(6) The department may assess civil fines on a hospital according to RCW 70.41.130.

(a) The department may assess a civil fine of up to $10,000 per violation, not to exceed a total fine of $1,000,000, on a hospital when:

(i) The hospital has previously been subject to an enforcement action for the same or similar type of violation of the same statute or rule; or

(ii) The hospital has been given any previous statement of deficiency that included the same or similar type of violation of the same or similar statute or rule; or

(iii) The hospital failed to correct noncompliance with a statute or rule by a date established or agreed to by the department.

(b) The department will assess a civil fine in accordance with Table 1 and subsection (g) of this section:

Table 1

	Fine Amounts in Relation to the Severity of the Violation		
	Impact ~~of Potential or Actual Harm~~		
Scope	Low	Moderate	High
Limited	Up to $1,000	$1,000-4,000	$2,000-8,000
Pattern	Up to $2,000	$2,000-5,500	$3,500-9,000
Widespread	Up to $3,000	$3,000-7,000	$6,500-10,000

Commented [TJ(1]: Recommendation from stakeholder to remove reference to harm in the table title to align better with statutory language which does not use the term "harm".

(c) The "s~~S~~everity of the violation ~~of noncompliance~~" will be considered when determining fines. Levels of severity are categorized as low, moderate, or high, and defined as:

(i) ***"Low"*** means harm could happen but would be rare. The violation undermines safety or quality or contributes to an unsafe environment but is very unlikely to directly contribute to harm;

(ii) ***"Moderate"*** means harm could happen occasionally. The violation could cause harm directly, but is more likely to cause harm as a continuing factor in the presence of special circumstances or additional failures. If the deficient practice continues, it would be possible that harm could occur but only in certain situations or patients;

(iii) ***"High"*** means harm could happen at any time or did happen. The violation could directly lead to harm without the need for other significant circumstances or

failures. If the deficient practice continues, it would be likely that harm could happen at any time to any patient.

(d) Levels of harm are classified as the following based on the impact of harm on an individual's functional ability and the duration of the impact:

(i) Death;

(ii) Severe Permanent Harm - Severe lifelong bodily or psychological injury or disfigurement;

(iii) Permanent Harm - Lifelong bodily or psychological injury or increased susceptibility to disease;

(iv) Temporary Harm - Bodily or psychological injury, but likely not permanent;

(v) Additional Treatment - Injury limited to additional intervention during admission but no other injury;

(vi) Emotional Distress or Inconvenience - Mild and transient anxiety or pain or physical discomfort;

(vii) No Harm - Reached patient, but no harm was evident;

(viii) Near Miss - Event occurred but did not reach patient;

(ix) Unsafe Condition - Any circumstance that increases the probability of a patient safety event.

(ed) Factors the department will consider when determining the severity of the ~~noncompliance~~ violation ~~may~~ include~~, but are not limited to~~:

(i) ~~Whether harm to the patient has occurred, or could occur, including but not limited to a violation of patient's rights;~~

~~(ii) The impact of the actual or potential harm on the patient;~~ The level of harm that occurred;

Option 1: (i~~i~~) The degree to which the hospital deviated from ~~failed to~~ standards of care or demonstrated non-compliance with requirements, procedures, policies or protocols resulting in harm~~; meet the patient's highest practicable physical, mental, and psychosocial well-being;~~ and

Option 2: (iii) The degree to which the hospital failed to meet the patient's ~~highest practicable~~ physical, mental, and psychosocial well-being; and

(i~~ii~~v) Whether a fine at a lower severity has been levied and the condition or deficiency related to the violation has not been adequately resolved.

Commented [TJ(2]: Stakeholders suggested using NCRI or NQF levels of harm definitions. It is difficult to find without a membership. AHRQ seems to be referenced a lot: AHRQ Harm Scale (army.mil) SSE-2_getting_to_zero-9-30-14.pdf (ashrm.org)

Commented [TJ(3R2]: Additional recommendation to use The Press Ganey HPI Cause Analysis Field Guide™

Commented [TJ(4]: Removed per stakeholder request

Commented [TJ(5]: Seems to combine previous (i) and (ii) and ties in the "levels of harm" above

Commented [TJ(6]: Stakeholder's felt too subjective. Most liked incorporating "standards of care" language.

Commented [TJ(7]: Suggestion from stakeholder

(fe) The scope of the violation is the frequency, incidence or extent of the occurrence of the violation(s). The levels of scope are defined as follows:

(i) "***Limited"*** means a unique occurrence of the deficient practice that is not representative of routine or regular practice and has the potential to impact only one or a very limited number of patients, visitors, or staff. It is an outlier. The scope of the violation is limited when one or a very limited number of patients are affected or one or a very limited number of staff are involved, or the deficiency occurs in a very limited number of locations.

