State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	60429197	A. BUILDING: _____ B. WING _____	C 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

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L 000	INITIAL COMMENTS STATE COMPLAINT INVESTIGATION The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-322 Private Psychiatric and Alcoholism Hospitals, conducted this complaint investigation. Onsite dates: 08/11/21 to 08/13/21, 08/24/21 to 08/27/21 and 09/15/21 Administrative review dates: 09/30/21 Case number: 2021-8636 Intake number: 114241 The investigation was conducted by: Investigator #15 There were violations found pertinent to this complaint.	L 000	1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction; WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and WHEN the correction will be completed. 3. Your PLANS OF CORRECTION must be returned within 10 calendar days from the date you receive the emailed Statement of Deficiencies. Your Plans of Correction must be emailed by 08/19/22. 4. Return the ORIGINAL REPORT via email with the required signatures.	
L 340	322-035.1H PROCEDURES-BEHAVIOR WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following	L 340		

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L 340	Continued From page 1 written policies and procedures consistent with this chapter and services provided: (h) Managing assaultive, self-destructive, or out-of-control behavior, including: (i) Immediate actions and conduct; (ii) Use of seclusion and restraints consistent with WAC 246-322-180 and other applicable state standards; (iii) Documenting in the clinical record; This Washington Administrative Code is not met as evidenced by: . Based on observation, interview, and document review, the hospital failed to implement policies and procedures to manage assaultive, out of control behavior to protect patients from assault and abuse in 2 of 2 patients (Patient #1508 and #1509). Failure to ensure that hospital staff follow policies and procedures to protect patients from abuse and assault risks serious harm to patients due to physical and psychological injury. Findings included: 1. Document review of the hospital's policy and procedure titled, "Assaultive Patient: Precautions and Treatment," policy number PC.AP.01, last reviewed 02/21, showed the following: a. The purpose of the policy was to provide information about preventing and responding to patients with a potential for aggression and violence. b. Upon admission, patient will be assessed for	L 340		

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L 340	Continued From page 2 risk of aggression/violence utilizing the standardized aggression/violence assessment. c. Scoring: 0 - 1 Low Risk, 2 - 3 Moderate Risk, and Greater than 3 High risk d. Level I Assault Precautions Interventions (Low Risk, Score = 1): i. Assist patient to identify triggers of assaultive urges and document on the Assault Precautions treatment plan. e. Level II Assault Precautions Interventions (Medium/Moderate Risk, Score = 2-3): i. Focused treatment team meeting immediately following the threat of violence/assault with specific treatment interventions. ii. Medication regimen reassessed. iii. Patient's observation level will be evaluated iv. Daily assault/violence assessment to be conducted using standardized aggression/violence assessment. f. Level III Assault Precautions Interventions (A patient that has been indicating a high risk of violence/assault or a patient that has had a physical confrontation of violence/assault during admission, Score = greater than 3): i. Focused treatment team meeting immediately following the threat of violence/assault with specific treatment interventions. ii. Medication regimen reassessed.	L 340		

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L 340	Continued From page 3 iii. Patient's observation level will be evaluated. iv. A limited "safe place" for the assaultive patient will be identified, including patient room, seclusion room, quiet room, mechanical restraint use. v. Patient will be considered for hospital transfer based on acuity. vi. An assault/violence risk assessment will be done every shift using the Shift Violence Checklist. 2. Document review of the hospital's policy and procedure titled, "Patient Observations," policy number PC.P.300, last reviewed 02/21 showed the following: a. The purpose of the policy was to maintain patient safety ensuring that staff makes and documents routine safety rounds on patients in accordance with the level of observation order by the physician and/or initiated by the Registered Nurse (RN). b. All patients will be on a minimum of 15-minute observations. c. 1:1 Observation is the highest level of observation and is reserved for patients who are so unpredictable that without a dedicated staff member there is a risk of the patient harming self or others: i. Requires a precaution level, for example suicide, elopement, fall risk, etc. ii. The provider order may specify "waking hours" or "continuous 1:1" and is reassessed daily and renewed if needed.	L 340		

