ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/ Frequency/ Goal
A-000	An unannounced, on-site survey to investigate self-reported incident #11743, as authorized by the Centers for Medicare and Medicaid services, was conducted by staff from the Vermont Division of Licensing and Protection, from 6/16/14 to 6/18/14.The Conditions of Participation authorized for review included Patient Rights, OAPI, Nursing Services and Physical Environment. The following regulatory violations were found.	**Subsequent to a three day survey completed June 18, 2014 by the Division of Licensing and Protection (State Survey Agency), the Brattleboro Retreat has undertaken a series of targeted actions that address areas of noncompliance in Condition of Participation 42 CFR 482.21 Quality Assessment and Performance Improvement Program and 42 CFR 482.41 Physical Environment as well as one standard level requirement.** **We are fully committed as an organization to correct any identified deficiencies and to continually strive to improve the quality and safety of patient care. This plan of correction constitutes the facility's credible allegation of compliance.** **The executive team has reviewed CMS-2567 Statement of Deficiencies and agreed upon the following plan of correction:**			
A 263	482 .21 OAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services	**To enhance patient safety the hospital will implement within in its performance improvement program a more structured approach in the report and review of incident reporting to improve its analysis, action planning, communication and coordination of activities to address potential safety concerns.** **1a.All incident reports will be reviewed in a daily (M-F) forum that includes clinical managers, quality, risk and members of the executive team. Review and reporting will include an Environment Of Care (EOC) category to identify those incidents**	**1. a. 7/14/14**	**1.a. Director of Quality**	**1.a. Category included in 100% incident review at morning meeting**

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	furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on interview and record review, the Condition of Participation tor Quality Assessment and Performance Improvement (QA/PI) was not met due to the hospital's failure to analyze and initiate action plans to ensure patient safety, based on a significant event report related to access to patient rooms at all times. The information obtained during the investigation evidenced a systemic problem with a lack of communication of critical information between member(s) of the Safety Committee and the QAPI Committee and a failure to assure staff communication and referral of all patient safety concerns.	**with potential for systemic impact on patient safety needing immediate follow up and intervention. EOC and other patient related incidents are reviewed by the Nursing Supervisor with the Administrator-on-Call (AOC) on weekends with the AOC and Nursing Supervisor determining whether immediate action on any safety related incident is necessary and they are also reported at Monday meeting** **b. Facilities coordinator or designee will attend morning meeting for documenting reported EOC concerns** **c. Facilities coordinator or designee will enter the work order as type Safety Issue. All safety related work orders determined to require immediate action will happen in stat fashion.** **d. Facilities coordinator will report status of work orders at the morning meeting** **e. Director of Facilities will report the status of safety related work orders at the Patient Safety meeting** **f. Director of Facilities and Director of Quality will meet monthly to review EOC incident reports and completed work orders to ensure that data is analyzed and**	**b. 7/9/14** **c. 7/15/14** **d. 7/10/14** **e. 7/24/14** **f. 8/ 18/14**	**b. Director of Facilities** **c. Director of Facilities** **d. Director of Facilities** **e. Director of Facilities** **f. Director of Quality**	**b. Included on >95% attendance sheet** **c. Safety issue included in work orders** **d. Included in minutes** **e. Included in 100% Pt Safety minutes** **f. Reported at Safety Committee**

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		those systemic issues are identified and resolved. This data is reported at the Quality Performance Improvement Committee through Safety Committee			
		2. On all inpatient units, MHWs will continue to perform EOC safety rounds once per shift (3 times per day) using established EOC checklist to identify safety concerns. Unit managers will review checklists daily M – F and will report trends to Quality and Facilities. Review and as necessary modify MHW Environment of Care (EOC) checklist. Weekend Charge Nurses will review MHW weekend EOC checklist and report concerns to Supervisor	**2. 8/22/14**	**2.Director of education**	**2.Review of 100% EOC MHW checklist by unit manager with immediate concerns reported to facilities; trends reported at Pt Safety Committee**
		3. Increase frequency of organization wide EOC rounds from quarterly to monthly for 6 months, and re-evaluate frequency at 6 months.	**3. 8/22/14**	**3. Patient Safety Officer**	**3. Reflected in EOC rounding schedule**
		4. Vary membership of EOC rounding group to use a variety of perspectives/observations.	**4. 8/22/14**	**4. Patient Safety Officer**	**4. Reflected in EOC Rounding attendance sheet**
		5. Develop a Retreat specific EOC checklist tool for EOC rounding to improve tracking and trending of environmental and safety concerns.	**5. 8/22/14**	**5. Patient Safety Officer**	**5. Tool utilized 100% in EOC**

