ATTACHMENT A
TO FORM CMS 2567 STATEMENT OF DEFICIENCIES & PLAN OF CORRECTION
Submitted by Santa Clara Valley Medical Center

Preparation and execution of this Plan of Correction does not constitute an admission or agreement of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and executed solely because it is required by federal or state law. The following constitutes Santa Clara Valley Medical Center's (SCVMC) credible allegation of compliance with the Medicare Conditions of Participation.

TAG A 043 GOVERNING BODY

(Please also refer to responses for Tags A 115 PATIENT RIGHTS; A 385 NURSING SERVICES; and A 263 – QAPI.)

1. Plan for Correcting Deficiencies

All deficiencies have been addressed and corrected as discussed in detail in this Plan of Correction. The governing body will continue to ensure the comprehensiveness and effectiveness of the corrective actions and the patient safety and quality improvement program, to ensure a safe environment for all patients. The Chief Executive Officer (CEO) and the Enterprise Senior Leadership Team (ESLT) will direct and enforce compliance with this Plan of Correction and all reporting to the governing body.

2. Plan for Improving Processes

SCVMC's Medical Staff Quality Improvement Committee (QIC) will receive and evaluate monthly reporting of metrics and oversight of quality assurance and performance improvement (QAPI) activities for the hospital. Designation of cases to go through the root cause analysis (RCA) process have been reviewed with risk staff, with an emphasis on adverse and sentinel events, which are reported monthly to the QIC, the SCVMC Patient Safety Committee (PSC), the SCVMC Medical Leadership Council (MLC), and the Enterprise Medical Executive Committee (EMEC).

Additional leadership for quality oversight was added through the creation of a new Chief Quality Officer (CQO) position, which is responsible for organizational risk, quality, and performance improvement oversight, and which reports directly to the CEO. The current CQO is a physician with additional postgraduate training and experience in medical quality improvement. The CQO, in conjunction with the Director of Quality and Safety, will provide greater depth, transparency, and oversight of patient safety and quality of care for the system, including through membership on and regular reporting to the QIC, PSC, MLC, EMEC, and the ESLT.

To ensure effective monitoring and review of patient care and quality concerns, the CQO will be responsible for assuring that all adverse events, sentinel events, and cases or incidents that are

determined to require medical staff peer review and/or an RCA will be reported and reviewed at the QIC, PSC, MLC, EMEC, and any other appropriate quality committees, as well as documented within committee minutes. These committees will review and discuss performance improvement projects and quality metrics, including for this Plan of Correction. The CEO will continue to update the governing body through monthly reporting and as-needed reporting on incidents, sentinel events, and patient safety matters, as well as semi-annual reporting on quality and safety performance, including system and process improvements and concerns, the number and types of sentinel events, and actions taken to promote safety (both prospectively and in response to safety occurrences).

3. Procedure for Implementing the PoC

The Plan of Correction has been implemented, with detailed documentation of steps outlined in the individual Tag responses below.

4. Monitoring and Tracking

The CEO and ESLT will monitor performance of this Plan of Correction, with regular reporting to the governing body, as indicated and at least monthly, until all monitoring and tracking activities are completed with 100% compliance. The CQO will ensure that the QIC, PSC, MLC, EMEC, ESLT, and CEO are updated at least monthly on compliance with this Plan of Correction.

5. Person(s) Responsible for Implementation

Chief Executive Officer.

6. Completion Date for Correcting Each Deficiency

The completion dates for correcting each deficiency are indicated in the individual Tag responses below.

TAG A 084 CONTRACTED SERVICES

1. Plan for Correcting Deficiencies

The policy of the governing body (Policy 5.4.5.5 Monitoring, Administration and Evaluation of Contracts) is that departments are required to "develop performance standards and implement a process that incorporates monitoring, administration, and evaluation of contracts," and that these performance evaluations are used to "evaluate the propriety of entering into contract extensions or future agreements with the same contractor."

A Contract Monitoring Tool (CMT) is used for SCVMC service contracts to determine if a contractor meets the objectives and scope of the contract in a satisfactory manner. The tool also

obtains information about the timeliness and quality of services, whether performance standards were met, any performance issues, and whether the contract should be renewed for an additional term.

The CMTs for the Orthoscan contract and the Airgas contract were completed on October 4, 2022, and October 5, 2022, respectively. The completed CMTs for these two contracts are on file with the contracts department.

2. Plan for Improving Processes

Departments that support hospital contracts ("contracts departments") were re-educated on October 5, 2022, about the requirements of Policy 5.4.5.5 and that CMTs must be completed on all service contracts prior to the annual renewal or expiration of each service contract. The information contained in the CMT will be used to evaluate the contract and to determine if the contract should be continued or renewed for an additional term. Any significant concerns about contractor performance, safety, or effectiveness will be escalated immediately to the Chief Executive Officer.

3. Procedure for Implementing the PoC

A new policy to complement the governing body policy 5.4.5.5 was developed to inform staff of the CMT form, annual completion of the form, and monitoring and evaluation of contracted services. This policy was distributed to all staff and providers, including contracting departments, by email from the CEO on February 3, 2023.

4. Monitoring and Tracking

On at least a monthly basis, a summary of the performance of the contracts (based on information contained in the associated CMTs) will be provided by each contracting department to the CEO. The CEO will report to the governing body periodically, but not less than semi-annually, on those contract evaluations, and as needed to address any concerns about contractor performance, safety, or effectiveness.

Beginning no later than February 13, 2023, to ensure that contracts are reviewed on at least an annual basis, SCVMC's Chief Operating Officer will audit at least 10 random service contracts per month to ensure that the CMTs have been completed for at least three months until 100% compliance is achieved on the sample size for three consecutive months. The results will be reported to the CEO and ESLT, and any missing CMTs will be reported to the relevant contracts department for follow-up. Any significant concerns about contractor performance, safety, or effectiveness shall be escalated immediately to the CEO.

5. Person(s) Responsible for Implementation

Chief Operating Officer.

6. Completion Date for Correcting Each Deficiency

The CMTs for the Orthoscan contract and the Airgas contract were completed on October 4, 2022, and October 5, 2022, respectively. The new contract monitoring policy was sent by email from the CEO to all staff and providers, including contracting departments, on February 3, 2023. The CEO will report on contract evaluations for the period of October 2022 through January 2023 to the governing body on February 8, 2023, and will report on contract evaluations periodically thereafter, but not less than semi-annually.

TAG A 115 PATIENT RIGHTS

Please refer to responses for Tags A 117 PATIENT RIGHTS: NOTICE OF RIGHTS; A 144 PATIENT RIGHTS: CARE IN SAFE SETTING; A 172 PATIENT RIGHTS: RESTRAINT OR SECLUSION; and A 174 PATIENT RIGHTS: RESTRAINTS OR SECLUSION.

TAG A 117 PATIENT RIGHTS: NOTICE OF RIGHTS

Patient 15

1. Plan for Correcting Deficiencies

On September 22, 2022, the SCVMC registration staff member who presented a Spanish Conditions of Admission form to Patient 15, whose preferred language is Vietnamese, met with their supervisor for a one-on-one re-education session regarding the importance of providing vital documents to each patient or their representative in their preferred language, and, if the document is not already translated into that language, of using SCVMC language assistance services to ensure that the patient receives information in a language they understand. SCVMC also obtained a signed Conditions of Admission form in the correct language for Patient 15 on September 23, 2022.

2. Plan for Improving Processes

On February 3, 2023, SCVMC adopted a revised Conditions of Admission and Consent for Outpatient Treatment policy (Enterprise # 0278) explicitly stating that Conditions of Admission and Consent for Outpatient Treatment forms "must be provided and explained in the patient's, or their representatives, preferred language and/or if the document is not available in the preferred language, a qualified interpreter will be utilized to ensure the patient receives the information in a language they understand." As detailed below, staff responsible for patient registration and account creation ("Registration Staff") have received (and will continue to receive) additional written and in-person education about this requirement, and compliance will be monitored through regular audits as noted below.

3. **Procedure for Implementing the PoC**

On February 3, 2023, SCVMC provided written re-education to Registration Staff regarding the importance of (1) identifying a patient's or their representative's preferred language, (2) recording or verifying that preferred language in the medical record, (3) providing vital written material—including, but not limited to, Conditions of Admission and Consent for Outpatient Treatment forms, and Patient Rights and Responsibilities forms—in the patient's or their representative's preferred language; and (4) furnishing other language assistance services, such as qualified interpretation services, as appropriate. This written communication consisted of a Registration Staff-wide message, and included copies of the updated Conditions of Admission and Consent for Outpatient Treatment policy (Enterprise # 0278), SCVMC's Language Assistance Services policy (Enterprise # 0134), a two-page SCVMC guide titled "Qualified Language Interpretation and Translation Services" (which was originally circulated to all SCVMC workforce members on August 31, 2022), and a two-page tip sheet explaining how to properly log language information in the Electronic Health Record (Epic HealthLink) ("EHR") titled "Language Preference and Interpreter Documentation" (which was originally circulated to all Registration Staff on September 9, 2022).

Between February 6 and 10, 2023, Registration Staff will receive in-person education by reviewing these materials with their managers and supervisors during daily team huddles. Managers and supervisors will document this in-person education through follow-up e-mails to Registration Staff.

4. **Monitoring and Tracking**

Beginning no later than February 13, 2023, the Director of Patient Access will review a random sample across all units of 50 patient medical records each month to ensure that Conditions of Admission and Consent for Outpatient Treatment forms have been completed in that patient's preferred language. This monitoring will continue for at least three months and until 100% compliance has been achieved on the sample size for three consecutive months. Any concerns will immediately be reviewed with the individual unit managers and Registration Staff member(s) in question. Results will be reported monthly to the QIC. The Director of Patient Access will be responsible for monitoring corrective actions, as well as coordinating with managers and supervisors to provide any necessary re-education to individual Registration Staff members.

5. **Person(s) Responsible for Implementation**

Director of Patient Access.

6. **Completion Date for Correcting Each Deficiency**

The specific deficiency noted with respect to Patient 15 was corrected on September 23, 2022. Policy revisions were completed and issued to all Registration Staff members, along with written

educational materials, on February 3, 2023. In-person training for Registration Staff regarding the policy revisions and re-education will be completed by no later than February 10, 2023.

Patient 35

1. **Plan for Correcting Deficiencies**

The Sepsis QI coordinator Y (QC Y) who spoke with the surveyors was mistaken when she said that Patient 35 did not have a copy of Patient Rights signed and that this task was in a work queue for the admitting department. At the point of patient registration, each patient is provided with specific documents, including the Patient Rights and Responsibilities form. This form is a handout and, under SCVMC Policy # 301.4, was not required to be signed or scanned. At the time of the CMS survey, the EHR was not set up to explicitly document whether staff provided the Patient Rights and Responsibilities form to patients. However, a plan of correction was implemented with the steps noted below.

2. **Plan for Improving Processes**

On February 3, 2023, SCVMC adopted a revised "Patient Rights and Responsibilities" policy (Enterprise # 0276) to clarify Registration Staff's duty to provide the form to patients or their representatives in their preferred language upon every visit or admission. The previous policy required Registration Staff, "[a]t the time of admission, or as soon as reasonably possible after admission, [to] provide[] the patient/legal representative or significant other with a copy of the 'Patient Rights and Responsibilities' included in patient rights section of Patient Information Booklet (available in English, Spanish and Vietnamese)." The new policy provides as follows:

> At the time of admission (inpatient) or registration (outpatient), or as soon as reasonably possible after admission, provide the patient/patient representative with a copy of the Patient Rights and Responsibilities document.
>
> The document must be provided in the patient's preferred language or using a qualified interpreter to ensure the patient receives the information in a language they understand.
>
> Document that the Patient Rights were given to the patient/patient representative in the document table in the Electronic Health Record (EHR).

In addition, SCVMC has taken steps to improve documentation of the distribution of the Patient Rights and Responsibilities form. On February 3, 2023, the form was added to the "documents table" in the EHR. This requires Registration Staff to formally record in the EHR every time they issue the form to a patient or their representative. The EHR has also been programmed to issue a warning to Registration Staff any time they "file" (save) a record without indicating whether the Patient Rights and Responsibilities form was issued.

As part of SCVMC's education efforts, all Registration Staff will be provided with:

- a copy of the updated "Patient Rights and Responsibilities" policy;
- written education, in the form of a HealthLink tip sheet, regarding the requirement to document the distribution of the Patient Rights and Responsibilities form in the EHR upon each patient visit or admission; and
- in-person education regarding this requirement during daily Registration Staff huddles, which will be documented through follow-up emails to all Registration Staff.

3. Procedure for Implementing the PoC

The revised "Patient Rights and Responsibilities" policy was distributed to all Registration Staff on February 3, 2023.

Registration Staff received the written tip sheet detailing the updated EHR documentation requirement on February 3, 2023.

Registration Staff will receive additional education regarding the requirement during team huddles and through confirmatory emails during the week of February 6, 2023.

4. Monitoring and Tracking

Beginning no later than February 13, 2023, the Director of Patient Access will review a random sample across all units of 50 patient medical records each month to ensure to ensure distribution of the Patient Rights and Responsibilities form is recorded in the EHR. This data will be reported to the QIC monthly. Monitoring will continue for at least three months until 100% compliance is achieved on the sample size for three consecutive months. The Director of Patient Access will be responsible for monitoring corrective actions, as well as coordinating with managers and supervisors to provide any necessary re-education to individual Registration Staff members.

5. Person(s) Responsible for Implementation

Director of Patient Access.

6. Completion Date for Correcting Each Deficiency

On February 3, 2023, SCVMC issued an updated policy requiring Registration Staff to document the provision of the Patient Rights and Responsibilities form to each patient or their representative in their preferred language upon every visit or admission; launched new EHR functionalities requiring Registration Staff to document the form's distribution upon every visit or admission; and issued written guidance about how to employ these new functionalities. Registration Staff will receive in-person training regarding these new requirements during the week of February 6, 2023, while auditing of the use of the new EHR functionalities will begin no later than February 13, 2023.