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L 340	Continued From page 4 iii. Staff who are assigned to monitor the 1:1 patient will have no other assignments. iv. Staff are to remain in visual range and close proximity (arm's reach) of the patient at all times. There should be nothing between the patient and assigned staff, for example furniture, nurses station counter, equipment, etc. v. The RN will assess the patient a minimum of two times per shift and document patient condition in the progress note. Assessment will include the need for continued 1:1 observation. Patient #1508 3. Patient #1508 is a 44-year-old male, admitted involuntarily on 05/20/21 with a psychiatric diagnosis of Schizoaffective Disorder and Post Traumatic Stress Disorder (PTSD). Patient #1508 had an extensive history of aggression and assault. Prior to his admission on 05/18/21, he assaulted two other residents at his living facility, punching one resident in the face 3 times. He left the facility after the assault, then was arrested by police after he returned to the living facility with a lead pipe. Upon admission to Cascade Behavioral Hospital, Patient #1508 was placed on Assault Precautions - Level II and observations every 15 minutes (Q15). Review of the medical record showed the following: a. On the Dynamic Appraisal of Situational Aggression: Inpatient Version, dated 05/21/21 staff assessed Patient #1508 with a score of zero, indicating that the Patient is not a risk for aggression. Review of the medical record on 08/13/21 found that staff failed to document the reassessment of the Patient's risk for aggression	L 340		

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L 340	Continued From page 5 other than the initial assessment on 05/21/21, as directed by hospital policy. b. Weekly Treatment Plan Updates for the weeks of 06/03/21, 06/24/21, 07/01/21, 07/08/21, 07/15/21, and 07/22/22 found that staff documented that Patient #1508 was unpredictable and physically aggressive, attempting to attack peers. Staff failed to document the implementation of interventions to address the Patient's assaultive/aggressive behavior or initiate changes to the treatment plan. c. The Incident Report Log for dates between 05/01/21 to 08/24/21 showed that Patient #1508 attacked his peers on six separate incidents: 05/21/21, 05/24/21, 06/23/21, 06/27/21, and twice on 07/19/21. Patient #1509 4. On 07/19/21, Patient #1508 attacked Patient #1509 twice, at approximately 11:45 AM and again at approximately 2:45 PM. Patient #1509 was 65-year-old male admitted involuntarily on 06/24/21 with a psychiatric diagnosis of Schizophrenia and a medical diagnosis of Parkinson's Disease (disorder of the central nervous system that affects movements), Chronic Obstructive Pulmonary Disease (COPD), Seizure Disorder, and Hypertension (high blood pressure). The Patient had a history of Traumatic Brain Injury (TBI) and possible developmental disability. Upon admission, Patient #1509 was grossly disorganized, highly irritable, and confused, using a wheelchair for ambulation. The Patient was placed on Assault Precautions, Fall Precautions, and 1:1 Observations. 5. Investigator #15's review of the medical	L 340		

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L 340	Continued From page 6 records for Patient #1508 and #1509 for the incidents reported on 07/19/21 showed the following: a. On the Patient Observation form for Patient #1508, dated 07/19/21, staff documented that the Patient was on observations every 15 minutes between the times of 12:00 AM to 4:45 PM. Staff failed to document if Patient #1508 was on any enhanced safety precautions. b. On the Patient Observation form for Patient #1509, dated 07/19/21, staff failed to document the Patient's level of observation, however staff documented observations every 15 minutes (Q15) between the times of 12:00 AM to 12:00 PM. Staff documented that Patient #1509 was on Fall Precautions. Medical record review found a duplicate Patient Observation form, dated 07/19/21 for the times between 12:00 AM to 3:25 PM. Staff documented that Patient #1509 was on observations every 5 minutes (Q5) and Fall Precautions. The two Observation forms dated 07/19/21 contained incongruent documentation and it is unclear if Patient #1509 was on 1:1, Q15, or Q5 observations at the time of the assaults. c. On the Provider Order dated 07/18/21, the provider ordered staff to continue 1:1 observation status for Patient #1509. d. On 07/19/21 nursing staff documented that at approximately 11:45 AM, Patient #1509 was sitting in his wheelchair in the hallway. Patient #1508 walked down the hallway, past Patient #1509. The two patients spoke briefly. Patient #1508, who was wearing boots at the time, turned around and kicked Patient #1509 in the face several times. Nursing staff documented that Patient #1509 sustained several superficial	L 340		

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L 340	Continued From page 7 lacerations on the nose and left eye. The medical record failed to contain documentation of interventions or de-escalations provided by the support staff conducting the Patient's observations. e. On the Provider Order dated 07/19/21 at 12:10 PM, the provider ordered that 1:1 observation would be discontinued, and Patient #1509 be placed on Q5 observations. f. On 07/19/21 nursing staff documented that Patient #1508 assaulted Patient #1509 a second time, at approximately 2:45 PM. Patient #1509 was sitting in his wheelchair near the nurse's station, waiting for transport to the Emergency Department (ED). Patient #1508 approached Patient #1509 and began punching him in the right leg and neck. Staff called a Code Gray (request for an emergency response to assist with a combative or violent patient). Patient #1509 was assessed by the medical provider and nursing staff provided ice to the patient's face and neck. The Patient was then transported to the hospital for medical evaluation. g. On the Incident Report dated 07/19/21 staff documented that the RN was with another patient, but also observing Patient #1509 (who was on 1:1 observation) when Patient #1508 attacked Patient #1509 for a second time. 6. Investigator #15's review of the medical records found that hospital staff failed to respond to Patient #1508's assaultive/aggressive behavior by implementing interventions or initiating changes in the plan of care, as directed by hospital policy. 7. On 08/13/21 at 11:30 AM, during an interview	L 340		

