-staff partnership and an informative dialogue on the systems issues in play at WSH, a joint approach to advocacy at the state level should be undertaken in order to modify the admission-discharge processes currently in place for WSH. We see changing the balance of power to include the hospital in the decision making process for civil admissions and discharges, as well as being able to speed the process in the forensic services when patients are deemed discharge ready, as vital to make the hospital a dynamic contributing part of the overall community effort to treat the state's citizens in the least restrictive environment of care. The hospital cannot be seen as a place to hold the people deemed unsafe in the community for unlimited periods and yet still be responsive to the same community when more people are being mandated into the facility. The hospital is already large by all current national standards for psychiatric hospitals, and the prevailing system in place would require it to grow larger or multiply into new institutions to add capacity.
- **Environmental changes.** It is imperative that there are improvements to both the physical environment and the overall treatment approach and culture. From the former perspective, a cleaner and safer facility would improve functionality and remove dangerous conditions. In the latter perspective, creating a climate of safety for patients and staff so the emotional and mental energy expended is directed more to care and treatment and less to fear and intimidation. Being able to attend to unsafe, dysfunctional or dirty environmental conditions will change a significant part of the climate of WSH as being depressing or hopeless. Repairing recreational equipment and facilities that patients need for recreation will impact the quality of services and the patients' experience of their time in the hospital. Changing staffing matrices where necessary, be it additional staff or changing the mix of staffing on a unit, if

done in conjunction with the treatment team, can lead to major changes in morale and direct care performance. It is not always more staff in the matrix. As said by clinical leaders, patients and even some direct staff, it is the right mix of staff and the right people in the right places. A review of the PERT team process is underway and needs to be inclusive of all treatment disciplines as the impact on the staff has been tremendously discouraging, creating an impression that it is not a clinically led facility but a security led one. Finding the most effective crisis intervention training program and communications skills training is imperative to developing a safer culture. Again, these are things staff should be a part of as the research and review of options is undertaken.

- **Allocation of staff.** A critical issue as current vacancies are filled and new positions are also made active will be the structure of unit staffing. There are significant questions with the on-call system; namely, staff not knowing patients or processes, and these can contribute to unsafe conditions. More regular staff being assigned to home units with less reliance on regular floating will enhance the team, patient communications, and consistency of operations. It will also increase accountability for performance as more staff will fall directly under a specific supervisor responsible for coaching, mentoring, and managing their job efforts. We strongly encourage a problem solving effort for optimal staffing patterns and assignments. Aside from unit-based staffing, decisions need to be made on Recovery Center staffing, professional services staffing and allocation, and psychiatric staffing in partnership with each discipline to maximize completion of role assignments and promote job satisfaction.
- **Unit structure and leadership.** With the impending changes in staffing and the rapid cycle performance improvement efforts that will need to be made all the way down to department and unit levels, having an effective and responsive chain of command is imperative. It is highly recommended that each treatment unit have a leader who has the task of integrating the multidisciplinary provision of care and ensures staff have what they need, and the unit is in good order. Most critically, it is imperative that staff are doing the right things and in the proper way. The teaching and mentoring roles for such leaders to defined groups of staff is critical for ensuring organizational teaching is understood and implemented as planned. The monitoring and oversight function of such unit leadership will better ensure processes of treatment and documentation are being carried out according to standards and policy. Accountability will likely be dramatically improved. With the many performance improvement activities to be carried out, the unit leader will be a vital bridge to the staff, ensuring unit participation in such processes, assisting with data collection, and creating unit data dashboards, and all will help in developing a team culture on the unit.
- **Direct treatment services.** This area is where everything outlined above must translate into action and outcomes. There are numerous areas where training and education must meet with monitoring and feedback to ensure proper compliance with the delivery and documentation of services. Training and mentoring will be even

more critical with the arrival of new staff. Areas of focus are clearly identified by the CMS survey visits. To highlight just a couple that are imperative:

- Treatment Planning – A process must be developed for proper creation of a treatment plan along with reviewing and updating as necessary. Plans must move beyond the generic and basic descriptors to be patient specific, derived from the assessment material focusing on presenting problems, strengths and weaknesses; goals and objectives need to be measurable, attainable and relevant; with periodic times for measurement defined. There are numerous formats to explore but the one chosen must not only meet all regulatory criteria but must also be readily adaptable to the Electronic Health Record being developed.
- General documentation – All charting disciplines will need to be trained in proper charting that draws connections from assessment to the plan to the progress notes. Doing so will make discipline charting relevant to the Plan of Care and enable staff to better assess progress or lack thereof for subsequent treatment plan reviews and updates. Other documentation issues noted during the site visits including adequate documentation of restraint and seclusion episodes, suicide assessments, and assessment of safety for risk, and 1:1 monitoring. All need to be captured within a structured system allowing for adaptation to the EHR. First, relevant policies and processes need to be in place with appropriate staff training, mentoring, and monitoring before any real change in documentation will be meaningful and consistent.
- Modification of treatment services - During our visit we heard numerous worthwhile ideas put forward to enhance services at WSH. As improved staffing is brought on board, there is a great opportunity to look at such things as patient assignment to units and types and locations of service delivery. Staff and patients both repeatedly noted a dearth of addiction-related treatment and services, something now commonplace in most settings as probably near half of patients admitted have symptoms related to dual diagnoses. During staff and leadership interviews, ideas were presented pertaining to expanding the breadth of treatment services to more formally offer cognitive behavior therapy and dialectical behavior therapy, as two examples of evidenced-based practices aimed at specific problems and diagnostic conditions. It was also noted that unit-based activities are lacking compared to the Recovery Center schedules. Since many patients go through periods of resistance to the Center/Mall treatments, it is imperative that an array of individual and group treatment offerings be available for patients remaining on the units. Patients themselves, during our interviews made suggestions in areas of recreational activities and fitness that are both thoughtful and relevant to care and would contribute to a more positive environment. Examples included:
 - Increasing the emphasis on fitness and health by adding more access time to the gym and yard, while repairing and replacing broken equipment.

- Integrate fitness training and counseling on the use of the gym to help structure it and make it goal oriented in terms of fitness and socialization skills. Also, allow free time activities there under proper supervision and through level attainment for increased privileges.
- Add extracurricular activities like field trips and bus excursions into town for doing business of daily living, a good normalization experience. Patients in the hospital for extended periods and demonstrating stability and increasing level attainment should get both the rewards and responsibilities of their progress.
 - Setting up leisure space off units such as a lounge or game room to allow people to interact and de-stress.
 - With the increase in staffing and ability to supervise properly, restore more level privileges for things like more on grounds freedoms. The perception of many patients is that high profile transgressions like elopements and violent episodes have led to restrictions that negatively impact the vast majority of patients who are trying to progress. They blame many of the negative events on ill prepared or unfocused staff or shortages of staff that led to people committing transgressions. They expressed frustrations at the increasing limitations placed on them each day.
 - While not recreational, another activity discussed was more vocational rehabilitation and training. There were compliments to the work programs through the Treatment Recovery Centers that allow patients to earn a little money but feel there are many other avenues of work readiness preparations to be explored and expanded upon.
 - Data reviewed in various quality improvement meetings suggested that the token systems found in several of the units led to greater involvement in treatment and other improvements. Higher staffing levels were noted as being required for such areas. Staff and patients both expressed satisfaction with these programs during reviews on the units that provided such programming.
- **Unit structure and function** – Our unit observations combined with staff and patient interviews and reviews of standard practices in other institutions leads us to suggest a review of the admission structure and unit assignments for patients. A greater reliance on standard admission units as opposed to admissions to all acute units may allow for a better division of services. This would allow for an array of standard assessment processes focused on these particular units and serve as an entry way into the hospital. Step-downs could occur to more general acute units as patients demonstrate adjustment to the hospital and even some stabilization of the most acute symptoms evident upon admission. Staffing levels, both specialized and general, could be determined based upon the structure and function of each unit combined with unit size and general acuity. Within the Center for Forensic Services, it may be possible to further divide the units beyond such categories as NGRI or Competency Restoration. Within these areas further division could take place based upon a level system that is

more consistent and standardized than the one currently in place. Currently, some units are seen as easier in which to advance levels while others are more difficult. If more standardization was used, then new admissions and unstable, lower functioning patients could be grouped and staffed accordingly. Unit programs and privileges would be determined accordingly. Other units could house patients reaching intermediate and then upper levels with each step up being granting more rights and more responsibilities.

3. Patient Rights Protections

The moment a person enters Western State Hospital, is admitted, and becomes a patient there is a responsibility to protect. From then on, the focus is on that individual and the care must be patient-centered. The responsibility is a great one and especially so when patients are under a civil commitment or a judge's order. Patients cannot readily access the outside merely by opening a door. The patients are dependent on the staff who are now in control of their freedom. Whenever patients are reliant on staff who have control over their freedom, the possibility for abuse exists. Unless it is recognized as a possibility, a true culture of safety is in jeopardy. It is paramount that the senior leadership foster and ensure principles of dignity and respect in a safe and therapeutic environment throughout the organization. However, a culture of safety depends heavily on the commitment of a staff whose morale is high, are staffed at appropriate levels, are appropriately trained, and are respected members of the patient's treatment team and the organization.

Based on the findings referenced in the CMS reports of 2015-2016, WSH is non-compliant with the patient rights protection standard. During the onsite visit the CSM team observed hospital meetings, individually interviewed staff and patients, facilitated various staff and patient focus groups, and conducted tours throughout the hospital across shifts. The data collected by the CSM team supports the CMS findings regarding non-compliance with patient rights. There were also problems noted by the Compliance Team and NRI in the proper documentation and use of seclusion and restraint.

a. Current State of Patient Rights at Western State Hospital

In evaluating the current state of adherence to patient's rights protections, we need to look at regulatory specific citations, and also their impact in the broader sense. As with all areas of citation, the impact is wide-ranging and ultimately ties back to the quality and outcomes of care delivered at the Hospital. According to 482.13 PATIENT RIGHTS, a hospital must protect and promote each patient's rights. The following citations were identified in the survey reports:

- Personal privacy (A143) – Lack of room privacy between patients, at door windows and regarding toileting.
- Care in a safe setting (A144) – Failed to ensure patients' rights by not adhering to suicide risk assessment and follow-up protocols, response to alleged sexual assault complaints, and environmental reviews to ensure the physical plant does not contain potentially hazardous conditions that could cause harm or allow for patients to harm themselves.

- Restraint or seclusion (A168; A175) – Adherence to protocols for ordering restraints and evaluation, attending to patients being restrained.
- Confidentiality of records (A147) – most specifically pertaining to entries into the incorrect patient record.

While each of these leads back to leadership (specifically Governing Body) for responsibility and oversight of patient protections (A043), the most critical aspect of the citations are their links to issues pertaining to other areas of direct service delivery and/or efforts to improve upon those services, including:

- QAPI (A263) – failed to develop and implement a hospital wide quality assessment and performance plan. Data collection and analysis (A273) – failed to develop and implement effective performance improvement plans and projects related to data collection and analysis to support the goals that the governing body approved.
- Patient Safety (A286) – failed to develop and implement effective performance improvement plans and projects to address patient safety.
- Treatment Plans (B118, B125, B148) – failed to ensure the Master Treatment Plans were revised to include alternative interventions for those patients unwilling, unable or not motivated to participate in the prescribed active treatment program. Also, revising treatment plans based on notable changes in conditions such as episodes of restraint or seclusion. In addition, developing plans specific to individual needs and measurable to outcomes.

Many of these citations are functions of people not completing work duties as defined in policy and procedure or failing to document in a manner that reflects the interventions actually made or attempted. The data analysis completed by NRI noted later addresses issues of documentation as well. When combined with activities not being held as scheduled or at all, one is consistently led back to issues of adequate staffing and training to better support adherence to both treatment schedules and protocols for provision and documentation of care. Indeed citations also included direct reference to adequate staffing such as:

- Nursing Services (B150) – failed to provide adequate numbers of RNs, LPNs and MHTs.
- Therapeutic Activities (B158) – lack of adequate number of therapeutic staff to implement activities consistent with the needs of the patients/insufficient therapeutic staff available.

During onsite observations and interviews with staff and patients pertaining to day-to-day operations, patients' rights challenges were obvious from the arrival of an individual patient to WSH. The hospital does not have one centralized admission ward for the civilly committed patients and one for the forensic patients. The hospital's process for new admission intakes can occur on many wards, including six acute, one geriatric, and two forensic wards. Instead, it groups patients at different points of progress in their care, leaving individuals at very divergent levels of stability being treated with similar protocols and expectations.

The process of admissions can produce privacy and safety issues. CSM observed a scheduled female new admission intake from beginning to end. This female patient was strapped to an ambulance stretcher and wheeled onto the ward by the ambulance staff. The patient was calm while on the stretcher. She was placed in front of the nursing station on the ward and dayroom area where there were other patients present. The psychiatrist and social worker came out from the nursing station and greeted the patient, while the ambulance staff was being released from responsibility. The patient was helped off the stretcher by an MHT/direct care staff who now sat with her to sign consent forms. They remained in the dayroom with other patients present. Throughout this portion of the admission process, although the psychiatrist, social worker, and nurse were aware of the patient, she remained on the stretcher and vulnerable from other patients and in a non-confidential setting. The patient was ultimately taken to another room to complete the intake process with the psychiatrist, nurse, and social worker. Additionally, in a review of the documentation and from the patient interview, it appeared that this civilly-committed patient was not in need of a secure setting at the level of WSH and rather in need of community placement. The team agreed with this observation and said that this happens frequently, causing distress to both patients and staff. From a rights perspective, it calls into question compliance with the mandate to treat in the least restrictive setting of care. No significant process for documentation/tracking for data on questionable admissions currently exists and reflects little control over patient entry at the organizational level, clearly a system's issue.

Aspects of safety at WSH are an issue for both patients and staff. During one of the patient focus groups, all of the 13 patients present stated that they did not feel safe in the hospital, 11 Patients reported being assaulted, several of them multiple times. Three of the patients said that they were attacked while on a 1:1 more than once. Most felt that steps taken to prevent another assault were insufficient, that the staff were unable to keep them safe, and it was up to them to do that for themselves. Patients would express frustration that they had little recourse when assaulted without jeopardizing their own status. Both programmatically and legally, they felt their rights to protection were minimal. In support of this, a majority in the staff focus groups felt that the wards and the malls were unsafe for both patients and staff. Even a cursory review of the Mortality and Morbidity Committee minutes reflected many incidents of patient to patient assaults, some of which led to eventual death of patients. NRI data reported below show additional evidence of problems with levels of assault.

Nursing services CMS standard B150, regarding adequate nursing staffing was corrected and in CMS compliance when WSH implemented the on-call pool nurse staffing process. Many of the staff across disciplines cited consistency problems with the on-call program. Too frequently, the pool nurse assigned was not familiar with the patient, ward routine, or the clinical and support staff. This unfamiliarity with the patient and ward routine places increased pressures on the direct care staff because patients go to the staff they know. The nursing schedulers assign the pool nurses where there are gaps, and due to the size of the hospital nurses are rarely reassigned to a previously assigned ward. Among the many impacts upon quality in this scenario, the lack of knowledge pertaining to patient triggers and de-escalators puts more people at risk due to acting out episodes by patients.

The Rehabilitation department staff cuts caused a decrease in the staff to patient ratio, and this impacted treatment in the mall programs. In the Rehabilitation focus group, staff said that this has led to many groups of 30 patients with one leader. At times with staff shortages due to absences and vacations, a group will double to as many as 60 patients and be led by one leader. This was actually observed during tours when patients waiting in the mall area after groups were started were moved to another group when it was discovered that the group leader was out sick. Staffing issues also led to these patients not being noticed before we were touring and our staff guide intervened to get them into another group. Hall monitors positioned around the mall area had done nothing to intervene, in part because they are from various wards and not knowledgeable about every patient. The situation weakens the therapeutic quality of the group and the over-crowding compromises patient safety in a number of ways. First, it might provoke some patients that are overwhelmed by too many others, especially those they are not familiar with. Second, many of the rooms are already serving numbers of patients above posted capacity, so there are life safety concerns. The treatment team assigns patients to the mall programs, but when the prescribed groups are full the patient is assigned to another group where there are openings or availability, not according to clinical need and/or desire. Also, we were told by staff that patients are sent to the malls if they are physically sick and when they are aggressive, which is a good indication that there is lack of communication about patient needs between the rehabilitation staff and the treatment team. It is our belief that this is more an issue of trying to meet metrics of "active treatment" hours vs. active treatment that is related to clinical needs. So, there is a pressure to get patients to the mall for treatment under almost any circumstance, as well as to reduce pressures back on the sending unit or ward.

Patient and staff focus groups revealed that the patients receive little to no advanced notification of the date and time of their treatment plan meetings. The patients reported participation with a team member in the preparation for their treatment plan prior to the meeting rarely occurs. Active treatment is minimal on the units and substance abuse counselors/programs are not available at WSH, although there are some groups that address substance abuse problems. Patients and staff are concerned about the lack of activities on and off the unit on day, evenings, and weekends. In general, Rehab staff are not assigned to the wards. Our Center tours confirmed there is a lack of active treatment on the wards, since patients were observed to be mostly idle sitting in chairs or wandering around the dayroom areas. During the tours, one MHT staff voiced concerns about the lack of on-ward activities and the need for supplies like books, music/musical instruments, and games for the patients. The staff were frustrated that they could not secure simple supplies for their patients.

CMS found repeated problems with properly documenting seclusion and restraint procedures. These same issues were found during the Compliance Team's review of charts. It appeared that these were errors of omission with a lack of proper documentation. Interviews with staff and reviews of charts gave reason to believe that the events were generally properly completed. Issues arising from staffing, cumbersome documentation, and inadequate communication have contributed to the deficiencies noted. These issues must be rectified in order to allow the organization to demonstrate compliance with required standards reflective of respecting patient rights. Yet, we were also told during patient and staff focus groups, during individual interviews with patients and staff, and during observations that all problems are not limited to poor

documentation. There were repeated comments that there are times when there is a more correctional focus versus a therapeutic focus with use of seclusion and restraint that was more punitive or control focused and not to ensure safety around imminent risks. There were reports of threats by staff made to patients and other behaviors that were used (inappropriate rewarding of some patients) to "keep the peace." Many of these are difficult to verify, but the number and frequency of them was troublesome, and in our experience they correlate with an organization that has lost its therapeutic focus and become more custodial and correction focused. While onsite, there was a patient that was secluded and had been restrained for a refusal to put his clothes on. No imminent risk of physical harm to himself or others was shown. Overall rates of seclusion and restraint are higher than similar organizations as evidence by ORYX data. Data on assaults between patients and by patients of staff are higher than average as shown by NRI reported data, and a review of the Mortality and Morbidity Committee minutes shows regular reviews of very serious injuries and even death. Staff and patients reported not feeling safe and secure in the organization.

b. Target for the Plan of Correction for Patient Rights at Western State Hospital

The ideal is to protect and promote the rights of every patient at WSH, while providing care in a safe environment that protects a patient from immediate harm. This is consistent with the mission of the hospital, as well as regulatory and accreditation standards, not to mention legal and ethical standards. This must begin with admission, where a patient arrives at WSH based upon an agreed upon set of standards whereby the state hospital has been determined to be the appropriate level of care currently needed by that individual. A confidential and safe environment begins during the intake process; therefore, a private and safe space must be available/provided for the patient and admitting staff. From that point forward privacy, as appropriate to patient and unit safety needs, should be a given aspect of respectful patient care. Clinical and direct care staff should be trained and responsible for ensuring patient rights are adhered to consistently. This also includes proper informed consent whereby the patient is informed of treatment options, part of decision making on the nature and extent of care, and treated with dignity and respect. Patients unable to actively and meaningfully engage in this process should have proper legal safeguards to ensure that their rights are not abridged except when they are at imminent risk of danger to themselves or others and legal steps and processes are in place for decisions against their will and/or whenever they are not able to decide. Any abridgements of such patient rights need to be eliminated as soon as the patient is able to safely and appropriately make such decisions.

Treatment should take place in an environment monitored and maintained to be free of risks to the safety of both patients and staff, including both the physical plant and interpersonal safety. A properly staffed and trained workforce will provide appropriate and quality treatment with adequate staffing patterns and adequate physical plant and other resources to improve patient outcomes in at least two ways. First, it will create a setting where patients and staff feel safe and able to focus on the therapeutic aspects of the programming and the milieu. This will promote an environment of vibrant treatment activity in both design and practice. Second, the increased resources will allow for greater individualization and

intensity of care, improving outcomes by the through improved quality of programming and service. A culture of continuous quality improvement needs to permeate the organization from top to bottom, with information flowing in both directions. Quantifiably-validated initiatives are needed to further reduce violent episodes and to reduce the use of restrictive means of care such as restraints and seclusion. Treatment planning, delivery of care, and clinical documentation needs to be done thoroughly and in a collaborative, interdisciplinary manner inclusive of patient input. Sufficient staffing across disciplines and at all levels of programming will allow treatment recovery centers to function optimally, since there will be adequate input into and involvement of all members of the clinical team in assessing patient needs and identifying necessary activities to address all problems within a comprehensive plan of care. This will also allow for ongoing reassessment for progress, as well as identifying issues that will require a revision of plans. Individual and group interventions will be flexible and available on units for those patients requiring more structure and support in the delivery of service.

Finally, discharge planning will be done in conjunction with the patient, family and/or significant others, and community providers to ensure each individual has access to appropriate resources to be able to move to a lower level of care as his/her condition may permit, and in the most expeditious manner. This will foster and honor the most important individual right being of freedom to be in the community and out of state custody, as legal and ethical dictates require.

c. Root Cause Analysis – Factors to consider in the current state of patient’s rights

The patient rights protection gap resulted from failures of senior leadership and the mid-level management issues: changes in the organizational structure, lack of communication, loss of consistent ongoing training, and a reduction of staff. The situation created an environment non-conducive to patient safety, privacy, and other required protections.