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		6. Assign role of scribe to a staff member with a clinical background on the EOC rounding team	**6. 8/22/14**	**6. Patient Safety Officer**	**6. Role assigned**
		7. Investigate feasibility of modifying the Electronic Incident reporting system to include an EOC sub category to improve data collection, alert functions and analysis.	**7. 7/24/14**	**7. Director of Informatics**	**7. If able, include EOC as sub category**
		8. Include "Unit Specific Safety Concerns" as a standing agenda item on Safety Committee.	**8. 7/24/14**	**8. Director of Quality**	**8. Included in 100% Safety Agenda**
		9. Implement a "If you see something, say something" campaign to encourage all staff to report EOC safety concerns	**9. 7/28/14**	**9. Director of Informatics**	**9. Increase in staff reported EOC safety concerns as evidenced by comparison pre implementation and three month post**
A286	Refer to A-286 482.21(a), (c)(2), (e)(3) PATIENT SAFETY (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ...	**To enhance patient safety the hospital will implement a more structured approach in the report and review of incident reporting to improve its analysis, action planning, communication and coordination of activities to address potential safety concerns.** **1a. Include an EOC category at morning meeting M-F to identify those incidents with potential for systemic impact needing immediate follow up and intervention. EOC incidents reviewed by the Nursing Supervisor with the Administrator-**	**1. a. 7/14/14**	**1.a. Director Quality**	**1 a. Category included in 100% incident review at morning meeting**

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	(c) Program Activities (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to ensure that its QAPI Program (Quality Assessment and Performance Improvement Program) analyzed and implemented preventive actions and mechanisms to provide feedback and learning strategies hospital wide related to patient adverse event reports. Findings include: Based on review of hospital events reports and interviews with members of the QAPI and Safety	**on-Call (AOC) on weekends with the AOC and Nursing Supervisor determining whether immediate action on any safety related incident is necessary and reported at Monday meeting** **b. Facilities coordinator or designee will attend morning meeting for documenting reported EOC concerns** **c. Facilities coordinator or designee will enter the work order as type Safety Issue. All safety related work orders determined to require immediate action will happen in stat fashion.** **d. Facilities coordinator will report status of work orders at the morning meeting** **e. Director of Facilities will report the status of safety related work orders at the Patient Safety meeting** **f. Director of Facilities and Director of Quality will meet monthly to review EOC incident reports and completed work orders to ensure that data is analyzed and those systemic issues are identified and resolved. This data is reported at the Quality Performance Improvement Committee through Safety Committee.**	**b. 7/9/14** **c. 7/15/14** **d. 7/10/14** **e. 7/24/14** **f. 8/18/14**	**b. Director of Facilities** **c. Director of Facilities** **d. Director of Facilities** **e. Director Facilities** **f. Director of Quality**	**b. Included on >95% attendance sheet** **c. Safety issue type included in work orders** **d. Included in minutes** **e. Included in 100% Pt Safety minutes** **f. Reported at Safety Committee**

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	Committees on 6/17/14, the hospital failed to implement a plan to assure that staff had timely access to the Tyler 3 Unit patient rooms at all times, in the event of an emergency situation. Staff con1irmed that patient rooms lock automatically when closed and that doors are kept closed when not occupied. Currently, patients are allowed to be in their rooms with the door locked tor 5 minute periods to allow for privacy while dressing (undressing) with designated staff monitoring of the 5 minute time limit. When patient's wish to be in their rooms otherwise, the door is to be kept open several inches, to allow staff visual monitoring. Per review of event reports dating from January 30, 2014, to June 1, 2014, there were two instances when patients attempted suicide by self-harming behaviors behind locked bedroom doors and a separate occasion when a key broke off in a patient bedroom door lock, necessitating a call to maintenance staff to remove the broken key from the lock to allow staff access to the patient room. During interview on 6/17/14 at 2:43 PM, the Director of Environmental Services confirmed	**2. Review and as necessary modify MHW Environment of Care (EOC) checklist that is completed 3times per day.** **3. Increase frequency of organization wide EOC rounds from quarterly to monthly for 6 months and re-evaluate frequency at 6 months.** **4. Vary membership of EOC rounding group to use a variety of perspectives/observations.** **5. Develop a Retreat specific EOC checklist tool for EOC rounding.** **6. Assign role of scribe to a staff member with a clinical background on the EOC rounding team** **7. Investigate feasibility of modifying the Electronic Incident reporting system to include an EOC sub category.** **8. Include unit specific safety concerns as a standing agenda item on Safety Committee.**	**2. 8/22/14** **3. 8/22/14** **4. 8/22/14** **5. 8/22/14** **6. 8/22/14** **7. 7/24/14** **8. 7/24/14**	**2.Director of Education** **3. Patient Safety Officer** **4. Patient Safety Officer** **5. Patient Safety Officer** **6. Patient Safety Officer** **7. Director of Informatics** **8. Director of Quality**	**2. Review of 100% EOC MHW checklist by unit manager immediate concerns reported to facilities; trends reported at Pt Safety** **3. Reflected in EOC rounding schedule** **4. Reflected in EOC Rounding attendance sheet.** **5. Tool utilized 100% in EOC rounds** **6. Role assigned** **7. If able, include EOC as a sub category** **8. Included in 100% Safety Agenda**