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L 340	Continued From page 8 with Investigator #15, the Director of Risk (Staff #1501) stated that she was unable to verify (based on Patient #1509's incongruent Observation forms) how the staff was monitoring the Patient on 07/19/21. Staff #1501 stated that staff is instructed to follow the hospital's policies and procedures when responding to incidents of aggression and assault. 8. On 09/28/21 at 12:05 PM, during an Interview with Investigator #15, a Behavioral Health Associate (BHA) (Staff #1527), Staff #1527 clarified that observations every 5 minutes (Q5) is for when patients are a danger to themselves or others. Patients have to be monitored every 5 minutes. Staff #1527 stated that often for their unit, there will be a patient census of 30 patients, with 3 BHA's, and there may be 5-7 patients who are on Q5. The 3 BHAs will divide up, sometime monitoring 10 patients with 2-3 of the patients requiring Q5 monitoring. The BHAs are also responsible for "lots of other activities, such as food and drinks, ADL's, and laundry." Staff #1527 stated that it creates a "risky situation, because it's difficult to do Q15 and Q5 observation rounds when serving food and drinks and helping a patient to toilet or shower." Staff #1527 stated that there are days that "we don't take breaks, and when we do take a break, that leaves the other BHA's to watch 15-30 patients." "When the unit has a high acuity, none of us get to go, we are stuck." Staff #1527 stated that there are days when a patient needs a higher level of observation (1:1), and there is no extra staff to help, we basically have to treat them as a Q5 and take extra time to visit that patient."	L 340		

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L1065	Continued From page 9	L1065		
L1065	322-170.2E TREATMENT PLAN-COMPREHENS WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and treatment, transfer, and discharge planning for each patient admitted or retained, including but not limited to: (e) A comprehensive treatment plan developed within seventy-two hours following admission: (i) Developed by a multi-disciplinary treatment team with input, when appropriate, by the patient, family, and other agencies; (ii) Reviewed and modified by a mental health professional as indicated by the patient's clinical condition; (iii) Interpreted to staff, patient, and, when possible and appropriate, to family; and (iv) Implemented by persons designated in the plan; This Washington Administrative Code is not met as evidenced by: . Based on interview, policy review and record review, the facility failed to ensure that the treatment plans were reviewed, the patient's progress was evaluated, and recommendations for revisions to the plan of care were implemented, as indicated for 1 of 2 patients (Patient #1508). Failure to evaluate and provide recommendations to initiate changes to the plan of care in response to the patient's negative response or lack of progress to the provided interventions, results in hospitalizations without effective, patient-specific treatment and creates barriers to patient's	L1065		

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L1065	Continued From page 10 progress, negatively impacting patient outcomes. Findings included: 1. Document review of the hospital's document titled, "Treatment Planning," policy number PC.T.200, last reviewed 01/21, showed that treatment plan reviews and updates shall include the following: a. Review of progress towards goals and effectiveness of interventions for each open problem on the Problems List. b. Modifications or additions made to goals and interventions, as appropriate. 2. Document review of the hospital's document titled, "Social Services and Therapeutic Activities," policy number PC.ACT.01, approved 02/21, showed the following: a. Any new goals identified during the course of treatment will be added to the Master Treatment Plan (MTP) form. b. All groups will be designated to address each patient's individual treatment goals and patient's response to interaction. c. All therapists will document the patient's progress or lack of progress towards treatment in the Therapy Progress Notes. 3. Document review of the hospital's policy and procedure titled, "Assaultive Patient: Precautions and Treatment," policy number PC.AP.01, last reviewed 02/21 showed the following: a. The purpose of the policy was to provide	L1065		