The following issues were identified that led to these problems:

- **Deterioration of the hospital environment from both a physical and psychological perspective.** As staffing and budget cuts for operations occurred, oversight of the buildings and grounds became less local, detailed, and responsive. The entire facility deteriorated and proper maintenance of the plant, including replacements of defective or outdated program supplies, slowed and often lapsed. See details below by the Compliance Team on the cumbersome process and procedures using an outside vendor, as well as the large backlog of work orders. Basics of care such as means to offer privacy and respect broke down slowly but steadily, gaining momentum with each subsequent budget year and reduction in support. A perfect storm that was brewing as environmental risks increased, basic supplies for activities decreased, and staffing at all levels deteriorated.

- **The reduction of staff without replacement was met with ineffective reorganization of the disciplines or departments affected.** The loss of ward or unit managers, who were the assistants to the Center Directors, produced a deterioration of communication and coordination of programming, staffing, and oversight of the therapeutic environment on the wards. Specifically, it led to a deterioration of clinical practice and its documentation due to less monitoring, over-stretched staff, and difficult working conditions. An increase in errors and omissions occurred, as did fidelity with proper procedures. The example noted in the CMS findings of the LPN that was pouring medicines ahead of time is a perfect example of this. A lack of proper training, oversight, and controls allowed this and similar problems to develop and expand. Once these issues became identified, the organization often resorted to processes and procedures that actually served to burden the staff and put the patients at further risk, as evidenced with this example of pulling another staff member for all units to be part of the patient identification process prior to the LPN medicating, and thus losing that person pulled for other unit duties involving patient care.
- **Implementation of new programs without proper involvement of managers and staff.** The development and implementation of the PERT program is an example. Direct care staff reported that they were never involved and mistrusted the program and its staff from the start and they still do. It began as a sincere effort to improve patient and staff safety, but it was soon seen as a disconnected and autocratic leadership implementing practices that reduced medical and nursing oversight of care and did not address the very problem it was meant to rectify.
- **Active treatment and other appropriate activities are minimally available to the patients on the unit.** Staffing cuts affected the rehabilitation staff that were assigned to the wards. Loss of rehabilitation staff with no replacements produced insufficient programming on the wards. This was particularly evident during CSM's weekend and offsite tours, but it was also very obvious during the day. The MHT/direct care staff level problems has been exacerbated by a lack of coordination, support, and supplies and available options. An example of the latter was the significant impact of activity options when a fence was installed to reduce elopements, but it served to significantly curtail and even end availability of a snack bar, vocational activities, and other activities that patients could be involved in. The role of MHT level staff has primarily become one of patient monitoring, physical support, and intervention as necessary when aggression or violent events occur. Loss of professional staff through reduction and inability to fill/retain slots has contributed to a loss of active treatment options involving more intense clinical interventions, both individually and in treatment mall offerings. For example, there are only a few evidenced-based groups using CBT or DBT, and almost no offerings related to substance abuse issues. Social workers offer one group that is run through a rotation process, and psychologists indicated few opportunities to provide advanced therapy due to demands to complete assessments and reports related to competency. Many other examples of these limitations were observed by CSM and reported by patients and staff.

- **Admissions Waiting List/Discharge Waiting List.** There are on average about 150 patients waiting to be admitted and 120-150 patients waiting to be discharged at any given time. This places stress on the resources of the hospital and the community. Staff and leaders reported constant pressure to admit patients ahead of others already on the waiting list, and the CEO has even been threatened with contempt of court for not agreeing to this. Patients appropriate for discharge are forced to live in a restrictive setting instead of returning to the community when there are few available resources in the community. By report and observation, many referred admission patients more appropriate to be in a less restrictive setting or in need of community housing are kept in a more restrictive hospital setting, either in a community hospital or at the state hospital. Using a hospital, especially a state hospital, as housing/shelter option is the most expensive, least productive, and most injurious of patient rights. Unfortunately, the entire behavioral healthcare system in Washington State is in need of significant change to improve this situation. WSH alone cannot fully improve this, no matter how effective and efficient they become. More and a greater range of services in the community are needed, as are revisions to various statutes that mandate state hospitalization when other options would be better. Community education for judges and other government officials at various levels of the state, county, and city/town level are also needed.
- **Patient to Patient/Patient to Staff assaults are a complex problem that is influenced by many factors.** Insufficient numbers of staff in the malls and on the units is likely a major reason for this, but increasing staff alone is too simple of a solution. Additional factors need to be considered. There are no easily available statistics on the nature of the patient population at WSH, but anecdotal reports by staff and leaders at WSH and CSM's own experience at other such facilities suggests that the patient on average are more challenging. Many of those that would have been in the state hospital, even 20 years ago, are treated in the community through the full range of treatment options available there. Those that are now being admitted, by and large, have more challenging problems and issues. They are often older with all the attendant physical health problems of the elderly, and the statistics on how poorly those with persistent and severe mental illness age supports this contention. The CSM team was actually palpably struck by how physically sick many of the patients seemed (above and beyond what we have seen at other state hospitals), and many staff at WSH agreed with this. Those now hospitalized are also likely to be the ones that are more treatment resistant with regards to medications, since those more responsive would not have made it here. Furthermore, the number and level of patients with forensic issues here and in most other state hospitals has increased over the years relative to those civilly committed. Additionally, there has been high turnover of many staff, despite many others that have lengthy longevity at the hospital, so experience and the skills that often go with it are constantly undermined. Along with this, there has been a reduction of ongoing and necessary training at point of entry and in ongoing updates of knowledge and skills at WSH (see the staff training area). The physical plant has deteriorated over time, as noted above. These and other factors have contributed to a physical and therapeutic environment that is

less able to respond in working with a patient population that is likely more challenging. Bad things happen under such circumstances.

- **Impaired leadership.** Reports by staff and leaders (see above for greater detail on leadership issues) indicated that less frequent and less effective communication with the staff occurred, as the leadership and management staff were reduced. This was compounded by many leaders assuming greater responsibility for more areas and supervisees. This led to less support and direction of staff, inability to ensure fidelity with organizational policies and procedures, and this coupled with reduced staff and more challenging patients led to issues with programming and ultimately with reduction of protections of patient rights.
- **Nursing coverage.** Reports by staff and leaders indicated that on-call/pool nurses assigned to wards are often not familiar with the patients on the ward or the wards direct care and clinical staff. The unfamiliarity of the pool staff with the ward appears to be a consistent problem because the assignment constantly changes given the size of the hospital staffing model that focuses more on putting bodies into positions, thus impacting both quality and safety. Interviews with staff indicated that this approach to ensuring wards meet their staffing requirements is another example of the disconnect of leadership from staff and patients, and a lack of appreciation for or not understanding that staff need to form relationships and be familiar with the individuals for whom they provide care and vice versa.

d. Recommendations:

It is important to note that the majority of all staff that we met while at WSH had low morale and they had much to say about what areas needed help and how to fix the problems. Nevertheless, they expressed hope for the future of the hospital with the new administration. The staff wants the hospital back on course and they want to help get it there. There is a sense of cautious optimism around the initiatives to add and retain staff, and to make other necessary changes for effective patient care. Many patients said that in spite of the negatives they were able to stabilize on medications and use other assistance to get better and work toward discharge. There was clear frustration with the challenges keeping them from returning to the community, both within the civil and forensic portions of the hospital. Some specific steps to improve patient's rights include:

- **Focus groups.** Implement a process for conducting yearly or bi-yearly focus groups (patients and staff) and use the data collected to ensure and improve patient rights and safety.
- **Improve direct senior leadership access and accountability of the Patient Advocate.** The present individual is passionate about this, but there is little real connection to senior leadership and little accountability for this individual's scope of work. She is actively involved with patients, reports regularly and thoroughly to the Patient Care Committee (as evidenced in minutes), but in discussion with her and

others there is minimal direction and oversight given to her and little apparent impact on the functioning of the institution in response to identified problems or possible solutions.

- **Leadership rounds need to be improved in scope and regularity to maintain open lines of communication with staff.** When making rounds, greater sharing of information can and should occur. This increased administration visibility encourages a culture of safety and showing of support, especially as the concerns and insights of both patients and staff are heard, but ultimately responded to with meaningful change. A schedule for the leadership group to make rounds hospital wide and across all shifts is needed. Assigning 2-3 leaders to make rounds together might synergistically improve collaboration across all levels of the organization. Documenting ward rounds through data collection methods can improve patient and staff safety and the therapeutic environment. The Lean methodology identified in the QAPI plan embraces such efforts to communicate with those at the front lines, and it needs to be a two-way process.
- **Environmental rounds.** Develop a plan to conduct environmental rounds on a regular basis. Include a representative from the following (at least): management, ward staff, clinical staff (not just or only nursing), security, housekeeping, and engineering. Document and repair life safety issues and ensure timely repair/follow-up. See findings and recommendations from the Compliance Team on related details.
- **Improve surveys and other methods of being informed by patients on their issues and concerns patient issues, and repeat regularly.** Move beyond purely patient satisfaction toward perception of care more generally.
- **More actively involve patients in participating in treatment planning,** and start better notification of and preparation for treatment planning meetings, follow-up with a second survey, use data to improve patient rights and needs. This was a common issue found during interviews with patients and staff, and during observations of such meetings. Involve all staff that work with patients, particularly the normally missing MHT and Rehab staff.
- **Pool nurse assignment/staffing.** Review current staffing process of the pool nurse assignment, and staffing in general. There are too few nurses, particularly RNs during most shifts to cover all the required elements in thorough and complete fashion, and free them up for more patient education and teaching, supportive involvement, and in other clinically related interactions. Investigate ways to give staff assignment continuity for better familiarity with the patient, staff and ward routine or change assignment to regular unit positions to better fill gaps by creating a more regular unit staff more patient familiarity and more safety. In related fashion, we often heard about and observed RNs filling MHT absences. They often engaged in nursing-related functions (e.g., review of treatment plans, etc.), but this is not a good use of RNs and a regular basis.

- **Ward or unit manager/program coordinator.** Hire mid-level management staff to assist Center Directors. Assign such managers to cover one or two wards, depending on acuity and other factors. Duties should minimally include coordination of patient programs, ensuring therapeutic environment, transfer lists, staff performance monitoring, direct link from more senior leadership, education, and working to translate performance improvement ideas, practices, and data to staff and taking staff impressions back up the chain.
- **Ward Activities.** Increase activities on the ward. Center Directors need to coordinate with Rehabilitation Services to provide programming ideas and required supplies to be used by the ward MHTs. Alternate program activities on the ward are needed for agitated or sick patients. Rehab Department should provide MHTs with training regarding the use of supplies. Center management can encourage Rehabilitation department staff and the direct care staff to form a partnership in providing excellence in patient care. More nursing staff would allow for ward education efforts around medication, illnesses and conditions, wellness and health ideas, etc. Repetition and variety are both needed.
- **Admissions Intake Process.** Provide a confidential safe space for all new admissions at intake. Review the process for accepting new admissions; include admitting psychiatrist in the review of paperwork prior to acceptances. Include in the procedures a mechanism for reporting/collecting data on all questionable/inappropriate admissions. Involve the hospital's discharge team to focus on the questionable admission and appropriately discharge the patient with a goal of doing so within 72 hours. Involve/keep informed WSH leadership and/Central office so that data collected can be used to change statutory commitment issues and create increased placement options and involvement of community placements agencies.
- **Treatment Plan Notification.** As frequently reported by patients and staff, patients have little or no notification of their treatment plan meeting prior to the meeting and have little participation in developing their plan. While we noted unit variation around treatment planning, many patients reported little or no involvement prior to and even during such meetings. All patients need to be notified of their scheduled treatment plan meeting a minimum of 72 hours prior to the meeting. Patients need access to one of the team members to discuss the plan prior to the meeting, as often as needed. As with any proposed process change, a process of review on the nature and success of such changes are needed and must include patients and staff.
- **Reduced Patient Assaults.** Increase staffing with appropriate ratio of staff to patients. Hold back agitated and physically sick patients from attending the mall program temporarily, since this disrupts the programming of others and further stresses the patient not as able to benefit from such off-unit programming. Provide appropriate programming on the ward. Coordinate better communication between the team members and the mall staff. Set targets with specific interventions though a

collaborative performance improvement process and track/report progress not just up through the QAPI process but down to the units as well.

- **Mall Program Staff.** Increase the number of trained Rehabilitation staff, reduce the size of the patient groups, and coordinate with the treatment team to ensure that patients are assigned to the appropriate groups consistent with their treatment goals and objectives.

4. Qualified and Supportive Staffing Resources

In a psychiatric hospital, CMS conditions of participation require adequate numbers of qualified professional and supportive staff to evaluate patients, formulate written and individualized comprehensive treatment plans, provide active treatment, and engage in discharge planning. Western State Hospital has gone through many leadership changes over the years. The frequency and magnitude of these changes have been disruptive by the report of almost everyone CSM talked to, and many of these changes were not for the best, even if we only look at perceptions. Staff morale is very low after these many years of change, often of a downsizing nature with a lack of proper physical plant, personnel, and other resources. This has led to organizational malaise and apathy. Yet, many of the staff across the disciplines remain hopeful that the new administration will succeed. Given the improved resources and support the hospital may be receiving, WSH can aspire to again meeting its mission mandates and complying with regulatory and accreditation standards.

Resources can be clinical staff, support staff, affiliations, money, or materials that can be used by the hospital in order to effectively function and improve patient care and reduce risks to patients. Resources are maximized when used in the most appropriate manner, but they can be used in inefficient or ineffective ways if leadership does not have the flexibility to use them as the hospital staff and management decide based upon careful analysis of needs, strengths and weaknesses. The mission should drive the organization and evidence-based management and clinical practices should be used to ensure that the work of the organization is done and consistent with regulatory and accreditation standards.

a. Current state of Qualified and Supporting Staffing resources at Western State Hospital

As noted throughout this report, staff are the core resource in any medical organization, and even more so in a psychiatric facility. This key resource has been compromised by budgetary reductions during a difficult economic era from at least 2008. This has been compounded by:

- Vacancies borne out of retirements in an aging workforce
- Attrition due to better opportunities outside the state system in terms of money and benefits
- A flight from a difficult therapeutic environment and one progressively more violent and unsafe. The hospital has been perpetually challenged to meet unit-based minimum staffing requirements, struggling to do so through use of on-call staff,

mandating overtime, and postponing staff use of personal/vacation time off. The net result are tired, overworked staff unable to work at optimal levels and harboring resentment toward management for what is seen by labor as unfair and poorly planned workplace practices. Some specifics of the staffing issues include:

- **Psychiatry:** 45 total positions of which 11 are vacant. This is an appalling level of vacancy. The vacancies stretch the staff beyond what the Medical Director, and most anyone else, sees as efficient or effective. Coverage duties detract from patient focused care on home units, and psychiatrists are not as knowledgeable about patients on covered units. CMS found numerous instances of missed days of psychiatric care or gaps in treatment planning. The impact on proper monitoring and documentation of high-risk patients and those in seclusion and restraints was documented to be below standards. Various committees in need of psychiatric involvement struggle to involve them, and these necessary duties of oversight and involvement in ensuring quality burden an already overtaxed clinical group. All of these concerns were voiced by psychiatrists, individually and in groups. The ability to cover is marginal at best, and when there are absences due to illness and vacation, the problems are compounded. There are various reasons for this, which are addressed elsewhere.
- **Medical Services:** It was reported to our group that there were also two vacancies among the 12 positions for medicine. The doctors feel they are spread thinly covering 2-3 units each and are not able to effectively work as part of the treatment team, and contribute effectively to the treatment plans. There were a number of physicians who felt that they were unable successfully to treat conditions within the hospital due to this and other challenges, so patients were often unnecessarily transferred to community facilities for acute medical care with all the attendant challenges that this can entail. It was noted by a number of nursing staff that limits in the availability of IV and wound care staff put even more stress upon the psychiatric nursing staff on the floors.
- **Nursing Staff:** Most units we visited on various shifts were staffed with a single RN, the position being an RN2 or charge. A unit would have an RN3 as a supervisor for all shifts, generally present during the dayshift for the majority of hours. Each Center has an RN4 who oversees all nursing staff in the Center for a given shift, much like an Assistant Director of Nursing (ADN). Gaps in RN availability are sometimes replaced on the units by MHTs in order to meet the staffing levels, but there were other instances of the reverse of this (noted above). In any event, all nursing functions required of an RN must be done by one staff member. Observations of units where there were agitated patients, ones requesting many PRN medications, patients on 1:1 or even 2:1 staff to patient coverage, and other demands put this single RN in essentially crisis mode for the entire shift. There was little left for patient education, mentoring of MHTs, meaningful observation and interactions with all patients necessary for proper report at end of shift, and even some necessary and required time for breaks and meals. Use of on-call staff to cover vacancies and call-outs for RN, LPN, and MHT staff lead to units being covered by staff unfamiliar with the patients or processes of the unit. This impacts both quality and safety due to a lack of proper information and familiarity to adequately provide appropriate, patient specific interventions. It must be noted that while the State has developed plans to hire a

substantial number of additional nursing positions. There are still many vacancies that have not been filled because of limitations in the hiring package and recruitment efforts. Without more effective recruitment and retention, newly budgeted positions will not have any near term impact. Advanced Practice Nurses and Clinical Nurse Consultants are available to provide consultation, training and assistance with nursing procedures, yet they are limited in number and it is often challenging for staff nurses to find the time for such guidance and mentoring.

- **Social Services:** There are new hires budgeted. Recruitment tends to be limited to MSW graduates with 2 years of experience or less, no LCSW staff are coming there to work. Their work is focused on assessments and discharge planning, with only one group in the Recovery Center/Malls staffed in a rotating basis. Social workers and leaders reported very little individual work with patients. Fear of violence is expressed as a number have been assaulted, creating more of a collective sense of post-traumatic stress and fear. There is a specific Discharge Planning group that assists across the teams, but it is a small group relative to the size of the hospital patient population, and the challenges in the community make this team work especially hard and wide to provide discharge options for patients.
- **Psychology:** There are 27 doctoral level psychologists on the civil side and approximately 14 master's level staff. The master's staff do more group work in the Recovery Centers while the doctoral staff work in the Centers, but reported spending a great deal of time doing 180-day continued commitment evaluations. There are a few groups provided by the doctoral level staff, primarily CBT and DBT groups, but little else. This is a source of dissatisfaction and they feel underutilized as treatment professionals. In the Forensic area there were noted to be more master's level staff providing direct care work in groups in the Recovery Center and on units. On some of the units that utilize a token economy system as part of the treatment process, there is more involvement by the doctoral level staff, but this remains a relatively small part of the hospital's total units, even though there were a number of staff, individually and in groups, that desired to have more active, focused programming like this and in other ways.
- **Rehabilitation Staff:** A number of disciplines are involved in this group, including occupational therapists, recreation therapists, and Institutional Counselors and they are all generally off the wards and based in the Recovery Centers. As with other position titles, reductions have had an impact over the years in terms of range and numbers of staff.
- **Substance Abuse Counselors:** There are a number of staff trained as substance abuse counselors, but there is no true MICA program. A few groups are run over the week by these individuals, but all report that it is not nearly enough to deal with this serious and numerous co-occurring issue. This is a significant gap area for the hospital, based on reports by staff and leaders, and in comparison with other programs that CSM has worked with. Patients stated that much of the focus is limited to AA/NA type groups and the non-specialized counselors are not as effective at skill development with the patients.

The CMS site visits resulted in a number of citations pertaining to direct care and support staff relating to facilities management, personal privacy, and unsafe environment:

- Failure to ensure patients' rights to receive care in a safe setting by providing a sufficient number of properly trained and competent staff (A144)
- Confidentiality of records (A147)
- Restraints or seclusion, ensure that staff receive training on management of patients in restraints (A168, A175)
- Nursing services failed to develop and implement an action plan to provide sufficient numbers of trained and competent patient care staff (A385)
- Infection control failed to develop and implement an effective infection control program (A747)
- Therapeutic activities, failure to provide appropriate number of therapeutic staff to implement activities consistent with needs of the patients (B158).

The budget cuts that caused the downsizing of the rehab staff (B158) resulted in a decrease in qualified staff to run mall groups. Patient groups of as high as 30 or more are run by one leader and at times groups double to 60 with one leader. The mall program serves a large group of patients; however, loss of trained rehabilitation staff resulted in the loss of active treatment programs on the ward. Staffs assigned to the wards were removed without replacement. The resources of the Rehabilitation Department available to support direct care staff disappeared. The net result, often reported by staff and patients and observed on unit tours, is an environment of little programming or constructive activity for the patients on the units who are not at the malls.

The Pharmacy Department is a support to the hospital and the treatment teams. The doctoral level pharmacists attend treatment team meetings and morning briefings on their assigned wards. This is a notable positive contribution to patient safety in the area of medication selection and administration, since this is a patient population that often has not been as responsive to medications, needs a complex array of them, or has complicating factors (e.g., other health problems, infection control issues, etc.) that make finding the best combination of medications and dosage a challenging process. This group has also been instrumental in providing other analytic supports to the organization. One of their members has been actively involved in the development of the electronic health record system, and was eventually deployed full time in this endeavor.

Non-clinical, support service areas have also been challenged. Numerous staff commented that getting repairs done is very difficult. Off hours there is just one coverage person who is more of a minor repair person, documenting larger issues to be followed up on during the weekdays. Even weekday reports into facilities are often lost or slow to be addresses, contributing to unsafe environmental conditions on the units. See additional details by the Compliance Team below.

The net result of the shortages in various professional and support staff positions has led to a culture of just trying to get the basics done, since there is little time or support for more than

this. Therapy activities suffer, treatment planning meetings are missed, shortcuts are taken and all the basic functions that lead to quality care (e.g., patient and peer communication, proper adherence to procedures, adequate and timely documentation, etc.) deteriorate. It was reported by many disciplines that they feel disempowered and/or disrespected. Few feel able to adequately and regularly provide the full range of services they are capable of using based on training and experience.

b. Target for the Plan of Correction for Qualified and Supportive Staffing Resources

The goal for Western State Hospital must be to create an environment where the proper staff, both in skills and numbers, are available where and when needed. Assessments, treatment planning, ongoing therapeutic activities, and discharge planning all need to be completed in an efficient and coordinated fashion. Use of professional staff should be targeted to the specific activities necessary to help patients get well and be ready to return to the community. Community placement efforts should be made with the expectation that patients ready to leave will not be remaining in the hospital much longer and that they will be successful in the community.