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	that a key had broken off in a patient locked door and that nursing staff called facilities personnel to remove the key to gain entrance to the room. He/she confirmed it would take about 5 minutes for staff to fix the lock, once on the unit after receiving the call. When asked if this had happened before, the Director of Maintenance stated that it was not a common occurrence but possibly one time per year. Later the same day (at 3:30 PM), during interview, the Director of Quality confirmed that there had been patient suicide attempts made in the patient rooms and that he/she was not aware of any Instances where a key broke off in a Tyler 3 patient door lock. The Director Of Quality acknowledged that it would be a safety concern to gain timely access to a room in the event of an emergency situation.He/she estimated it could take as long as 20 minutes from event to access to the room in such an emergency. He/she confirmed that neither the Safety Committee nor the Quality Committee had analyzed and reviewed this event report and taken any action to ameliorate this potential risk for patient safety. The Director of the Environment confirmed (6/17/14) that he/she had not been involved in any hospital wide safety initiatives concerning this safety risk. Although the hospital put an interim sa1ety plan in place (on 6/17/14 after the meeting with surveyors } so that	**9. Implement a "If you see something, say something" campaign to encourage all staff to report EOC safety concerns**	**9. 7/28/14**	**9. Director of Informatics**	**9.Increase in staff reported EOC safety concerns as evidenced by comparison pre implementation and three month post**

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	staff on Tyler 3 and Osgood Units could gain timely access to patient rooms if needed, the failure to formulate a safety plan based on review of the original even report, posed a potential safety risk to the patients of the two units.				
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on staff interview and record review, nursing staff failed to provide ongoing evaluation and assessment of a patient with a change in health status. in accordance with accepted standards of nursing practice and hospital policy, for 1 of 10 patients in the targeted sample. (Patient #1} Findings include: Patient #1, who was hospitalized with Suicidal Ideation (SI)) and recent Self Harming (SH) behaviors, expressed a positive "Yes" response to safety screening questions during interview with a Mental Health Worker (MHW) #1 on 5/4/14 and the RN failed to complete a reassessment at that time, per facility policy. The following day, the patient attempted suicide in their room and required transfer to another hospital	**1. Develop an electronic report to capture any instance of MHW identifying in the electronic medical record an instance of positive safety question response that requires notification of RN for assessment** **2. a. Audit that required RN assessments are completed as per policy.** **b. Identify gaps in documentation; provide education as appropriate.**	**1. 7/9/14** **2.a. 7/9/14 baseline data** **2.b. 9/5/14**	**1.Director of Informatics** **2.a. Clinical Managers** **b. Clinical Managers**	**1. Available in EMR** **2. Repeat audit for 4mo, to reach 100% compliance by 11/9/14**

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	for medical treatment. Per record review on 6/16/14 and confirmed during interview with the MHW on 6/17/14 at 11:45 AM, the Patient Flow Sheet (a screening form used by MHW to note changes in patients), for Patient #1 dated 5/4/14 documented the following: "Verbalizing Suicidal Ideation": Yes, ...Isolating in Room: Yes,....Concerns/interventions : Pt. rated her depression at an 8 out of 10 and endorsed Sl and ....."feeling hopeless...." The Flow sheet stated the change in behavior/symptoms was reported to RN #1. During interview at the above stated time on 6/17/14, the MHW confirmed that she did report Patient #1's "Yes" answers obtained from the screening interview on 5/4/14 (Yes to Sl and Isolating in room). to her charge RN on 5/4/14, per the hospital's policy. Per review, the "Patient Safety Assessment and Documentation" policy (2013/08,) stated under "Shift Progress/Reassessment Note, #3, "Any 'yes' response(s) obtained from the patient during a safety screening interview, when done by a MHW or LPN (Licensed Practical Nurse), must be reported immediately to an RN. The RN will then complete a more comprehensive evaluation using the RN assessment of Patient Safety				