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L1065	Continued From page 11 information about preventing and responding to patients with a potential for aggression and violence. b. Upon admission, patient will be assessed for risk of aggression/violence utilizing the standardized aggression/violence assessment. c. For patients assessed with a Moderate to High Risk of violence/aggression the following interventions will be implemented: i. Focused treatment team meeting immediately following the threat of violence/assault with specific treatment interventions. ii. Medication regimen reassessed. iii. Patient's observation level will be evaluated iv. Daily assault/violence assessment to be conducted using standardized aggression/violence assessment. 4. Patient #1508 is a 44-year-old male, admitted involuntarily on 05/20/21 with a psychiatric diagnosis of Schizoaffective Disorder and Post Traumatic Stress Disorder (PTSD). Patient #1508 had an extensive history of aggression and assault. Prior to his admission on 05/18/21, he assaulted two other residents at his living facility, punching one resident in the face 3 times. He left the facility after the assault, then was arrested by police after he returned to the living facility with a lead pipe. Review of the medical record showed the following: a. On the Master Treatment Plan (MTP) dated 05/23/21, staff documented that the primary psychiatric problem for Patient #1508 was	L1065		

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L1065	Continued From page 12 Anger/Aggression. b. On 05/23/21, staff initiated an Individual Treatment Plan (ITP) for Anger/Aggression. Patient #1508's Long-Term Goal was to "exhibit no aggression, threatening, hitting, posturing for a minimum of 3 days prior to discharge." The Patient's Short-Term Goal was to "utilize at least one new coping strategy over a 7-day period to cope with feelings of anger/aggression." Staff interventions to aid the Patient in achieving his goals included assessing and monitoring for symptoms and response, monitoring patient behavior, encourage group attendance to build insight and coping mechanisms, and to provide therapeutic groups focusing on emotional regulation. c. Weekly Treatment Plan Updated for the weeks of 05/27/21, 06/03/21, 06/10/21, 06/17/21, 06/24/21, 07/01/21, 07/08/21, 07/15/21, and 07/22/21 found that staff documented that the Patient was making poor or minimal progress towards his treatment goals and was not attending the therapy and activity groups when offered. Staff failed to document the implementation of interventions to address the Patient's assaultive/aggressive behavior or initiate changes to the treatment plan. d. Weekly Treatment Plan Updates for the weeks of 06/03/21, 06/24/21, 07/01/21, 07/08/21, 07/15/21, and 07/22/22 found that staff documented that Patient #1508 was unpredictable and physically aggressive, attempting to attack peers. Staff failed to document the implementation of interventions to address the Patient's assaultive/aggressive behavior or initiate changes to the treatment plan.	L1065		

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L1065	Continued From page 13 e. The Incident Report Log for dates between 05/01/21 to 08/24/21 showed that Patient #1508 attacked his peers on six separate incidents: 05/21/21, 05/24/21, 06/23/21, 06/27/21, and physically attacked the same peer twice on 07/19/21. The peer was sent to the Emergency Department for medical evaluation and treatment after the attacks. 5. Investigator #15's review of the medical records found that staff failed to respond to Patient #1508's continued escalation in aggressive/assaultive behavior. Staff documented the Patient's refusal to attend groups or activities during his admission (05/23/21 to 07/29/21). Staff also documented Patient #1508's repeated incidents of aggressive/assaultive behavior. Staff however failed to document the evaluation of the Patient's response to interventions provided, the progress towards his treatment goals, or make recommendations and initiate modifications to the treatment plan based on the patient's response and/or lack of progress to the interventions provided. 6. On 08/13/21 at 2:20 PM, during an interview with Investigator #15, the Director of Social Services (Staff #1506) stated that currently the provider and the social workers were attending treatment team meetings. Staff #1506 stated that she was unsure how often the nursing staff was able to attend treatment team. She reported that if the nursing staff was not able to attend, the provider was reviewing the medical record during treatment team. During the interview, Staff #1506 verified that staff failed to document the evaluation and recommendation to Patient #1508's treatment plan for aggressive/assaultive behavior. Investigator #15 asked Staff #1506 about the process for addressing these	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	60429197	A. BUILDING: _____ B. WING _____	C 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

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L1065	Continued From page 14 behaviors. Staff #1506 stated that they "may" initiate a treatment plan for aggression/assaultive behavior, it "depends." Staff #1506 was unable to provide criteria for when a treatment plan would be initiated, and when it was not necessary. Staff #1506 stated that the patients progress towards their treatment goals should be reviewed during treatment team and changes made to the plan of care when indicated.	L1065		

Cascade Behavioral Hospital
Plan of Correction for
State Investigation
(Case #2021-8636)