TAG A 144 PATIENT RIGHTS: CARE IN SAFE SETTINGS

Patient 1

1. **Plan for Correcting Deficiencies**

On September 16, 2022, a root cause analysis (RCA) of the incident involving Patient 1 was performed. Following the RCA, SCVMC committed to providing additional resources and education to help nursing staff more effectively identify patients with suicidal ideation, create a safer physical environment for patients at risk of intentionally harming themselves or others, and monitor such patients, including those on legal holds. As detailed below, SCVMC has taken specific steps in each of these areas to enhance patient safety.

2. **Plan for Improving Processes**

SCVMC has adopted a multi-pronged approach to making care settings safer for patients at risk of harming themselves or others. As detailed in the next section, this approach has included: (1) more granular tracking of patients on 5150 holds to identify those at risk of suicide as early as possible; (2) making changes to the environmental safety checklist, and re-educating nursing staff on how to use the checklist, to ensure that potential safety concerns are promptly and accurately identified, documented, and resolved (including, as necessary, through escalation up the chain of supervision); and (3) amending the hospital's "Constant Observation, 1:1 Care, and Enhanced Supervision" policy (VMC # 392.1) to clarify the criteria for use of sitters and types of observation, modifying the EHR to direct staff and providers to select constant observation for patients who are a danger to themselves or others or are on a legal hold, and providing accompanying in-person education to nursing staff.

3. **Procedure for Implementing the PoC**

    a. *Tracking Patients on Legal Holds to Identify Those at Risk of Self-Harm*

Since August 2022, the Inpatient Nursing Manager for Quality has conducted a daily (weekday), manual review of the medical records for all new inpatients on 5150 holds to identify those at risk of suicide. The Inpatient Nursing Manager for Quality emails the list of suicidal inpatients to the Nurse Managers of the units where the patients are located and to the Nursing Directors with instructions to ensure that constant observation is active, that room safety checks are completed, and that suicide care plans for those patients are active. Nurse Managers and Nursing Directors may also obtain a system-generated list in the hospital's EHR showing all inpatients with legal holds to ensure that for those patients—including suicidal patients—constant observation is active, room safety checks are completed, and suicide care plans are active.

On November 1, 2022, the governing body approved the creation of positions for a new behavioral response team of psychiatric nurses who will conduct rounds on patients with legal holds. This team will also assist the hospital in better assessing and identifying individuals at

risk of suicide, responding to agitated patients and/or patients with psychiatric issues, and working with the inpatient psychiatric liaison team. This team of psychiatric nurses may also be available to assist with ensuring that suicide care plans and constant observation are active and that room safety checks are done for suicidal patients. SCVMC is in the process of hiring for these new positions.

b. Enhancing the Environmental Safety Checklist Process

SCVMC has also made improvements to its environmental safety checklist process. Environmental checks are conducted every shift and as needed in areas where suicidal patients are roomed, with specific attention to objects that could potentially be used for violence or self-harm. These checks employ an "Environment of Care Checklist," which consists of a series of questions that focus nursing staff's attention on potential ways a patient might harm themselves or others, so that such hazards may be removed.

On February 3, 2023, the checklist was modified in the EHR in a manner that encourages nursing staff to err on the side of caution when evaluating whether a component of a patient's environment might pose a safety risk; elevate any questions or situations requiring special intervention early in the patient's stay; and ensure that constant observation is used whenever appropriate. While the previous dropdown menu for each question posed on the list—including queries such as "Is the area free of lamps, and any items that could be used as a weapon?" and "Is furniture secured or heavy enough to prevent it from being picked up and thrown or moved to block door?"—consisted of a binary set of "met" or "not met" responses, the updated checklist directs nursing staff to one of three context-specific options: (i) "yes," (ii) "no - patient is on constant observation," or (iii) "other – call NM [Nurse Manager] or Supervisor." This revised set of options is designed to steer nursing staff away from responding "met" when they have any doubt about whether one or more aspects of a potentially self-harming patient's environment might present a safety risk, and to ensure that constant observation is used for patients who present a danger to themselves or others.

To help nursing staff understand how to properly use the upgraded menu of options, SCVMC provided written education in the form of a HealthLink tip sheet on February 3, 2023. Nursing staff will also receive in-service training during the week of February 6, 2023, to go over these changes and be re-educated on how best to leverage the checklist in practice. This training will illustrate the above concepts using specific examples. It will also expressly direct nursing staff to consider each patient's unique physical capabilities, mental state, and circumstances when assessing the room for safety—and to immediately escalate any concerns through the chain of command to get issues resolved swiftly.

c. Bolstering Constant Observation Procedures

SCVMC has also updated its policies and procedures to clarify how to appropriately deploy constant observation for patients at risk of harming themselves or others, including those on legal holds. In recognition of the fact that constant observation is one of the most effective ways to mitigate identified safety hazards for patients at risk of harming themselves or others, SCVMC

updated its “Constant Observation, 1:1 Care, and Enhanced Supervision” policy (VMC # 392.1) on February 3, 2023, to:

- highlight the importance of determining the underlying reasons for the patient’s behavior prior to assigning a particular level of observation, including, but not limited to, by evaluating the cause(s) and level of any anxiety or confusion, evaluating the room assignment, assessing and managing pain, and accounting for external stimuli;
- expressly require that “[a]ny patient who is expressing suicidal ideation or is on a legal hold (5150/5250/1799) must be on CO [Constant Observation, defined as continuous unbroken observation by appropriate staff from a distance of not more than one arm’s length] with the sole exception of patients who are physically unable due to their medical condition (e.g., on ventilator, sedated, catatonic, unconscious) to harm themselves or others …”; and
- clarify that “[n]ursing may determine the need for CO when a patient is assessed/identified as a danger to self and/or others or on a legal hold. A current diagnosis of suicidal ideation or legal hold will trigger a 1:1 staffing with constant observation. … For patients who are danger to self/others and patients on a legal hold (5150/5250), the CO will not be discontinued until the patient has been evaluated by a psychiatrist or psychologist in the unit or by transport to EPS or other psychiatric care facility.”

These policy changes were accompanied by EHR upgrades on February 3, 2023, to help further alert nursing staff about when to select constant observation—as opposed to other modes of observation, such as one-to-one care or enhanced supervision—to keep patients a risk of self-harm or harm to others safe. While the drop-down menu under “Type of Observation” previously featured just one entry for “Constant Observation,” it now includes three: (i) “Constant Observation (danger to self and/or others”); (ii) “Constant Observation (Legal Holds 5150/5250/1799); and (iii) “Constant Observation (3 or 4 Limb Restraints).” These upgraded selections underscore that patients who have been determined to pose a danger to themselves or others, as well as patients who are on a legal hold, require constant observation.

Nursing staff and providers received a copy of the updated policy and a HealthLink tip sheet detailing the changes to the EHR on February 3, 2023. Nursing staff will also receive in-service training during the week of February 6, 2023. In addition to discussing the above concepts and requirements, the training will re-educate staff on other criteria relating to the appropriate use of constant observation, including by underlining the need to document hourly when a patient is on constant observation, and by contrasting constant observation with other forms of patient observation, such as one-to-one care and enhanced supervision.

4. **Monitoring and Tracking**

Since August 2022, the Inpatient Nursing Manager for Quality has conducted a daily review of the medical records of all new inpatients on 5150 holds at risk of suicide to assist nurse directors and nurse managers in ensuring that, in 100% of cases, the environmental safety checklist has been completed, constant observation has been ordered, and a suicide plan is active. In the event

of missing documentation, the Inpatient Nursing Manager for Quality promptly notifies the appropriate Nursing Manager to follow up with the nursing staff concerned. After each patient is discharged, the Inpatient Nursing Manager for Quality further reviews the records to confirm that counseling or other follow-up care is provided to patients upon discharge. Effective February 13, 2023, results will be reported monthly to the QIC and Executive Nursing Counsel (ENC) until 100% compliance is achieved for three consecutive months.

Effective February 13, 2023, the Inpatient Nursing Manager for Quality will further audit 10 medical records per month for patients on constant observation to ensure that appropriate, hourly documentation relating to constant observation was performed, and that the environmental safety checklist was completed as appropriate based on the patient's circumstances. The review will capture a 24-hour period for each patient. In the event of non-compliance, the Inpatient Nursing Manager for Quality will immediately notify the appropriate Nursing Manager to correct deficiencies and provide re-education for the nursing staff concerned. Monthly audits will continue until 100% compliance has been achieved for three consecutive months.

5. Person(s) Responsible for Implementation

Inpatient Nursing Manager for Quality.

6. Completion Date for Correcting Each Deficiency

The RCA for the incident involving Patient 1 took place on September 16, 2022. Since August 2022, the Inpatient Nursing Manager for Quality has conducted a daily (weekday) review of records for new inpatients on 5150 holds to identify those at risk of suicide and liaise with the Nurse Managers and Nursing Directors overseeing those patients' care to ensure that constant observation is active, room safety checks are completed, and suicide care plans are active. On November 1, 2022, the governing body approved the creation of positions for a new behavioral response team of psychiatric nurses that will conduct rounds on patients with legal holds. SCVMC improved its policies, procedures, and EHR functionalities relating to constant observation and the use of environmental safety checklists on February 3, 2023. Nursing staff and providers received copies of the policies and accompanying written education that same day. Nursing staff will receive in-person training regarding these topics during the week of February 6, 2023. Monthly audits will begin effective February 13, 2023 and continue until 100% compliance has been achieved for three consecutive months.

<u>Patients 16, 39, 40, 41, 42, 43, and 44</u>

1. Plan for Correcting Deficiencies

For Patient 16, in the immediate aftermath of their elopement, an internal review of the incident was conducted (though not documented). Employee performance was reviewed and addressed in accordance with the County's labor and employment processes. In May 2021, Emergency Department (ED) nursing staff received verbal re-education on environment safety checks,

constant observation, and related documentation processes. On January 30, 2023, an RCA was performed on Patient 16's elopement.

For Patients 39, 40, 41, 42, and 43, the incidents were addressed the day they occurred in accordance with hospital policies and procedures. Staff intervened and returned Patient 39 to their room before they could elope; located Patient 41 on hospital grounds and promptly returned them to their room; and contacted the public safety officer per protocol upon learning of the elopements of Patients 40, 42, and 43. Occurrence reports were filed in all instances except for the one involving Patient 39, as that patient did not ultimately elope.

For Patient 44, a nursing manager investigated the incident and interviewed the staff involved on October 12, 2021. An RCA was performed on January 30, 2023.

2. Plan for Improving Processes

In addition to the process improvements and procedures for implementing the plans of correction detailed in the above subsections relating to Patient 1—which apply with equal force in contexts such as those involving Patients 16, 39, 40, 41, 42, 43, and 44—SCVMC has taken specific operational, educational, and data monitoring steps to reduce the number of elopements, including those involving patients on legal holds who are at risk of harming themselves or others, and AWOL incidents involving patients in locked psychiatric facilities, as detailed below.

3. Procedure for Implementing the PoC

Effective no later than February 10, 2023, patients on legal holds will be placed in conspicuous, lime-green colored scrubs. This will allow nursing staff and other hospital workforce members to rapidly identify patients who may be at risk of harming themselves or others and who are attempting to elope—and, in turn, to prevent and respond to that attempted elopement as quickly as possible.

To help reduce the risk of future elopements from locked inpatient psychiatric units, like the one involving Patient 44, on February 3, 2022, SCVMC implemented enhancements to the Psych Navigator tool in its EHR. Nursing staff are now required to enter specific interventions, such as redirecting AWOL risk patients away from the exit doors and checking for safety before entering and exiting doors, and to follow up with a care plan.

During the week of February 6, 2023, nursing staff will receive in-service training on how to prevent and respond to elopements. The training will cover how to take all reasonable measures to avert the elopement of any patient from the hospital, including when that patient is on a legal hold. The training will re-educate nursing staff on the importance of taking steps such as safely following the patient, providing verbal redirection, noting the patient's description, swiftly escalating the issue up the chain of supervision, recording the facts of the event in the medical record, and timely completing an electronic occurrence report.

During the in-service trainings occurring the week of February 6, 2023, nursing staff will also be re-educated regarding the elopement reporting requirements contained in SCVMC's "Code Green – Elopement/Missing Patient" policy (Enterprise Policy # 0179). This includes, but is not limited to, all elopements meeting high-risk criteria (i.e., patients on a legal hold; actively experiencing suicidal/homicidal ideation; with cognitive impairment; undergoing detoxification or substance use treatment; with required monitoring or attachment to equipment; or having any other reason that the clinician believes is a threat to patient health or well-being).

Finally, in-service trainings will include detailed re-education regarding the SCVMC Acute Psychiatric Services policy (A-4556-0040) applicable to patients in the locked inpatient psychiatric unit, including on how to assess AWOL risk, properly document that risk and accompanying interventions using the enhancements to the EHR, and prevent and respond to AWOL incidents.

4. Monitoring and Tracking

In addition to the monitoring detailed in the above subsections relating to Patient 1—which are also pertinent to the prevention of elopements by patients on legal holds—effective February 13, 2023, the Inpatient Nursing Manager for Quality will conduct a monthly audit of the medical records for all eloped patients on 5150, 5250, and 1799 holds to ensure that hospital policies and procedures were appropriately followed and that events were entered into the occurrence reporting system. Audits will continue until 100% compliance has been achieved for three consecutive months, with results reported to the ENC and PSC monthly.

The Clinical Risk Department reviews all elopements for patients on legal holds in the EHR. In January 2023, the Clinical Risk Prevention Manager completed a data-driven review of all elopements that did not meet the criteria for a root cause analysis for the period between October 1, 2022, and December 31, 2022, to allow the Clinical Risk Department to identify contributing factors in those elopements. The findings will be reported to the PSC on February 7, 2023, so that the PSC may formulate recommended actions.