Ideally, all disciplines will work in a collaborative, respectful, and multidisciplinary fashion, while contributing their unique expertise based on training and experience. A culture of accountability must be developed where all staff have clear expectations for performance that are measured and used to provide feedback and mentoring as necessary. Ideally, this will mean more local oversight of staff in their day-to-day functioning compared to the more distant and limited oversight of the current structure.

As staffing levels are improved through state initiatives, this will produce additional nursing positions and allow for salary adjustments for many disciplines to allow for better recruitment of vacant positions and to retain good staff and produce less turnover. The state legislation passed in March calls for consultation on staffing at the state hospital, aimed at getting the proper number of staff in each of the required disciplines in order to meet targets for providing the necessary treatment activities to promote patient health, wellness, and recovery. This is a complex process that should not be reduced to mere calculation of the number of units of each activity and the time spent to complete each one. Nonetheless, proper utilization of staff is paramount to staff satisfaction and patient outcomes. As staffing levels are improved, scheduling becomes a critical issue. Nursing staff report feeling disempowered, since it has often been difficult for them to get a day off especially on the weekend or use their vacation time. An organization that has adequate staffing across disciplines allows for mandated and necessary time off that promotes renewed energy and commitment. Such a workforce will perform better, commit fewer errors, and have greater ability to focus on the patients for whom they are providing care. Less use of on-call pools can allow for more staff to be assigned consistently to one or just a couple of units, thereby increasing staff-patient familiarity and rapport. This can lead to a safer environment and one that is more clinically focused.

The improved staffing environment envisioned above needs to take place within an organization that has a coordinated leadership structure that can provide more direct oversight of unit functioning. This coordinated leadership needs to be deployed through adequate levels of unit leadership to promote proper reviewing/coordination of team meetings, patient activities/programs, PI projects, and environmental safety checks/repairs fostering a better patient-centered and safe unit and overall hospital. Proper staffing will also allow for appropriate allocation of resources to support functions necessary in a well-functioning hospital, including infection control, training and education, quality assurance and performance improvement, and other areas that produce vibrant departments involving all staff in the mission of serving patients.

c. Root Cause Analysis - Factors to consider in the current state of Qualified and Supportive Staffing at WSH

Changes in leadership numbers and functions over the years, including more recent leadership months prior to CSM's visit, with a focus toward and reliance upon top down dictates resulted in a breakdown of communication. The lack of stable leadership and understaffing contributed to an inability to meet program needs and impacted staff development, training, and performance improvement that compromised patient safety and quality of care to patients. See Leadership section above for details on this. Basically, discipline support and the care and focus on the patient became less manageable. Staff were no longer being monitored for performance or adherence to policy and practice. New policies were enacted without real enforcement or follow-up. That which is audited tends to be done well, while that which is not tends to break down. Yet, this needs to be done in a thoughtful manner involving all stakeholders, and not just another add on to the demands of direct care and practice. Too often, there were reactive measures and add-on procedures and practices that were not efficient, often not effective, and that served to alienate and overwhelm already overwhelmed staff. This led to less time and energy and available compassion or patients.

Hospital resources directed by the central office have not always proven to be effective when supervision is so far removed from the area of actual work. This is reported to have contributed to difficulties in recruitment and hiring, as well as facility maintenance to cite just a couple of examples.

Noncompetitive salaries have led to recruitment and retention problems and resulting vacancies, exacerbating the impact of budgeted staff reductions over the years. This combined with an aging staff with potential for being more settled in their ways, less energetic and resilient to overwork, and moving toward retirement produced another perfect storm at a hospital already beset with problems and challenges.

Lack of control over the civil admissions and difficulties in discharging patients has caused large waiting lists to be admitted (averaging about 150) and a large list to be discharged (averaging 100+). This not only stresses the hospital's resources, but affects staff motivation. Patients and staff alike need to see success and progress. An institution where patient movement is almost static leads to a lethargy and loss of incentive to keep trying, and this

was found in interviews with both groups. In touring units in both South Hall and Central, when asking staff about patient movement the responses were “one or two a month” and “a couple left recently, one more is scheduled this month.” There is an attitude of resignation often found in long-term correction programs or long-term care or nursing homes; a programmatic focus more on custodial and even warehousing efforts than rehabilitative.

Rehabilitation staff reductions led to the increased size of mall groups with fewer staff available in groups, as well as diminished and disrupted on-ward active treatment efforts. This has led to problems in tracking patients between the wards and the Recovery Centers, as well as mall assignments not fitting patient needs but patients fitting into the groups that are available.

d. Recommendations for Improvement

The state and the newly implemented leadership team have already begun some notable initiatives. There were at our initial visitation and since been salary adjustments for professional disciplines, commitment of resources for additional nurses, and engagement of experts to offer guidance and assistance with determining optimal staffing patterns for effective care. These are all positive steps in building a stable and effective workforce at WSH. When these efforts bear fruit, it will be more effective if the structure and culture of the hospital is already moving toward one of increased safety, focus on effective and comprehensive care, and greater staff accountability. Some specific recommendations include:

- **Fill psychiatric and other physician vacancies and develop better engagement of this group.** The hospital uses many locum tenens, but it needs a fully, permanently staffed and well trained Psychiatry Department and Medical Services Department. The new Chief Medical Executive displays a vision for the future that is honed by an awareness of the current state of the art in his discipline and use of evidenced-based practices. His challenge is to effectively lead the medical staff to partner with the hospital leadership, integrate new standards for care, and work as a team. By report and observations, the present group has felt disempowered, unable to adequately cover home units while covering for other units, feels burdened by other necessary administrative tasks (e.g., membership on various clinically-focused, etc.). The CME’s plan for piloting contract psychiatric staff for NGRI evaluations is one example of some new ideas that can move this organization toward better medical coverage. It would serve to better allocate regular staff resources to patient care, allow for an infusion of new energy, and serve as a means of moving staid practice patterns in new directions. Such efforts are difficult to implement with an overwhelmed and understaffed group of medical professionals. These and other initiatives will be needed going forward.
- **The hospital could pursue an affiliation with a University/Medical school to train residents and with colleges for psychology, social work, and rehabilitation interns.** Some of this is happening in psychology, and there was a prior connection to

the University of Washington's Medical School. Interns can extend staff numbers and infuse into the Department/facility an enthusiasm to both teach and learn. It keeps staff up to date with their fields in order to mentor effectively. It can also provide a new resource for recruiting future staff.

- **Review on-call pool/float nurse allocation and assignments.** Consider moving on-call nursing to regular staff assignments, since this can better use the resource of the pool nurses to fill vacancies on the wards. The increase of staff familiarity with the ward routine and assigned staff and patient population will increase patient safety and quality of care. Nursing management needs to be collaborative in searching for solutions to operational issues by engaging the nurses and MHT in the process, as is consistent with Lean methodology. Visits to other psychiatric facilities for best practices could knowledge and give staff a renewed enthusiasm about their role in this hospital.
- **Nursing recruitment, retention, and satisfaction needs improvement.** The staffing scheduler process should be reviewed for efficiency. Nursing leadership must insure that there is no favoritism, and that the needs of units comes first and not just filling openings. We heard many reports that nursing staff were moved to other units to fill a need, but they could have been kept on the same unit for a similar need. Nursing retention and recruitment is a critical issue for the hospital in providing consistent quality care. Salaries and job satisfaction are important to this issue, as the cost of recruitment and training is enormous. As staffing improves, it is imperative that staff utilize their vacation time regularly. It is both a staff satisfier and a vital for better performing staff. The department must continue and expand upon its efforts to seek out nursing programs, form affiliations with nursing schools, initiate job fairs, provide sign-on bonuses to compete with community hospitals that do the same, etc.
- **The MHT staff are one of the core unit-based staff, closest to the patients every day and providing assistance with their basic needs.** Along with nursing, they are the only group that is regularly on the units 24/7/365. By report, their morale is low and over the years more and more of their salary has gone to pay for benefits. This staff is under pressure to work increased overtime hours, often working double shifts. Sometimes, when over worked, staff can lose focus and the care of the patient diminishes. Nursing leadership must ensure a sound work force at this level. The MHTs know the patients well and are aware of the problems that the patients have, individually and collectively. Involving them in planning efforts for improving the future of the hospital is imperative, as good management practice and Lean methodology espouse. A two-way communication with these employees will be vital to good patient safety and recovery.
- **Ensure optimal functioning of the Recovery Centers.** The mall programs serve a large group of patients and are a resource that needs to be supported with the appropriate numbers of trained staff. It is at the forefront of current models for inpatient psychiatric care, since it serves as movement toward community-based

programming methods. It involves more options for choice, the opportunity for more variety, and provides more natural socialization experiences with others. Regular assessment of the mall process is needed to maintain a high level of active treatment, treatment needed and wanted by patients, and higher levels of patient satisfaction. Efforts to expand beyond the malls to other campus activities and programs, as well as community-based programs are needed. There have been unnecessary and detrimental reductions of these normalizing steps and opportunities. This must also be factored into the individual plan of care and utilizing Rehabilitation staff in the process of planning and designing programs. The reduction of Rehabilitation staff affected the active treatment on the wards. Program evaluation efforts and performance improvement initiatives are needed that involve all stakeholders in the same review process to ensure that the on-ward programming is given the resources needed. The Center Directors should lead this evaluation along with the Rehabilitation Director and with input from the treatment teams and mall staff. It is also imperative to have adequately supplied rehabilitation, recreation, and ward-based activities. Building a team to review necessary equipment and supplies can engage direct service staff in the process of rebuilding the programming at WSH and also serve as interdisciplinary team building.

- **Optimal allocation of resources is needed.** While doing a staffing analysis is a critical part of the WSH “makeover,” the answer will not just be found in increasing or decreasing specific position allocations. Utilizing staff effectively can be more profound in changing a culture than just adding staff alone. Interviews and subsequent data reviews demonstrated that up to 60 staff per shift are often engaged in providing 1:1 close observation of at-risk patients. The leadership has recognized that with a decrease of management focus and subsequent loss of accountability by staff, these 1:1 assignments were not being reevaluated for necessity. This level of care has routinely been assigned to as many as 7% of patients in the Hospital. Our review indicates that outside of some private specialty institutions, the average percentage of patients on 1:1 observation varies between 2 – 6%. Were Western State to reach an average of 4%, it would mean as many as 24 staff would be freed up to assume other critical patient care activities.
- **Team building within units and between treatment disciplines is needed.** It was noted repeatedly in staff interviews and meetings with Center/Discipline leaders that there are rivalries and tensions between staff of the different specialties. Issues of respect and territoriality for providing assessments, therapy, and leadership in planning care were all voiced. There is often some tension between disciplines, but it is magnified in an organization under duress. Leadership must provide the structures to build teams around a common purpose of treating patients and running a quality institution.
- **Related to team building is the need for leadership that integrates the disciplines at the ward/unit level.** The organization’s leadership has suffered like the line staff in becoming overstretched and even absent in parts of the organization. Currently, the

discipline leaders for Social Work Services and Director of Psychology Services also serve as Center Directors. Discipline leadership is necessary from a scope of practice perspective, supervision, and training. However, the Center Director role is more focused on overall unit functioning across disciplines. These positions should be separate. In addition, the Centers need a layer of supervision and management at the unit level to further support multidisciplinary efforts and unit operations at the most local level. Reporting up to the Center Directors, unit leaders will better monitor, support, and hold accountable all unit-based staff for their roles in treatment and unit operations:

An anticipated technical resource to come is the Electronic Health Record currently in development. This critical tool can contribute to improved and more efficient clinical documentation, support safety and performance improvement efforts, produce more reliable service delivery, and promote regulatory compliance. The focus of WSH's participation in the development of the EHR is crucial to its success for the hospital in the future. Leadership must support that participation with dedicated staff knowledgeable in unit operations and requirements to ensure the system is built based upon the processes that WSH needs to have in place for quality and safe patient care.

5. Staff Training and Education

A competent and well-trained staff is the core of any medical service, be it medical/surgical or psychiatric/behavioral health. This is even more important in the behavioral health field, where there is less use of the instrumentation and technology than found in other medically-related services. The core vehicle of treatment becomes the individuals on the treatment team; their personal attributes combined with the skills developed in assessment, delivery of services, communication and presence, as well as understanding and adherence to policies and processes aimed at delivery of care in a safe and therapeutic environment. Training and education impact all aspects of a quality healthcare program, intersecting with the quality of services staff provide, safety and promulgation of patient's rights, and efforts at improving processes all ultimately impact treatment outcomes.

From an organizational perspective, it is incumbent upon WSH's leadership to ensure the correct people are being recruited and hired. These quality staff must then be initially oriented to practice at the hospital, trained and retained, and they must be supported in their work to deliver safe and effective services. Skill development and training needs to consider the patients being served now and as they might change over time, using the most appropriate evidence-based practices, and adhering to standards of care as determined by research in the field that inform regulatory standards. All organizations must modify their practices to meet the actual needs and responses of their patients, so ongoing performance improvement efforts are needed to audit current functioning and modify interventions to improve processes and outcomes.

a. The Current State of Training and Education at Western State Hospital

As cited in the reports from the three CMS surveys undertaken during the fall and winter of 2015-16 at WSH, there were multiple areas of concern that are either a direct or indirect result of staff competencies and the outcome of training efforts that had fallen short of meeting the organization's needs and industry standards. Our interviews with staff and patients at WSH, and our review of applicable policies, plans and data/records of care served to confirm the findings of the regulatory surveys. While leadership, governing body standards are implicated in all the negative findings, this section will focus directly upon training and education efforts and the impact on delivery of care processes.

CSM's finding during our site visit confirms CMS survey findings that WSH lacked thorough and ongoing education efforts across all staff. This likely contributed to a breakdown in clinical service delivery and outcomes. The staples of training and education such as annual mandatory competency reassessments and training had diminished or were no longer being completed. An example were the Nursing Competency Fairs, which were regularly scheduled days where nurses and direct service staff of the units could refresh core competencies through education and demonstration, as well as be trained in new, updated policies and procedures. This can lead to deterioration in skills and practice, as poor habits or forgetfulness can take hold in daily delivery of service. Annual mandatory education requirements for most, if not all disciplines, were not being completed or even scheduled each year. It is also notable that new policies and practices were being transmitted to the line staff through memos or written standards, but without opportunity for dialogue and clarification. These practices were then not audited adequately to ensure understanding and proper implementation. The net result was an inconsistent application of practices both between different staff and different units.

The impact of the above deterioration of an organized and monitored education program was seen in the following areas of service delivery, all receiving citations during the three CMS surveys:

- **Clinical documentation of treatment (B103):** Staff were not documenting the services they actually did provide or the specific interventions made. A lack of any documentation or poor documentation leads to a perception that many activities are not being completed even when services were rendered properly. As a legal document, this is more than a perception, since the old adage is true: "If it's not in the chart, you didn't do it."
- **Treatment planning (B122, B125, B148):** Staff not following through with this function as required by policy and standard, as well as not demonstrating proper development of goals, objectives, interventions, and frequency. Treatment plans were regularly very general and vague with few clear goals or measurable objectives, and they were not regularly related to diagnostically-related symptoms and level of functioning issues. Even when these were adequate, the actual practice of providing

identified treatment to address these issues were often not as directed, needed, or wanted. Levels of active treatment by the simple metric of hours provided were often deficient too.

- **Proper adherence to standards for the application and monitoring of restraints (A175, B144):** Staff were not properly monitoring and/or documenting the outcomes of their oversight of patients in restraints. This was found across disciplines involved in this from nurses to physicians.
- **Infection Control (A247):** There was reported lack of compliance with hand hygiene and issues of completion of TB screening and direct patient care processes.

On a general level, issues of staffing and the usability of the medical record also contribute to the above noted shortcomings and will be further discussed in terms of root cause analysis and further recommendations.

b. Target for the Plan of Correction for Training and Education at Western State Hospital

The ideal outcome of the corrective action plan is to have a structure and process in place that facilitates adherence to standards for ongoing education and training. It needs to ensure that regulatory requirements for annual mandatory updates (i.e., 100% of staff completing required annual education), but also delivers training on new policies and processes that are developed. Education efforts need to be data driven, evidence-based, involving all stakeholders, and provided in a manner that fosters learning and follows with audits to ensure that learning is translated into appropriate practice. Corrective actions to retrain staffs that are unable to demonstrate required practice need to occur in a timely fashion. This will require an appropriately staffed and trained Education Department and/or other efforts that are properly overseen and accountable to Senior Leadership. Technology can be of assistance in both the monitoring of education efforts as well as staff success in adhering to good practice standards. Ultimately, a well-designed electronic health record can create effective shortcuts to build in means of clinically appropriate documentation and make auditing of results more accurate and easily obtainable. Lastly, units must be staffed adequately and consistently to ensure all disciplines are able to devote the necessary time and energy to their specific roles in patient care and documentation, as well as participate in the functions of multidisciplinary treatment.

c. Root Cause Analysis - Factors to consider in the current state of Education and Training

As introduced in the prior sections, the factors leading to the breakdown in training and education can be categorized as a function of leadership and organizational structure; problems in daily operational functioning, and a lack of detailed monitoring and oversight within the responsible departments. While issues of adequate unit-based staffing and

consistency of said staff are critical to the success of the operation, these are better addressed in full in other areas of this report. The same can be said for the tools and technology that can lead to more effective treatment documentation and ultimate monitoring through more complete and reliable electronic means. What we can focus on here in more detail are the structure and processes within the hospital's training and education efforts. Some of the critical problematic factors discerned through the site visit, document review, and interviews are as follows:

- **Loss of focus in the process and importance of education for staff.** Through a series of leadership changes and a focus on daily operational difficulties requiring immediate attention, the standard of operations has become more akin to putting out fires rather than building a structure that is more fireproof. When there were daily issues of violent assaults, issues of missing patients, mistakes in care delivery, and problems in covering basic unit structure and treatment services; the system responded through reactions to each event rather than a systematic review of causes so a detailed response plan could be created. To some degree, leadership and thus direct and indirect service staff became reactive to years of budget deficits and cost cutting, attempting to do "more with less" when in reality it becomes doing "different with less". Rather than working to make those differences organized and effective through analysis and prioritization, it became more of a culture of cutting corners, taking shortcuts, and subsequently reacting to the negative outcomes of those actions.
- **Structure and resources for training and education.** As currently comprised, the Staff Development is primarily responsible for the development and oversight of training and education efforts, with a Coordinator, a team manager, one trainer, and two RNs. Staff Development is within the Quality Management Department, reporting to the Director of QM. There are a few positions in Nursing that provide training/education support, including an ARNP, three clinical nurse specialists, and a nurse educator. For a facility with a present census of 825 patients served by over 2000 staff, this training complement is minimal. It has become difficult to develop and implement the range of required and clinically necessary training due each year much less work on specialty programs to address discipline specific needs of such divergent groups as physicians, nurses, allied health professionals and the range of rehab, tech, and counselor staff roles. During staff interviews there were numerous references to the dissolution of the Nursing Training Fairs and lack of training noted by such disciplines as social work and psychology. This does not even touch on education requirements in healthcare to support staff engaged in facilities and environment of care roles as well as other indirect support functions. The reporting structure within Quality Management is oddly placed, even if underscoring a focus on performance improvement. Ultimately, we saw little evidence of ongoing training beyond New Staff Orientation (NEO).
- **Breakdown of oversight functions.** Loss of positions within the hospital over the years not only impacted direct service through cuts in staffing and vacancies, but also led to a breakdown in organizational leadership structure. The lack of middle management at the unit level leads to gaps in training, enforcement, monitoring, and mentoring/coaching for improvement. Middle level management support is integral to

the success of staff training and education. As leadership was consolidated in more complex and removed ways, the degrees of oversight became too broad to allow for adequate supervision and intervention. Thus, when new policies and reeducation was being done, the ability to ensure proper rollout was not available in a consistent and direct manner. Many dedicated staff were met during unit rounds and questions were raised as to the inconsistent application of policy and procedure, as well as the need to just make sure the basics were completed during the shift. In addition, the State's Learning Management System (LMS) is not structured in a manner that would facilitate leadership oversight of educational compliance. Only an employee's direct supervisor can access education records and leaders up the ladder are dependent upon their direct reports auditing and interventions. There are no summary reports provided or available to Center or discipline leaders.

- **Disconnect between leadership and staff.** Budget cuts leading to staff reductions, constant changes in leadership and structure and sometimes arbitrary top-down dictates in response to operational issues has led to a mistrust of leadership by staff. This was reflected in staff interviews as well as the results of staff surveys, as in the 2016 Culture of Safety Survey where staff did not express belief in leadership commitment and follow through. With regard to training and education, it was notable that allied professional staff in particular expressed lack of buy-in to policies and practices, feeling that the staff could have provided valuable input from their experience in day-to-day operations that would have contributed to a better plan and more compliance with the new processes. In the most dramatic instance, it was expressed as follows: "If we don't believe it is the right thing to do we just ignore it." This speaks to a disconnect as well as lack of oversight and monitoring.

d. Recommendations for Improvement

Before discussing recommendations specific to training and education, it is necessary to note that the state's initiative to enhance staff retention and recruitment through salary adjustments as well as the approval of additional clinical positions is a vital positive step to improve all aspects of the organization's performance. Having adequate numbers of dedicated staff in the right positions will contribute to improved attention to proper processes by the staff and lead to better compliance with training efforts aimed at a better quality, safer workplace. Having adequate numbers of staff will also allow for coverage in order to better complete required annual education. It may also allow for some adjustment for staffing assignments, allowing on-call staff to be moved to specific unit assignments or at the least be limited to just two or three float units. This will positively impact such staff by enabling them to learn the processes and protocols specific to just one or a couple of units, preferably within one service type.

