

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 010006	(X3) Date Survey Completed 04/11/2019
Name of Provider or Supplier North Alabama Medical Center	Street Address, City, State 1701 Veterans Drive, Florence, AL	
For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.		

(X4) ID Prefix Tag	Summary Statement of Deficiencies (Each deficiency should be preceded by full regulatory or LSC identifying information)
A0144	<p>PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2)</p> <p>The patient has the right to receive care in a safe setting.</p> <p>This STANDARD is not met as evidenced by: Based on review of facility policy and procedure, emergency department (ED) medical records (MR) and interviews, it was determined the ED staff failed to follow their own policy for creating a safe environment in the ED, complete and document patient safety interventions to protect ED patients at risk for self-harm. These deficient practices affected 3 of 3 ED MR's reviewed for patients at risk for self harm and included ED MR's # 7, MR # 13 and MR # 9. This had the potential to negatively affect all patients at risk for self harm who receive care at this facility. Findings include: Facility Policy: Policy/Procedure Title: Suicide Patient Policy # H110.PCS.165 Revised Date: 01/2019 "Scope Team Members Performing: Psychiatrist, Physician, Registered Nurse (RN), Patient Care Assistant, Social Worker Physician Order Requirements: Yes RN's: Assessment and implementation of suicide precautions, evaluation of patient's ongoing risk assessment and needs. MSA's (Medical Service Assistants), PCT's (Patient Care Technician): Collect data and monitor patients Purpose The purpose of this policy is to guide the patient care staff in identification of individuals at risk for suicide and to implement necessary actions toward preventing self harm while under the care of or following discharge from the organization. Policy Guidelines 1. Suicide precautions may be ordered by the patient's physician or may be initiated by the nurse with a physician's order obtained as soon as possible. a. Depending on the SAD PERSONS SCORE (SAD PERSONS scale is an acronym utilized as a mnemonic device. It was first developed as a clinical assessment tool for medical professionals to determine suicide risk) and Suicide Risk Assessment, a patient admitted with a status for serious self-injurious behavior (or risk of) will be placed on the appropriate suicide</p>

precautions. 1. SAD PERSONS Scoring SCORE Requirements 0-4 No suicide risk assessment is required. 5-6 Add the Suicide Precautions Plan of Care, Suicide Risk Assessment: Routine Observations 7-8 Add the Suicide Precautions Plan of Care, Suicide Risk Assessment: Constant Visual Observation 9-or above Add the Suicide Precautions Plan of Care, Suicide Risk Assessment: 1:1 Observation Note: The Emergency Department will add the Suicide Intervention instead of the Suicide Preventions Plan of Care. b. Patients with a history of suicide attempt within the last two weeks should be placed on suicide precautions according to the SAD PERSONS score. c. Patients who verbalize intent to harm themselves or express a suicide plan should be placed on suicide precautions according to their SAD PERSONS score. 2. The continued need for suicide precautions should be re-evaluated every shift and as needed...state the reason for continuing or discontinuing precautions...documented... by the physician. 4. Patients on suicide precautions should be questioned every shift regarding suicide intent and more frequently if a positive response is obtained or if suspicion is high that a patient may attempt suicide. 5. The patient will be closely monitored at all times. Observation levels will be discussed with the attending physician and the observation level will be determined by a physician. Observation levels Definitions Routine Observation-The patient will be checked every 15 minutes by a staff member and every 30 minutes by a registered nurse. Document, as appropriate, in the medical record... Constant Visual Observation-Constant Visual observation is the second level of observation...includes all...components of the routine observation. Additionally, the patient is either observed in a video monitored room or observed at all times by the naked eye. The RN assigned...is responsible to ensure that Constant Visual Observation is in place. The RN documents each shift the continuation of 1:1 observation. 1:1 Observation-1:1 observation is the third level of observation...includes all...components of routine observation. Additionally, a staff member is assigned by the charge nurse to be physically present with this patient at all times. The RN assigned...is responsible to ensure...that 1:1 observation is in progress at all times...documents each shift the continuation of 1:1 observation. 1:1 Sitter Responsibilities-The responsibilities of the caregiver assigned to provide 1:1 observation of a suicidal patient shall include, but not limited to: Observation: Maintains visual observation at all times. Accompanies patient...diagnostic testing... maintains a line of sight...when the patient has a visitor, or uses the bathroom. General Safety Assesses the room environment...remove items...pose...ligature...self harm risk (See Attachment A) 7. A physician's order is required to discharge suicide precautions, with rationale and patient evaluation...in the progress notes. 8. An RN may independently initiate Constant Visual Observations or 1:1 Observation if it is assessed that the patient is at risk to act on suicidal ideations (SI). The physician must be notified immediately....and order...be obtained. Only the physician may discontinue an order for suicide precautions...Constant Visual...or 1:1 Observation. Procedure 1. Obtain physician order for suicide precautions for: b. Patients treated in the Emergency Department (ED) or admitted due to suicide attempt. c. Patients who express intent to harm themselves or demonstrate serious self-injurious behavior. On admission, completed the Suicide Risk Assessment, if indicated by the SAD PERSONS Score. Repeat the Suicide Risk Reassessment every 4 hours, if a positive response is obtained on any of these three questions. Are you currently having internal voices telling you to kill yourself? Are you thinking about killing yourself? Do you have a way to kill yourself available to you? If the response to all three above questions is NO on the Suicide Risk Reassessment, then repeat...at a minimum of every shift, at least every 12 hours... Initiate the Suicide Plan of Care (This adds all the necessary interventions.) Note: The ED will add the Suicide Intervention instead of the Suicide Preventions Plan of Care. Explain precautions to patient (and family...). Inform...restrictions and rationale... 3. Complete environmental assessment and