To continue informing the PSC's long-term policy decisions, effective February 2023, the Clinical Risk Prevention Manager will begin receiving an automated monthly report in the EHR tracking the elopement of patients on legal holds, so that the Clinical Risk Prevention Manager may confirm that all the elopements have been appropriately reported through the online electronic reporting system. The Clinical Risk Prevention Manager will audit this data until 100% compliance has been achieved for three consecutive months, after which reports will be reviewed quarterly. Any missing reports will promptly be routed to the appropriate departmental manager for follow-up. The Clinical Risk Prevention Manager will ensure that the overall audit findings are reported to the ENC and PSC monthly until 100% compliance has been achieved for three consecutive months, and then quarterly thereafter.

Finally, effective February 13, 2023, the Acute Psychiatric Services (APS) QI Manager will conduct a monthly audit on 10 patients to confirm compliance with completion of AWOL risk/safety assessments and interventions for identified high risk AWOL patients. Monthly

audits will continue until 100% compliance is achieved for three consecutive months. The APS QI Manager will ensure that the results are reported to the APS Quality Committee and QIC monthly and the ENC semi-annually.

5. Person(s) Responsible for Implementation

Inpatient Nursing Manager for Quality;
Clinical Risk Prevention Manager;
APS QI Manager.

6. Completion Date for Correcting Each Deficiency

SCVMC responded to the incidents involving Patients 39, 40, 41, 42, and 43 at the time each occurred. The RCAs for the incidents involving Patients 16 and 44 took place on January 30, 2023. SCVMC launched enhancements to the EHR on February 3, 2023. SCVMC will implement upgrades to its elopement prevention and response procedures during the week of February 6, 2023. Nursing staff will also receive in-person re-education regarding elopement and AWOL prevention and response policies and procedures during the week of February 6, 2023. Monthly audits will begin no later than February 13, 2023, and continue until 100% compliance has been achieved for three consecutive months.

TAG A 172 PATIENT RIGHTS: RESTRAINT OR SECLUSION

1. Plan for Correcting Deficiencies

The audit trail for Patient 15's medical record revealed that documentation of the assessment for renewal of restraints was entered in the comments section of the order but was inadvertently deleted.

Changes have been made for restraint orders in the EHR. Questions have been added to the restraint order to require the ordering provider to attest that a face-to-face assessment has been completed prior to each renewal of restraints. This change also makes it so this documentation cannot be inadvertently deleted.

2. Plan for Improving Processes

Changes were made to the restraint order in the EHR to prompt the ordering provider to document that face-to-face evaluation occurred prior to reordering/ordering of restraint and documentation of reasons for restraints. This documentation is required, cannot be skipped, and cannot be inadvertently deleted.

3. Procedure for Implementing the PoC

The updated EHR restraint order was released on January 31, 2023. The providers received written education from the CMIO on January 30, 2023, regarding the changes to the restraint

order. Nursing staff will be verbally educated on the new changes during department huddles and meetings during the week of February 6, 2023.

4. **Monitoring and Tracking**

Effective January 31, 2023, the SCVMC Clinical Risk Prevention Manager will audit a sample of 30 charts monthly until 100% compliance is reached on the sample size for three consecutive months. Any concerns will be reviewed with individual providers. Results and areas for improvement will be reported monthly to the PSC and the QIC.

5. **Person(s) Responsible for Implementation**

SCVMC Clinical Risk Prevention Manager

6. **Completion Date for Correcting Each Deficiency**

January 31, 2023 was the completion date for EHR modification to the restraint order and provider education. Nursing staff education will be completed the week of February 6, 2023. Auditing began on January 31, 2023 and will continue until 100% compliance is achieved on the sample size for three consecutive months.

TAG A 174 PATIENT RIGHTS: RESTRAINT OR SECLUSION

1. **Plan for Correcting Deficiencies**

During video conference meetings with nurse managers and assistant nurse managers in October 2022, the Inpatient Nursing Manager for Quality discussed potential findings from the CMS Survey, including the need to document discontinuation criteria for removal of restraints.

2. **Plan for Improving Processes**

The EHR now prompts the end-user to select a discontinuation criterion each time restraints are discontinued. The EHR also contains a nursing task list which now reminds nurses to select discontinuation criteria when restraints are discontinued.

3. **Procedure for Implementing the PoC**

A new feature was created in the EHR to guide the end user to select discontinuation criteria when removing restraints. A newsletter was emailed to all inpatient nurse managers, assistant nurse managers, and nurses on February 3, 2023 to alert them to this new feature and to provide instructions for use. In addition, nursing staff in all units will be re-educated on the requirement to document restraint discontinuation criteria and educated on the new prompt during in-person department huddles and meetings during the week of February 6, 2023.

4. **Monitoring and Tracking**

Starting no later than February13, 2023, the Inpatient Nursing Manager for Quality will conduct monthly auditing of restraints to ensure compliance with documentation of the discontinuation criteria. Thirty patient records will be reviewed monthly until there have been three consecutive months of 100% compliance on the sample size. If there are fewer than 30 patients with restraints in any given month, then all patient records will be reviewed for that month. Any failures to document discontinuation criteria will be escalated to the nurse manager for the unit where the incident occurred, so that the nurse manager can follow up with the appropriate staff. Monthly auditing results will be reported to the Executive Nursing Council.

5. **Person(s) Responsible for Implementation**

Inpatient Nursing Manager for Quality.

6. **Completion Date for Correcting Each Deficiency**

The new prompt and updated task list in the EHR were activated on February 3, 2023 and a newsletter was emailed to staff and providers upon activation. Nursing staff education on the prompt and updated task list will occur during the week of February 6, 2023. Monitoring will begin no later than February 13, 2023.

TAG A 263 QAPI

Please refer to Tags A 286 PATIENT SAFETY; A 273 DATA COLLECTION & ANALYSIS; A 315 PROVIDING ADEQUATE RESOURCES; and A 308 QAPI GOVERNING BODY, STANDARD TAG.

TAG A 273 DATA COLLECTION & ANALYSIS

1. **Plan for Correcting Deficiencies**

A new chairperson—a specialist in pulmonary critical care—was appointed to the Critical Care Committee (CCC) on December 30, 2022. The SCVMC Hospital Medical Director and the newly appointed chair worked in collaboration with the Quality Department to develop a comprehensive QAPI plan for the targeted temperature management (TTM) project, which aims to improve mortality and neurological outcomes in patients who have survived cardiac arrest by evaluating the implementation of TTM in patients who have had cardiac arrest. The QAPI plan has clearly defined goals and objectives, data/metrics to be collected and analyzed, outcome measures to be tracked, responsible parties, and reporting structure. The QAPI plan will be presented to the QIC by the Chair of the CCC no later than February 17, 2023. The Chair of the CCC will report on the TTM project to the QIC at least semi-annually. In addition, additional resources have been assigned to support the CCC, including the TTM project.

2. Plan for Improving Processes

The Quality Department will provide great guidance and oversight for quality and process improvement projects. No later than February 10, 2023, the Quality Department will provide education to the CCC on appropriate methodology to be used in developing quality and process improvement projects. During the week of February 6, 2023, the Quality Department will also conduct a review of any other CCC projects to ensure that those projects are well-designed, with clearly defined goals and objectives, data/metrics to be collected and analyzed, outcome measures to be tracked, responsible parties, and reporting structure. Any projects that do not meet the criteria will be restructured with an appropriate QAPI plan presented to the QIC.

3. Procedure for Implementing the PoC

The CCC will meet within one week of the QIC to implement the TTM QAPI plan. The CCC Chair will meet with the quality coordinators assigned to support the committee monthly prior to the next regularly scheduled CCC meeting to review the TTM project's progress with data collection, analysis, workflow and identify and correct any concerns. The Chair of the CCC will present the progress on this project to the QIC at least semi-annually.

In addition to the Quality Department's education of the CCC and review of CCC projects during the week of February 6, 2023, two quality coordinators and one analyst have been assigned as of February 2, 2023 to support the CCC, including the TTM project.

4. Monitoring and Tracking

The Chair of the Critical Care Committee will report on the TTM project to the QIC at least semi-annually.

5. Person(s) Responsible for Implementation

Critical Care Committee Chair;
Director of Quality and Safety; and
SCVMC Hospital Medical Director

6. Completion Date for Correcting Each Deficiency

The new TTM QAPI plan was completed February 5, 2023. The TTM QAPI plan will be presented to the QIC no later than February 17, 2023, and once approved, will provide progress reports to the QIC at least semi-annually.

The Quality Department will complete educational training to the CCC members regarding how to develop quality and process improvement no later than February 10, 2023. The Quality Department will review any other CCC projects during the week of February 6, 2023, and any deficient projects will be restructured with an appropriate QAPI plan presented to the QIC.

TAG A 286 PATIENT SAFETY

1. **Plan for Correcting Deficiencies**

In the immediate aftermath of Patient 16's elopement, an internal review of the incident was conducted but not formally documented. On May 18, 2021, all Emergency Department (ED) nursing staff received mandatory, in-service training to review SCVMC Policy #392.1 (Constant Observation, 1:1 Care, and Enhanced Supervision), Enterprise Policy #0030 (Suicide/Safety Precautions and Care of the Patient in Non-Behavioral Health Areas), and the SCVMC Department of Emergency Medicine Standards Manual section on management of patients with psychiatric emergencies. This training included discussion of, among other things, what to do if a sitter must leave a patient, what to do if a patient elopes, how to make the room/environment safe, and the room safety checklist.

During October 2022, the SCVMC Clinical Risk Prevention Manager provided information to ESLT members involved in adverse and sentinel event reporting regarding the definition of sexual assault and reporting requirements. In addition, the form used to notify ESLT members regarding an adverse or sentinel event was updated on October 28, 2022, to specifically identify sexual assault (including alleged sexual assault) as an adverse event, which must be reported to the California Department of Public Health and would trigger an RCA.

As of January 30, 2023, RCAs have been performed for Patient 16's elopement and the two patient-to-patient alleged sexual assaults identified.

2. **Plan for Improving Processes**

Per Enterprise Policy 0179 (Code Green – Elopement/Missing Patient), providers and nurses are expected to report elopements through the online electronic reporting system. This includes, but is not limited to, all elopements meeting high-risk criteria (i.e., patients on a legal hold; actively experiencing suicidal/homicidal ideation; with cognitive impairment; undergoing detoxification or substance use treatment; with required monitoring or attachment to equipment; or having any other reason that the clinician believes is a threat to patient health or well-being). To reinforce reporting expectations, ED and inpatient providers and nurses will receive re-education on the requirement to report elopements in the hospital's online electronic reporting system.

The Clinical Risk Department reviews all elopements reported in the hospital's online electronic reporting system. The Clinical Risk Prevention Manager now maintains a spreadsheet to track elopements on a monthly basis and conducts an in-depth review of elopements that do not meet criteria for an RCA, so that the Clinical Risk Department can identify contributing factors in those elopements. In January 2023, the Clinical Risk Department completed a retrospective review of elopements from October 1, 2022, through December 31, 2022, and the findings will be reported to the PSC on February 7, 2023, so that the PSC can formulate any recommended actions. On an ongoing basis, the Clinical Risk Department will continue tracking and reporting monthly to the PSC on the findings from its review of elopements.

Reportable Adverse and Sentinel Events Policy, Patient Safety Plan (PSP) and Performance Improvement Plan (PIP) for the hospital have been reviewed and revised to include a decision guide for determining when to conduct an RCA. The Reportable Adverse and Sentinel Events Policy directs RCAs to be conducted for all sentinel events, including all sexual assaults and all elopements with significant injury. The Reportable Adverse and Sentinel Events Policy has also been updated to include the Joint Commission's definition of sexual assault. These updates are completed and distributed to all staff and providers as of February 3, 2023.

The online electronic reporting system for incident reporting indicates criteria for sentinel events and triggers RCA initiation. On February 5, 2023, the Clinical Risk Prevention Manager revised the SBAR reporting form for ESLT members (i.e., the notice of significant events provided to hospital leadership) to state that a root cause analysis is required for all adverse events and sentinel events (including sexual assaults).

3. Procedure for Implementing the PoC

Nursing staff will be re-educated on the handling of elopements. Beginning the week of February 6, 2023, the Nursing Directors and Inpatient Nursing Manager for Quality will provide verbal re-education of nursing staff at department huddles and meetings regarding investigating, reporting, and documenting elopements, including timely completing an electronic occurrence report.

Nursing staff will be educated on the revised Reportable Adverse and Sentinel Events Policy, PSP, and PIP. During the week of February 6, 2023, Quality & Safety, Clinical Risk, and Medical Staff leaders will be educated on these revised policies.

The Clinical Risk Prevention Manager distributed the revised SBAR form to the Clinical Risk Department and ESLT members on February 5, 2023.

4. Monitoring and Tracking

Effective February 2023, the Clinical Risk Prevention Manager will begin receiving an automated monthly report in the EHR tracking the elopement of patients on legal holds, so that the Clinical Risk Prevention Manager may confirm that all the elopements have been appropriately reported through the online electronic reporting system. The Clinical Risk Prevention Manager will audit this data until 100% compliance has been achieved for three consecutive months, after which reports will be reviewed quarterly. Any missing reports will promptly be routed to the appropriate departmental manager for follow-up. The Clinical Risk Prevention Manager will ensure that the overall audit findings are reported to the ENC and PSC monthly until 100% compliance has been achieved for three consecutive months, and then quarterly thereafter.

The Clinical Risk Prevention Manager and the Chair of the PSC will review all adverse events each month to ensure RCAs are conducted when indicated, with particular focus on sentinel events and adverse events and as outlined by the updated policy, PSP and PIP.

On a monthly basis, the CQO will provide a summary report of all sentinel events and RCAs with action items as well as elopement data to the PSC, MLC, EMEC, and the ESLT.