Specific to training and education our recommendations include the following:

- **Improve the focus on staff training and education.** Leadership must support the structures devoted to this function, advocate for and provide for necessary resources, and through organizational governance and leadership processes demonstrate

attention to all the relevant aspects of staff training and development. This includes the use of data to monitor that necessary training is happening, as well as making performance improvements as issues related to training, skills demonstration, and related areas are found to be deficient. Consideration should be given to of a realignment of education and training with greater clinical involvement and oversight, and greater oversight by leadership.

- **Build a better leadership-staff partnership.** As noted above and in additional meetings with physician-based and other union leadership, all disciplines and staff are looking to be involved in the direction and future success of Western State Hospital. All stated the common plea of “let us provide some feedback and input to leadership.” This is a positive desire that needs to be embraced in line with Lean ideas of involvement by those providing direct work in the organization, and such involvement will serve to enable better buy-in to any policy or procedural implementations and to improved performance. Leadership can facilitate this process directly through education-focused efforts aimed at initiating such a dialogue. This can begin with educating staff throughout the organization on the systems issues at play that are impacting the successful operation of Western State Hospital as a treatment facility. This can create a strong advocacy group to impact state policy and resource allocation, as well as help leadership and staff to move in the same direction. A secondary step in this process is building the alliance with staff through a cooperatively established restating of the hospital’s mission, vision, and values. As these are restated and reviewed with all, they become a foundation for New Employee Orientation efforts as new and additional staff are brought in, and in re-engaging already existing staff. Since the collective bargaining agreements cover the vast majority of employees, providing a process of feedback and opportunity to propose alternative ideas on major initiatives instead of making it an issue of contention.
- **Extend this communication effort to the mission and content of staff training and education.** Involve staff in identifying needs for further training, use their expertise in developing and refining training, and help them to create a Staff Development Department that meets the needs of all staff and therefore of the entire organization. Things to consider from an expanded and more diverse department that goes beyond “the basics and mandatories” are such ideas as:
 - Make some aspects of education more mentoring oriented, less didactic
 - In similar fashion, more training would take place on units and less in classes
 - Build better teams through staff assignments and training on collaboration
 - Train staff in leadership skills
 - Offer Grand Rounds and some in-house CEU programs. These can be targeted to specialty disciplines such as psychiatry, social work, psychology or rehabilitation and may require some investment in outside trainers.
 - Restore the Competency Fairs and enhance staff opportunities and methods to complete annual education requirements.

- **Ensure training in areas of noted gaps.** As noted from the CMS surveys and our site visit, a dedicated training effort is necessary in critical areas cited in the findings. These include:
 - Treatment planning: a collaborative decision with staff should be made on a documentation format that meets all required areas and then subsequent training on developing writing effective plans.
 - Restraint and seclusion monitoring: education on all regulations and internal policies on parameters to monitor and assess and how to document outcomes.
 - Teach effective charting skills to demonstrate clinical interventions and outcomes related to goals/objectives. As with the treatment plan process, a decision can be made on a charting format based on best practices in the field (e.g., SOAP, DAP, and others).
 - Training on safety in the work place and therapeutic communications, crisis de-escalation. Again, staff input may be critical to getting support for any new programs in this area.
 - General training on safety and infection control processes for all staff.

- **Improvement of oversight of training and education compliance.** A training and education/development program is only as good as its effective rollout and utilization. To the degree that programs at WSH have stalled after presentation and initial implementation, it highlights the need for a level of more local leadership and follow-up. Unit level managerial positions of some type would allow for programs to be more hands-on delivered at the unit level, can better provide for mentoring, can cross disciplines more effectively, and will facilitate more reliable implementation. In addition, such a level of management can improve auditing and data collection. While an EHR, as discussed previously, would allow for even more effective implementation and monitoring of many initiatives, this must be done carefully. As stated in our NRI report, before finalizing any EHR, clear and effective internal processes must be in place that can be translated into the EHR development and rollout. In the meantime, local level management will need to utilize the current system as effectively as possible through a standardization of data entry points and processes. Additionally, the current LMS system will require some reprogramming at the Central level to allow for better leadership oversight of employee education and better availability of data in the form of summary reports (by discipline, unit, educational program, etc.)

6. WSH's Quality Assessment and Performance Improvement Program (QAPI)

a. The Current State of WSH's QAPI Program

Organizational quality or performance improvement programs and related efforts are the hallmark of all modern healthcare organizations (Donabedian, 2005)³. As such, there are

³ Donabedian, A (2005). Evaluating the quality of medical care. 1966. *The Milbank Quarterly*, 83 (4), 691–729. doi:10.1111/j.1468-0009.2005.00397.x

many regulatory and accreditation conditions and standards that address these requirements. There have been a number of findings of deficiency in this area (directly and indirectly) across the various CMS visit reports since late last year, and the SIA requirements include a substantial focus on this area, as noted above. CSM devoted a considerable effort to reviewing WSH's performance improvement programs and initiatives. Various documents were reviewed (including the most recent QAPI plan, minutes of various committees, as well as related minutes and documents reflecting dissemination and use of performance improvement data), WSH's Quality Management leadership and many of its staff were interviewed, meetings of the many committees were attended, etc.

The SIA requires a specific review of the following areas for QAPI (as a minimum):

- 1) continually operates and has adequate resources;
- 2) effectively increases patient safety and improves quality of care;
- 3) sufficiently demonstrates involvement by hospital leadership (including the governing body);
- 4) widely disperses its activities throughout the hospital;
- 5) adequately collects and analyzes data;
- 6) diligently uses data to drive its decision making, including in its processes for determining the selection of tracking measures that comply with 42 C.F.R. § 482.21 concerning tracking, measuring and analyzing adverse patient events; and
- 7) clearly demonstrates the program has a process for developing, implementing and evaluating its performance improvement projects and activities.

Each of these areas will be reviewed separately with a review of findings (i.e., the Gap Analysis), the probable reasons for any problems (i.e., the Root Cause Analysis), and recommendations will be provided.

Any good performance improvement process begins with a plan describing its scope, defining terms, identifying staff and leaders involved in the process, and outlining its processes and procedures around completing its tasks. WSH has developed a detailed plan entitled "Quality Assessment and Performance Improvement Plan 2015-2016—Draft Version 1/15/2016" and it provides an overview of the various performance improvement structures, processes, and directives. It is a detailed 54-page document that provides enough detail to understand the scope and nature of planned performance improvement at WSH across all clinical, leadership, environmental, and administrative areas. The major committees outlined in this document include the QAPI Steering Committee, Patient Care Committee (PCC), and the Quality Council (QC). Members of the CMS team attended meetings of all these committees while onsite, and reviewed minutes of all of these committees since January 1, 2016 to understand the actual functioning and adequacy of these important structures in the overall performance improvement efforts at WSH. In addition, we had various meetings with individuals associated with most aspects detailed in the QAPI Plan. We met with a number of the principals of the Quality Management Department. These meetings included Mark Haines-Simeon, the Director of Quality Management; Dr. Theresa Becker (former

Research Investigator) and her replacement Dr. Selena Jones in the Research, Evaluation and Data Analysis unit; Rae Simpson; various members of the Staff Development unit, including Dan Gapsch, Training Coordinator; Bill Bungard, SAFE Team Manager; Andy Prisco, trainer; an Electronic Health Record briefing with Drs. Jackson, Jones, and Campbell to review the status of the EHR that is being developed for implementation later in 2016 (by report); and Jannah HIMS Manager. Various minutes, documents, and other sources were reviewed during offsite and onsite activities, and staff throughout the organization were interviewed to address, in part, the nature of involvement with and dissemination activities from these overall committees and units to the organization's members.

- 1) **QAPI Program: Continually Operates and has Adequate Resources.** The first component of the first element for review that the QAPI program continuously operates is easily determined through a review of the various minutes of its constituent parts. The various committees outlined in the QAPI plan meet on a regular basis, as evidenced by report of all involved and in reviewing the minutes of the major committees and those that report to them. There has been attendance by core members of all the committees (see more detailed review below on the adequacy and representativeness of attendance) and reports from these committees are sent, reviewed, and documented in various governance and leadership meeting minutes. The second component (i.e., has adequate resources) is more challenging to evaluate. A number of methods will be presented to triangulate on this issue: (a) the organization's delineated staffing model, (b) an internally-generated proposed staffing model with comparison to standards from the field, (c) a comparison to other standard models from the field and the experience of CSM, (d) the "proof in the pudding" standard based on direct observations by CSM around WSH's actual functioning.

A review of the Quality Management Table of Organization (TO) delineates the structure and individual leaders and staff that comprise an important element of the overall QAPI program. The rest of the QAPI structure is filled out by committee structures and processes involving other staff and leaders throughout the organization. In this sense, the QM department provides a service to the rest of the organization around data collection, performance improvement support and expertise, and related processes. The far right side of the TO is related to IT and IT Applications. This was not a major focus of CSM's review, except as the proposed EHR is concerned, and this will be reviewed later in the document. Even a cursory review of this TO will show a number of concerns regarding adequacy of resources. First, there are a number of important vacant positions, some newly filled or refilled positions, and a number of oddities about components in this department that might serve to detract from its mission. This is problematic for any organization, but especially for one that is experiencing significant problems. All proposed and vacant positions need to be filled to meet even a minimal definition of "has adequate resources." A detailed review of the job descriptions, present personnel qualifications and experience, and related issues was not attempted during this initial review of WSH. A general examination does not suggest any significant deficits, but any proposed changes

should include this to ensure appropriate skills, experience, and alignment with present and future structures or restructuring.

During onsite interviews with the Director of Quality Management, he was asked about his impressions on the adequacy of the department. He presented a draft proposal that he had developed on this, and it suggests a substantial level of deficiency between its present structure and staffing levels and what he feels is an acceptable level of staffing. His analysis shows a “point of reference” to Oregon State Hospital, which cites a capacity on its two campuses of 620 and 174 patients or a total of 794 patients⁴, making it smaller but in the same general range in size as WSH. Oregon State Hospital has a reported staffing level of 24 FTEs for its Research Staff, Performance Improvement, and Compliance units. This document proposes an increase from 13 to 17 FTEs. The proposed numbers and analysis are reasonable, although the recommended levels of increase are rather modest, but this is a clear step in the right direction. Again, even filling the vacant positions would help, but more is clearly needed. Several members of the CSM team telephonically communicated with the Superintendent of Oregon State Hospital, Greg Roberts, to review this information and to gain additional perspective on their efforts.⁵ He indicated a smaller number than 24; namely, 12 Lean Leaders, plus 4 Data Analysis Staff, plus the Director for a total of 17 FTEs across the two facilities. He also indicated that the main site has about 600, while the other site has a capacity for 175, but that only about 75 patients are there at this point. The Lean Leaders are thoroughly trained in Lean methodology, are distributed throughout the hospital and are considered mentors to the programmatic areas they work with to assist in developing, monitoring, and modifying performance and quality initiatives. The Data Analysis Staff are experts in data analysis and presentation functions, but work actively with the Lean Leaders and their areas to improve functioning. He noted that all staff, from housekeeping to maintenance to direct care staff and elsewhere are trained in basic Lean ideas. This more detailed information suggests a staffing and level of training that is substantially higher than is currently in place at WSH or as proposed. Lean is also embraced by WSH, but the efforts described to prepare the entire organization at Oregon State Hospital and the use of outside expert consultants over years is a far cry from what is happening at WSH. Greg Roberts indicated that the successful changes at his facility would not have occurred without this level of investment.

The idea of comparison with other standards for staffing QAPI-type programs was already broached above with a review of the current Director of Quality Management’s outline for proposed staffing levels. CSM has been involved in working with a number of state hospital systems, as well as other behavioral healthcare programs. It has been our experience that there are a wide-variety of structures and staffing levels, but that quality programs that experience few Joint Commission, CMS, or other oversight-identified deficiencies have significantly

⁴ <http://www.oregon.gov/oha/osh/Pages/about.aspx>

⁵ Greg Roberts (personal communication, July 28, 2016)

higher staffing levels relative to their size than does WSH. Additionally, a pure metric of patient and/or staff numbers to FTEs does not do justice to the unique issues at WSH. Its large size, old campus, lack of an EHR, and chronic history of underfunding and ongoing problems factor together to demand a higher than average level of staffing in and around performance improvement programs. There is little literature on this, but a 2008 article in *Quality Management in Health Care* provides some interesting survey data⁶. They used a simple metric similar to what was alluded to above: # of Patient Beds/FTEs. There was not an adequate response rate or full responses to the survey, but the range was from 1:17-1:117 with a 1:58 average. At the time of our visit, WSH had approximately 850 patients, and using the 13 current to 17 proposed FTEs, we get a 1:65 to 1:50 staffing level, respectively. In our view, 5 FTEs for Staff Development should not be put into the mix, since we have seldom seen this in our experience, unless it is focused on training around quality or performance improvement (and it is not at WSH). Removing them from the mix reduces significantly the number of FTEs devoted to quality improvement at WSH to 1:106 currently and 1:71 as proposed. More practically, the program only has a director, Compliance and Standards Manager, a Performance Improvement Manager, and four (4) staff in Research and Evaluation and Data Analysis (one very new and one since the first of the year; and not of the same level of training). The remainder of the staff are risk management, the aforementioned Staff Development, one policy person, and IT staff. This reduces to a ratio of 1:106 noted above, and this is far below the levels at Oregon State Hospital which are 17:675 or 1:40. The level of training and focus is not close to being equivalent across the board between the two hospitals. Greg Roberts (personal communication, and noted above) indicated that it took years to fully develop to the level and functioning it has now (he began in 2010 and reported a facility in similar disarray).

Finally, we can review the “proof is in the pudding” perspective to evaluate the adequacy of QAPI programs at WSH. The QAPI Plan identifies a number of organizational committees devoted to quality improvement activities. There is an oversight QAPI Steering Committee, Medical Executive Committee and its Patient Care Committee, and the Quality Council. A number of other committees, departments, and individuals report to these various oversight committees. Various members of the CSM team attended all of the oversight meetings, and there was subsequent on- and off-site reviews of minutes from these and other committees from the first of 2016. Overall, the plan seems fine by design in terms of covering important and required areas, but it is unwieldy in its complexity and many parts. In actual practice, the unwieldiness of the plan was more evident in what appeared to be a lack of clarity of purpose, significant overlap of purpose and review, and many leaders and staff being members of the various meetings.

⁶ Perry-Ewald, J. (2008). Q: How many quality professionals does it take to support a hospital?
A: It depends. *Quality Management in Health Care*, 17(4), 341-348.

During onsite observations, CSM was able to directly observe the operation of the central committees that comprise the QAPI programming structure. Offsite review of these and reporting committee minutes provided additional information and insights. In a review of six (6) months of meeting minutes for the QAPI Steering Committee, there was generally good attendance by key leaders and staff, although there were regular absences by some and a lack of all Center Directors attendance on a regular basis. Much of the work over this period of time was devoted to CMS surveys and various POCs for citations from CMS. There was not a clear and consistent documentation of follow-up of items identified in prior meetings. There is more a sense of reactivity and patchwork efforts versus a clear focus and vision that would be expected from such a steering committee. Some of this is understandable with the many surveys and findings and a focus on attempting review and address POC demands, but it also means that the organization was not able to plan for more substantial change efforts that are needed. In a review of six (6) months of Patient Care Committee (PCC) meeting minutes, a number of trends were obvious. The CEO or designee was virtually never in attendance, the representative of Center directors was frequently missing, the Quality Management Director regularly missed, there was essentially no updates regarding social work, psychology, rehabilitation, or PTRC. Other areas were more intermittently addressed, and the most consistent areas of review were consumer affairs, pharmacy, nursing, and medical services. Even the most regularly updated did not always provide much information at times. The Quality Control (QC) Committee minutes since the first of the year were also reviewed. Attendance and representation across programmatic and other areas was better with this committee. There were isolated absences from time to time, but no substantial problems were identified. This appeared to be the major workhorse committee of the organization, with the range of issues reviewed and the frequency of ad-hoc meetings completed to deal with immediate CMS findings. RCAs and other related issues were regularly reported here. There was substantial data and reporting to this committee, although full compliance with performance improvement processes is not fully evident in the minutes or during observation. The full QAPI plan was unveiled to this committee on January 13, 2016. Then new PIP Manager was introduced on February 17, 2016 and more regular reporting of PIP projects did not show until mid-March, 2016. There were repeated identifications of problems with various PIPs from getting volunteers for these projects, to a lack of clarity on their purpose and focus. In fact, there was a notation during the June 22, 2016 minutes that there has been little guidance on PIPs and project groups are frequently unsure of direction and how to proceed. This is consistent with interviews and other document reviews by CSM. A full review of the charter for these committees was not completed, but even this cursory review shows what appears to be significant gaps in one of the primary committees in the QAPI plan. A review of six (6) months of various committees that report to either the PCC or QC committee included the Mortality and Morbidity Committee, Pharmacy and Therapeutics Committee, Infection Control Committee revealed regular meetings, generally good attendance (less so for IC, which had more regularly excused members and some meetings without physicians present), with a focus on data and analysis. One can see reports

of these committees up through PCC and/or QC, but there is no clear use of full performance improvement methodology reflected in the minutes or other documents reviewed, except for the P&T Committee. Much more of it is narrative and impressionistic. Some of this is warranted, but there is little of the Lean methodology focus that the QAPI plan identifies and CSM was told were the basis of quality improvement efforts.

The functioning of the committees is more obviously problematic. The problem was the amount of work confronting the committees as clearly evidenced when sitting in on their meetings. Much of the focus was on more basic or preliminary design and analysis efforts that would seem better done by staff supporting the committees or at times prior to the committee meeting. Much of this more regular work has been swamped by a focus on voluminous reports and tracking documents related to various plan of correction initiatives devoted to ongoing CMS findings. The ability to be a data-driven organization using performance improvement ideas has often devolved into more of a quality assurance approach that is constantly focused on Band-Aid efforts that serve to strain the resources at all levels of the organization in filling out another tracking form for another isolated issue. The work never gets fully done, it is followed up at the next meeting or an additional meeting, and other efforts or demands accrue over time to never allow for reflective and considered efforts to improve the organization. In general, the correct data is being collected around required data, but it remains more of the old quality assurance process of reams of data collected over time, but without the time and resources available to review them, make appropriate quality or performance improvement efforts, and check for needed change over time. In addition, this data seldom seems to be communicated below these higher level committees with enough regularity or in an appropriate manner to make them useful at the front lines of care to improve organizational operation. Staff interviewed throughout the organization were either unaware of such information and efforts, did not have time to review it or use it, and/or felt that it was another onerous demand on top of already overwhelming demands to take care of immediate needs of patients. There are few, if any, middle-level managers in the organization to take responsibility for overseeing their areas from a quality improvement perspective in sending up issues or receiving information related to their areas to make improvements. Survival mode is the modus operandi from all reports by staff.

- 2) **QAPI: Effectively Increases Patient Safety and Improves Quality of Care.** By definition, the series of findings by CMS over the last year suggests a pattern of organizational behavior that is contrary to effectively increasing patient safety and improving quality of care. Many organizations have findings stemming from CMS (or Joint Commission) surveys, but the number, pattern, and inability to ultimately correct these and others uncovered in follow-up surveys underscores WSH's inability to ensure basic levels of standards compliance. Ongoing improvement under this set of circumstances is unlikely and seldom possible. Quality or performance improvement efforts in the service of increasing patient safety and improving quality of care are fundamental elements in modern healthcare. The findings of CMS were

again substantiated during by the Compliance Team reviewed latter in this document with little variation across standards or conditions of participation. On some levels this is not surprising, since there had been little change in the organization since the last onsite surveys by CMS in February 2016 and reported on in March 2016. Those changes that were made, although significant and to be addressed later in this report, had too little time to make any meaningful difference. That said, interviews with staff and leaders showed that there was an expectation that change efforts had been made to attempt to address the findings and improve the organization. CSM observed some of these in various documents that showed instituting of audit processes following efforts to train/retrain staff on old or revised policies. As we have addressed elsewhere, the organization has substantial staffing and leadership position deficits that make any deep and stable changes unlikely to be made or maintained. Even the best quality improvement efforts cannot be designed, implemented, tracked, and modified without direct care and other staff available and able to make the changes happen. WSH hospital has significant deficits in the Quality Management department to assist in this, and there are even more serious deficits in the rest of the organization.

A Plan of Correction (POC) for previous CMS findings was submitted on February 11, 2016 to include a focus on surveys completed on October 28, 2015 and November 5, 2015. The subsequent surveys by CMS shows that these efforts were not successful in addressing QAPI-related CoPs that had been previously found. WSH's efforts to implement the promised POC, which was largely overseen by the Quality Management Department, were unsuccessful. During onsite and offsite interviews and document reviews, it was found that there had been some efforts to identify issues in a consolidated tracking document identifying findings across all surveys over from 2015-2016. Despite this, it is evident that much of the progress was only made in the column named "Need Clarification on Items." The column identified as "WWW: Who is the owner – who will take action? When is a response do back? What action is needed?" was not completed, although there had been some reported progress in initiating this. No formal documentation was found on this. The CSM team was onsite from June 2-10, 2016, so there was little time for changes from this tracking form. Thus, the CMS findings of deficits in the overall QAPI program are essentially identical with our findings. There were consistent reports across various staff that the preceding CEO had interfered with proper up and down communication across the entire organization in direct and indirect ways. This impacted the QAPI process in a few ways. First, there was an inability (maybe even unwillingness) to address the data and plans from QAPI in meaningful ways. There was a reported micro-management style by the CEO that did not allow for proper chain of command delegation or eventual ability of information from those lower in the organization to impact senior leadership. The lack of attention to or inability to address staff and other infrastructure problems led to an organization that was repeatedly struggling with meeting basic functioning demands. The ongoing struggles with addressing Joint Commission and then CMS findings served to swamp an already overwhelmed organization, and particularly the Quality Management Department. More on this will

be provided in the root cause analysis and recommendation section later in this document.