(ii) ***"Pattern"*** means multiple occurrences of the deficient practice, or a single occurrence that has the potential to impact more than a limited number of patients, visitors, staff. It is a process variation. The scope of the violation becomes a pattern when more than a very limited number of patients are affected, or more than a very limited number of staff are involved, or the situation has occurred in several locations, or the same patient(s) have been affected by repeated occurrences of the same deficient practice.

(iii) ***"Widespread"*** means the deficient practice is pervasive in the facility or represents a systemic failure or has the potential to impact most or all patients, visitors, staff. It is a process failure. Widespread scope refers to the entire organization, not just a subset of patients or one unit.

(gf) When determining the scope of the violation the department will also consider the duration of time that has passed between repeat violations, up to a maximum of two prior survey cycles. ~~that relate to the same or similar circumstances.~~

Commented [TJ(8]: Stakeholders discussed linking the timeframes (# of years) to time between survey cycles; however, CAHs are surveyed more frequently than other hospitals. A more equitable impact would be to link it specifically to the survey occurances rather than a number of years.

Option 1:

(hg) When a fine amount is identified based on the scope and severity table in (6)(b), the department will reduce the fine amount as follows based on the operation size of the hospital and number of licensed beds: The hospital will be categorized based on the most recent reported licensed bed capacity or average daily census, whichever is lower.

Commented [TJ(9]: Stakeholders would like this to be based on "staffed beds" however, that is in constant flux and would require additional tracking. Another option would be to use Average Daily Census which is reported on the hospital renewal application.

(i) Up to 25 beds- reduce fine amount by ~~thirty-five percent~~5035% ~~or assess the minimum fine amount within the specified scope and severity range, whichever is greater~~;

Commented [TJ(10]: Percentages recommended by stakeholders during workshop.

(ii) 26 to 99 beds- reduce fine amount by ~~twenty-five percent~~3525% ~~or assess the minimum fine amount within the specified scope and severity range, whichever is greater~~;

(iii) 100 to 299 beds- reduce fine amount by ~~fifteen percent~~ 2515% ~~or assess the minimum fine amount within the specified scope and severity range, whichever is greater~~; and

(iv) 300 beds or greater- no reduction in fine amount.

Option 2:

(h) When a fine amount is identified based on the scope and severity table in (6)(b), the department will reduce the fine amount as follows based on the operation size of the hospital and number of licensed beds:

(i) Up to 25 beds- reduce fine amount by 95.8%;

(ii) 26 to 99 beds- reduce fine amount by 79.2%

(iii) 100 to 299 beds- reduce fine amount by 33.5% or assess the minimum fine amount within the specified scope and severity range, whichever is greater; and

(iv) 300 beds or greater- no reduction in fine amount.

Option 3:

(h) When a fine amount is identified based on the scope and severity table in (6)(b), the department will reduce the fine amount as follows based on the operation size of the hospital and number of licensed beds. The hospital will be categorized based on the most recent reported licensed bed capacity or average daily census, whichever is lower.

(i) Up to 25 beds- reduce fine amount by 90% ~~35% or assess the minimum fine amount within the specified scope and severity range, whichever is greater~~;

(ii) 26 to 99 beds- reduce fine amount by 75% ~~25% or assess the minimum fine amount within the specified scope and severity range, whichever is greater~~;

(iii) 100 to 299 beds- reduce fine amount by 55% ~~15% or assess the minimum fine amount within the specified scope and severity range, whichever is greater~~; and

(iv) 300 beds or greater- no reduction in fine amount.

~~(~~(i~~h~~) A hospital may appeal the department's action of assessing civil fines under RCW 43.70.095.

(i) The department may not retaliate against or engage in any form of intimidation against the hospital for appealing fines issued under this chapter.

Commented [TJ(11]: Recommendation from stakeholder: These discounts are based on the average number of beds in the category. So hospitals would pay fines based on number of beds. 100%=300 beds. In the smallest category the average number of beds for the category is 12.5 beds so 12.5/300*100=4.2%. The size correction is therefore 95.8%. So on for the other hospitals.

Commented [TJ(12]: Similar to option 2, but established based on operating budget data.

These discounts are based on the average operating budget (based on 2019 data reported to DOH) of hospitals placed in categories based on their ADC. Fine would be at 100% for a hospital with an ADC of 300+. In the smallest category (0-25 ADC) the average operating budget is about 10% of a large hospitals operating budget so the reduction in fine amount would be 90%.

Note: If legal opinion states that we cannot use ADC and must use bed count only, then the discounts would be as follows:
0-25-90%
26-99- 80%
100-299-40%
300+-0%
Less hospitals would qualify for lower categories if using bed count only.

Commented [TJ(13]: Researched and found that negotiations happen outside of the appeals process. The appeals process is if the negotiations don't reach an agreement.

Commented [TJ(14]: Recommendation from stakeholder.