5. **Person(s) Responsible for Implementation**

Clinical Risk Prevention Manager and Chief Quality Officer

6. **Completion Date for Correcting Each Deficiency**

On May 18, 2021, ED nursing staff received mandatory, in-service training on SCVMC Policy #392.1, Enterprise Policy #0030, and the SCVMC ED Standards Manual, including what to do if a sitter must leave a patient, what to do if a patient elopes, how to make the room/environment safe, and the room safety checklist.

On October 28, 2022, ESLT members were educated by the Clinical Prevention Risk Manager regarding reporting of sexual assaults and the SBAR form was updated to specifically identify sexual assault (including alleged sexual assault) as an adverse event, which must be reported and would trigger an RCA.

Monthly, in-depth review and tracking of elopements began in January 2023, and monthly reporting of elopements to the PSC will begin February 7, 2023. The in-depth review of elopements that do not meet criteria for an RCA also began in January 2023. The auditing of elopement reports will begin February 2023. Reporting and monitoring will be ongoing.

On January 30, 2023, the RCAs for Patient 16 and the two patients to patient alleged sexual assaults were completed. Final approval of the action plans developed during those RCAs will be presented to the PSC on February 7, 2023.

The Reportable Adverse and Sentinel Events Policy, PSP, and PIP were updated and distributed to all staff and providers as of February 3, 2023.

The automated report in the EHR to identify elopement of patients on legal holds was created February 3, 2023. Review of the list against reports in the online electronic reporting system will begin no later than February 13, 2023 and continue until three consecutive months of 100% compliance have been achieved.

On February 5, 2023, the Clinical Risk Prevention Manager revised the SBAR reporting form (i.e., the notice of significant events provided to ESLT) to state that an RCA is required for all adverse and sentinel events, including sexual assaults.

Nursing staff education on the revised policies and elopement reporting will begin during the week of February 6, 2023.

TAG A 308 QAPI GOVERNING BODY, STANDARD

Please refer to responses for Tag A 084 CONTRACTED SERVICES.

TAG A 315 PROVIDING ADEQUATE RESOURCES

1. Plan for Correcting Deficiencies

As explained in more detail in the response to Tag A-273, the SCVMC Hospital Medical Director and the CCC Chair—who is a specialist in pulmonary critical care and was newly appointed on December 30, 2022—worked in collaboration with the Quality Department to develop a comprehensive QAPI plan for the TTM project, which aims to improve mortality and neurological outcomes in patients who have survived cardiac arrest by evaluating the implementation of TTM in patients who have had cardiac arrest. The QAPI plan has clearly defined goals and objectives, data/metrics to be collected and analyzed (including Code Blue data), outcome measures to be tracked, responsible parties, and reporting structures. This quality plan will be presented to the QIC no later than February 17, 2023. The CCC will provide a report on the TTM project to the QIC at least semi-annually, and the CCC will meet within one week of the QIC to implement the TTM QAPI plan. As of February 2, 2023, two quality coordinators and one analyst have been assigned to support the CCC, including the TTM project.

2. Plan for Improving Processes

The SCVMC Quality Department has assigned at least one quality coordinator/analyst to support each SCVMC quality committee that reports to the QIC (such committees are hereinafter referred to as "quality committees") with data collection, analysis, and training relating to quality process improvement. Quality coordinators will work with each quality committee to review the QAPI plan for existing quality projects that impact that quality committee. For new quality projects, quality coordinators will collaborate with the quality committee to develop a QAPI plan including specific objectives, data to be collected, and patient outcome measures, which will help ensure that the hospital's performance is effectively measured, assessed, and improved to reduce risk to patients. Each quality committee will report to the QIC on its QAPI projects at least annually.

In addition, the CQO and the Director of Quality and Safety will work with the President of the Medical Staff, MLC, EMEC, and nursing leadership to develop a quarterly newsletter on various quality topics to share with the medical, nursing, and hospital staffs. The first quarterly newsletter will be issued by March 1, 2023.

3. Procedure for Implementing the PoC

Effective February 2, 2023, at least one quality coordinator/analyst has been assigned to support each quality committee that reports to the QIC for quality projects. The quality coordinator/analyst will meet with their assigned quality committee by no later than February 17, 2023, to review the ongoing quality projects and associated QAPI plans for that quality

committee. Quality coordinators will help the quality committees modify those plans as appropriate.

Each quality committee and quality coordinator will also work together to develop a working agenda for their respective quality committee's next regularly scheduled meeting, which will include a timeline for review of all projects, as well as educational and training sessions regarding process improvements and best practices.

Any new quality improvement project will be based on a QAPI plan to be developed by the quality committee with the support of the quality coordinator, and in consultation with quality department leadership, the overseeing medical director, the CQO, the QIC, nursing leadership, and other stakeholders, as appropriate.

The QIC will update the reporting calendar to include the reporting schedule on an annual basis. Each quality committee will be notified of their scheduled report time on the same date the reporting calendar is updated.

4. Monitoring and Tracking

Each quality committee will provide a comprehensive, data-driven report of its activity to the QIC at least annually. The report will include a summary of each completed, current, and proposed QAPI project. The summary must include the project's goals/objectives, the data being collected, the type and frequency of analysis, patient outcome measures, and the planned duration of the project. For completed QAPI projects, the summary will also include a detailed description of the findings, and any practice changes that were implemented.

5. Person(s) Responsible for Implementation

Chief Quality Officer;
Director of Quality and Safety; and
President of the Medical Staff.

6. Completion Date for Correcting Each Deficiency

At least one quality coordinator/analyst was assigned to each quality committee for quality projects on February 2, 2023. Each quality committee and quality coordinator will meet by no later than February 17, 2023, to review the quality committee's projects and develop a plan to address any concerns. Quality coordinators will educate the quality committee to which they are staffed about SCVMC's quality improvement processes, as well as the resources available to strengthen QAPI planning. The Quality Department will disseminate a quarterly newsletter on key quality-related topics, with the first issue to be published by March 1, 2023. Finally, the QIC will update the reporting calendar to include an annual reporting date for all quality committees with QAPI projects and disseminate it to each quality committee by no later than March 30, 2023.

TAG A 340 MEDICAL STAFF PERIODIC APPRAISALS

MD TT and MD UU

1. **Plan for Correcting Deficiencies**

Following the survey, the Chair of Surgery spoke with MD TT, reviewed MD TT's case volume and scope, and developed a plan for a Focused Professional Practice Evaluation (FPPE) to ensure that MD TT did not exercise the privileges pending review. On February 1, 2023, MD TT was placed on an FPPE for the Sentinel Lymph Node Biopsy and Insertion and Maintenance of Pulmonary Artery Catheter privileges pursuant to the FPPE policy (Enterprise # 0106), Ongoing Professional Practice Evaluation (OPPE) policy (Enterprise # 0070), and the Enterprise Medical Staff Bylaws, (Bylaws), Article 7.4-3b. This FPPE allows for appropriate proctoring due to insufficient procedure volumes.

Following the survey, the Chair of Surgery spoke with MD UU and reviewed MD UU's case volume and scope, and developed a plan to ensure MD UU did not exercise privileges pending review. On February 1, 2023, MD UU relinquished the Sentinel Lymph Node Biopsy Privilege and was placed on an FPPE for the Insertion and Maintenance of Pulmonary Artery Privilege pursuant to the FPPE policy, OPPE policy, and the Bylaws. The FPPE allows for appropriate proctoring due to insufficient procedure volumes.

2. **Plan for Improving Processes**

As detailed below, the Department Chairs/Division Chiefs will review proof of case volume and scope ("case information") for all privileges requested at the time of reappointment. The MSO will review the case information submitted to ensure the requirements for the privileges have been met. If the requirements have not been met, the provider's file will be considered incomplete per the Medical Staff Bylaws (Bylaws) until such time as the case information is provided, or there is a recommendation from the Department Chair/Division Chief to proceed with an FPPE, as indicated below.

3. **Procedure for Implementing the PoC**

Effective February 6, 2023, case information will be obtained for review with reappointment applications. The individual physician and the Department Chair/Division Chief will review and validate that the case information meets the required minimums for the privileges. If the minimum case numbers are not met, the Department Chair will make a recommendation to the Advisory Credentials Committee (ACC) (or the Enterprise Interdisciplinary Practice Committee (EIDPC), if involving an allied health provider) regarding whether the privileges should be denied for failure to meet minimum qualifications, or whether an FPPE should instead be

implemented pursuant to the FPPE policy and the Bylaws. The recommendation will follow the process for appointments and reappointments as established in the Bylaws.

On February 3, 2023, the MSO sent an email to all members of the Medical Staff and Allied Health Providers regarding the foregoing requirements. The President of the Medical Staff will provide ongoing education at the next scheduled MLC, EMEC, and Quarterly Medical Staff meetings in February and March.

The ACC and EIDPC will also be educated about the foregoing requirements and will review all files, including case information, to ensure that the requirements have been met. Education will be provided at the next scheduled ACC and EIDPC meetings in February and March. Privileges will not be granted if the required volume criteria are not met, unless the Department Chair recommends an FPPE per the FPPE policy and the Bylaws. If the Department Chair determines that an FPPE is appropriate, they will submit the FPPE plan to the ACC or EIDPC for approval at the time of reappointment.

4. Monitoring and Tracking

Beginning February 6, 2023, the Chair of the ACC and the Chair of the EIDPC will review the case information for 10 randomly selected files (or 100% of files, if fewer than 10 are available) submitted by the MSO to the ACC and the EIDPC for reappointment to ensure compliance with the applicable requirements and this plan of correction. The Chair of the ACC and the Chair of the EIDPC will report the results to the MLC on a monthly basis. Any non-compliant files will be removed from review, and privileges will not be granted until case information is obtained or an FPPE is recommended and there is demonstration that the requirements have been met. The audits will continue until such time as 100% compliance is achieved on the sample size for 3 consecutive months.

5. Person(s) Responsible for Implementation

The Enterprise Medical Staff President.

6. Completion Date for Correcting Each Deficiency

The specific deficiencies relating to MD TT and MD UU were corrected on February 1, 2023. Written provider education occurred on February 3, 2023. Provider education will continue at next scheduled ACC, EIDPC, MLC, EMEC, and Quarterly Staff meetings currently scheduled in February and March, 2023. Monitoring of the plan of correction through monthly audits began on February 6, 2023 and will be completed following three consecutive months of 100% compliance.

MD SS

1. **Plan for Correcting Deficiencies**

On October 6, 2022, the MSO received and reviewed the case log from the contracted company through which MD SS provides services. The case log demonstrated that MD SS had adequate clinical volume based on work provided at other institutions.

2. **Plan for Improving Processes**

Effective February 6, 2023, the MSO will request case information from the contracted company at the time of reappointment to ensure adequate case volumes are met.

3. **Procedure for Implementing the PoC**

Effective February 6, 2023, all providers, including neuromonitoring providers, will be required to submit a case log of volume, which can be from other institutions where they provide care. The case log will be reviewed by the Division Chief or Department Chair to ensure that it demonstrates clinical competence for the privileges the provider is requesting prior to the application progressing to the ACC or EIDPC. If a case log is not present or has not been approved by the Department Chair/Division Chief, the application will not be complete and will not proceed for further review.

4. **Monitoring and Tracking**

Beginning on February 6, 2023, the Chair of the ACC will perform a prospective monthly audit of 10 telemedicine neuromonitoring physicians going through the reappointment process (or 100% of physicians, if fewer than 10 are going through reappointment) to ensure 100% compliance with the applicable requirements and this plan of correction for three consecutive months. Any files that are non-compliant will be removed from consideration until the case log has been obtained and reviewed as outlined above. The ACC will report audit results to the MLC monthly.

5. **Person(s) Responsible for Implementation**

The Enterprise Medical Staff President.

6. **Completion Date for Correcting Each Deficiency**

The specific deficiency relating to MD SS was resolved on October 6, 2022. Monitoring of the plan of correction through monthly audits began on February 6, 2023 and will be completed following three consecutive months of 100% compliance.

TAG A 341 MEDICAL STAFF CREDENTIALING

MD SS

1. **Plan for Correcting Deficiencies**

MD SS resigned from the Medical Staff on December 31, 2022. Had MD SS remained on the Medical Staff, an active member of the Medical Staff would have proctored MD SS per the Bylaws and FPPE policy.

2. **Plan for Improving Processes**

Effective February 3, 2023, the Department Chair will submit the initial FPPE with a proctor identified to the MSO at the time of initial appointment. The MSO will notify the Department Chair at 6 months and again at 9 months after initial appointment if the completed FPPE has not been received with proctoring completed. The Medical Staff Office will notify the ACC at 9 months after initial appointment if the FPPE with proctoring has not been completed. The ACC, in conjunction with the Department Chair, will determine if the FPPE should be extended up to 24 months, if appropriate, consistent with the Bylaws.

3. **Procedure for Implementing the PoC**

On February 3, 2023 and February 6, 2023, written education was provided to ACC and EIDPC members, and Department Chairs/Division Chiefs by the Enterprise Medical Staff President on the requirement to complete and document all initial FPPEs with proctoring within the time frame outlined in the FPPE policy. This written education will be complemented by verbal education at the next scheduled ACC, EIDPC, MLC, EMEC, and Quarterly General Staff meetings in February and March.

4. **Monitoring and Tracking**

Beginning on February 6, 2023, the Chairs of the ACC and EIDPC will perform prospective monthly audits of all initial appointments to ensure that the initial FPPE and proctor information has been submitted with the file for consideration. Any non-compliant files will be addressed by the Enterprise Medical Staff President or MLC President who will contact the Department Chair and request that the form be submitted. The application file will not be reviewed and approved by the ACC or EIDPC until the FPPE plan with proctor has been submitted to the MSO. The audits will continue until 100% compliance is achieved for three consecutive months.

5. **Person(s) Responsible for Implementation**

The Enterprise Medical Staff President.

6. **Completion Date for Correcting Each Deficiency**

Written education was completed on February 3, 2023. Verbal education will be completed at the next scheduled meetings of the ACC, EIDPC, MLC, EMEC, and Quarterly Staff meetings in February and March. The monthly audits began February 6, 2023.