removal of harmful items (See Attachment A). a. Observe hardware in room. c. Conduct a search...the patient's belongings with a witness at the initiation of suicide precautions. e. All belongings...searches...documented on inventory list. g. Remove any harmful objects...send to the patient's home or include on the Safety Deposit[form to Security... h. Place the patient in paper scrubs...to protect... from self harm. 5. Initiate in Meditech (hospital electronic software) the "Suicide Precautions Order Set". 8. The level of suicide risk precautions will be part of the nurse to nurse hand-off communication..." 1. ED MR # 7 presented to the ED on 1/15/19 at 10:54 AM and discharged on 1/15/19 at 6:57 PM. The chief complaint was hearing voices, anxious. On 1/15/19 at 10:58 AM, the ED RN, triaged the patient, Priority -psych/suicidal patient. Review of the physician's history of present illness completed at 11:10 AM revealed the patient presents complaining of auditory hallucinations and suicidal ideation and voices in his/her head telling her/him to cut themselves. The ED physician documented a depressed mood, mental illness, history of depression, suicide, Schizophrenia, Bipolar and anxiety. There was no physician order for Suicide precaution initiation. At 11:40 AM, the ED RN documented patient reported hearing voices telling me to hurt myself, denies SI but reported past suicide attempt. At 11:48 AM, the RN documented the following suicide risk assessment: Behaviors "NO", for sometimes feel life not worth living and sometimes people would be better off without you. There were 5 additional questions in the Behavior section left blank, not answered. History "YES", for have you had thoughts of hurting yourself and have attempted suicide in the past. There were 4 additional questions in the History section left blank, not answered. Six (6) of 6 questions in the suicide risk assessment section titled, Present Plan were not completed. The Summary section of the Suicide Risk Assessment was not completed. There was no documentation the risk assessment findings was discussed with the physician. The observation level was not completed. The RN documented in the Suicide/Homicide Plan, have you had any thoughts of harming yourself or others? Yes. In addition, the SAD PERSONS Scale documentation completed revealed MR# 7's gender and age range with a HX (history) Suicide documented. The SAD Scale Result was 3, No suicide risk assessment is required, for a person with SI and a plan. The SAD PERSONS score failed to identify MR # 7 as at risk for self harm. On 1/15/19 at 11:48, the ED RN documented room clear, patient belongings in brown bag and patient in blue scrubs. At 12:38 PM, the ED RN documented patient "request some kind of medication to calm her/him down and quit hearing these voices". At 1:15 PM, Ativan 1 mg (milligram) by mouth was given. There was no physician order for suicide precautions documented in the medical record. There was no documentation suicide interventions which included an appropriate observation level was identified and implemented for a patient with SI and a plan per policy and procedure. The MR documentation revealed at 6:06 PM the patient reported feeling much better. At 6:30 PM, the physician documented patient ready for discharge and outpatient follow up was arranged for the next day. At 6:56 PM, the patient was discharged with patient instructions on "Anxiety". There was no ED RN documentation a suicide risk reassessment was completed every 4 hours after the initial assessment included positive responses for SI and a plan. In an interview on 4/11/19 at 9:48 AM, Employee Identifier (EI) # 38, CNO (Chief Nursing Officer) confirmed the above findings. 2. ED MR # 13 presented to the ED on 1/16/19 at 10:33 AM. The chief complaint was patient attempted to hang self yesterday with a rope and depression. The ED RN triage documentation at 10:33 AM revealed Priority "3 p-psych/suicidal patient". At 10:41 AM, the ED physician evaluated the patient and documented an attempted suicide yesterday, SI and depression. There was no physician order for suicide precautions initiation. On 1/15/19 at 11:00 AM, the ED RN documented room clear, patient belongings in brown bag and patient in blue scrubs. The Suicide/Homicide documentation revealed thoughts of