10/18/2022

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure & Target for Compliance
LOOO	Initial Comments Submission of this plan of correction is not an admission by the hospital that the citations are true or that the hospital violated the law. Immediately following receipt of the statement of deficiencies on 8/9/22, Hospital Leadership and members of the Governing Board reviewed the findings identified by the surveyors in the statement of deficiencies and began formulating a plan of correction.	CEO	Completion date: 11/15/22	
L340 322-035.1H Procedures-Behavior WAC 246-322-035 Policies and Procedures	The CNO and Director of Risk reviewed the Assaultive Patient Precautions and Treatment policy and determined the policy needs revised to clarify the risk interventions for each risk level and removal of assault levels that are no longer applicable. The policy will be revised and submitted to Quality Council for approval by 10/26/22. The standardized aggression/assault tool (DASA) was revised. The patient observation policy was revised 4/2022 prior to receipt of 2567 as part of policy routine policy review. The CNO implemented a new process where staff notify the house supervisor via phone when an incident of aggression/assault occurs. The house supervisor will ensure immediate interventions have been taken and patients are safe. The house supervisor uses a newly developed audit tool to review the medical record before the end of shift to ensure documentation reflects whether the patient has had an assault/violence risk reassessment, implementation of immediate interventions, provider notified for medication and patient observation review, treatment plan is updated, and incident report completed. Any issues of noncompliance will require the house supervisor to complete just in time training and notification to the CNO. The CNO/Clinical Educator is providing in-person education with the RNs regarding the Assaultive Patient Precautions with a completion date of education by 11/11/22. The education includes the following:	CNO Director of Risk	Completion date: 11/15/22	**Monitoring Process** The Director of Risk reviews 100% of incidents of aggression/assault weekly to ensure immediate interventions were taken and documentation reflects assault/violence risk reassessment completed, treatment plan is initiated/updated, and provider is notified for review and possible new orders pertaining to medication and patient observation level/precautions. The Director of Risk reports findings from review of aggression/assault incidents to the CEO and CNO weekly. The CNO audits 4 charts per unit per month to determine if the standardized aggression/violence assessment is accurate based on other documentation in the medical records. The target goal for compliance with completion of the standardized aggression/violence assessment completed is 90%. Monitoring for compliance will continue until 90% compliance is reached for 3 months; then the Director of Risk will continue reviewing

POC received 10.19.22
Approved 11.17.22
Mary Drew MSN, RN
DOH

Cascade Behavioral Hospital
Plan of Correction for
State Investigation
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Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure & Target for Compliance
LOOO	Initial Comments Submission of this plan of correction is not an admission by the hospital that the citations are true or that the hospital violated the law. Immediately following receipt of the statement of deficiencies on 8/9/22, Hospital Leadership and members of the Governing Board reviewed the findings identified by the surveyors in the statement of deficiencies and began formulating a plan of correction.	CEO	Completion date: 11/15/22	
L340 322-035.1H Procedures-Behavior WAC 246-322-035 Policies and Procedures	The CNO and Director of Risk reviewed the Assaultive Patient Precautions and Treatment policy and determined the policy needs revised to clarify the risk interventions for each risk level and removal of assault levels that are no longer applicable. The policy will be revised and submitted to Quality Council for approval by 10/26/22. The standardized aggression/assault tool (DASA) was revised. The patient observation policy was revised 4/2022 prior to receipt of 2567 as part of policy routine policy review. The providers/CMO and Director of Clinical Services have provided input and approved the policy and form changes as well as the education materials and curriculum. The CNO implemented a new process where staff notify the house supervisor via phone when an incident of aggression/assault occurs. The house supervisor will ensure immediate interventions have been taken and patients are safe. Immediate interventions are carried out by any of the clinical staff including BHA's, nurses, clinicians, and providers. Interventions can include but are not limited to identification of the trigger, removal of the trigger and any extra stimulus (separation of patients if more than one is involved), verbal de-escalation, use of identified coping skills, calling a code for additional support, and use of restrictive interventions if deemed necessary by the RN and/or provider. If the provider is on site they will orders interventions necessary to maintain safety including but not limited to the use of emergency medications, seclusion, and/or restraint based on the clinical presentation of the patient. If the provider is not on-site they will be notified by the RN as the safest possible time to obtain orders based on recommendations	CNO Director of Risk	Completion date: 11/15/22	**Monitoring Process** The House Supervisor audits the medical record prior to the end of the shift in which the incident occurred to ensure proper safety measures were implemented immediately and the documentation reflects whether the patient has had an assault/violence risk assessment, implementation of immediate interventions are documented, provider notification for medication and patient observation review, treatment plan update, and completion of the incident report. The Director of Risk reviews 100% of incidents of aggression/assault weekly to ensure immediate interventions were taken and documentation reflects assault/violence risk reassessment completed, treatment plan is initiated/updated, and provider is notified for review and possible new orders pertaining to medication and patient observation level/precautions. The Director of Risk reports findings from review of aggression/assault incidents to the CEO and CNO weekly. The target goal for