A review of ORYX Data provides another method to review whether the QAPI program contributes to greater patient safety and quality of care. WSH has been involved in Joint Commission accreditation processes until its recent decision to suspend this. Thus, they have been required to participate in ORYX HBIPS Core Measure Set data collection and submission. Until January 21, 2015, there was an "Accountability Composite Rate" across all the required measures that related to a specific standard under Performance Improvement. It was suspended, but it is still provided for information purposes. In the past, a rate of below 85% on this accountability composite rate led to a determination of noncompliance. For discharges from 2Q2013 through 1Q2015, WSH's rate was 62.7%, and of the total of 15 measures reviewed (of which 4 factored into the accountability rate), 13 showed undesirable results. For 1Q2014 to 4Q2015 the accountability composite rate was 68.8% and 14 measures were undesirable and 2 desirable. For 4Q2013 to 3Q2015 the rate was 65.6% and 14 undesirable and 2 desirable. From 3Q2013 to 2Q2015, the rate was 63.9% and 13 undesirable and 2 desirable. These results suggest a pattern of problems across measures and across significant time periods. Overall, there has been no meaningful improvement in these areas and this reflects a chronic problem in maintaining patient safety and quality of care.

NRI was also able to provide some additional customized data that provides further information on these issues, specifically around injuries, assaults, and elopements. This analysis provides additional patient-level data not included or required in the above ORYX core data submissions. This allows for a drill down to the nature of issues, the unit, etc. This can allow for a more focused performance improvement efforts reflective of unique issues at WSH. Since there is generally not nationwide comparisons available, one cannot tell how WSH does in comparison to other organizations, at least in most cases (the exception being elopement and WSH's rate was higher than the average at .00046 per inpatient day vs. .00012 in other participating facilities). Yet, it can be used to track progress in reducing safety-related issues. The one comparison rate shows problems vs. comparable institutions, and there is no clear evidence that WSH uses this unique data for performance improvement initiatives, despite having the data available and sending it to NRI.

CSM did not perform any additional in-depth assessment around safety and quality of care data analysis, since the picture was already quite clear. Yet, the data from the ORYX and NRI analyses (some identified above and some later), and those from the organization itself suggest significant and ongoing problems. In particular, a review of minutes and other reports from WSH reveals ongoing problems with the Level 3 PIPs identified in the most recent QAPI Plan for focus during 2016:

- reducing quarterly rate of assaults
- reducing quarterly restraint and seclusion episodes

- increasing active treatment hours
- reducing patient to staff assaults
- review of adverse events
- increasing the culture of safety.

There were problems with improving rates, lack of clarity in what was being addressed, difficulty finding and verifying data in the charts, and problems in deciding what to do.

- 3) **QAPI: Sufficiently Demonstrates Involvement by Hospital Leadership (including the Governing Body).** This area was extensively cited and otherwise implicated in the various CMS findings based on surveys from 2015-2016. The WSH QAPI Plan 2015-2016 was not adopted by the WSH Governing Body until 10/30/15, yet it shows a Draft Version date of 1/15/2016. It was not reviewed until 1/13/16 in the QC Committee, a central committee outlined in the plan. Thus, we see some level of governing body involvement, and minutes show that the Quality Director, Mark Haines-Simeon, was at various meetings of senior leadership, and information was presented to various leadership groups. Senior leadership individuals were regularly involved or attended the QAPI Steering Committee, PCC, QC, and other committees. Yet, there is obvious disconnect between what is on paper and may even have been documented on presentation of plans, information, and analysis at committee and other meetings; and a modern-day quality improvement driven organization. It is as-if we had the organizational equivalent of the neurological split-brain research with the left side not knowing what the right side is doing, and vice versa. WSH is an organization covering many of the bases, but unable to connect them in a meaningful, proactive, and productive manner. As noted in many places above, there is a strong reactive nature at all levels of organizational functioning, particularly with regards to leadership and specifically related to quality improvement efforts. By report after CMS's onsite visit, a re-organized plan was recently approved and began to be rolled out. There are few staff to support quality improvement efforts and they are often dependent upon volunteers from staff that are already busy and often overwhelmed. There is little organizational knowledge and skill at embracing the Lean methodology that is described as the backbone of WSH's quality improvement methodology. The contrast with a similar facility, Oregon State Hospital, outlined above is stark in how bare the cupboards are at WSH. Governing Body had not met since the first of the year by the time of CSM's visit, and even prior minutes show only general overview of quality initiatives. Meetings and committees are frequently composed of many of the same individuals discussing many of the same issues. The already stretched staff and leadership spend too much of their time in meetings, have little time for review and reflection, and less time for being out in the organization to observe issues, provide support and guidance to staff, and ensure that good quality and safe and secure environments are provided for patients.

- 4) **QAPI: Widely Disperses its Activities Throughout the Hospital.** As might be expected with the above issues, there was little evidence that QAPI activities and information were dispersed throughout WSH. The lone exception was many individuals were aware of various audit forms that they saw or had to complete, but this was perceived as more of a nuisance and “one more damn form,” as one person noted. A few individuals were aware that there was a QAPI website but there were no clear methods to determine whether staff actually utilized the process. No staff interviewed (other than senior leaders) had accessed the site. We could not help but think of the old adage, “If a tree falls in a forest and no one is around to hear it, does it make a sound?” Practically, it does not and that is the case with many QAPI efforts. Repeatedly, we heard two things from staff. First, they do not have time for anything other than the demands of direct patient care work, since they are often short-staffed, overworked, and dealing with challenging patients. Staff are not attending to all clinical functions reliably, nor is documentation complete, and both tasks that are integral to QAPI activities. Second, and somewhat less frequently, there was comment that things were different years ago. What was most frequently noted is that each unit or ward had local-level leadership who communicated data and analysis to them, used it to guide changes, and provided motivation, direction, and support on how to use it to make changes. Without this leadership, education on new processes is inconsistent and not reviewed for consistent application by staff. Additionally, we heard that communication in the past went upstream to more senior leadership with needs and insights that could then be addressed. The exception that proves the rule involves the Pharmacy Department. They are an active group of highly trained doctoral pharmacists. We saw ample evidence of evidence-based practices, use of data that was reported in minutes and charts, and even efforts not directly pharmacy related where this team provided value-added work to the clinical teams and ultimately to better and safer patient care. The number of pharmacists and their level of training is highly unusual in even very good programs, but it provides an example to follow for how to appropriately have highly qualified staff using quality improvement principles and practices. The complexity and challenges of WSH’s patient population suggests that this level of support should be maintained and even improved with regard to pharmacy, but also used to guide other efforts in the hospital.
- 5) **QAPI: Adequately Collects and Analyzes Data.** CSM was unable to fully evaluate all aspects of the adequacy of data collection and analysis at WSH. The CMS findings certainly suggest deficits in need of correction, especially around the frequency of these efforts to allow for timely and appropriate decision making. The seminal report by the Institute for Medicine (1999) entitled “To Err is Human: Building a Safer Health System”⁷ clearly suggested that mistakes will be made by fallible human beings. As noted in the review noted above, “One of the report’s main conclusions is that the majority of medical errors do not result from individual

⁷ For a review, see

<http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/1999/To-Err-is-Human/To%20Err%20is%20Human%201999%20%20report%20brief.pdf>

recklessness or the actions of a particular group—this is not a ‘bad apple’ problem. More commonly, errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them” (p. 2). The implications from the report and this brief quote apply to the clinical delivery system, as well as to oversight and quality improvement efforts too. We have significant concerns about the nature of data in the charts due to staff shortages even to meet minimal WSH requirements. There are too few staff to provide adequate care based on standards in the field, and the demands of trying to provide care to challenging patients in a physical environment that is far from ideal. The lack of an electronic health record (EHR) compounds these difficulties. Then, any additional audit tools beyond normal charting requirements and reports provide additional burdens on already overtaxed staff. Finally, the ability to perform what is called “abstraction” of the data from the charts by various members of the Quality Management team is tempered by the challenges of finding the necessary data required or desired, being able to read it in an unambiguous fashion, and being able to do that with limited staff in Quality Management. The description of the process to CSM during onsite interviews seemed akin to an archeological dig under difficult conditions. It fits what one member of our team has called the Law of Multiplying Fractions, which he illustrates by asking what do you get when you multiple, for example, $1/2$ by $1/4$, by $1/3$. The answer is $1/24$, which is less than any of the less than full units used in the example. One cannot expect good results when each level of the process of data entry, data collection, and data analysis are potentially compromised.

The CSM team was able to participate in a meeting held on June 8, 2016 to review a PowerPoint presentation entitled “Culture of Safety Survey” by the Quality Management Department. The instrument used was thoughtfully designed based on other instruments used in the field. The survey was completed between May 1- May 15, 2016, so it was a recent snapshot of the organization. An essentially equivalent survey was used at WSH in 2015, so comparative data was available. I assume that accurate summary statistics were provided, and that tests of significance were appropriately applied. The process of disseminating this information and findings was appropriate, as one way to review staff perceptions of safety. Unfortunately, the positive characterizations of this process ends here. Two significant problems exist with this data collection, analysis, and presentation. First, the response rate to the survey was quite low at 24%, and this was lower than the previous survey, which was similarly low. The issue of nonresponse bias is thus a significant issue here. Response rate is not the only issue in assessing the quality of data, but it is an important one. The best way to address such nonresponse bias is to work on having a higher response rate, but other ways can be used to address this.⁸ There is voluminous literature on this that will not be addressed here. There was a

⁸ Halbesleben, J. R. B., & Whitman, M. V. (2013). Evaluating survey quality in health services research: A decision framework for assessing nonresponse bias. *Health Services Research*, 48(3), p. 913-930. DOI: 0.1111/1475-6773.12002

very brief comment about the low rates and someone in the group wondered whether the results were usable. The concern here is that little attention was given to this, and various leaders were heard to be “searching for the positives,” as one person noted in the discussion. As a guide to decision-making, such results might be useful, but only with careful caveats. The response bias is unknown, and apparently there was no attempt or ability to evaluate it. Additionally, the attempt to go after positive findings served to ignore the many concerning and negative findings. It is vital to identify strengths in an organization and build on them, but aggressive attention is needed to address areas that are not functioning properly. This is particularly vital when addressing issues of safety. Finally, such searching for significant or positive results can inflate or increase the probability of making incorrect probability-based decisions when the multiple comparisons are not independent or controlled for. It is imperative that appropriate scientific processes are used to help inform leaders and decision-makers. It is the role of the experts in this, the Department of Quality Management and its researchers, to provide this guidance by example and in clear, direct, and assertive fashion. This was not observed during this meeting.

CSM reviewed Performance Improvement Project (PIP) processes through a review of PIP Committee minutes, a review of a number of PIP initiatives, a review of how they were presented in various other committees’ minutes, and through interviews with staff and leaders. As noted above, the new manager did not start until earlier this year, so there was not as active a process of oversight and management of the PIPs as was being seen by the time of CSM’s onsite visit. There is some good work being done, but the comments in the Seclusion and Restraint PIP minutes of May 5, 2016 summarize best the issues confronting WSH: “Sammy [a PIP team member] and whoever he can get to help him will take the current policies/procedures etc. and draft recommended changes.” The July 21, 2016 minutes from this same project had this at the bottom of its Status Update: “Needs Requests: LEADERSHIP SUPPORT-The S/R team will need ongoing visible, vigorous, consistent and persistent support from leadership in order for this project to succeed facility wide.” This is at the heart of the issues at WSH. Even a vitally important performance improvement area related to patient rights, safety, treatment, etc. and one with repeated citations by CMS and with chronic problems evidenced by ORYX and WSH data is left to scrounge for staff to assist. Similar issues were found across projects and issues. There was good use of graphs and dashboards and other performance improvement tools and analytic practices in the initiatives reviewed, but this is happening in isolation and as something being done by others, not as part of each area or unit being actively involved and participating in the efforts and seeing the results. We repeatedly heard staff and leaders note that there is little data on these projects shared with staff and even when it is and posted, staff have little time to review it and find ways to use the data to make required changes. In our discussions with Greg Roberts at Oregon State Hospital, he noted a similar scenario at his hospital that was changed with a greater level of training of all staff, having more quality improvement staff and mentors available that were highly trained in Lean methodology and active involvement by these quality staff on the units. Even with commitments of staff, time resources, and

outside training and consultation, he noted that it took years to implement and see the full fruits of these changes.

As part of this overall consultation report, NRI visited WSH from July 7-8, 2016 to perform a validation survey of the ORYX data that is collected to meet Joint Commission of required data sets for accreditation and deemed CMS status. The visiting NRI onsite staff were Lucille Schacht, PhD, Senior Director of Performance and Quality Improvement; and Vera Hollen, MA, Senior Research Analyst. Their "Data Integrity Review Report" covered October 2015-March 2016. As noted in this report, "NRI completed an on-site comprehensive Data Integrity Review (DIR) to assess the degree to which data collected, stored, and shared by Western State Hospital for performance measurement purposes are accurate and reliable. The review encompassed documentation and data systems, systemic data flow, and definition compliance to ensure data reliability. NRI has been conducting rigorous data integrity reviews since the inception of the Behavioral Healthcare Performance Measurement System (BHPMS) in 1999. Evaluating the data from each hospital for accuracy and completeness is an essential part of ensuring the reliability and validity of the comparison data...NRI's review process assesses both the degree of data validity, the data accurately reflect the information that they purport to capture, and data reliability, the same results are achieved each time the data are abstracted. These are concepts widely held to be fundamental in any performance monitoring system and these concepts are especially important when an entity is 'graded' by their performance level. Verifying that the data meet specified definitions and are accurate ensures that performance rates are meaningful" (p. 1). For the purposes of this overall consultation report, CSM viewed this as an important independent and structured assessment of an important aspect of WSH's overall ability to collect, aggregate, and submit data that is used by regulatory and accreditation bodies to be assured that they evaluate important metrics related to clinical care. It was more specifically a review of the Quality Management Department at WSH.

Overall, the NRI data-integrity findings found a 78% agreement rate between various data elements from initial reporting to NRI and the onsite data "reabstracted" from the charts using their "Cumulative Data Element Agreement Rate (DEAR) score. The range was from 8-100%. The report notes the following:

Data elements with low inter-rater reliability for WSH include:

- Patient demographic data: Hispanic ethnicity, marital status, prior living arrangement, admission referral source, Medicare coverage,
- Patient clinical information: diagnosis, comfort care
- Measure data: screening for risk of violence to self, screening for psychological trauma, screening for patient strengths, continuing care plan create, continuing care plan transmitted, reason for multiple antipsychotics at discharge, tobacco use status, tobacco counseling treatment, tobacco medication treatment, reason for no tobacco medication treatment

- Event data: unreported manual hold restraint events, unreported elopement event, dates for leave

For their “Cumulative Category Assignment Agreement Rate (CAAR) score,” the score was 87% with a range from 20-100%. The report notes the following:

Low reliability with certain data elements impacted the following measure classifications (category assignment):

- HBIPS Screenings within 3 days of admission
- HBIPS Restraint time
- HBIPS Continuing care plan created
- HBIPS continuing care plan transmitted within 5 days of discharge
- Tobacco 1 – Screening to tobacco use within 3 days of admission
- Tobacco 2/2a – Treatment with practical counseling and medication for patients who screened positive for tobacco use
- Restraint time
- Patient injury events
- Elopement events

There are other metrics reviewed that indicate problems as well, and the reader is directed to the full report noted above. Overall, these are not positive findings and attest to problems in data collection and documentation and/or aggregation or abstraction problems. What is particularly concerning is that many of the low-reliability areas are related to safety and security. These findings match the experience of CSM in our review of charts, interviews with staff, and descriptions of the data collection and abstraction process by Quality Management staff. We could not help but characterize this abstraction process as more akin to an archeological dig than to a process consistent with modern processes. The NRI report cites the electronic health record system that is being designed for later implementation by WSH. This was frequently cited by the staff and leaders as the solution to these problems. Ultimately, it probably is, but it was very clear that this system will not be ready for implementation before 2017. Also, CSM’s experience with other organizations implementing such systems is that they are never fully ready at time of startup. Considerable resources are needed prior to implementation to ensure that the system meets the needs of the organization, preparing staff for the transition is imperative, implementation seldom happens without setbacks, and there are always changes and corrections that need to be made after initial implementation. Additional focus on this will be made later in this report.

- 6) **QAPI: Diligently uses data to drive its decision making, including in its processes for determining the selection of tracking measures that comply with 42 C.F.R. § 482.21 concerning tracking, measuring and analyzing adverse patient events; and clearly demonstrates the program has a process for developing, implementing and evaluating its performance improvement projects and**

activities. As should be clear by this point, WSH has shown difficulty in all the above areas and would thus have difficulty in “diligently uses data to drive its decision making.” There is a reasonable plan, evidence of significant efforts at all levels of the organization in collecting data, and evidence of use of data around decision making. Tracking measures have been selected, there is measurement and analysis of adverse patient events, and evidence of processes to develop, implement, and evaluate its performance projects and activities. Yet, there have been chronic problems over the last year, in particular, in meeting CMS CoPs and Joint Commission survey standards. WSH had little advance warning of these issues from its own efforts, and constantly seems to be surprised and developing plans of correction in response to outside evaluations rather than having a system that can consistently uncover beginning problems and correct them in a timely and productive manner. The ad hoc after the fact fixes tend to be bandage approaches that serve to add more work to an already overtaxed staff and organization rather than developing ways to improve clinical, leadership, and other processes. The oversight quality assessment and improvement efforts are seldom able to capture enough of the correct information in a timely fashion and then communicate it effectively to leadership to allow for natural and minor course corrections. Leadership does not seem to be able to know how to use such information or is equally overwhelmed and unable to respond appropriately even when information is available or to make changes to make it available or request it in ways that will allow it to respond appropriately. It has been a system like a car careening down a hill in icy conditions out of control and most efforts to fix it have caused overcorrections that make any future corrections more difficult.

b. Target for the Plan of Correction for WSH’s QAPI Program

The focus for any Plan of Correction involving WSH’s QAPI Program must include resolving the citations from the various CMS surveys during 2015-2016 that culminated in the SIA that this report is. Specifically, an improved QAPI Program needs to remain in continuous operation across all levels of the organization and with adequate resources; demonstrating involvement by all levels of hospital leadership (including governing body); is widely dispersed in its activities to address all levels of clinical, administrative, and operational functioning; adequately collecting and analyzing data to diligently drive decision making (including developing tracking measures to comply with 42 C.F.R. § 482.21 concerning tracking, measuring and analyzing adverse patient events); and clearly having a process for developing, implementing and evaluating its performance improvement projects and activities. On all these counts, to greater and lesser degrees, WSH has been deficient and was at the time of CSM’s review in early June 2016. As CSM has found with many organizations in similar situations, WSH’s quality and performance improvement efforts have been and are marginalized in a variety of ways, including not being clearly integrated in leadership thinking and operation, being considered to reside solely or primarily in a program or department and not across the whole organization, as more of the old quality assurance model of collecting data and developing reports, and in being provided a lack of resources of time, training, and personnel (within the department or program devoted to quality improvement and across the organization). Both these broad areas (i.e., those identified in

the SIA and the marginalized issues) need to be addressed by WSH. There is hope for the future, since there are some foundations in the system that can be built upon, and the SIA provides incentives throughout the entire behavioral healthcare system in the State of Washington that might allow for the required resources and changes that will be needed for WSH and the entire system to become models of good care delivery.

c. Root Cause Analysis - Factors to consider in the current state of QAPI Program at WSH

The same general issues that have been identified throughout this report have served to reduce the effectiveness of WSH's QAPI program and its impact on organizational efficiency and effectiveness. We heard many reports about the golden days prior to 2008 when the organization had much fuller resources and greater focus. CSM is sure that many of these perceptions are true and that simply and magically restoring resources and structures from the past might make some things better. Yet, CSM's experience is that this is seldom fully accurate nor sufficient for present day demands and practices. As is inherent in the underlying concepts of quality or performance improvement, there is a notion that continuous improvement is necessary and that systems need to evolve to meet new patient population needs and desires, be responsive to new needs and desires of the communities and other stakeholders that patients come from and return to, be based on current evidence-based practice, and be responsible in using the resources of the local, state, and national governments in efficient and effective ways. Also, the situation at WSH (now and at other past and future times) is not wholly due to its own factors. As implied in the preceding statements and other points throughout the document, there are broader governmental and community factors that have directly influenced and continue to influence the operations of WSH. These cannot be forgotten in any ongoing improvement efforts. CSM's analysis shows the follow major root causes for the inadequate QAPI Program efforts at WSH:

- **The lack of proper vision for the QAPI program.** The importance of such a program, first and foremost, is as a method for leadership to ensure that WSH is functioning properly and continuously improving is clinical, operational, and administrative effectiveness. The present plan was only recently approved, but it remains convoluted and impractical. It is not fully or adequately embraced by leadership or implemented effectively throughout the hospital.
- **Lack of adequate resources devoted to the QAPI program and its implementation.** There are not enough staff within the QAPI program to adequately provide the data collection, analysis, and mentoring/training needed to inform leadership on how the organization is functioning or to adequately plan for implement change efforts. Beyond the department, staff and leaders are in need of additional training to understand and use quality improvement processes, as well as the time to be involved in such efforts. A Lean methodology is identified, but it does not seem to be clearly and adequately implemented at any level within the organization.
- **The QAPI Plan structure and implementation is confusing, duplicative, and not productive.** There are too many higher-level committees, with too much duplication of staff and leaders attending, and a lack of clarity on what is being done and where.

This leaves all overwhelmed, confused, and unable to effectively plan for and implement good quality improvement oversight. This happens at the highest levels, down through individual PIP initiatives, and into the hospital units and staff. A newer plan is reportedly being developed and preliminary information suggests that it is more streamlined. This would be an improvement, but more will be needed.