hanging". The SAD PERSONS scale documentation revealed a history of suicide and psychiatric care, organized /serious attempt. At 11:00 AM, the SAD PERSONS Scale result documented was 4 (no suicide risk assessment required), which was an inaccurate patient assessment. There was no documentation routine, constant or 1:1 observation was completed for a patient at risk for self harm and no documentation suicide precautions were performed for an at risk patient from 11:00 AM to 6:19 PM. There was no documentation suicide risk reassessments every 4 hours was completed by the ED RN. At 6:19 PM, 7:33 PM, 8:35 PM and 10:16 PM, the ED RN documented police at bedside. At 11:07 PM, which was 11 hours later, the ED RN documented the Summary of Suicide risk assessment discussed with MD (medical doctor) and Observation Level 1:1 Staff. However, there was no documentation staff observation 1:1 was performed. The patient was discharged on 1/17/19 at 12:22 AM per emergency medical transport for transport to a psychiatric inpatient facility. During an interview on 4/11/19 at 10:00 AM, EI # 38 confirmed staff failed to follow policy and procedure for the ED patient identified as at risk for self harm including completion of the suicide risk assessment, completion of an appropriate SAD PERSONS score, performing the suicide risk reassessment every 4 hours, identification of the appropriate observation level, initiation of a suicide precaution order set and documentation of all suicide risk precautions completed. 3. ED MR # 9 presented to the ED on 1/21/19 at 1:25 PM. The chief complaint was depression. On 1/15/19 at 1:28 PM, the ED physician evaluated the patient and documented increased depression, anxiety and insomnia with patient reports of " I am at the end of my rope", and denied SI. The exam results were depressed mood, anxious. On 1/15/19 at 1:30 PM, the ED RN, triaged ED MR # 9, Priority 2, depressive disorder. At 1:31 PM, the ED RN documented the "room clear". The SAD PERSONS scale result was 3, depression/hopelessness. There was no documentation the staff implemented safety interventions for a patient at risk of self injurious behavior (major depressive disorder diagnosis) to ensure the patient was kept safe while in the ED. On 1/21/19 at 7:45 PM, the patient was transferred to an inpatient psychiatric facility with the diagnosis of major depressive disorder. There was no physician order for suicide precautions, no appropriate observation level implemented and no suicide reassessment completed per ED RN every 4 hours. In an interview on 4/11/19 at 10:30 AM, EI # 38 confirmed ED staff failed to follow the facility policy and procedure for assessment and implementation of safety precautions for all patients identified at risk for self harm in the ED. During observations of care in the ED on 4/9/19 at 9:20 AM, the surveyors toured the department including "POD D", 3 ED safe rooms designed for use with Behavioral Health (BH) patients in the ED. During the tour, 2 of 3 ED rooms in POD D were occupied with BH patients. One ED door was open, there was a staff sitting outside the door. The other ED room's door was closed with a staff sitting inside the closed door. There was a police officer inside the corridor of POD D. The surveyors observed facility staff performing observation with 2 ED patients within BH POD. In an interview on 4/9/19 at 9:30 AM, EI # 38 reported hospital staff are now assigned to observe at risk ED patients following a recent audit.