	made by the RN after their immediate assessment of the situation. The house supervisor uses a newly developed audit tool to review the medical record before the end of shift in which the incident occurred to ensure proper safety measures as described above where immediately implemented and that the documentation reflects whether the patient has had an assault/violence risk reassessment, implementation of immediate interventions, provider notified for medication and patient observation review, treatment plan is updated, and incident report completed. Any issues of noncompliance will require the house supervisor to complete just in time training and notification to the CNO. The CNO/Clinical Educator is providing in-person education with BHA's on managing assaultive/aggressive patients to include verbal de-escalation, removal of the trigger/stimuli, use of coping skills, when to call for additional support, and notifying the RN to assess the situation. The CNO/Clinical Educator is providing in-person education with the RNs regarding the Assaultive Patient Precautions with a completion date of education by 11/11/22. The education includes the revised policy and procedure for assessment and reassessment of patients for risk of assaultive/violent behavior; managing an aggressive incident including verbal de-escalation, use of coping skills, removal of the trigger/stimuli and assessing for need of restrictive interventions; implementing interventions after an incident of aggression/assault; updating the treatment plan; and completion of incident report after aggression/assault. This education further includes but is not limited to the following: • All patients will be assessed for risk of aggression/violence upon admission utilizing the standardized aggression/violence assessment. • Any incident of aggression/assault will result in patient being reassessed utilizing the standardized aggression/violence assessment, incident report completed, and house supervisor notified. • Risk Interventions based on standardized aggression/violence assessment: o Score 0-1 low risk: ▪ Assist the patient to identify drivers for assaultive urges and triggers ▪ Assist the patient in identifying specific ways they communicate their aggressive feelings and how to dissipate them o Score 2-3 moderate risk: ▪ Score 0-1 interventions			compliance with RN, BHA, and Social Services education is 90% compliance. The target goal for ensuring compliance with implementation of immediate interventions to promote safety and documentation reflection of patient assault/violence reassessment, implementation of immediate interventions, provider notification for medication and patient observation review, updated treatment plan, and incident report completion is 90% compliance. The target goal for House Supervisor Audits completed by the end of the shift is 90% compliance. The CNO or leadership designee audits 4 charts per unit per month to determine if the standardized aggression/violence assessment is accurate based on other documentation in the medical records and that the observation rounds match the precaution orders. Members of the executive team complete daily leadership rounds reviewing at least 10 observation sheets per unit to ensure compliance in real time and 100% of 1:1 orders to ensure they are followed per policy. The target goal for compliance with completion of the standardized aggression/violence assessment and observation rounds completed is 90%. Monitoring for compliance will continue until 90% compliance is reached for 3 months; then the Director of Risk will continue reviewing medical records for compliance with the when incidents of aggression/assault are reported. Audit tools and leadership rounds will be evaluated to measure and track compliance rate and will be reviewed weekly in the focused audit review meeting. Reports, trends, and aggregate data are reported monthly to Quality Council and quarterly to the Medical

	▪ Obtain orders for Assault Precautions and discuss during multidisciplinary safety huddle(s) ▪ Initiation and/or update of treatment plan goals and interventions to minimize aggressive/assaultive incidents o Score greater than 3: ▪ Score 0-1 and 2-3 interventions ▪ Obtain orders for Assault Precautions and discuss during multidisciplinary safety huddle(s) ▪ Medication regimen reevaluated ▪ Patient observation level and precautions reevaluated ▪ Implementation of immediate intervention including limited safe space (patient room, seclusion room, quiet room, and/or physical restraint use) o Actual assaultive/aggression incidents ▪ Immediate separation of patients ▪ Implementation of immediate intervention including limited safe space (patient room, seclusion room, quiet room, and/or physical restraint use) ▪ Reassessment utilizing DASA tool and implementation of interventions based on score ▪ Providers are notified and orders obtained, if applicable ▪ Incidents are discussed during leadership meetings, multidisciplinary treatment team huddles, and treatment team updates Staff demonstrating competency, by scoring 80% on exam, will be tracked by employee roster. Any staff member who does not demonstrate competency by 30 days after pending acceptable plan of correction with exception of staff on leave of absence, who must complete training prior to returning to work, will be removed from the schedule until they complete the training and demonstrate competency, by scoring 80% on exam, with assessment and reassessment of patients for risk of assaultive/violent behavior, implementing interventions after an incident of aggression/assault, revising treatment plan and completion of incident report after aggression/assault.			Executive Committee and Governing Board. The CNO reviews house supervisor audits after aggression/assaultive incidents for compliance with assault/violence risk reassessment, implementation of immediate interventions, provider notified for medication and patient observation review, treatment plan updated, and incident report completed weekly. Reports, trends, and aggregate data are reported monthly by the CNO to Quality Council and quarterly to the Medical Executive Committee and Governing Board. The target goal for compliance with the policy on assault/violence risk reassessment, implementation of immediate interventions, provider notified for medication and patient observation review, treatment plan updated, and incident report completion after an incident of aggression/assault, utilizing the house supervisor audit, is 90%. Monitoring for compliance will continue until 90% compliance is reached for 3 months; then the house supervisor will return to reporting issues of noncompliance via email/phone call to the CNO. Audit tools and leadership rounds will be evaluated to measure and track compliance rate and will be reviewed weekly in the focused audit review meeting. The CNO will provide refresher training to the staff identified as not being in compliance and progressive discipline if not corrected. The PI Director will audit the leadership rounds using the Leadership Rounds Audit tool to verify:

	The new hire and annual skills fair training will be revised to include the revised policy and procedure for assessment and reassessment of patients for risk of assaultive/violent behavior, implementing interventions after an incident of aggression/assault, treatment plan updated, and completion of incident report after aggression/assault. All direct care staff receive Handle with Care (HWC) training prior to taking independent care assignment. Handle With Care's entire program is dedicated to the reduction of violence through: • Staff's use of preventative actions that result in a decrease in the need for the use of physical restraint • The use of prompt, skillful and appropriate intervention when physical restraint is necessary, in order to minimize injures to patients & staff • Creating a universal perception of physical and psychological safety in the milieu The Leadership Rounding tool was revised to capture the number of patient observations reviewed for • Presence of patient observation levels and precautions on the patient observation sheet and if just in time education had to be completed; and • Review of all 1:1 patients to confirm that the staff has no other assignment, patient is within vision and at arm's length, there isn't anything between the staff and patients, and if just in time education is needed. • Areas of non-compliance will be addressed immediately with the Charge RN and House Supervisor. All areas of non-compliance will be reported daily in Flash. The CEO is providing in-person education to all the leaders who complete leadership rounds by 11/11/22. The presentation includes a copy of the review of the revised leadership rounding tool and process listed below: • During Leadership Rounds, review 10 patient observation sheets per unit unless census is less than 10 in which 100% of patients observations sheets will be reviewed to identify whether all patient observation sheets reviewed have precautions and observation levels marked on the sheet. Provide just in time training for any deficiencies found and notify the CNO. • During Leadership Rounds, review 100% of all patients on 1:1s on the unit to confirm that the staff have no other assignments and are within vision of the patient and at arm's length, and there			• Presence of patient observation levels and precautions on the patient observation sheet and if just in time education had to be completed; and • Review of all 1:1 patients to confirm that the staff has no other assignment, patient is within vision and at arm's length, there isn't anything between the staff and patients, and if just in time education is needed. The target goal for accurate precautions and level of observations documented on the observation sheet is 90% compliance. The target goal to ensure 1:1 patients have a staff member designated to them with no other assignment, that the patient is within vision and at arms' length, and there isn't anything between the staff and patients is 90% compliance. Data will be tracked through the leadership rounds and chart audit tool which is then complied in a workbook for determining trends and monitoring sustainability. Non-compliance with any area will be reported weekdays in flash meeting, weekly in focused audit review meeting, monthly in Quality Council and quarterly to the Medical Executive and Governing Board committees. Areas that do not meet compliance will require an action plan following the PDCA – Plan, Do, Check, Act format and will be monitored in Quality Council monthly and Medical Executive Committee and Governing Board quarterly.