MD RR

1. **Plan for Correcting Deficiencies**

Following the survey, MD RR was transferred to active status on January 24, 2023. MD RR was previously misclassified as having telemedicine status when MD RR had been granted privileges for in-person care. MD RR is providing both direct patient care and telemedicine care.

2. **Plan for Improving Processes**

Effective February 3, 2023, the MSO and the Chair of the ACC will ensure that no ophthalmologist will be granted telemedicine status until a specific telemedicine privilege has been created for Ophthalmology.

3. **Procedure for Implementing the PoC**

On February 6, 2023, a written reminder will be issued to ACC members that telemedicine status is not available for Ophthalmology and that no telemedicine status will be approved for Opthamology until a specific telemedicine privilege for Ophthalmology is created and approved pursuant to the Bylaws.

4. **Monitoring and Tracking**

Beginning no later than February 6, 2023, the Chair of the ACC will prospectively review any Ophthalmology initial appointments or reappointments that are classified under telehealth status. The applicants will be notified that there is not an option for telemedicine status at this time. The applicant and ACC may recommend a change in the category of membership based on the Bylaws. No telemedicine status will be approved by the ACC for Ophthalmology until a specific telemedicine privilege has been created. The audits will occur until 100% compliance has been achieved for three consecutive months.

5. **Person(s) Responsible for Implementation**

Enterprise Medical Staff President.

6. **Completion Date for Correcting Each Deficiency**

Following the survey, the MSO and ACC reviewed MD RR's file and identified that he should be transferred to active status, which was approved by the governing body on January 24, 2023. Effective February 6, 2023, the Chair of the ACC will ensure that no telemedicine status is granted for Ophthalmology until a specific telemedicine Opthalmology privilege is created and approved. Beginning no later than February 6, 2023, the Chair of the ACC will audit all Opthalmology privileges until 100% compliance has been achieved for three consecutive months.

TAG A 353 MEDICAL STAFF BYLAWS

1. **Plan for Correcting Deficiencies**

The Enterprise Medical Staff Rules provide that the PSC "shall meet monthly[.]" To ensure that this requirement is met, the Chair of the PSC has instituted a firm monthly meeting schedule for 2023. The schedule was finalized and circulated to PSC members on November 15, 2022.

2. **Plan for Improving Processes**

Every year, in the month of November, the Chair of the PSC will develop and institute a monthly PSC meeting schedule for the following calendar year.

3. **Procedure for Implementing the PoC**

The new PSC meeting schedule for each calendar year will be sent to PSC members as soon as it is finalized, and no later than the last day of November of the preceding calendar year, to ensure that PSC members have advanced notice of meeting dates and can block off those times on their calendars.

The monthly meeting schedule will also be carefully designed to avoid conflicting with county, state, and federal holidays, which presented the most common source of unexpected PSC member absences and meeting cancellations in previous years.

4. **Monitoring and Tracking**

At least semi-annually, the Chair of the PSC will ensure that the PSC schedule reflects that meetings shall occur monthly. At each PSC meeting, the Chair will also confirm the date of the following meeting with the members present. Finally, should a pre-scheduled meeting need to

be cancelled in a particular month for any reason, the Chair will ensure that the meeting is rescheduled for a date later that same month.

5. Person(s) Responsible for Implementation

Chair of the Patient Safety Committee.

6. Completion Date for Correcting Each Deficiency

The new monthly schedule for 2023 was adopted and circulated to PSC members on November 15, 2022.

TAG A 385 NURSING SERVICES

Please refer to responses for Tags A 398 SUPERVISION OF CONTRACT STAFF; A 405 ADMINISTRATION OF DRUGS; and A 407 VERBAL ORDERS FOR DRUGS.

TAG A 398 SUPERVISION OF CONTRACT STAFF

Patient 1 and Patient 16

1. Plan for Correcting Deficiencies

Patient 1

On September 16, 2022, an RCA of the incident involving Patient 1 was performed. Following the RCA, SCVMC committed to providing additional resources and education to help nursing staff more effectively identify patients with suicidal ideation, create a safer physical environment for patients at risk of intentionally harming themselves or others, and monitor such patients, including those on legal holds. As detailed below, SCVMC has taken specific steps in each of these areas to enhance patient safety.

Patient 16

In the immediate aftermath of Patient 16's elopement, an internal review of the incident was conducted (though not documented). Employee performance was reviewed and addressed in accordance with the County's labor and employment processes. In May 2021, ED nursing staff received verbal re-education on environment safety checks, constant observation, and related documentation processes. On January 30, 2023, an RCA was performed on Patient 16's elopement. During the week of February 6, 2023, all nursing staff will receive in-service training and verbal re-education during departmental huddles and meetings on communication within the chain of command and requirements for patients on constant observation.

2. Plan for Improving Processes

SCVMC has adopted a multi-pronged approach to making care settings safer for patients at risk of eloping and/or harming themselves or others. As detailed in the next section, this approach has included: (1) more granular tracking of patients on 5150 holds to identify those at risk of suicide as early as possible; (2) making changes to the environmental safety checklist, and re-educating nursing staff on how to use the checklist, to ensure that potential safety concerns are promptly and accurately identified, documented, and resolved (including, as necessary, through escalation up the chain of supervision); (3) amending the hospital's "Constant Observation, 1:1 Care, and Enhanced Supervision" policy (VMC # 392.1) to clarify the criteria for use of sitters and types of observation, modifying the EHR to direct staff and providers to select constant observation for patients who are a danger to themselves or others or are on a legal hold, and providing accompanying in-person education to nursing staff; and (4) re-educating staff on preventing and responding to elopements.

3. Procedure for Implementing the PoC

a. Tracking Patients on Legal Holds to Identify Those at Risk of Self-Harm

Since August 2022, the Inpatient Nursing Manager for Quality has conducted a daily (weekday), manual review of the medical records for all new inpatients on 5150 holds to identify those at risk of suicide. The Inpatient Nursing Manager for Quality emails the list of suicidal inpatients to the Nurse Managers of the units where the patients are located and to the Nursing Directors with instructions to ensure that constant observation is active, that room safety checks are completed, and that suicide care plans for those patients are active. Nurse Managers and Nursing Directors may also obtain a system-generated list in the hospital's EHR showing all inpatients with legal holds to ensure that for those patients—including suicidal patients—constant observation is active, room safety checks are completed, and suicide care plans are active.

On November 1, 2022, the governing body approved the creation of positions for a new behavioral response team of psychiatric nurses who will conduct rounds on patients with legal holds. This team will assist in responding to agitated patients and/or patients with psychiatric issues, work with the inpatient psychiatric liaison team, and assist the hospital in better assessing and identifying individuals at risk of suicide. SCVMC is in the process of hiring for those positions. This team of psychiatric nurses may also be available to assist with ensuring that suicide care plans and constant observation are active and that room safety checks are done for suicidal patients.

b. Enhancing the Environmental Safety Checklist Process

SCVMC has also made improvements to its environmental safety checklist process. Environmental checks are conducted every shift and as needed in areas where suicidal patients are roomed, with specific attention to objects that could potentially be used for violence or self-harm. These checks employ an "Environment of Care Checklist," which consists of a series of

questions that focus nursing staff's attention on potential ways a patient might harm themselves or others, so that such hazards may be removed.

On February 3, 2023, the checklist was modified in the EHR in a manner that encourages nursing staff to err on the side of caution when evaluating whether a component of a patient's environment might pose a safety risk; elevate any questions or situations requiring special intervention early in the patient's stay; and ensure that constant observation is used whenever appropriate. While the previous dropdown menu for each question posed on the list—including queries such as "Is the area free of lamps, and any items that could be used as a weapon?" and "Is furniture secured or heavy enough to prevent it from being picked up and thrown or moved to block door?"—consisted of a binary set of "met" or "not met" responses, the updated checklist directs nursing staff to one of three context-specific options: (i) "yes," (ii) "no - patient is on constant observation," or (iii) "other – call NM [Nurse Manager] or Supervisor." This revised set of options is designed to steer nursing staff away from responding "met" when they have any doubt about whether one or more aspects of a potentially self-harming patient's environment might present a safety risk, and to ensure that constant observation is used for patients who present a danger to themselves or others.

To help nursing staff understand how to properly use the upgraded menu of options, SCVMC provided written education in the form of a HealthLink tip sheet on February 3, 2023. Nursing staff will also receive in-service training during the week of February 6, 2023, to go over these changes and be re-educated on how best to leverage the checklist in practice. This training will illustrate the above concepts using specific examples. It will also expressly direct nursing staff to consider each patient's unique physical capabilities, mental state, and circumstances when assessing the room for safety—and to immediately escalate any concerns through the chain of command to get issues resolved swiftly.

c. Bolstering Constant Observation Procedures

SCVMC has also updated its policies and procedures to clarify how to appropriately deploy constant observation to keep patients at risk of harming themselves or others, including those on legal holds, safe. In recognition of the fact that constant observation is one of the most effective ways to mitigate identified safety hazards for patients at risk of harming themselves or others, SCVMC updated its "Constant Observation, 1:1 Care, and Enhanced Supervision" policy (VMC # 392.1) on February 3, 2023, to:

- highlight the importance of determining the underlying reasons for the patient's behavior prior to assigning a particular level of observation, including, but not limited to, by evaluating the cause(s) and level of any anxiety or confusion, evaluating the room assignment, assessing and managing pain, and accounting for external stimuli;
- expressly require that "[a]ny patient who is expressing suicidal ideation or is on a legal hold (5150/5250/1799) must be on CO [Constant Observation, defined as continuous unbroken observation by appropriate staff from a distance of not more than one arm's length] with the sole exception of patients who are physically unable due to their medical

condition (e.g., on ventilator, sedated, catatonic, unconscious) to harm themselves or others …"; and

- clarify that "[n]ursing may determine the need for CO when a patient is assessed/identified as a danger to self and/or others or on a legal hold. A current diagnosis of suicidal ideation or legal hold will trigger a 1:1 staffing with constant observation. … For patients who are danger to self/others and patients on a legal hold (5150/5250), the CO will not be discontinued until the patient has been evaluated by a psychiatrist or psychologist in the unit or by transport to EPS or other psychiatric care facility."

These policy changes were accompanied by EHR upgrades on February 3, 2023, to help further alert nursing staff about when to select constant observation—as opposed to other modes of observation, such as one-to-one care or enhanced supervision—to keep patients a risk of self-harm or harm to others safe. While the drop-down menu under "Type of Observation" previously featured just one entry for "Constant Observation," it now includes three: (i) "Constant Observation (danger to self and/or others"); (ii) "Constant Observation (Legal Holds 5150/5250/1799); and (iii) "Constant Observation (3 or 4 Limb Restraints)." These upgraded selections underscore that patients who have been determined to pose a danger to themselves or others, as well as patients who are on a legal hold, require constant observation.

Nursing staff and providers received a copy of the updated policy and a HealthLink tip sheet detailing the changes to the EHR on February 3, 2023. Nursing staff will also receive in-service training during the week of February 6, 2023. In addition to discussing the above concepts and requirements, the training will re-educate staff on other criteria relating to the appropriate use of constant observation, including by underlining the need to document hourly when a patient is on constant observation, and by contrasting constant observation with other forms of patient observation, such as one-to-one care and enhanced supervision.

d. Bolstering Constant Observation Procedures

During the week of February 6, 2023, nursing staff will receive in-service training on how to prevent and respond to elopements. The training will cover how to take all reasonable measures to avert the elopement of any patient from the hospital, including when that patient is on a legal hold. The training will re-educate nursing staff on the importance of taking steps such as safely following the patient, providing verbal redirection, noting the patient's description, swiftly escalating the issue up the chain of supervision, recording the facts of the event in the medical record, and timely completing an electronic occurrence report.

During the in-service trainings occurring the week of February 6, 2023, nursing staff will also be re-educated regarding the elopement reporting requirements contained in SCVMC's "Code Green – Elopement/Missing Patient" policy (Enterprise Policy # 0179). This includes, but is not limited to, all elopements meeting high-risk criteria (i.e., patients on a legal hold; actively experiencing suicidal/homicidal ideation; with cognitive impairment; undergoing detoxification or substance use treatment; with required monitoring or attachment to equipment; or having any other reason that the clinician believes is a threat to patient health or well-being).

Finally, in-service trainings will include detailed re-education regarding the SCVMC Acute Psychiatric Services policy (A-4556-0040) applicable to patients in the locked inpatient psychiatric unit, including on how to assess AWOL risk, properly document that risk and accompanying interventions using the enhancements to the EHR, and prevent and respond to AWOL incidents.

4. Monitoring and Tracking

Since August 2022, the Inpatient Nursing Manager for Quality has conducted a daily review of the medical records of all new inpatients on 5150 holds at risk of suicide to assist nurse directors and nurse managers in ensuring that, in 100% of cases, the environmental safety checklist has been completed, constant observation has been ordered, and a suicide plan is active. In the event of missing documentation, the Inpatient Nursing Manager for Quality promptly notifies the appropriate Nursing Manager to follow up with the nursing staff concerned. After each patient is discharged, the Inpatient Nursing Manager for Quality further reviews the records to confirm that counseling or other follow-up care is provided to patients upon discharge. Effective February 13, 2023, results will be reported monthly to the QIC and ENC until 100% compliance is achieved for three consecutive months.

Effective February 13, 2023, the Inpatient Nursing Manager for Quality will further audit 10 medical records per month for patients on constant observation to ensure that appropriate, hourly documentation relating to constant observation was performed, and that the environmental safety checklist was completed as appropriate based on the patient's circumstances. The review will capture a 24-hour period for each patient. In the event of non-compliance, the Inpatient Nursing Manager for Quality will immediately notify the appropriate Nursing Manager to correct deficiencies and provide re-education for the nursing staff concerned. Monthly audits will continue until 100% compliance has been achieved for three consecutive months.