- **The massive size of the organization and disparate nature, needs, and legal issues of patient populations all combine to yield a complexity that is difficult to address in a unified manner.** This issue is essentially beyond the purview of the QAPI program itself, but it does impact its effectiveness. See above sections on Leadership, etc.
- **The lack of a modern health record system.** WSH uses an amalgam of paper records and various electronic record keeping systems. None of these are interconnected at present, and they all use different methods and protocols for data entry and retrieval. The plan for and development of a new EHR is underway, but clearly not ready for implementation in the immediate future.

d. Recommendations for Improvement of the QAPI Program

- **A clear, workable, and consistent model of quality improvement needs to be developed and implemented.** A clearer model and plan needs to be developed with stronger integration into leadership thinking and operation. It also needs to be thoroughly integrated into the fabric of all levels of organizational functioning. Staff and patients need to be considered stakeholders in this process and not just people assessed and/or used to carry out data collection. Proper training at all levels of the organization are needed on the importance of quality improvement, its methods and tools, and its practical benefits for care delivery and clinical change, as well as safety and security for all stakeholders in the hospital. This sets the stage for the remainder of the recommendations.
- **Adequate staffing and leadership for the QAPI program needed.** The program is not adequately staffed for an organization of WSH's size, complexity, and level of need. The recommendations from the department director are a start, but even this does not seem adequate from the experience of CSM or our contact with a similarly sized hospital with similar levels of problems in the past.
- **Adequate training for all staff and leaders are quality improvement concepts and use.** The Lean model that the program uses is reasonable and consistent with a similar hospital reviewed for this evaluation, but the level of training across the organization and present level of knowledge and skills at WSH is in need of massive improvement. It is likely that additional consultation efforts will be needed, if the Oregon State Hospital experience and that of CSM are any indicator. It needs to be developed and refined onsite, not just imported from elsewhere.

- **The QAPI Plan structure and implementation needs to re-thought and re-implemented.** There are too many higher-level committees, with too much duplication of staff and leaders attending, and a lack of clarity on what is being done and where.
- **Review of the nature and structure of the organization, as well as possible movement of some programs offsite should be considered.** Efforts to improve leadership and other changes to the program reporting structures needs to be made to make for clear lines of authority within the organization and to ensure that each programmatic area has the right mix of staff, leaders, buildings, etc. to meet the needs of all stakeholders, but primarily the patients. There are programs that might benefit from being moved off campus (e.g., those for clients with developmental and intellectual disabilities). This will promote clearer programming and allow for better quality improvement efforts.
- **A modern health record system needs to be developed and appropriately implemented.** The plan for and development of a new EHR is underway, but in CSM's analysis it is not ready for implementation in the future. There had been hope that it would be ready by late Summer or early Fall 2016, but many of the modules and needed elements had not even been developed, not to mention tested at the point of CSM's onsite visit. Our experience is that these systems are never implemented without problems and the level of extra work and duplication at initial rollout is substantial. Any such system change is best begun with some sort of piloting first. The system is being developed for the state and to be used at WSH and Eastern State Hospital. The latter is a 200+ bed state hospital, and would thus be a preferred pilot for the EHR before it is used at WSH. It is the right thing to work toward such a system, since it will be crucial to quality improvement, clinical documentation efforts, and other organizational needs. Yet, it needs to be done when it is ready and when WSH is ready for it. Rushing it out would be a huge mistake, but further planning and developing should clearly continue.

B. SUMMARY TABLE OF RECOMMENDATIONS

LEADERSHIP

<p>1. Leadership Structure</p>	<ul style="list-style-type: none"> • Modify CEO Direct Reporting structure (completed by CEO – June, 2016 • Improve the reporting span of control at all levels of the organization • Ensure that leadership at all levels embraces a quality or performance improvement mentality and approach in their focus and work. • Review meeting and reporting structures for efficiency • Consider potential for increased ward based leadership
<p>2. Governing Body</p>	<ul style="list-style-type: none"> • Better define clarity of role in oversight and strategic direction • Incorporate community-based stakeholders in the design and oversight of services, including advocacy groups, behavioral healthcare providers, and other important stakeholders.
<p>3. Accountability Mechanisms</p>	<ul style="list-style-type: none"> • Provide effective integration of old and new leaders into cohesive team with defined responsibilities • Structure meetings around deliverables • Develop and implement culture of accountability down to the line staff level. • Gain better direct over control hiring and firing, recruitment and retention efforts, and other human resources functions. • Ensure that this is a mission-driven organization focused on the delivery of safe, effective, and respectful delivery of care to patients in the least restrictive manner.

QUALITY AND APPROPRIATENESS OF SERVICES

1. Improve Leadership-Staff relations	<ul style="list-style-type: none"> • Leaders more present on wards • Staff education on internal and System issues • Task oriented groups including staff to develop solutions to POC issues
2. Systems changes in service delivery	<ul style="list-style-type: none"> • Advocate for modifications in the admission and discharge determinations/process for the Hospital
3. Physical environment changes	<ul style="list-style-type: none"> • More responsive facilities repair and maintenance • Repair or replacement of program/recreational equipment
4. Treatment environment (culture) changes	<ul style="list-style-type: none"> • Create a culture of safety through modification of ward staff mix and direct care matrix • Review and modify the PERT Team process • Staff training and education
5. Allocation of staff	<ul style="list-style-type: none"> • Move from on-call to assigned ward model • Review staffing needs for Recovery Centers • Allied Professional staff review (MD, PhD, SW, RT, OT) • Training/Education and Infection Control
6. Effective middle level management/supervisory structure	<ul style="list-style-type: none"> • Develop ward based leadership model • Optimize reporting hierarchy
7. Treatment Issues - documentation	<ul style="list-style-type: none"> • Modify treatment planning to ensure specificity and measureable objectives • Create processes adaptable to the EMR • Overall documentation enhancement relating assessment to plan to progress notes • Staff retraining in all aspects of documentation (such as Restraint and seclusion charting)
8. Treatment Issues - programmatic	<ul style="list-style-type: none"> • Review potential for dedicated admission units • Enhance addiction related services • Develop appropriate specialty treatments that are evidenced based. • Improve unit based treatment options • More fitness/health related activities • Activities aimed at daily life skills • Vocational training services • Expand leisure activities

	<ul style="list-style-type: none"> Expand token or level system for patient status and privileges
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PATIENTS RIGHTS PROTECTIONS

1. Communication-Feedback	<ul style="list-style-type: none"> Focus groups – patients and staff Leadership rounds Environmental rounds team Patient survey process
2. Treatment Issues - Programmatic	<ul style="list-style-type: none"> Increase patient involvement in treatment planning. Better coordination between wards/mall regarding patient assignments and participation Reduce patient-staff ratio in mall groups Improve confidentiality and coordination of admission process Increase ward programming options
3. Staffing - Leadership	<ul style="list-style-type: none"> Enhance local level of leadership at ward level Improve tracking and staff accountability
4. Staffing - Safety	<ul style="list-style-type: none"> Improve staff assignment process to provide better continuity on wards. Improve staffing allocation to address risk of violence

QUALIFIED AND SUPPORTIVE STAFFING RESOURCES

1. Psychiatry	<ul style="list-style-type: none"> Plan to complete filling vacancies Building leadership partnership with medical staff. Pilot a carve out for specialty services (NGRI Evaluations) Add more current evidenced based interventions.
2. Other Professional Disciplines	<ul style="list-style-type: none"> Create a viable plan for filling vacancies in nursing and allied professional roles Develop a plan that includes orientation and integration toward the desired “culture” Ensure adequate staffing assigned to core support areas of Education, Infection Control, Performance Improvement

3. Other direct service roles	<ul style="list-style-type: none"> • Better integration of the MHT, IC staff into the active treatment plan.
4. Retention – Job satisfaction and morale	<ul style="list-style-type: none"> • More ward based staffing assignments – less float staff • Better coverage to ensure staff get vacation/personal time • More inclusion in problem solving and PI • MHT staff included in State incentives for recruitment and retention • Involve Recovery Center/Mall staff in treatment planning process
5. Staffing allocation	<ul style="list-style-type: none"> • Complete consultant study and evaluate recommendations regarding optimal levels for different disciplines • Examine effectiveness of 1:1 close observation on safety
6. Hospital as teaching institution	<ul style="list-style-type: none"> • Explore options for a University affiliation and Residency Training site • Develop robust internship program for allied professional disciplines • Develop a nursing school affiliation for site based training.
7. Team building – coordination	<ul style="list-style-type: none"> • Promote better cooperation and respect between disciplines • Improve teamwork around common goals • Provide adequate leadership for oversight and accountability
8. Electronic Medical Record	<ul style="list-style-type: none"> • Provide adequate resources to develop core processes that can translate to the EMR

STAFF TRAINING AND EDUCATION

1. Improve focus/emphasis on training and education	<ul style="list-style-type: none"> • Better connection to clinical operations • Provide necessary resources for size and breadth of staff • Data driven approach to curricula planning • Improved training rollout, monitoring and record keeping at unit and organizational level. • Build components into the EMR as it is developed.
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2. Improved leadership-staff partnership	<ul style="list-style-type: none"> • Leadership communication on hospital and system issues • Outreach to staff for input on solutions • Become partners for advocating Systems changes and implementing internal changes.
3. Process of staff education/training	<ul style="list-style-type: none"> • More unit based training • More mentoring, “hands-on” • Training on communication, collaboration and leadership skills • Restore competency fairs • Add Grand Rounds and CEU offerings
4. Training content requirements	<ul style="list-style-type: none"> • Address noted gaps and citations: treatment planning, restraint and seclusion, medication administration, charting to goals and objectives, crisis intervention-safety, infection control processes

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM

1. QAPI structure	<ul style="list-style-type: none"> • Develop a clear, workable model • Better integration into leadership process • Effective implementation through the organization • Proper staff training in concepts methods and tools of Quality Improvement • Review and streamline organizational reporting process
2. QAPI resources	<ul style="list-style-type: none"> • Provide appropriate Management staff • Adequate technical and support staff relative to the size and scope of the Hospital. • Provide the Senior Leadership support to ensure implementation is successful
3. QAPI training model	<ul style="list-style-type: none"> • Devote resources to a robust training effort for all staff. • Examine other models and integrate with own needs.
4. Organizational structure and Quality Improvement efforts	<ul style="list-style-type: none"> • Review impact of the complexity and breadth of the organization on quality efforts

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5. Impact of the Electronic Medical Record (EMR)

- Consider the importance of PI data functions in development
- Ensure processes are well designed in practice before translation to the EHMR
- Plan for the initial learning curve impact on the organization.

III. FIELDS COMPLIANCE SUPPORT REVIEW

Working with Clinical Services Management on this consultation was the Compliance Support team of Fields & Associates, Inc. In the week of June 6-10, 2016 this team spent the equivalent of 20 days of onsite consultative time evaluating the deficiencies identified in the most recent CMS surveys.

This highly experienced team consisted of:

- Richard Fields, MD,
- Anne Menz, Ph.D., RN,
- Barbie Pankoski, CHFM, CHSP-FSM and
- Joseph Gigliotti, MSW

The Compliance review process was performed at Western State Hospital (WSH). The purpose of the site visit was to assist Clinical Services Management in the performance of a gap analysis of WSH operations and leadership. In addition the review assessed WSH's compliance with CMS standards in general and with recent citations in particular. The key function of Fields' group was to complete a survey type assessment providing the most updated analysis of compliance within the areas cited by CMS during the last three site visits. The findings of Fields' review were generally consistent with the results of recent CMS surveys. Repeated problems and the incapacity of the organization to design and implement an effective corrective action plan resulted in Immediate Jeopardies and systemic noncompliance with CoPs.

In the context of this entire report, the Compliance Team's review and recommendations were conceived of as a more micro- to mid-level process of evaluation that would allow for an inductive process of going from particulars that had proven to be problematic and still needing correction at this level. This would allow for further reliable generalization (built on the repeated findings of CMS) to overarching findings and recommendations. In contrast, the Functional Analysis approach began at the more macro-level (but informed by the particular findings of CMS and the Compliance Team) to assess for systems' issues that have contributed to the failure of WSH to regularly and consistently meet CMS CoPs. It was expected and found that there were similar and overlapping findings, but this provides additional validation for the entire methodology of this evaluation effort. It is expected that ongoing corrections will be needed to address findings at all levels of the organization from the micro- to the macro-level to allow for WSH to meet the goals of the SIA, which are to demonstrate "substantial compliance with all Medicare CoPs." We will leave the findings and recommendations in their respective areas of this report, but all of them need to be addressed with many of the more micro-level probably requiring less time and effort, but the more mid- to macro-level requiring more time and resources, as would be expected from their nature. Yet, it is to these more difficult issues that the SIA is ultimate focused on, since short-term fixes were not effective over the last year.

The Fields' process was structured to identify various treatment delivery and operational factors that were contributing to WSH's ongoing problems. The methodology involved sampling the various units, reviewing WSH data and reports, and to providing feedback to the CSM team regarding the strengths and deficits of the facility and staff. The tracer activities were designed by the team to provide an update from the most recent CMS surveys in 2015-2016. This allowed for, minimally, a three-month period to assess the Hospital's initial efforts at meeting the Plan of Correction they were implementing and provide insights into areas of continuing difficulty and prioritization. In addition, the Fields' Review allowed CSM to develop confidence in the interrater reliability of the findings of Fields' team and the CMS surveyors. The insight provided by the Fields' review also provides CSM with a baseline from which we can measure the degree and consistency of WSH's improvement projects.

Key Consultation Activities performed by the Compliance Team included:

- Life Safety Code Building Tour, EOC/EM documents and plan review
- Sample Patient interviews and observations
- Treatment team observations and discussions
- Leadership/Discipline chief interviews and discussions
- Policy, procedure, document and data reviews
- Topical discussions/reviews (e.g., treatment planning, restraint and seclusion)
- Sentinel Events/RCA discussions
- Observation of on and off ward activities and interventions
- Exit Conference with prioritization of strategy recommendations

As noted, the Fields' Compliance Review was included in the CSM assessment structure to provide a perspective regarding the progress that had been made by WSH as it has continuously sought to correct deficiencies found during various CMS site visits. Since March 2015, WSH has experienced a number of unsuccessful CMS evaluations that have led the facility to the brink of decertification. That action has recently been delayed by the implementation of a System Improvement Agreement with CMS. In the wake of this challenge, WSH has elected to withdraw from Joint Commission accreditation and a triennial survey that would have been due this month (June 2016). WSH leadership is working aggressively to address the deficiencies that stand as barriers to improvement. However, it should be noted that improvement efforts the organization has initiated are complicated by the fact that a majority of the executive management team has been recently hired/appointed. This includes the hospital administrator (who arrived concurrent with the CSM review. Three others, the Chief Medical Officer, Chief Nursing Officer and Quality Director, all began approximately six (6) months ago.

Despite this challenging context, our team observed a number of strengths for this organization to include:

- The System Improvement Agreement (SIA) that has already stimulated additional staffing resources and consultative assistance.
- Treatment Malls provide constructive engagement for a large percentage of patients

- Pharmacists are committed to regular participation in and support of treatment teams
- Advanced Practice Nurses and Clinical Nurse Consultants are available to provide consultation, training and nursing procedures.
- Nursing Educators have worked hard to maintain 40 hours of class room and demonstration training.
- The Engineering and Safety Department have a strong desire to make needed improvements; there was a strong dedication to the facility.
- Facility does a great job with the Fire Drill Matrix.
- Pre-Construction Risk Assessment (PCRA) dated 3/7/16 for Kitchen Pot and Pan Wash room is nicely documented.
- Direct Care staff exhibit a true willingness to learn and understand how to comply with CMS findings.
- The MAR has been upgraded to contain patient photos to support identification

The Fields' Compliance Review was included in the CSM assessment as a method to determine what, if any, progress had been made by WSH as it has continuously sought to correct deficiencies found during various CMS site visits. The results of those 2015 and 2016 CMS surveys ultimately culminated in the need for the SIA because of repeated problems and the inability of the organization to make sufficient corrections to achieve and then sustain compliance with CoPs and subsequent Immediate Jeopardies. Additionally, the review was planned to identify various treatment delivery and operational factors that were contributing to such ongoing problems. The methodology initially involved helping Fields to plan how to sample the various units, to share WSH data and reports, and to provide them any guidance on the nature of the facility and staff due to the rest of the team's greater preliminary and onsite involvement. The exact nature and follow through on their tracer activities were left to them to allow their evaluation to be independent of our impressions and to provide the desired update from the most recent CMS surveys earlier in 2015-2016.

While it is important to note there were many positive observations around staff commitment to improvement and learning (both clinical and support staff such as Engineering and Safety), contributions of the Pharmacists in support of the treatment team, APN and CNC involvement in consultation and nursing procedures, and the MAR upgrade of patient photos to support identification; there were critical areas that continue to fall short of standards compliance.

Based on observations, discussions and document review over the 5-day consultation, the following determinations were made regarding compliance with the previously cited conditions of participation:

- 482.12 Governing Body – COPD not met due to non-compliance with 482.13, 482.23 and 482.42
- 482.13 Patient Rights - COPD not met due to non-compliance with requirements related to restraint/seclusion
- 482.23 Nursing Services - COPD not met due to non-compliance with A385 and A405 compliance

- 482.42 Infection Control- COPD not met due to non-compliance with A749 hand hygiene and A748 and A756 leadership responsibilities.
- 482.61 Special Medical Record Requirements for Psychiatric Hospitals- COPD not met due to non-compliance with requirements related to active treatment/patient engagement and treatment plan documentation

Priority focus areas for achieving standards compliance and survey readiness included:

- Environment of Care – Safety and Maintenance Issues (better tracking and prioritization of work orders, timely response to those impacting patient safety).
- Nursing Practices – specifically around Infection Control (hand washing and glove use); Medication Administration (continued issues of pre-pouring and use of identifiers); Pain Management (documenting the reassessments that are being done more consistently in the EMR); Assessments (consistent completion of initial assessments and treatment plans on-time)
- Patient Engagement – Improve assessment and tracking of patient participation in treatment activities and improve on-unit opportunities for activities; coordinate such efforts better between the Centers and the Units.
- Quality Care – Ensure compliance with ongoing patient assessments, documentation and inclusion in the plan of care; evaluation and documentation of close observation for suicide risk patients is done as per policy; and treatment plans become more individualized and measureable.

Given the above findings/context and the 60-day time frame for submission of a full gap analysis to CMS, it is strongly recommended that priorities be established for optimizing standards compliance and survey readiness in the following four areas first:

A. KEY IMPROVEMENT OPPORTUNITIES (IMMEDIATE/30-60 DAYS)

1. Environment of Care

- Re: Safety Issues – Resolve identified issues in a more timely manner, improve communication with maintenance staff and develop a more finely tuned risk assessment and a prioritization process.
- Re: Preventative Maintenance – Make sure all work orders can be found and are complete (e.g., have required inventory). Consider establishing a centralized work order call center.

2. Nursing Practices

- Re: Infection Control – Ensure that the Infection Prevention and Control Committee functions as a hospital wide (vs. nursing) committee and that there is consistent understanding and practice regarding hand washing and use of gloves.
- Re: Medication Administration - Ensure more consistent adherence to proper administration procedures (e.g., not pre-pouring) especially regarding medication pass and use of identifiers.

- Re: Pain Management – Ensure more consistency in documentation of pain reassessment on the electronic medication administration record (MAR).
- Re: Assessments – Improve consistency/timeliness in completing nursing assessment and initial treatment plans.

3. Patient Engagement

- Re: Active Treatment
 - Develop and implement the processes, procedures and mechanisms necessary to more accurately monitor and evaluate patient participation (or lack thereof) in on and off unit treatment activities.
 - Develop structured approaches for on-unit alternative treatment activities
- Re: Treatment Coordination – Ensure effective communication and coordination of on unit treatment efforts between assigned Rehab unit staff and Nurse unit IC's.

4. Quality Care

- Re: Restraint/Seclusion (R/S)
 - Ensure that restraint documentation identifies imminent dangerousness/threat to immediate physical safety
 - Ensure Medical staff bylaws address delegation of face-to-face evaluations to nursing
 - Ensure that treatment plans are modified after episodes of R/S
- Re: Suicide Management – Ensure that physician documentation of close observation is consistent with hospital policy and procedure.
- Re: Treatment Plans – Enhance individualization by using ‘as evidenced by’ in the description of patient problems.

B. REPORT OF KEY ACTIVITIES, FINDINGS AND RECOMMENDATIONS

Activity/Issue: Record Reviews (Death, Closed)

Observations/Findings:

- During closed record review, two charts (# [REDACTED], # [REDACTED]) had a Nursing discharge assessment which is intended for patients who are being referred to another facility. The document is supposed to be completed by all 3 nursing shifts according to RN staff. In both cases, only the day shift nurse signed the form.
- Closed record # [REDACTED] had a release summary that listed a different referral location than the discharge continuity of care form.
- Two death records (# [REDACTED] and [REDACTED]) were reviewed. No autopsies were availed but there were no indications of inappropriate care.

Recommendations:

- Since the hospital uses multiple documents for the discharge planning process, care should be taken to ensure consistency between the documents.

Activity/Issue: Medication Management

Observations/Findings:

- Pt #6 F-8. This 84 y/o patient was being treated with Coumadin, a high risk medication. Blood levels were being recorded according to the Pharmacy Protocol; however, there was no indication on the Treatment Plan or amendments that there was a medical intervention or nursing intervention. Unit nursing staff were unfamiliar with the patient's progress since it is all handled by the Pharmacy staff. The pharmacist who last saw patient #6 wrote a progress note on 5-16 regarding his service and also said that the patient complained of foot pain and that he would let the RN know. This apparently did not happen since no other progress note was written in response to the patient's complaint of pain.
- Pt #3, F-5 was being treated for a leg wound since January and an infection requiring IV antibiotics on his left forearm. All IV treatments and follow up care were being provided by a group of staff called Clinical Nurse Consultants (CNC). The treatment plan, including the last review on 4-7-16 did not reflect this treatment nor the use of a 1:1 for the IV. On 5-13-16, a treatment plan addendum was created to reflect the 1:1 for an IV. There was no nurse on this unit who was aware of the patient's current condition due to RN's being pulled for coverage. I spoke with the CNC who provided an update on the patient's response to treatment and indicated that despite the patient's refusal of treatment that the wound had healed.
- The hospital Anticoagulant Policy does not include nursing responsibilities.
- Nursing staff are still setting up medication in advance of the medication pass as evidenced by a recent Pyxis Audit Report from March 07, 2016 through June 07, 2016. The audit has identified several repeat nurse offenders.
- Clinical Nurse Consultant was observed not using two identifiers when providing treatments to two patients. Another nurse administering medication to a patient in his room did not identify the patient.
- Nurses are documenting pain medication management using the pain scales for both initial assessment and reassessment. However, the reassessment documentation on the electronic MAR does not always reflect the pain scale as nurses may not use the appropriate drop box section. Policy states that pain scale will be used for both initial and reassessment.