	isn't anything between the staff and patients. The leaders confirmed understanding the above requirements by attestation.			
L1065 322-170.2E Treatment Plan-Comprehens WAC 246-322-170 Patient Care Services	The DCS reviewed the Treatment Planning: PC.T.200 and Social Services and Therapeutic Activities: PC.ACT.01 policies and determined the policies needed to be revised. The DCS/Clinical Educator is providing in-person reeducation to the social services staff, recreational therapy staff and RNs on the process of adding new goals identified during treatment to the Master Treatment Plan with incidents of assault/aggression triggering a new individualized treatment plan problem sheet; reviewing treatment plans for progress towards goals and effectiveness of interventions; making recommendations for revisions to the treatment plan in response to patient's lack of progress or negative response; and documenting in progress notes each patient's response to interventions and progress towards goals by 11/11/22. Training was revised to include a process to guide staff on immediate actions when a patient is assaultive/aggressive including verbal de-escalation, removal of the trigger/stimuli, use of coping skills, when to call for additional support, and notifying the RN to assess the situation to determine a need for restrictive interventions if all less restrictive interventions are exhausted and failed. This training is provided to all direct care staff including social services staff, nursing, BHA's, and recreational therapy staff. Any interventions carried out are communicated to the interdisciplinary team during the next daily safety huddle. The RN and/or social services staff attending the safety huddle bring pertinent information to the interdisciplinary treatment team meeting. The training included the use of case studies to demonstrate competency with this process, and this training will also be added to the new hire orientation and annual skills fair. Specifically, during the training, the staff will be provided with two case studies that require them to add new goals identified during treatment to the Master Treatment Plan with incidents of assault/aggression triggering a new individualized treatment plan problem sheet, review treatment plans for progress towards goals and effectiveness of interventions, make recommendations for revisions to the treatment plan in response to patient's lack of progress or negative response, and document in notes the patient's response to interventions and progress towards goals for each case study. The Clinical Educator reviews staff documentation and confirms that staff added new goals identified during treatment to the Master Treatment Plan, reviewed treatment plans and identified progress towards goals and effectiveness	DCS CNO	Completion date: 11/15/22	The DCS or leadership designee reviews 100% of Master Treatment Plans related to assaultive/aggressive incidents for compliance with initiating a new treatment plan problem sheet for patients that hadn't previously been identified as at risk for assaultive/aggressive behaviors and adding new goals to assist the patient with managing aggressive/assaultive behaviors if previously identified as at risk with ineffective goals and/or interventions monthly. This data will be measured through use of the audit tool and weekly reports. Reports, trends, and aggregate data are reported monthly by the DCS to Quality Council and quarterly to the Medical Executive Committee and Governing Board. The target goal for compliance is 90% for Master Treatment Plans related to assaultive/aggressive incidents with initiating a new treatment plan problem sheet for patients that hadn't previously been identified as at risk for assaultive/aggressive behaviors and adding new goals to assist the patient with managing aggressive/assaultive behaviors if previously identified as at risk with ineffective goals and/or interventions. Monitoring for compliance will continue until 90% compliance is reached for 3 months then return to standard Quality Plan audits. Reports, trends, and aggregate data are reported monthly to Quality Council and quarterly to the Medical Executive Committee and Governing Board.

	of interventions; made recommendations for revisions to the treatment plan in response to patient's lack of progress or negative response; and documented in progress notes the patient's response to interventions and progress towards goals. The CNO and DCS reviewed the treatment team process and determined that it needed to be revised. • Initial Treatment Team conference is held by day 3 of admission. • Treatment team meetings are held weekly after the initial treatment team meeting. • All disciplines will meet in treatment team together to provide and address the following: o Recent assessments and findings including any changes in condition or changes that resulted in a change in precaution/level of monitoring. Changes in condition include both medical and psychiatric including specifically addressing incidents of assaultive/aggressive behaviors, the inventions initiated, and the effectiveness of those interventions. o Progress toward stated goals on the psychiatric and medical problem sheets. o Effectiveness of present therapeutic interventions for each problem. o Consideration of whether the patient is going to group or is accepting or refusing alternative activities and whether there needs to be revision of interventions and goals. o Determination of the focus of treatment during the next few days. • All disciplines must sign, date, and time treatment plan documents. Staff demonstrating competency will be tracked by employee roster. Any staff member who does not demonstrate competency or complete training by 11/11/22 with exception of staff on leave of absence, who must complete the training prior to returning to work, will be removed from the schedule until they complete the training. The CNO and DCS implemented a new process where staff notify the house supervisor via phone when an incident of aggression/assault is reported. The House Supervisor then uses a newly developed audit tool to review the medical record before the end of shift for documentation of implementation of immediate interventions to address the patient's			The CNO reviews house supervisor audits after aggression/assaultive incidents for compliance with assault/violence risk reassessment, implementation of immediate interventions, provider notified for medication and patient observation review, treatment plan updated, and incident report completed weekly. Reports, trends, and aggregate data are reported monthly by the CNO to Quality Council and quarterly to the Medical Executive Committee and Governing Board. The CNO and DCS will provide refresher training to the staff identified as not being in compliance and progressive discipline if not corrected. The House Supervisor will support the CNO by providing real time education and monitoring of the RNs, social services staff, recreational therapy staff.

	assaultive/aggressive behavior and update to the treatment plan to include interventions implemented to assist the patient with managing aggressive/assaultive behavior. Any issues of noncompliance will require the House Supervisor to complete just in time training and notify the CNO or DCS.			