5. Person(s) Responsible for Implementation

Inpatient Nursing Manager for Quality.

6. Completion Date for Correcting Each Deficiency

The process of identifying suicidal patients to confirm safety measures, and the auditing of all suicidal patients' charts for safety measures, began in August 2022. The creation of the new behavioral response team was approved on November 1, 2022, and hiring for the team is currently underway. SCVMC improved its policies, procedures, and EHR functionalities relating to constant observation and the use of environmental safety checklists on February 3, 2023. Nursing staff and providers received copies of the policies and accompanying written education that same day. Staff re-education on communication within the chain of command, requirements for patients on constant observation, and preventing and responding to elopements will begin during the week of February 6, 2023. Reports and audits are ongoing.

Patient 10

1. **Plan for Correcting Deficiencies**

Effective February 3, 2023, a task list has been added to the EHR to ensure that nursing staff complete and document neuro checks as ordered by providers. The task list will indicate the frequency requirements as per provider order. The task list prompts staff to indicate in the EHR when an assessment has been completed and documented.

2. **Plan for Improving Processes**

Effective February 3, 2023, a feature was added to the EHR to automatically generate the task list whenever a provider orders neuro checks.

3. **Procedure for Implementing the PoC**

A newsletter was emailed to all inpatient nurse managers, assistant nurse managers, and nurses on February 3, 2023, to alert them to the new task list. All provider and nursing staff will be educated verbally and through e-Health Learning on the new neuro check task list during in-person department huddles and meetings during the week of February 6, 2023.

4. **Monitoring and Tracking**

The Inpatient Nursing Manager for Quality will ensure that nurse managers on each unit review records of patients with neuro check orders to ensure completion of neuro checks by nurses in their units. Each unit will review a total of 10 charts per month. If fewer than 10 neuro checks have been ordered in a unit in any given month, the unit shall review the charts for all patients with neuro check orders during that month. Audits will be conducted monthly until 100% compliance is achieved for three consecutive months. Results will be reported monthly to the ENC and QIC.

5. **Person(s) Responsible for Implementation**

Inpatient Nursing Manager for Quality

6. **Completion Date for Correcting Each Deficiency**

The neuro check task list was activated on February 3, 2023. Education on the new task list will occur during the week of February 6, 2023, and ongoing, monthly auditing will begin no later than February 13, 2023.

<u>Patients 13, 21 and 25</u>

1. **Plan for Correcting Deficiencies**

Reinforcement of pain policy requirements was conducted with all inpatient and ED Nurse Managers, including Nursing Directors, in October 2022.

During the week of February 6, 2023, nursing staff will be verbally re-educated on SCVMC's pain policy during department huddles and meetings, with a focus on pain management, re-assessment requirements, and documentation, including the EHR's automatic prompt for nurses to re-assess pain one-hour post-medication administration.

2. **Plan for Improving Processes**

To reinforce the hospital's pain policy, assessment, reassessment, and documentation requirements, nursing staff will be re-educated, and the Inpatient Nursing Manager for Quality will conduct monthly auditing to confirm compliance.

3. **Procedure for Implementing the PoC**

During the week of February 6, 2023, nursing staff will be verbally re-educated on SCVMC's pain policy during department huddles and meetings, with a focus on pain management, re-assessment requirements, and documentation, including the EHR's automatic prompt for nurses to re-assess pain one-hour after medication administration.

4. **Monitoring and Tracking**

Beginning February 13, 2023, the Inpatient Nursing Manager for Quality will conduct a monthly audit of 30 patient charts per month until 100% compliance is achieved on the sample size for three consecutive months. Any deficiencies will be reported to the applicable nurse manager for follow-up. Results will be reported to the ENC and QIC.

5. **Person(s) Responsible for Implementation**

Inpatient Nursing Manager for Quality

6. **Completion Date for Correcting Each Deficiency**

Reinforcement of pain policy requirements was provided to nursing leadership in October 2022. Re-education of nursing staff will be completed the week of February 6, 2023. Monthly auditing will begin no later than February 13, 2023.

Patients 7, 8, 10, 11, and 15

1. **Plan for Correcting Deficiencies**

Since August 2022, the Inpatient Nursing Manager for Quality has conducted a daily (weekday), manual review of the medical records for all new inpatients on 5150 holds to identify those at risk of suicide. The Inpatient Nursing Manager for Quality emails the list of suicidal inpatients to the Nurse Managers of the units where the patients are located and to the Nursing Directors with instructions to ensure that constant observation is active, that room safety checks are completed, and that suicide care plans for those patients are active. Nurse Managers and Nursing Directors may also obtain a system-generated list in the hospital's EHR showing all inpatients with legal holds to ensure that for those patients—including suicidal patients—constant observation is active, room safety checks are completed, and suicide care plans are active.

SCVMC Policy 392.1 (Constant Observation, 1:1 Care, and Enhanced Supervision) was updated to clarify, among other things, documentation requirements for patients under constant observation or enhanced supervision.

Effective February 3, 2023, the EHR will automatically generate a task list to prompt nurses to complete documentation every four hours when there is an order for a remote sitter. In addition, the remote sitter documentation in the EHR has been updated to clarify the specific information that needs to be documented every 4 hours.

2. **Plan for Improving Processes**

For patients with remote sitters, the EHR automatically generates a task list to prompt nurses to complete documentation every four hours when there is an order for a remote sitter. In addition, the remote sitter documentation in the EHR has been updated to clarify the specific information that needs to be documented every 4 hours.

For patients on constant observation:

a. Nurse managers are informed daily of inpatients at risk of suicide so that they can ensure constant observation of those patients;
b. SCVMC policy on constant observation was updated to clarify, among other things, documentation requirements for patients under constant observation; and
c. the EPIC system was updated for the end user to document the criteria for constant observation.

Beginning February 6, 2023, all nursing staff will receive education/re-education on the remote sitter documentation requirements and nursing task list, updated policy on constant observation and enhanced supervision, and requirements and frequency of documentation for constant observation and enhanced supervision.

3. **Procedure for Implementing the PoC**

The Inpatient Nursing Manager for Quality will continue identifying all inpatients at risk of suicide and emailing the list of suicidal inpatients to Nursing Directors and Nurse Managers to ensure that (among other things) constant observation is active. Nurse Managers and Nursing Directors will also continue to be able to obtain a system-generated list in the EHR of all inpatients with legal holds to ensure that constant observation is active for all such patients.

The updated SCVMC Policy 392.1 (Constant Observation, 1:1 Care, and Enhanced Supervision) policy was provided to all staff and providers on February 3, 2023.

Nursing staff will receive verbal education/re-education on the remote sitter documentation requirements and nursing task list, updated policy on constant observation and enhanced supervision, and requirements and frequency of documentation for constant observation and enhanced supervision during the week of February 6, 2023, in departmental huddles and meetings.

4. **Monitoring and Tracking**

Starting no later than February 13, 2023, patient record reviews will be conducted monthly to ensure completion of remote sitter documentation, constant observation documentation, and enhanced surveillance documentation. The Inpatient Nursing Manager for Quality will ensure that the nurse managers on each unit reviews a total of 10 charts per month or, if there are fewer than 10 charts in any given month, then all charts for that month. The record reviews will continue until there are three consecutive months of 100% compliance. Any deficiencies will result in follow-up with the relevant staff. Audit findings will be reported to the ENC and the QIC.

Since August 2022, the Inpatient Nursing Manager for Quality has conducted a daily review of the medical records of all new inpatients on 5150 holds at risk of suicide to assist nurse directors and nurse managers in ensuring that, in 100% of cases, the environmental safety checklist has been completed, constant observation has been ordered, and a suicide plan is active. In the event of missing documentation, the Inpatient Nursing Manager for Quality promptly notifies the appropriate Nursing Manager to follow up with the nursing staff concerned. After each patient is discharged, the Inpatient Nursing Manager for Quality further reviews the records to confirm that counseling or other follow-up care is provided to patients upon discharge. Effective February 13, 2023, results will be reported monthly to the QIC and Executive Nursing Counsel (ENC) until 100% compliance is achieved for three consecutive months.

In addition, effective February 13, 2023, the Inpatient Nursing Manager for Quality will further audit 10 medical records per month for patients on constant observation to ensure that appropriate, hourly documentation relating to constant observation was performed, and that the environmental safety checklist was completed as appropriate based on the patient's circumstances. The review will capture a 24-hour period for each patient. In the event of non-compliance, the Inpatient Nursing Manager for Quality will immediately notify the appropriate

Nursing Manager to correct deficiencies and provide re-education for the nursing staff concerned. Monthly audits will continue until 100% compliance has been achieved for three consecutive months.

5. **Person(s) Responsible for Implementation**

Inpatient Nursing Manager for Quality

6. **Completion Date for Correcting Each Deficiency**

EHR upgrades and distribution of the updated SCVMC Policy 392.1 (Constant Observation, 1:1 Care, and Enhanced Supervision) were completed on February 3, 2023. Nursing staff education will begin the week of February 6, 2023, and patient record reviews will begin no later than February 13, 2023.

Patient 45

1. **Plan for Correcting Deficiencies**

Patients are triaged, assessed, and re-assessed using the Emergency Nurses Association Emergency Severity Index (ESI). The hospital's Policy No. A-6634-017, "Department of Emergency Medicine Standards Manual – Assessment" dated 1/27/21 stated that "complete vital signs...shall be obtained on all patients **upon admission** and every two hours thereafter." RN XX may have mistakenly advised the surveyor that assessment should be every two hours for patients waiting in the ED lobby. On February 4, 2023, Policy No. 6634-017 was revised for clarification. The language now reads "**After being placed in an ED bed**, a patient reassessment is performed every 2 hours or more often as necessary based on acuity and/or change in patient status." Similarly, Policy A-6634-019 "Standards of Nursing Practice" was revised on February 3, 2023 to include the same language. Policy A-6634-012 "Triage Process" was also revised to clarify that the triage process is based on guidelines established in the ESI. Prior to placement in an ED bed, frequency of assessments is based on acuity and presentation per the ESI.

2. **Plan for Improving Processes**

Patient re-assessments that may include a focused assessment and/or repeat set of vital signs will be conducted based on the patient's clinical status as determined by the triage nurse. Clinical Resources and Community Standards for Emergency Departments will be reviewed to obtain evidenced based re-assessment times for patients in the lobby waiting for an emergency department bed.

3. **Procedure for Implementing the PoC**

The revised policies No. A-6634-017, A-6634-019, and A-6634-012 were distributed to all ED nursing and provider staff on February 3, 2023. ED provider and nursing staff were educated to

the policy revisions verbally during department huddles and meetings during the week of February 6, 2023.

4. Monitoring and Tracking

Starting February 6, 2023, ED nursing leadership will review 30 charts per month to ensure that focused assessment and/or repeat set of vital signs is conducted and repeated for patients in ED lobby waiting room as appropriate based on clinical judgment and patient's acuity status. Charts will be reviewed monthly for at least three months until 100% compliance is achieved on the sample size for three consecutive months. Any concerns will be reviewed with individual staff members. Results will be reported to ENC and QIC.

5. Person(s) Responsible for Implementation

Emergency Department Nurse Manager

6. Completion Date for Correcting Each Deficiency

Policy revisions were completed and issued to all ED providers and nursing staff on February 3, 2023. Training and in-service for providers and nursing staff regarding policy revisions will be completed no later than February 10, 2023.

Staff Competency for Sitter X

1. Plan for Correcting Deficiencies

In the aftermath of Patient 16's elopement, on May 18, 2021, all Emergency Department (ED) nursing staff received mandatory, in-service training to review SCVMC Policy #392.1 (Constant Observation, 1:1 Care, and Enhanced Supervision), Enterprise Policy #0030 (Suicide/Safety Precautions and Care of the Patient in Non-Behavioral Health Areas), and the SCVMC Department of Emergency Medicine Standards Manual section on management of patients with psychiatric emergencies. This training included discussion of, among other things, what to do if a sitter must leave a patient, what to do if a patient elopes, how to make the room/environment safe, and the room safety checklist.

On February 1, 2023, the ED adopted the same form as the inpatient nursing units for the constant observation competency so that the constant observation is standardized across the system. All staff, including sitters, will be trained on the new form, beginning February 6, 2023. This form includes a check to confirm that the sitter understands that constant observation applies to patients on legal holds or 3- or 4-point restraints; that constant observation requires remaining within an arm's length of the patient; that the patient must be monitored during all activities; and that the patients' hands must always be visible.

2. **Plan for Improving Processes**

The ED has adopted the inpatient nursing education format for the constant observation competency. The ED staff developer, ED nurse manager, and ED assistant nurse manager who use the form have all received a copy of the updated form.

3. **Procedure for Implementing the PoC**

The ED has adopted the inpatient nursing education format and will teach to it during the 2023 nursing competency session.

4. **Monitoring and Tracking**

The ED Nurse Manager has confirmed that the ED staff developer and ED assistant nurse manager have received the updated form and will use it going forward. The ED Nurse Manager will review annual competency trainings to confirm continued use of the updated form.

5. **Person(s) Responsible for Implementation**

Emergency Department Nurse Manager.

6. **Completion Date for Correcting Each Deficiency**

Education of ED nursing staff occurred on May 18, 2021 regarding SCVMC Policy #392.1 (Constant Observation, 1:1 Care, and Enhanced Supervision), Enterprise Policy #0030 (Suicide/Safety Precautions and Care of the Patient in Non-Behavioral Health Areas), and the SCVMC Department of Emergency Medicine Standards Manual section on management of patients with psychiatric emergencies.

The updated form for the constant observation competency was adopted on February 1, 2023.

Patient 21

1. **Plan for Correcting Deficiencies**

Upon discovering the laboratory kit in Patient 21's room during the surveyors' tour, a nurse manager immediately and properly disposed of the laboratory kit during the tour.

2. **Plan for Improving Processes**

Staff education and ongoing monitoring will reduce the risk of improper disposal of sharps.

3. **Procedure for Implementing the PoC**

In October 2022, nurse managers were re-educated regarding proper disposal of sharps.