Recommendations:

- The treatment plan should include all treatment provided, particularly when a high risk medication is involved and multiple providers are involved.
- The Pharmacy and nursing staff must communicate and ensure that the treatment plan reflects their coordinated efforts.
- Treatments provided by the CNC's should also be included in the treatment plan and communicated with unit nursing staff
- The Anticoagulant Medication Policy needs to be updated to reflect the role of nursing pre and post drug administration.
- Monthly Pyxis audits need to be initiated to identify the nurses, units and shifts that the pre poring of medication is occurring. Review of data would then allow for interventions, coaching and retraining as needed.

- Clinical Nurse Consultants need to follow policy and identify patients using two identifiers when providing treatments and or administering medications.
- Review the pain reassessment documentation process used by the nurses to ascertain need for retraining.

Activity/Issue: Infection Control Prep

Observations/Findings:

- Nurse observed gloving and then handling IV pole, door knob and patient wheel chair prior to administering a PIC line medication. Observed nurse not washing hands before putting on gloves and one nurse was observed not using proper handwashing techniques when administering medications. A nurse interviewed reported she cleaned the blood pressure equipment after each shift.
- The Infection Prevention and Control staff have had to reschedule APIC training until the fall thus delaying the training necessary to meet the qualifications of the Infection Preventionist.
- The Infection Prevention and Control Committee reports to Nursing Service and meeting minutes are not always directed to the Patient Care Committee and/or Quality Council.

Recommendations:

- Infection control practices related to the use of gloves and equipment cleaning is still an issue, RN III's need to prioritize their time to supervise and monitor nursing staff practices on their units. Nurses observed not using proper techniques can then accept retraining to learn when to gloves during treatment procedures, when alcohol gel versus handwashing is acceptable during medication administration and how to clean equipment according to policy.
- Hospital administrators must support the Infection Preventionist training in order to assure staff are qualified to ensure best practices.
- The Infection Prevention and Control Committee needs to function as a hospital – wide committee reporting directly to the Patient Care Committee.

Activity/Issue: Medical Staff

Observations/Findings:

- 13 of 45 psychiatrist positions are vacant causing 7 of the hospital's 30 units to be covered utilizing physician extra duty hours by varying combinations of other staff psychiatrists. The facility makes use of locum tenens, but recruitment is reportedly difficult.
- Medical Staff bylaws do not support the current practice of delegating the 1-hour face-to-face examination (for restraint/seclusion) to nurses. (See Restraints below)

Recommendations:

- Hospital leadership in conjunction with its governing body/Central Office needs to develop a more effective long-term strategy for recruitment and retention of psychiatrists.
- Update medical staff bylaws to appropriately support the current face-to-face practice.

Activity/Issue: Nursing

Observations/Findings:

- Based on discussion with the Nurse Educators and Staff Development Director, observation of an Inter-shift report and Staff Coordinator interview a number of competency-related concerns were identified:
 - Competency at the orientation level is recorded but there are no ongoing competency events as the competency fair was discontinued in February 2014 and Forensic Nursing training was discontinued in November of 2015.
 - Float Pool nurses are required to declare their experience on different units before accepting assignments but often times have to be assigned to unfamiliar units.
 - RN III's whose responsibility is to assure competency of their staff have been assigned additional duties.

Recommendations:

- Staff Educators and Nursing Educators in communication with the Advance Practice Nurses and RN III representatives need to develop a Nursing Competency Plan to include goals and objectives with time frames and communicate with hospital leadership for approval.

Activity/Issue: Patient Tracers

Observations/Findings:

- During a patient tracer on F-6, it was noted that Labs were ordered on 3/17 by the MD for Pt #5. The labs were refused, but there was no documentation of the refusal until 3/21 and 3/22
- During record review:
 - Three out of 8 patient records reviewed did not have completed nursing assessments
 - Six out of 12 patient records reviewed did not have the mini mental status completed.
 - Four out of 10 records patient reviewed were not evaluated for TB.
- Patient tracer (SB) was on 1:1 special observation, the assigned staff observer did not have any information about the patient other than name, treatment mall classroom and "do not let her hurt herself"
- Two procedures requiring IV replacement and PIC line medication were performed one in the dayroom, the other in the corridor.

Recommendations:

- Ensure that Nursing staff are reminded to adhere to documentation requirements for lab refusals per hospital policy.
- Communication between regularly assigned unit nurses and pool nursing staff needs to be enhanced to include information about patient treatment goals.
- Consider developing a process using the unit clerks to review the assessment documentation for incompletions and/or omissions.
- Patients requiring nursing/clinical procedures should be provided privacy and taken to a treatment and/or private room to perform the procedure.

Activity/Issue: Patient Engagement/Active Treatment

Observations/Findings:

- Patient #1 on F-2 admitted for competency restoration on 5/12/16, was refusing treatment and charges were dropped. Staff reported that he was no longer eligible for competency restoration services in the treatment mall and as a result, he was receiving no on ward scheduled activities.
- Pt #4 on F-7 was an NGRI patient refusing treatment mall activities. The treatment plan was modified to encourage the patient to attend the mall by locking her out of her room. This plan was not implemented by nursing staff. Note: the patient had enjoyed riding an exercise bike on the unit, but the bike was removed for repair about a month ago and not replaced.
- Active Treatment for patients unable or unwilling to attend scheduled treatment mall activities is not currently being monitored and tracked in a data base;
- The current T-Rex data base is entered by staff who are only able to count the number and names of those patients who leave the unit and attend the appropriate treatment mall.
- The Performance Improvement Project (newly formed in March) to increase activities for patients has not yet established a sufficient amount of baseline data necessary to measure improvement
- Unit S-10, 6/7 @ 0930 – There was no structured activity underway or planned for the unit. Approximately 10 unengaged patients were left on the unit with six of those being in their rooms on the bed and/or asleep. Staff complained that there were not sufficient numbers of staff to adequately supervise the unit and its patients.
- Unit S-7, 6/7 @ 1330, although it is reportedly hospital policy for patient room doors to be locked during therapeutic hours, very few of the patient room doors were locked at this time. Staff explained this is challenging to do. 10 patients were found in their rooms on their bed and or asleep.
- C9 Treatment Mall on 6/8 in the morning and afternoon had approximately 120 of 180 patients participating. Most including sample patient were actively engaged

Recommendations:

- The hospital must develop a patient tracking system capable of reporting an individual patient's participation or non-participation in on-ward activities and scheduled interventions.
- The hospital must monitor all patients for their participation in active treatment both on the ward and in the treatment malls, including weekends and evenings.
- Clinical leadership should analyze the pattern and needs of patients who are unable and/or unwilling to participate in the treatment mall and develop a structured approach to providing appropriate alternative treatment activities.
- The T-Rex data base should be enriched to match the patient's scheduled intervention on his/her treatment plan with their attendance
- The above data bases should be monitored at an individual patient level and feedback on patient involvement communicated to the treatment team members for their use in modifying treatment interventions.

- A formal process should be developed to ensure that Assigned Rehab unit staff and Nurse unit IC's meet to collaborate on the provision of on ward interventions for individual patients.
- The newly formed Performance Improvement Project must establish a baseline of current data in order to measure improvement over time. This baseline data must include both on ward and off ward activities. The subsequent measurement of improvement data may be used to help demonstrate the implementation of goal #1.2 in the State of Washington Strategic Plan - " Enhance the number of treatment hours in state hospitals".
- Consider developing and implementing a performance improvement initiative to reduce the number/rate of patients who are unwilling to participate in the mall.

Activity/Issue: Treatment Plans

Observations/Findings:

- Pt #5 on Unit F-6 has an NGRI status and has been refusing treatment mall activities. The Social work goals on the treatment plan were not specific to the patient and reflected general social work discipline activities. Consultation was provided to the social worker on how to document patient specific goals by using "as evidenced by" language in the treatment plan.
- Pt #7 on F-1 has been in restraints and on 1:1 for assaults to staff and patients during his hospitalization. The RN on the unit knows the patient well and described their efforts to successfully modify the patient's treatment. When asked about consultative assistance with a difficult patient was told that Clinical Case Consultation was not available in the Forensic building. The unit staff were attempting their own behavioral interventions by using the lines on the floor to control movement.
- The current approach to treatment plan documentation does not specifically identify a problem list, long or short term goals.
- Problem descriptions were not sufficiently individualized and contain generic terms such as depression, aggression staff process was sometimes confused for interventions.
- Two staff were found not to have completed the Q-15 minute observation sheet at quarter after the hour. Another staff was found to have completed an observation more than one hour in advance of the actual time.
- Although a number of Performance Improvement Projects (PIP) have been chartered recently, there is not one for treatment plan documentation. Multiple staff have suggested that the organization is waiting for and expecting the implementation of an electronic health record (EHR) to resolve recurring problems with treatment plan documentation. Implementation is reportedly to begin in November after it has been started at its sister facility.

Recommendations:

- During clinical chart review of treatment plan documentation, identify discipline specific goals that fail to individualize treatment and consult with staff and begin as soon as possible to encourage treatment teams to increase the specificity of problem descriptions by incorporating 'as evidenced by' into the documentation.
- Ensure that all clinical staff in the Forensic Building know how to access Clinical Case Consultation for behavioral intervention planning.

- Clinical leaders and treatment teams need to come to consensus as to how they would translate the wording of WSH treatment plans into CMS terms such as problem list, Long and short-term goals, interventions.
- Increase the specificity of problem descriptions by using the ‘as evidenced by’ phraseology.
- Refresh treatment team understanding of intervention versus staff process.
- Develop a consensus among staff as to what elements of the extant treatment plan would meet CMS expectations for a problem list, long and short term goals.
- Longer term, consider refresher training for all treatment teams on effective treatment plan documentation.
- Remind all staff about the importance (clinical and legal) for accurately documenting q15 minute observation sheets. Nursing leadership should periodically spot check the process.
- Leadership is cautioned against the idea that an EHR will automatically resolve its recurring problems with treatment plan documentation. Instead they are encouraged to develop good documentation habits among staff now that can be transferred to use of the EHR whenever it becomes available.
- Leadership/Governing Body is also encouraged to consider the use of an Independent Verification & Validation Service (IV&VS) to help ensure the most effective development and implementation of the planned EHR. (consider Preferred Provider: Project & Technology Consulting Services, Inc. (PTCSI) for IV&VS.)

Activity/Issue: Suicide

Observations/Findings:

- Observation on Monday, June 6, sample patient on unit S-10: A male staff member performing close observation with this patient, escorted her to the bathroom on her request. He stood partly in the doorway to allow the patient privacy but in so doing, lost direct line of sight.
- On Tuesday, June 7, a female nurse on S-10 described her process for taking a patient on suicide precautions (direct line of sight) for a shower as involving her standing partly in the doorway for purposes of privacy, and thereby losing line of sight.
- Another staff of the same gender as a sample patient (who had problems with polydipsia) explained that although the patient was on close observation, an exception was made with the status when the patient went to shower.
- Medical Records Procedure 8.9: Suicide Risk Assessment requires the attending physician to perform and document a risk assessment after 8 hours, but this is not being done consistently.

Recommendations:

- Clinical leadership needs to clarify how direct line of sight observation is to be managed when patients use the bathroom and address any gender and privacy requirements.
- Physicians need to be reminded of the documentation requirements of Medical Records Procedure 8.9. Their compliance should be audited at least once within the next 60 days with results to determine the need for further auditing.

Activity/Issue: Restraint Usage

Observations/Findings:

- Pt ^{45 CFR §164.514(b)} was secluded on 6/3/16 for 7 hours after he became naked and refused to put his clothes back on. During the review, the treatment team acknowledged that the documentation did not support the presence of imminent dangerousness. Further review of q15 min observations also failed to document behavior that would support continuation of seclusion as there were periods of 30, 40 and 60 minutes with no indications of dangerousness. Although the treatment team agreed with the above findings, the debriefing they conducted had not previously revealed this to them. It should also be noted that the treatment plan was not modified after this event.
- Pt ##### on Unit C5 was placed in seclusion at 0630 on 6/8/16. During review of the incident at 0930, the team acknowledged that the documented description of the event did not sufficiently indicate imminent dangerousness.
- Pt #2 on F-3 placed in restraints on 5/6 at 19:45; order was renewed at 23:45, but MD did not sign the order until 0400 on 5/7 which is not consistent with hospital policy.

Recommendations:

- Monitor all restraint and seclusion use for 100% compliance with documentation requirements consistent with Hospital policies and procedures
- Refresh all treatment teams on the importance of documenting imminent dangerousness and more specific detail on the use of less restrictive alternatives when utilizing restraint or seclusion.
- Remind all clinical staff that restraint or seclusion may only be utilized as a last resort to ensure immediate physical safety the patient, Staff or others. And, that documentation of the event needs to be adequate to support this or they will be vulnerable to questions about the appropriateness of use.
- Staff should also be reminded of the requirement to discontinue restraint or seclusion at the earliest possible time and that continuation of these measures requires documentation of patient behaviors consistent with that need. To that end, clinical leadership may wish to consider revising the behavioral coding system for restraint observation documentation.

Activity/Issue: Elopement Tracer

Observation(s)/Finding(s):

- Tracer was performed on the most recent elopement of 2 patients from C4, Room 101. Ward staff had expressed previous concern for patients under HB1114 rules being on this unit (rather than Forensic Unit). Unit C4 had windows with locking mechanisms, however locks were manipulated in some fashion to allow escape (no tools were found). Tracer showed that twenty years ago, windows had extra security of being screwed shut. However, approximately 10 years ago fire marshal had the facility remove screws, this hastened the escape. Facility has since obtained in writing from the fire marshal that windows can be screwed shut. When asked if other patients may have known there was a planned elopement which could have given staff a warning, the overall feeling is that the patients would not have reported it to staff for fear of being labeled as a "snitch" or because they were wrapped up in their own issues and would not want to be involved.

- During a tour of the S-Building going through the quadrangle from the admin bldg., a Porta-John (one of several in the quadrangle) was observed. The perimeter fence had been built around and on top of the Porta-John. This created an escape risk of an individual climbing on top of the Porta-John and using the conduit running along the top of the fence to climb over the 'no climb' fence and escape. A garbage truck was also observed picking up dumpsters while patients were freely walking in the area. The potential is for a patient to utilize the dumpster or truck to aid in an escape.

Recommendations:

- Recommend the facility add to daily safety rounds a security check of all patient room windows (not only on C4, but all units).
- Recommend facility try to create a culture of caring between patients and a process for reporting concerns to staff.
- Recommend an AWOL risk assessment of the quadrangle environment identifying risks and developing risk reduction activities as needed.

Activity/Issue: Environment of Care and Life Safety

Observations/Findings:

- Building tour found minimal penetrations in smoke barriers and the overall physical building to be in good shape.
- There were environmental issues in regards to opportunities for patients to "self harm" (bathroom fixtures, plumbing, door hinges).
- The Life Safety drawings did not include the locations of hazard rooms, travel distances to smoke barriers etc.
- Many of the required Preventative Maintenance Work Orders were missing from the prepared documents or the existing documents were missing required inventory (Water flow devices are required quarterly, only 2 PM's were available and Audio/Visual Devices did not have an inventory or a 2016 report). This could be more related to the process of oversight of the department and not because the PM's were not completed.
- Electrical panels are not labeled correctly as to the areas served. Breakers marked as "spare" are often found in the "on" position.
- Identified safety risk in the environment such as on unit S7, coat hook, restroom stall dividers, door closers on safe rooms and wardrobes with doors.
- Communication to Maintenance staff is not efficient as some of the maintenance staff do not have radios and have to return to the Engineering shop to receive another maintenance call or work order. The current process has floor staff entering work orders which go to one department and then to another, if the work order was not entered correctly it is being returned to sender or closed out. There are several "layers" of staff /management before an issue can be repaired.

Recommendations:

- Facility should ensure a risk assessment is completed to prioritize any "self harm" environmental deficiencies identified.
- The Life Safety drawings should be updated to include the locations of hazard rooms, travel distances to smoke barriers etc.

- Refer to: What to include in Life Safety Code Drawings (in Clarifications and Expectations: Super Suites TJC Perspectives, October 2012, October 2012 • Volume 32 • Number 10, page 13)
- The facility needs to coordinate timely process for turning in completed PM's to the "keeper" of the documents; facility should be in a constant state of readiness for any survey.
- Facility should check all electrical panels for complete/correct labeling.
- The facility should develop a risk assessment and a prioritization process for when safety issues are identified in the environment.
- Facility should evaluate current process for relaying information to maintenance staff. The ideal process would be for a centralized receiving station where all calls and work orders are prioritized and dispatched. There should not be so many steps to get a problem corrected.

Activity/Issue: Emergency Management

Observations/Findings:

- Emergency Management training has fallen behind for Incident Command structure, especially for leadership roles. Annual education for other staff has not been conducted recently.
- Emergency Management Command Center has not been activated in instances of emergencies (I.e. Elopement)
- Required Emergency Management drill with Community Emergency Command Services was not conducted last year or this year.
- Required Emergency Management drill did not include an influx of patients.

Recommendations:

- Recommend at minimum EM classes 100, 200 and 700 for those who have a role in the incident command center.
- Recommend facility utilize the Command Center as designed to ensure proper management of emergencies.
- Recommend the facility conduct an EM drill to show participation with the Community Emergency Command Services in 2016.
- Recommend the facility conduct an EM drill to show an influx of patients.

Activity/Issue: General Survey Management

Observations/Findings:

- On unit F- 1, the medication refrigerator had temperatures recorded daily for June and May. Many of the daily temperatures were recorded at 46°, which is the hospitals upper limit
- On Units F-1 and F-2, I asked for documentation of patient permission through treatment plan amendments for the lack of a curtain over the vision panels. One of 2 patients sampled on F-1 did not have the permission form in their chart.
- Multiple bedrooms identified by CMS as having 2 or more beds still do not have curtains to provide privacy for dressing.

- Treatment team members had different understandings about the required time frames for documenting annual assessments.
- Several annual assessments reviewed were signed after the expected due date.

Recommendations:

- Replace the unit F-1 refrigerator due to the consistently recorded 46° temperatures.
- Review all patient rooms that do not have a curtain over the vision panel and ensure that the patient's permission is documented.
- While awaiting a response from the State of Washington AG's office, consider an alternative strategy to provide privacy for dressing for patients residing in multiple bed bedrooms. Solicit patient ideas and feedback on this issue.
- Review the relevant documentation policies, refresh all clinical disciplines and ensure they have a consistent, accurate understanding of the time frames for completion of their annual assessments.
- Conduct a spot check of annual assessment audits to determine the extent to which compliance is a concern.

C. SUMMARY OF HIGH PROBABILITY CITATIONS, FINDINGS AND RECOMMENDATIONS

Standard	Finding	Recommendation
A-143 (§482.13(c)(1) Patient Rights: Personal Privacy)	1 of 2 patients on F-1 did not have documented permission for vision panel curtain to be removed	Check all rooms without vision panel curtains for documentation of patient permission
A 144 (§482.13(c)(2) Patient Rights: Care in a Safe Setting.	There are 620 open work orders in the Facilities Engineering Department dating back since 6/5/14. There is not an appropriate prioritization process. (Some of the open items are patient safety concerns). The AMMS work order system appears to put all the burden of documentation on the nursing staff, often the Work Order is not filled out correctly or missing information which delays the process of correcting. Work Orders have to be identified as programmatic or maintenance in order for them to be dispatched to the correct department. Often Work Orders are sent back or show closed because the correct information was not given to the requester. Not all Facility maintenance staff have radios which makes the timely correction of issues very ineffective.	<ul style="list-style-type: none"> • Recommend the Facility reevaluate the process of multiple layers of management, approval process and prioritization of Safety related work orders. • Recommend the facility reevaluate the process for dispatching maintenance calls. A central receiving station for all work order related calls may prove to be more effective in correcting issues rather than the multiple layered process now in place. • The facility should consider issuing radios to all maintenance staff not only for efficiency but for safety as well.

<p>A 144 (482.13(c)(2) Patient Rights: Care in a Safe Setting.</p>	<p>Required Annual testing of emergency lights has not been completed</p>	<p>Recommend the facility perform required emergency light testing (every 12 months hospital performs a functional test of battery powered lights required for egress for a duration 1.5 hours or replaces all batteries every 12 months and during replacement, performs a random test of 10% of all batteries for 1.5 hours.</p>
<p>A 144 (482.13(c)(2) Patient Rights: Care in a Safe Setting.</p>	<p>Required monthly testing of emergency lights could not be located for Bldg. 4 January and February 2016. Several Bldgs. were missing the April and May 2016 reports.</p>	<p>The facility may have more of a process issue of getting completed PM's to the "keeper" of the documentation rather than PM's not being completed. Recommend the Facility reevaluate the process of multiple layers of management to get to the real issue of missing documentation.</p>
<p>A 144 (482.13(c)(2) Patient Rights: Care in a Safe Setting.</p>	<p>Required monthly testing of Generators was missing for April and May 2016.</p>	<p>The facility may have more of a process issue of getting completed PM's to the "keeper" of the documentation rather than PM's not being completed. Recommend the Facility reevaluate the process of multiple layers of Management to improve the real issue of missing documentation.</p>

<p>A 144 (482.13(c)(2) Patient Rights: Care in a Safe Setting. K-50 Fire Drills are held at unexpected times under varying conditions, at least quarterly on each shift.</p>	<p>Fire Drills seem to be at a predictable time on 2nd shift. Fire Drills do not document exactly what happened during the drill. (All drills seem to be perfect).</p>	<p>When drills do not go exactly right, ensure documentation and any education given is reported on critique form (I.e. someone forgot to close a door or didn't know how to pull the pull station).</p>
<p>A-0154 §482.13(e) Standard: Restraint or seclusion. ...Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.</p>	<p>During chart review of two sample patients who experienced restraint, documentation of the restraint episode failed to substantiate the presence of an immediate and serious danger. In addition, coded observations of the patient's time in seclusion also failed to adequately support the continuation of the restriction for length of time it lasted.</p>	<p>Ensure all clinical staff appreciates the use of restraint or seclusion as a last resort that is only utilized to ensure immediate physical safety.</p>
<p>A-0154 §482.13(e) Standard: Restraint or seclusion. ...Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.</p>	<p>During chart review of two sample patients who experienced restraint, documentation of the restraint episode failed to substantiate the presence of an immediate and serious danger. In addition, coded observations of the patient's time in seclusion also failed to adequately support the continuation of the restriction for length of time it lasted.</p>	<p>Ensure all clinical staff appreciate the use of restraint or seclusion as a last resort that is only utilized to ensure immediate physical safety.</p>
<p>A-0166 §482.13(e)(4) - The use of restraint or seclusion must be -- (i) in accordance with a written modification to the patient's plan of care.</p>	<p>Based on medical record review and interviews with staff, it was determined that the facility failed to ensure written modifications to the patient's plan of care being made after a patient is physically restrained.</p>	<p>Update clinical staff knowledge and ensure awareness of requirement to modify the treatment plan after episodes of restraint or seclusion.</p>

<p>A 144§482.41(c)(2) Patient Rights: Care in a Safe Setting For additional guidance on performing tests, see NFPA 72, 1999 edition (Table 7-3.2).</p>	<p>Cannot locate any identified Supervisory Signal Devices on PM's. As a result, unsure if facility has devices or if they are being tested Quarterly.</p>	<ul style="list-style-type: none"> • Facility should verify with the vendor if they have Supervisory Signal devices in place. • Facility should ensure all Supervisory signal devices are listed on the PM form.
<p>A 144§482.41(c)(2) Patient Rights: Care in a Safe Setting For additional guidance on performing tests, see NFPA 72, 1999 edition (Table 7-3.2).</p>	<p>Bldg. 17- 1/13/16, 5/10/16,1/13/15, 6/2/15, These PM's were available by hard copy in the binder, with only 2 current quarters (Quarterly testing is required for water-flow devices and semi-annual for valve tamper switches. However, in the AMMS (Automated Maintenance Management System), all 4 quarters are available. There is a disconnect between the department CMO who completed the PM's and the administrative holder of the completed documents. As a result, the documents or PM's with completed check lists/task sheets are not being turned in to the appropriate office in a timely fashion.</p>	<p>Facility needs to reevaluate the process for completing the PM's and ensuring the documents are received by the appropriate administrative holder of the PM's.</p>

<p>A 144§482.41(c)(2) Patient Rights: Care in a Safe Setting For additional guidance on performing tests, see NFPA 72, 1999 edition (Table 7-3.2).</p>	<p>Bldg. 17- 4/18/15, Work Order report for electromechanical releasing devices does not have an inventory /file list for electromechanical releasing devices (automatic door release) 2016 was not available in binder. Facility may be including door hold magnets and closers into one number, PM shows there are 45 automatic door releases, the only ones required to be tested are those tied in to the fire alarm.</p>	<ul style="list-style-type: none"> • Facility needs to inventory electromechanical releasing devices and locate the 2016 PM. • Facility needs to reevaluate the process for completing the PM's and ensuring the documents are received by the appropriate administrative holder of the PM's.
<p>A 144§482.41(c)(2) Patient Rights: Care in a Safe Setting For additional guidance on performing tests, see NFPA 72, 1999 edition (Table 7-3.2).</p>	<p>Bldg. 17- 4/18/15, Report does not have an inventory/file list for electromechanical releasing devices 2016 was not available in binder.</p>	<p>Facility should locate the 2016 PM, ASAP and inventory devices.</p>
<p>A 144§482.41(c)(2) Patient Rights: Care in a Safe Setting For additional guidance on performing tests, see NFPA 72, 1999 edition (Table 7-3.2).</p>	<p>Bldg. 17- 4/18/15 2016 was not available in binder. Facility is not recording who received the alarm at 911 from at the Central Station Monitoring company and how long it took for them to receive the alarm.</p>	<p>Facility should add a line to PM for recording who received the call at 911 during the quarterly test and record how long it took for 911 to receive the call from the monitoring station.</p>
<p>A 144§482.41(c)(2) Patient Rights: Care in a Safe Setting For additional guidance on performing tests, see NFPA 25, 1998 edition (Section 6-3.5).</p>	<p>There are no parameters for the appropriate high and low water level alarm on work order reviewed for Bldg. 17 for the water level alarms.</p>	<p>Recommend adding parameters for Hi/Lo alarms on work orders for the water level alarms.</p>

<p>A 144§482.41(c)(2) Patient Rights: Care in a Safe Setting. For additional guidance on performing tests, see NFPA 25, 1998 edition (Section 9-2.6).</p>	<p>Bldg. 17-Annual PM was completed 6/2/15 however the facility is not recording the static and residual pressures or the time it took to return to normal.</p>	<p>Facility should record the static and residual pressure and the time it took to return to normal.</p>
<p>A 144§482.41(c)(2) Patient Rights: Care in a Safe Settings. For additional guidance on performing tests, see NFPA 25, 1998 edition (Section 9-7.1).</p>	<p>Bldg. 17- 1/13/16, 5/10/16, 1/13/15, 6/2/15, Only 2 current quarters of PM's were available by hard copy in the compliance binder. However, in the AMMS (Automated Maintenance Management System), all 4 quarters are available. There is a disconnect between the department CMO Who completed the PM's and the administrative holder of the completed documents. As a result, the documents or PM"s with completed check lists/task sheets are not being turned in to the appropriate office). There are required "task" associated with the testing, the PM does not state what is being tested/inspected.</p>	<p>Facility needs to reevaluate the process for completing the PM's and ensuring the documents are received by the appropriate administrative holder of the PM's.</p>
<p>A 144§482.41(c)(2) Patient Rights: Care in a Safe Setting. additional guidance on performing inspections, see NFPA 96, 1998 edition.</p>	<p>Bldg. 16- 12/16/15 Can not locate other semi-annual PM for 2015 or the current 2016 PM's</p>	<p>ASAP, locate missing semi-annual PM's.</p>

<p>A 144§482.41(c)(2) Patient Rights: Care in a Safe Setting. additional guidance on performing tests, see NFPA 90A, Standard for the Installation of Air Conditioning and Ventilation Systems, 1999 edition (Section 4-4.1)</p>	<p>Bldg. 17- Annual documentation was available for 2015 (4/7/15), Current 2016 not available.</p>	<p>ASAP, locate the 2016 documentation.</p>
<p>A 144§482.41(c)(2) In areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, and filtration efficiencies.</p>	<p>The facility has not identified which rooms are to be maintained under a certain pressure relationship. (i.e. Soiled room have to be under negative pressure, Soiled room on S-8 next to room 328 and Unit C-8, room next to 239 is not under negative pressure)</p>	<p>Recommend identifying rooms and verifying pressure annually. Facility should utilize the 2010 FGI guidelines.</p>

<p>A 144§482.41(c)(2) Patient Rights: Care in a Safe Setting</p>	<p>Facility was found to have some environmental issues where patients could possibly do self harm; On Unit S-7, Room 203, Restroom, the coat hook and restroom stall dividers, Restroom on S-7 at room 222, the strike plate for the door latch is very sharp and sticks out, On S-7 Room 237, the knob cover is missing for the blind control on the window (screw only/ no cover), S-7, room 248 there is a broken light fixture and ceiling tile. Unit S-7, room 237, there is a built box for patient belongings, the door to this box appears to be plexiglass and slides completely out of the box. S-7, shower room 218, restroom does shower door and fixtures are not appropriate for patients served. On Unit S-6, Room 120, toilet paper holders are sharp. On Unit S-6, room 100, there are stained tiles and light fixtures. On Unit S-9, staff is propping door open with plastic bag (dining room). On unit C-9, wires to radio are accessible to patients in 326, Light weight chairs are used in room 326.</p>	<ul style="list-style-type: none"> • Facility should utilize marked deficiency Life Safety drawing (left on site) to correct issues identified. • Facility should perform Risk Assessment to determine the prioritization of correcting environmental issues for possible self-harm opportunities.
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<p>A 144 §482.41(c)(2)The hospital tests utility system components on the inventory before initial use and after major repairs or upgrades.</p>	<p>The facility does not address the testing of Utility Equipment before initial use and after major repairs or upgrades. There is not a complete inventory of utility systems or of equipment such as Air Handling Units, Exhaust fans, cooling towers, fire alarms, sprinkler systems etc.</p>	<ul style="list-style-type: none"> • Recommend adding a Sentence in the Utility Management Plan regarding the hospital tests utility system components on the inventory before initial use and document. • Recommend the facility create a complete inventory.
<p>A-144 §482.13(c)(2) Patient Rights: Care in a safe setting</p>	<ul style="list-style-type: none"> • In Building S, safe rooms are being used for patient bedrooms. • On unit S-3, the safe room sleeps 2 patients and contains a ventilation grill. • On unit S-8 the comfort room has a cage around a fire strobe. • On unit S-7 the comfort room has a wall mounted door stop. 	<p>Remove all potential ligature risks from safe rooms and comfort rooms where patients may be left alone.</p>
<p>A-505 §482.25(b)(3) Unusable Drugs not used</p>	<p>F-1 Medication refrigerator has elevated temperatures</p>	<p>Replace refrigerator</p>

<p>§482.41(a)(1) K25 Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3.</p>	<ul style="list-style-type: none"> • Conduit is not sealed at smoke barrier in S-9, near room 401. • On Unit S-7 at smoke barrier near 237, there is an open end conduit with wire which is not sealed. J-Box cover is missing at smoke barrier • On S-7 by 201 and wires in electrical conduit is not capped. • On Unit S-7, in room 247, there is >1/8" gap around sprinkler head. • On Unit C-7 at smoke barrier near room 101, there is a hole in the concrete block and there is a >1/8" gap around sprinkler head in 122. 	<ul style="list-style-type: none"> • Reseal conduit on S-9 and on S-8. • Ensure gap around sprinkler head is <1/8". (refer to marked life safety drawings left with facility for exact location.).
<p>§482.41(a)(1) K27 Door openings in smoke barriers have at least a 20 min fire protection rating....."</p>	<p>Screws are missing in frames and window of smoke doors at Unit S-8, by 319.</p>	<p>Ensure doors have screws.</p>

<p>§482.41(a)(1) K46 Emergency lighting of at least 1/1/2-hour duration is provided in accordance with 7.9. 18.2.9.1, 19.2,9.1</p>	<ul style="list-style-type: none"> • Monthly, the hospital performs a functional test of battery-powered lights required for egress for a minimum duration of 30 seconds. In Bldg. 17- 5/4/16, 4/5/16 there was not a file list/inventory on the PM. • Annually, hospital either performs a functional test of battery-powered lights required for egress for a duration of 1 1/2 hours; or the hospital replaces all batteries every 12 months and, during replacement, performs a random test of 10% of all batteries for 1 1/2 hours, there was no proof of an annual PM. 	<p>Facility should create an inventory of all battery powered lights and perform Annual testing ASAP.</p>
<p>§482.41(a)(1) K 29 – (Hazard rooms shall be): One-hour fire rated construction (¾ hour rated doors) or an approved automatic fire extinguishing system. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field Applied protective plates that do not exceed 48" from the bottom of the door are permitted.</p>	<ul style="list-style-type: none"> • Hazard rooms have not been identified on the Life Safety Drawings. (I.e. Room 341 is a soiled room on unit C-9, Storage rooms 355 and 357 on C-9). • Administration Bldg. "18", at storage area to corridor next to room 315, there is a lot of combustible storage open to corridor. • Hazard room on S-6, room 126 does not have door closer. • On Unit S-1, room next to 104 is a Hazardous Storage room and does not have closer. • On Unit S-4, Hazard room 434, door is not latching to laundry. 	<ul style="list-style-type: none"> • Identify Hazard rooms identified in NFPA 101 on Life Safety Drawings. Remove combustible storage open to Corridor and place in appropriate hazard room. • Add door closer to S-6, room 126 and to storage room next to 104

<p>§482.41(a)(1) K72- Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress from, or visibility there of (except shower curtains) shall be in accordance with NFPA 70.7.1.10.</p>	<p>On Unit C-9, room 326, Chairs are in front of doors marked "EXIT"</p>	<p>Educate staff not to block exits</p>
<p>§482.41(a)(1) K 147- Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. 9.1.2.</p>	<p>Throughout the facility electrical panels were found not labeled correctly:</p> <ul style="list-style-type: none"> • Unit S7- Electrical room by 219, Panel 1B, Breakers 31-36 were in the "on" position but not labeled. • Unit C-8, in electrical closet across from 227, PNL 2A1, breaker #24 is not labeled. • Unit C-8 in room 245, Panel PNL2B, breaker 14 is not labeled and in the "ON" position. • On Unit W1-S, Panel K near Dining room, the electrical breaker index is not current. • Unit W1-N, electrical room near 15, Panel B Breaker 42 is listed as a spare but in the "ON" position. 	<p>Facility should check electrical panels throughout to ensure proper labeling.</p>

<p>§482.41(a)(1) K 75 Soiled linen or trash collection receptacles shall not exceed 32 gals in capacity...within any 64" area. "Trash receptacles > 32 gal.... shall be located in a hazardous area when not attended...."</p>	<p>On S-9, room 450, there is trash, boxes and pallets stacked up, near exit from dining room</p>	<p>Recommend facility educate staff to reduce trash and storage in this area.</p>
<p>A 144 (482.13(c)(2) Patient Rights: Care in a Safe Setting.</p>	<p>O2 Cylinders are not marked as Full / empty /Partial (I.e. Unit C-7, room 118)</p>	<p>Facility wide, there should be a labeling process for cylinder storage.</p>
<p>A 144 (482.13(c)(2) Patient Rights: Care in a Safe Setting.</p>	<ul style="list-style-type: none"> • Toilet paper is being stored in soiled /dirty rooms (I.e. on unit C-7, storage room next to room 139). • Vent is dirty is room 110 on unit C-7. Clean patient clothes are stored in Soiled room next to 339 on Unit C-9. 	<ul style="list-style-type: none"> • Facility should store clean paper products in a clean room not soiled. • Recommend facility create a vent cleaning preventative maintenance work order and clean on regular basis. • Facility should store clean patient clothing in a clean room, not a soiled rm.
<p>A 144 (482.13(c)(2) Patient Rights: Care in a Safe Setting.</p>	<ul style="list-style-type: none"> • On Unit S-7 in room 217, Staff are using 2 different refrigerator logs. One log has information for parameters, one does not. One log shows dates missed for checking. • Unit W1-N at Kitchen /Dining area, refrigerator log was not checked June 2. 	<p>Recommend being consistent on use of forms, educate staff on importance of not missing dates.</p>

<p>B103 §482.61 Condition of Participation: Special Medical Record Requirements for Psychiatric Hospitals The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution.</p>	<p>The organization failed to consistently document treatment plans that were individualize and focused on specific psychiatric problems with interventions that were not routine, generic discipline functions.</p>	<p>Encourage staff to be more specific and individualized in the documentation of problems by using the phrase ‘as evidenced by’ in the description.</p>
<p>B113 §482.61 (b)(3) Each patient record must contain a mental status.</p>	<p>Six out of 12 records reviews did not have a mental status exam completed</p>	<p>Mental status exams have to be part of the psychiatric evaluation completed within the policy timeframe.</p>
<p>B118 §482.61 (c)(1) Each patient must have an individual comprehensive treatment plan</p>	<p>Problem descriptions were not sufficiently individualized and contain generic terms such as depression, aggression. Staff process was sometimes documented as interventions.</p>	<ul style="list-style-type: none"> • Consider providing a training for all clinical staff/treatment team members on effective treatment plan documentation. • Also consider conducting periodic external review of a sample of treatment plans for review and comment.

<p>B119 §482.61(c)(1) The plan must be based on an inventory of the patient's strengths and disabilities.</p>	<p>The lack of specificity in problem documentation sometimes makes it difficult to determine the extent to which the plan is based on the patient's disabilities. Strengths that represent personal attributes (i.e., knowledge, interests, skills, aptitudes, personal experiences, education, talents and employment status) which may be useful in developing a meaningful treatment plan are not consistently identified.</p>	<p>See recommendation in B118 above.</p>
<p>B122 §482.61(c)(1)(iii) The specific treatment modalities utilized;</p>	<ul style="list-style-type: none"> • Hospital failed to ensure treatment plans contain specific, individualized interventions. • Staff interviewed who were providing special observations of patients (1:1) were not given information about the patient's treatment plan or interventions. 	<ul style="list-style-type: none"> • See recommendation in B118 above. • Staff providing 1:1 special observation need to have more information about the patient.
<p>B125 §482.61(c)(2) The treatment received by the patient must be documented in such a way to assure that all active therapeutic efforts are included</p>	<p>The hospital failed to provide active treatment, including purposeful alternative interventions, for patients who were unwilling and/or unable (due to their condition) or were not motivated to attend the mall treatment programs that were offered. There was no structured, on unit programming for those patients left behind.</p>	<p>Develop a structured approach to providing alternate treatment activities to patients unable and/or unwilling to participate in the treatment mall.</p>

<p>B127 §482.61(d) Progress notes documented by nursing</p>	<p>Nursing uses a checklist to document progress toward nursing intervention rather than a narrative.</p>	<p>Narrative progress notes need to be reinstated as they reflect progress toward accomplishment of individualized goals.</p>
<p>B146 §482.62(d) Hospital must have adequate numbers of qualified staff to evaluate patients, participate in treatment planning and provide active treatment measures.</p>	<ul style="list-style-type: none"> • The number of staff needed per unit are maintained, however due to staff shortages, staff must be assigned from a pool of available personnel. Many of these staff persons are not familiar with the unit or the patient. • Also due to high numbers of patients requiring 1:1 observation and deployment of staff to the treatment mall there is not an adequate number of staff on the units to maintain active treatment continuity. 	<p>It appears that nursing will be able to hire 51 more nursing positions, however it will take time to accomplish recruitment, training and tenure of these new positions, in the meantime it is important to review the present practices of 1:1's, treatment mall staff deployment and the Nurse III present work load for better use on nursing personnel.</p>
<p>B148 §482.62(d)(1) The nursing director is responsible for implementation of continuous quality improvement programs, provision of orientation, in-service and continuing education in accordance with acceptable nursing practices especially in the areas of psychiatric nursing.</p>	<p>The Competency Fair and Forensic Nursing Training have been discontinued and competency skill observation and demonstrations by Nurse III's have been curtailed due to increased responsibilities.</p>	<ul style="list-style-type: none"> • Nursing staff must receive training beyond orientation and unit specific due to the special need of the hospital patients. • Staff Development and Nursing Educators in collaboration with the Advanced Practice Nurses need to m, plan, and prioritize training needs and present the plan to leadership.

<p>B150 §482.62(d)(2) There must be adequate numbers of registered nurses, license practical nurses and mental health workers to provide the nursing care necessary under each patient's active treatment program</p>	<p>The need to assign "pool" nursing personnel to meet adequate staffing numbers on each unit has resulted in staff assigned not being familiar with patients or the unit and supervisory staff not having the time to properly orient or mentor the assigned "pool" nurse.</p>	<p>The plan to hire 51 nursing positions will enhance the existing situation, however there is a need to plan for training the new personnel and the "pool" nurses by acknowledging the special populations that are in the hospital and providing the training needed to meet their needs.</p>
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IV. DOCUMENTS AND MATERIALS REVIEWED

CMS System Improvement Agreement Between CMS, WDOH, WSH, and WDSHS
Patient Care Committee Minutes—January 2016 to July 2016
Quality Council Committee Minutes—January 2016 to July 2016
QAPI Steering Committee Minutes—January 2016 to July 2016
Infection Control Committee Minutes—January 2016 to July 2016
Mortality and Morbidity Committee Minutes—January 2016 to July 2016
Senior Leadership Minutes—January 2016 to July 2016
Nursing Management Team Meeting Minutes—January 2016 to July 2016
Governing Body Minutes—December 22, 2015 to July 2016
WSH Quality Assessment & Performance Improvement Plan—2015-2016
Nurse Manager Report—June 3, 2016 June 4, 2016
Electronic Bulletin Board—Wednesday Movie and Recreation Schedule
WSH Department of Quality Management—Proposed recommended staffing level—Undated, but provided by Quality Management Director during onsite review.
WSH Antimicrobial Stewardship Program—Proposal; undated by provided during PCC Committee Meeting during onsite review.
WSH General Hospital Orientation Schedule—June 6-June 10, 2016
South Hall Recovery Center Catalog—April 25, 2016 thru August 31, 2016
PTRC-E Rehab Services On-Ward Programing—May 2016
WSH Infection Prevention Program Risk Assessment and Plan
Pharmacy Quarterly Report for 1st Quarter 2016
Clinical Risk Management Report to Patient Care Committee—Quarter 1, 2016
State Hospital Coordinated Quality Improvement Program Quality Improvement Team Charter—Quality and Safety of Patient Care
Deep Dive Data Review—Quality Management Department—WSH—07/1
NRI Customized Data Analytics for Western State Hospital—Analysis Completed 6/2/16
NRI Data Flow Map Form—7/13/16
NRI Cumulative CAAR—7/13/16
NRI Cumulative DEAR—7/13/16
NRI Data Integrity Report—7/13/16
NRI Primary Source Identification—7/13/16
ORYX Performance Measurement Report—2015Q1
ORYX Performance Measurement Report—4Q2015
ORYX Performance Measurement Report—Q22015
ORYX Performance Measurement Report—Q32015
All CMS Reports 2015-2016
All Joint Commission Reports 2015
Executive Leadership Team Bio and Org Chart
WSH Direct Reports Chart
All WSH Plans of Correction to CMS—2015-2016