Nursing units will receive re-education in department huddles and meetings during the week of February 6, 2023, to ensure that sharps are not left unattended in patient rooms or any areas where unauthorized individuals could access the items.

4. **Monitoring and Tracking**

In September 2022, the Director of Nursing Professional Practice performed random audits of inpatient units to ensure that there were no exposed sharps and or other environmental safety concerns.

For many years, the Inpatient Nursing Manager for Quality and the hospital's Quality and Safety Department has conducted weekly environment of care rounds to visually confirm that inpatient units meet regulatory requirements for patient safety and HIPAA compliance; there is no anticipated end date for these environment of care rounds. Any deficiencies are brought to the attention of the unit's nurse manager for follow-up. The desired goal is 100% compliance. The Quality and Safety Department reports overall findings quarterly to the PSC.

5. **Person(s) Responsible for Implementation**

Inpatient Nursing Manager for Quality.

6. **Completion Date for Correcting Each Deficiency**

The laboratory kit in Patient 21's room was properly disposed during the survey in September 2022. Random audits of inpatient units were completed in September 2022. Weekly environment of care rounds continue to be ongoing.

TAG A 405 ADMINISTRATION OF DRUGS

1. **Plan for Correcting Deficiencies**

Enterprise Policy # 0011 states: "Indications for PRN drugs - To avoid therapeutic duplication, if more than one medication is ordered for the same indication, the medications will be ranked by order of administration preference." In this case, the appropriate standards were followed because the order for Ondansetron (Zofran) was for a single dose, to be administered by nursing staff at a specific time as determined by the ordering provider—not a PRN (or "as needed") order requiring nursing staff to decide when to administer the medication based on the patient's condition.

SCVMC has long had systems in place to ensure that PRN orders are not issued without an indication. Since 2013, the hospital's EHR has included an "indication" field that providers must complete. The system prevents a provider from signing a PRN order without recording an indication. SCVMC most recently confirmed on January 31, 2023, that this EHR configuration remains active.

2. Plan for Improving Processes

Recognizing that this is an area in which confusion may arise, SCVMC further educated providers about PRN order requirements through written guidance and new forms of training, as described below.

3. Procedure for Implementing the PoC

On January 31, 2023, the Director of Pharmacy provided all medical staff, nursing supervisors, and inpatient pharmacists with a written reminder that PRN orders must include an indication for use. This written reminder included a description of the relevant sections of Enterprise Policy # 0011, as well as a current copy of that policy. Nursing staff will receive in-service re-education regarding this requirement during the week of February 6, 2023.

SCVMC is also developing a training module for physicians, nursing staff, and pharmacists titled "Medication Ordering and Administration Standards for As Needed (PRN) Orders." This module will provide instruction on how to identify the elements of a PRN order, write a correct PRN order including indications, rank orders to avoid therapeutic duplication, and administer the right dose of the medication based on the PRN order and clinical condition. The module will include case studies to illustrate each scenario. Workforce members assigned the module will be required to complete it as part of their 2023 annual competency training.

4. Monitoring and Tracking

Beginning no later than February 13, 2023, the Director of Pharmacy will oversee a monthly audit of all PRN orders to ensure that they include indications for use, as well as a ranking by order of administrative preference to avoid therapeutic duplication. The Director of Pharmacy will conduct the audits over three consecutive days per month until 100% compliance is achieved for three consecutive months. The audit will be overseen by the Inpatient Pharmacy Clinical Coordinator, with results reported to the Medical Staff Enterprise Pharmacy and Therapeutics Committee and the QIC.

Furthermore, for each workforce member assigned the "Medication Ordering and Administration Standards for As Needed (PRN) Orders" module, attendance and completion will be recorded electronically. Attendees will be required to submit a course evaluation online following completion of the module.

5. Person(s) Responsible for Implementation

Director of Pharmacy.

6. **Completion Date for Correcting Each Deficiency**

As noted above, there was no deficiency in this instance because it involved a one-time order and not a PRN order. The hospital's EHR has been programmed since 2013 to prevent a provider from signing a PRN order without including an indication. Providers received a written reminder regarding the requirement for a PRN order to include an indication on January 31, 2023. SCVMC will also roll out a new training module dedicated to further educating medical staff, nursing staff, and inpatient pharmacists about PRN order requirements as part of these workforce members' 2023 annual competency training.

TAG A 407 VERBAL ORDERS FOR DRUGS

1. **Plan for Correcting Deficiencies**

Upon review of the medical record for Patient 10, it was determined that RN G was mistaken because the orders for a one-to-one sitter and suicide precautions were not verbal orders, but rather were placed per protocol. Accordingly, the orders were not sent to a physician for signature in the EHR system, as no signature was required.

2. **Plan for Improving Processes**

As described below, SCVMC has clarified its per protocol policies and procedures and implemented nursing and provider staff education initiatives to further guard against verbal and per protocol order errors.

3. **Procedure for Implementing the PoC**

On February 3, 2023, SCVMC amended its Provider Orders policy (Enterprise # 0015) to explicitly include "suicide precautions" among the list of orders within registered nurses' scope of practice. Orders for a one-to-one sitter were already featured on the per protocol list.

All SCVMC nursing staff received a written summary of the above policy change on February 3, 2023. Nursing staff will receive training regarding the update by way of in-service presentations the week of February 6, 2023. Nursing staff will also receive written copies of the presentation slides for individual review that week.

Although no verbal order was given in this instance, providers were re-educated by e-mail by the Enterprise Medical Staff President on February 3, 2023, regarding the requirement to sign verbal orders within 48 hours. Providers will receive further re-education regarding this requirement during the next scheduled MLC, EMEC, and Quarterly All Medical Staff meetings in February and March. In-person re-education will be overseen by the Enterprise Medical Staff President.

The Enterprise Medical Staff President will also be added to the distribution list for unsigned verbal orders older than 48 hours. In conjunction with the MLC presidents and department chairs, the President will promptly notify any provider found to be non-compliant. Providers

who fail to sign their verbal orders within the required 48-hour timeframe will be disciplined in accordance with the Medical Staff Rules and Bylaws.

4. Monitoring and Tracking

On the nursing side, no later than February 13, 2023, the Quality Nurse Manager for Inpatient Nursing will review 10 charts per month to ensure that suicide precaution orders are correctly placed per protocol. Monitoring will continue until 100% compliance is achieved for three consecutive months.

On the physician side, no later than February 13, 2023, bi-weekly reports will be sent to the Enterprise Medical Staff President listing the verbal orders that have not been signed within the required timeframe. The Enterprise Medical Staff President will follow Medical Staff Rules and Bylaws to notify involved providers and to enforce these requirements. The EMR Integrity Committee will also track compliance with the requirement and provide an aggregate report to the Enterprise Medical Staff President and QIC quarterly to ensure that verbal orders are being used appropriately.

5. Person(s) Responsible for Implementation

Quality Nurse Manager for Inpatient Nursing and Enterprise Medical Staff President.

6. Completion Date for Correcting Each Deficiency

Written re-education was issued to all providers on February 3, 2023. In-person education to nursing staff will be provided during the week of February 6, 2023. In-person education to providers will take place on February 9, February 23, and March 2, 2023. Compliance monitoring of nursing and provider activities relating to per protocol orders for suicide prevention and verbal orders, respectively, will begin no later than February 13, 2023.

TAG A 440 CODING AND INDEXING OF MEDICAL RECORDS

Patient 1

1. Plan for Correcting Deficiencies

Coding

The suicidal ideation diagnosis code was added to Patient 1's medical record on January 31, 2023. The code Y92.230 was removed from Patient 1's medical record on February 2, 2023.

Patient 1 is correctly documented in the EHR, but during the survey, an incorrect query of the EHR resulted in the EHR not fully capturing all patient discharges and expirations from July to August 2022, including Patient 1. When the Health Information Management Department (HIM) performed the correct query of the EHR, a complete list was generated, including Patient 1.

Duplicate Records

SCVMC does not merge records during an inpatient visit because it can jeopardize patient care and record integrity. First, the process to merge duplicate patient records takes approximately 5 to 20 minutes, and any accessing of the records during the merge will impact the integrity of the merge. Moreover, if the merge is done during an inpatient visit, the EHR does not allow for anyone to access the patient's records. This can jeopardize patient care if a critical patient need arises during the merge. Second, when a merge takes place during an inpatient visit, pending orders or tests may not be documented in the appropriate record, and test orders may not be visible in the new, deduplicated MRN for the patient. Patient 1's records were therefore merged on August 21, 202,2 at 3:08 pm, after the encounter with Patient 1 ended.

To ensure that all information necessary to monitor patient condition and provide appropriate care could be promptly accessed and retrieved, a flag was placed on all records for Patient 1 on August 12, 2022, at 10:27 am—the same morning that Patient 1 was admitted to the hospital. This flag alerted any clinician accessing the record that there was at least one other record for Patient 1, and the flag provided the information to access Patient 1's other record. Patient 1's charts were also marked at that time for merging.

In addition, although the information in Patient 1's duplicate record from ED visits in July 2022 provided information on Patient 1's past suicidal thoughts and plans, Patient 1's medical record for the August 2022 admission sufficiently documented the patient's risk for self-harm, including the fact that Patient 1 was admitted for injuries due to attempted suicide.

2. Plan for Improving Processes

Coding

HIM coding staff perform approximately 95% of the coding for the hospital's inpatients, and an outside vendor performs coding for professional services and approximately 5% of the coding for inpatients. Coding will be improved through the following steps:

1. **Education/re-education of HIM coding staff**. Ongoing education of inpatient coding staff to ensure that all pertinent coding diagnoses are included.
2. **Auditing of patient records**. As of January 2023, the outside vendor is auditing charts to ensure appropriate coding. Also as of January 2023, the auditor and the hospital's in-house coding management are conducting random audits to identify any coding errors for long-stay patients and patients who expire at the hospital.
3. **Auditing and monitoring of contract coders**. Beginning the week of February 6, 2023, a new vendor will begin auditing the performance of the existing vendor that conducts audits of the hospital's coding. This will help to further confirm accuracy in coding.

Duplicate Records

To ensure that all necessary patient information is promptly accessed and retrieved during an inpatient visit, SCVMC has revised the text of the flag placed on duplicate records to more clearly direct the treatment team to review all possible duplicate records for information necessary to monitor the patient's condition and provide appropriate care. This change was made, effective February 3, 2023.

On February 3, 2023, the CMIO also issued guidance to all treatment teams and registration staff to check for a duplicate record flag for every patient and to review any duplicate records for treatment purposes. The written guidance includes a tip sheet on procedures to review patient advisories/flags when a patient chart is opened in the EHR and to review the other record marked for merge to access all patient information for treatment purposes.

By March 17, 2023, HIM management and IT educational staff will provide a refresher training to all treatment teams to review patient advisories/flags when a patient's EHR chart is opened.

3. Procedure for Implementing the PoC

Coding

Proper coding will continue to be reinforced with HIM coding staff and management through materials provided by HIM coding management, as well as educational coding webinars offered by the American Health Information Management Association (AHIMA), Association of Clinical Documentation (ACDIS), California Health Information Association (CHIA), and AAPC (formerly known as the American Academy of Professional Coders) to ensure understanding of all coding regulations and thereby improve coding accuracy.

As of January 2023, the SCVMC's outside vendor is auditing patient charts to ensure appropriate coding. Also as of January 2023, the auditor and the hospital's in-house coding management are conducting random audits to identify any coding errors for long-stay patients and patients who expire at the hospital.

In late 2022, SCVMC executed a contract with another vendor to check the quality of the existing vendor's audits of hospital coding. Beginning February 6, 2023, the new vendor will audit an initial batch of 70 accounts that have already been audited by SCVMC's current vendor, so that SCVMC can compare findings from the two auditors.

For staff training and education on duplicate records, written guidance was provided to all treatment teams on February 3, 2023. This written guidance will also be placed in the EHR training module so that new clinical team and registration staff members can access it in the future during their orientation. Furthermore, throughout February and March 2023, HIM management and IT educational staff will conduct training at all clinical team meetings and registration staff meetings to review patient advisories/flags when a patient chart is opened in the

EHR and to access the details of duplicate records marked for merge to review all patient information for treatment purposes.

4. Monitoring and Tracking

Through the audits conducted by its existing vendor and new vendor, the Director of HIM will continue to ensure that coding accuracy rates are maintained at 94% or higher. The outside auditor for coding will continue providing monthly reports to the Director of HIM on overall coding accuracy. The Director of HIM and HIM staff will continue monthly meetings with the outside auditor to review coding guidelines and address common coding errors.

All in-house and contract coders must maintain an accuracy rate of 94% or higher. Coders who fail to meet that standard will be provided additional training, and if they continue to fail to meet the standard, appropriate disciplinary or contract action will be taken.

HIM will continue to provide semi-annual reports to the Utilization Management Committee (UMC) regarding coding accuracy rates. HIM will provide monthly reports on coding accuracy rates to the QIC and bimonthly rates to the EHR Integrity Committee.

5. Person(s) Responsible for Implementation

Director of HIM.

6. Completion Date for Correcting Each Deficiency

Staff training and education on coding practices, auditing and reporting on coding accuracy, and efforts to reduce the rate of duplicate records are all ongoing.

Beginning February 6, 2023, a new vendor will perform a quality control check of the existing auditor's review of hospital coding.

Written guidance on duplicate record procedures was issued to all treatment teams on February 3, 2023. In-person training for all treatment teams will begin in February 2023 and be completed no later than March 17, 2023.

Patient 16

1. Plan for Correcting Deficiencies

The hospital has reviewed Patient 16's records and confirmed that, on the date of Patient 16's elopement, staff documented his discharge disposition as an elopement, in compliance with the hospital's elopement policy.

No Code Green was called for Patient 16 because the criteria for a Code Green was not met. Code Green is used to enlist additional staff to search for a high-risk patient who has eloped and

not been found within ten minutes. In this case, staff followed Patient 16 when he eloped from the hospital and did not lose sight of him.

2. **Plan for Improving Processes**

The Elopement/Missing Person Policy (#VMC304.1) has been reviewed and revised, effective February 3, 2023, to include directives to document elopement disposition once patients are known to have eloped, and to direct ED staff to create a new patient encounter if a patient returns to the ED after elopement. This should reduce chart duplication and any potential coding/documentation confusion. Nursing staff will be educated as to the revised policies during the week of February 6, 2023.

3. **Procedure for Implementing the PoC**

The revised policy VMC 304.1 was distributed by email to all nursing and provider staff, including ED staff and providers, on February 3, 2023. ED provider and nursing staff were educated on the policy revisions verbally during department huddles and meetings during the week of February 6, 2023.

4. **Monitoring and Tracking**

Starting February 6, 2023, the Director of HIM will review 30 charts per month of ED patients to ensure that disposition is correctly documented. Charts will be reviewed monthly for at least three months until 100% compliance is achieved for three consecutive months on the sample size. Any concerns will be reviewed with department leadership and individual staff members. Results will be reported monthly to EHR Integrity Committee and QIC.

5. **Person(s) Responsible for Implementation**

Director of HIM and Director of Nursing Critical Care

6. **Completion Date for Correcting Each Deficiency**

Policy revision was completed and issued to all providers and nursing staff, including ED providers and staff on February 3, 2023. Training and in-service for ED providers and nursing staff regarding policy revisions will be completed during the week of February 6, 2023.

TAG A 449 CONTENT OF RECORD

1. **Plan for Correcting Deficiencies**

In October 2022 SCVMC formed a multidisciplinary Enterprise Downtime Committee (EDC) to develop policies, procedures, workflows and to create and revise forms and order sets to support clinical operations during a downtime.

All of the downtime forms that were identified during the survey have been reviewed and updated. The updated forms were uploaded to the EHR downtime portal and distributed to all units on February 3, 2023.

2. **Plan for Improving Processes**

The EDC will continue to review all critical downtime forms, policies, and order sets and update them initially and every three years thereafter, or more frequently as needed. The dates of review and approval by the EDC will be noted at the bottom of the forms, and the updated forms will be uploaded on the EHR downtime portal under Downtime Procedures and distributed in paper form to all the units. Policies are available on SCVMC's policy platform.

3. **Procedure for Implementing the PoC**

The forms identified during the survey were updated and distributed to patient care units on February 3, 2023. The EDC will ensure that all downtime forms, policies, procedures, and order sets are updated and reviewed at least every three years, and more frequently as needed.

4. **Monitoring and Tracking**

No later than February 13, 2023, the CMIO will conduct an audit of all patient care units that have received the updated forms identified in the survey to make sure the updated forms are available on the units and the old forms were destroyed. Results will be reported to the QIC.

The EDC will maintain a master list of all approved downtime forms and order sets, including the date of last approval and revision. Activities of the EDC will be reported to the EMR Integrity Committee, the ENC and the QIC.

5. **Person(s) Responsible for Implementation**

Chief Medical Information Officer

6. **Completion Date for Correcting Each Deficiency**

EDC was formed on October 20, 2022. Outdated forms identified during the survey were updated and distributed to the units on February 3, 2023.

TAG A 466 CONTENT OF RECORD: INFORMED CONSENT

1. **Plan for Correcting Deficiencies**

During the survey and continuing thereafter, SCVMC implemented an additional upgraded signature follow-up workflow for Registration Staff and their managers across all units, as indicated below. Moreover, on February 3, 2023, SCVMC contacted the patient's legal representative and obtained verbal confirmation of receipt of the inpatient Conditions of

Admission form. SCVMC also mailed the legal representative a copy of the form for their records on February 6, 2023.

2. Plan for Improving Processes

To prevent future deficiencies from arising in this area, SCVMC has instituted an updated signature follow-up workflow for staff responsible for patient registration and account creation ("Registration Staff"), as well as implemented related staff education initiatives and auditing processes, as described below.

3. Procedure for Implementing the PoC

During the survey and continuing thereafter, SCVMC implemented an additional upgraded signature follow-up workflow for Registration Staff and their managers across all units, as follows:

1. Unit Supervisors must review the Missing Signature Documents Work Queue in the EHR daily to assess the volume and distribution of documents missing signatures, identify particularly time-sensitive documents that are missing, and follow up with individual Registration Staff members to ensure that they take appropriate steps to timely obtain the missing signatures from patients or their legal representatives.

2. Based on this supervisorial feedback, as well as their own ongoing monitoring of the Missing Signature Documents Work Queue, Registration Staff must take all reasonable steps to timely obtain missing signatures from patients, including on the Conditions of Admission form, and to record that information in the EHR.

3. Registration Staff who are unable to obtain a signature must appropriately document that information in the medical record for further review and follow-up.

4. Registration staff who encounter difficulty with a particular account must promptly escalate the issue to their supervisor for assistance.

To further educate workforce members on this workflow, SCVMC distributed a HealthLink tip sheet to all Registration Staff and their supervisors on February 3, 2023. The Tip Sheet explains in detail how to properly use the Missing Signature Documents Work Queue. Supervisors will further provide in-person training on the key elements of the Tip Sheet during their daily team huddles with Registration Staff throughout the week of February 6, 2023. All Registration Staff will need to submit written acknowledgement that they have read and understand the instructions in the Tip Sheet by no later than February 10, 2023.

4. Monitoring and Tracking

As part of their daily monitoring, Unit Supervisors will maintain an active log demonstrating that they have reviewed the Missing Signature Documents Work Queue for purposes of efficiently

following up with individual Registration Staff members to ensure document completion. Any follow-up tasks will be noted on the log.

Furthermore, beginning February 10, 2023, the Director of Patient Access will review a weekly report of patient accounts featuring forms with missing signatures. This review will continue for three months, with monthly aggregate data reports submitted to the QIC. Results will be used to evaluate the efficacy of the workflow described above, determine whether additional steps are needed to reduce the number of accounts featuring forms with missing signatures, and identify whether particular registration teams require targeted assistance to rectify problems in this arena.

5. **Person(s) Responsible for Implementation**

Director of Patient Access.

6. **Completion Date for Correcting Each Deficiency**

SCVMC implemented the upgraded workflow for the collection of missing signatures during and after the survey. SCVMC issued supplemental written education materials on this workflow on February 3, 2023. In-person education regarding the materials will take place the week of February 6, 2023. Weekly monitoring reports will be generated for review and quality assurance purposes beginning February 10, 2023.

TAG A 467 CONTENT OF RECORD: ORDERS, NOTES, REPORTS

1. **Plan for Correcting Deficiencies**

Duplication Rate

Throughout the COVID-19 pandemic, the County has been the largest provider of mass testing and vaccination services in Santa Clara County. In total, the County-operated sites have provided more than 1.6 million COVID-19 tests and more than 1.9 million COVID-19 vaccinations not only to the individuals who receive care from SCVMC but also to the general public. To do so, the County created a public website for COVID-19 appointment scheduling, which members of the public used to schedule appointments, oftentimes with minimal demographic information. The duplicate records resulting from the County's emergency mass vaccination and testing services have all been flagged as potential duplicates and now require manual review and decision making. However, the number of duplicates should decrease precipitously with the planned closure of the County's mass vaccination and testing sites at the end of February 2023.

SCVMC has taken a multi-pronged approach to reducing the duplication rate for medical records, resulting in a decrease from 5.84% for January 21, 2022, to 3.22% for February 1, 2023. Since October 2022, SCVMC has increased internal staffing for deduplication by 20 hours per week and contracted with a vendor to deduplicate an additional 675 duplicate records per day. Increased internal staffing and vendor services for deduplication will continue until SCVMC has

reached the target duplication rate of 2.5%, which it expects to achieve in March 2023, but no later than mid-April 2023.

Accessibility of Duplicate Records

SCVMC does not merge records during an inpatient visit because it can jeopardize patient care and record integrity. First, the process to merge duplicate patient records takes approximately 5 to 20 minutes, and any accessing of the records during the merge will impact the integrity of the merge. Moreover, if the merge is done during an inpatient visit, the EHR does not allow for anyone to access the patient's records. This can jeopardize patient care if a critical patient need arises during the merge. Second, when a merge takes place during an inpatient visit, pending orders or tests may not be documented in the appropriate record, and test orders may not be visible in the new, deduplicated MRN for the patient. Patient 1's records were therefore merged on August 21, 202,2 at 3:08 pm, after the encounter with Patient 1 ended.

To ensure that all information necessary to monitor patient condition and provide appropriate care could be promptly accessed and retrieved, a flag was placed on all records for Patient 1 on August 12, 2022, at 10:27 am—the same morning that Patient 1 was admitted to the hospital. This flag alerted any clinician accessing the record that there was at least one other record for Patient 1, and the flag provided the information to access Patient 1's other record. Patient 1's charts were also marked at that time for merging.

In addition, although the information in Patient 1's duplicate record from ED visits in July 2022 provided information on Patient 1's past suicidal thoughts and plans, Patient 1's medical record for the August 2022 admission sufficiently documented the patient's risk for self-harm, including the fact that Patient 1 was admitted for injuries due to attempted suicide.

2. **Plan for Improving Processes**

To ensure that all necessary patient information is promptly accessed and retrieved during an inpatient visit, SCVMC has revised the text of the flag placed on duplicate records to more clearly direct the treatment team to review all possible duplicate records for information necessary to monitor the patient's condition and provide appropriate care. This change was made, effective February 3, 2023.

On February 3, 2023, the CMIO also issued guidance to all treatment teams and registration staff to check for a duplicate record flag for every patient and to review any duplicate records for treatment purposes. The written guidance includes a tip sheet on procedures to review patient advisories/flags when a patient chart is opened in the EHR and to review the other record marked for merge to access all patient information for treatment purposes.

By March 17, 2023, HIM management and IT educational staff will provide a refresher training to all treatment teams to review patient advisories/flags when a patient's EHR chart is opened.

3. Procedure for Implementing the PoC

Written guidance was provided to all treatment teams on February 3, 2023. This written guidance will also be placed in the EHR training module so that new clinical team and registration staff members can access it in the future during their orientation. Furthermore, throughout February and March 2023, HIM management and IT educational staff will conduct in person training at all clinical team meetings and registration staff meetings to review patient advisories/flags when a patient chart is opened in the EHR and to access the details of duplicate records marked for merge to review all patient information for treatment purposes.

4. Monitoring and Tracking

Monitoring of the duplicate rate will be performed weekly by the HIM Director. Duplicate rates are reported to EMR Integrity Committee every other month, with a goal of 2.5%. The Director of HIM runs reports weekly to identify any staff who are creating new MRN's without ensuring there is not already a patient record in the system for that patient. Staff identified as creating duplicate records due to insufficient check will be reported to their supervisor for additional training and monitoring.

5. Person(s) Responsible for Implementation

Director of Health Information Management.

6. Completion Date for Correcting Each Deficiency

Internal staffing for deduplication was increased as of February 2, 2023. Vendor staffing for additional deduplication services will be effective February 1, 2023. The new Duplicate Warning Advisory Flag system with updated language went live on February 3, 2023. Written guidance on checking for a duplicate record flag and reviewing duplicate records for treatment purposes was issued to treatment teams and registration staff on February 3, 2023. Training for all treatment teams and registration staff will begin in February 2023 and be completed no later than March 17, 2023. Monitoring of the duplicate rate is ongoing.

TAG K 918 ELECTRICAL SYSTEMS – ESSENTIAL ELECTRICAL SYSTEM

1. Plan for Correcting Deficiencies

a. Generator

As a result of the permanently installed Emergency Power Supply System (EPSS) failure on October 6, 2022, a temporary generator was connected on October 7, 2022x, as a backup power source while troubleshooting the root cause of the failure of the permanently installed generator (Cummins 1000-kilowatt diesel generator). Subsequently, the Facilities engineering staff discovered and corrected a program error in the fuel system controller. The EPSS was subsequently fully retested both without load and with load (run time for each test about three

hours), and the EPSS met operating requirements in both cases by October 14, 2022. The temporary generator was disconnected on October 14, 2022, and removed from the premises, leaving the permanently installed Cummins generator or EPSS as the primary backup.

b. Batteries

Regular conductance testing of generator for the four 12-volt sealed batteries started on October 6, 2022, and has continued to be tested on a weekly basis since then. Facilities staff were trained on weekly and monthly battery testing and inspections on all generator systems including the temporary generator system. The training on the battery testing occurred on October 4, 2022. The training on the fuel pump on the EPSS occurred on October 26, 2022.

2. Plan for Improving Processes

a. Generator

The facility will continue to comply with the requirements of NFPA 110, including monthly, annual, and triennial maintenance and testing of the EPSS. Facilities stationary engineers will continue to inspect and test the EPSS batteries weekly and monthly per NFPA 110 requirements.

b. Batteries

The four 12-volt sealed batteries will continue to undergo weekly and monthly conductance testing.

3. Procedure for Implementing the PoC

The batteries have been tested on a weekly basis since October 6, 2022. A log of the battery testing is maintained by hand in the Central Plant and regularly entered and stored in the Monthly Life Safety folder on SharePoint on the Facilities intranet site.

4. Monitoring and Tracking

The Fuel System inspection, components, and any failures are logged as part of the EPSS testing including monthly, annual, and triennial tests. Any failures will be immediately escalated to the Facilities Director and will be corrected.

Beginning no later than February 6, 2023, the Director of Facilities will audit completion of all battery and generator testing monthly until 100% compliance is achieved for three consecutive months. The results will be reported monthly to the EOC Committee and to the CEO.

5. Person(s) Responsible for Implementation

Director of Facilities.

6. **Completion Date for Correcting Each Deficiency**

The temporary generator was disconnected on October 14, 2022, and removed from the premises, leaving the permanently installed Cummins generator as the EPSS. The weekly battery testing began on October 6, 2022.