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	Progress Note." Per review of the medical record, there was no assessment completed by the day shift Charge AN, subsequent to "Yes" findings during the MHW's screening interview. During interview on 6/17/14 at 10 AM, RN #1 stated that he /she did not remember receiving any report from MHW **#1** regarding changes in responses to the safety risk screening tool. The RN confirmed that if he/she had received such a report, a new assessment must be completed by the RN, per the hospital's policy. Reference; Per Vermont title 26: Professions and Occupations, Chapter 28, Nursing, "Registered Nursing " means the practice of nursing which includes: (A) Assessing the health status of individuals and groups; (H) Maintaining safe and effective nursing care rendered directly or indirectly; (I) Evaluating response to interventions; (L) Collaborating with other health professionals in the management of health care.				
A 700	482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient,	**1. On all inpatient units, MHWs will continue to perform EOC safety rounds once per shift (3 times per day) using established checklist to identify safety concerns. Unit managers will review daily**	**1. 8/22/14**	**1.Director of Education**	**1. Review of 100% EOC MHW checklist by unit manager immediate concerns reported**

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	and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community This CONDITION is not met as evidenced by: Based on observation, staff interviews and record review, the hospital did not meet the Condition of Participation (COP) for Environment due to its failure to assure that the environment was maintained to ensure the safety of the patients on 1 applicable unit of the hospital. The hospital failed to take action on an event report noting a potential patient safety concern related to a work order to fix a key broken in a patient's door lock on the Tyler 3 Unit. The hospital also failed to assure that the Tyler building elevator used by patients and staff during the 3 days of survey was maintained in a safe condition .	**checklists and will report trends to Quality and Facilities. Review and as necessary modify MHW Environment of Care (EOC). Weekend Charge Nurses will review MHW weekend EOC checklist and report concerns to Supervisor** **2. Increase frequency of organization wide EOC rounds from quarterly to monthly for 6 months and re-evaluate frequency at 6 months.** **3. Develop a Retreat specific EOC checklist tool for EOC rounding.** **4. Vary membership of EOC rounding group to use a variety of perspectives/observations.** **5. Assign role of scribe to a staff member with a clinical background on the EOC rounding team** **6. Investigate feasibility of modifying the Electronic Incident reporting system to include an EOC sub category.** **7. Develop a more structured approach for quality review of incident reporting** **a. Include an EOC category at morning meeting M-F to identify those incidents with potential for**	**2. 8/22/14** **3. 8/22/14** **4. 8/22/14** **5. 8/22/14** **6. 7/24/14** **7.** **a. 7/14/14**	**2. Patient Safety Officer** **3. Patient Safety Officer** **4. Patient Safety Officer** **5. Patient Safety Officer** **6. Director Informatics** **7.** **a. Director Quality**	**to facilities; trends reported at Pt Safety** **2.Reflected in EOC rounding schedule** **3. Tool utilized 100% in EOC rounds** **4. Reflected in EOC Rounding attendance sheet** **5. Role assigned.** **6. If able, include category in EMR** **7.** **a. Category included in 100% incident review at morning meeting**

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		systemic impact needing immediate follow up and intervention. EOC incidents reviewed by the Nursing Supervisor with Administrator-on-Call (AOC) on weekends with the AOC and Nursing Supervisor determining whether immediate action on any safety related incident is necessary and reported at Monday meeting **b. Facilities coordinator or designee will attend morning meeting for documenting reported EOC concerns** **c. Facilities coordinator or designee will enter the work order as type Safety Issue** **d. Facilities coordinator will report status of work orders at the morning meeting** **e. Director of Facilities will report the status of safety related work orders at the Patient Safety meeting** **f. Director of Facilities and Director of Quality will meet monthly to review EOC incident reports and completed work orders to ensure that data is analyzed and those systemic issues are identified and resolved. This data is reported at the Quality Performance Improvement Committee through Safety Committee** **8. Include unit specific safety concerns as a standing agenda item on Safety**	**b. 7/9/14** **c. 7/15/14** **d. 7/10/14** **e. 7/24/14** **f. 8/ 18/14** **8. 7/24/14**	**b. Director Facilities** **c. Director Facilities** **d. Director Facilities** **e. Director Facilities** **f. Director of Quality** **8. Director of Quality**	**b. Included on >95% attendance sheet** **c. Safety issue type included in work orders** **d. included in minutes** **e. Included in 100% Pt Safety minutes** **f. reported at Safety Committee** **8. Included in 100% Safety**

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		Committee.			**Agenda**
		9. Implement a "If you see something, say something" campaign to encourage all staff to report EOC safety concerns	**9. 7/28/14**	**9.Director of Informatics**	**9.Increase in staff reported EOC safety concerns as evidenced by comparison pre implementation and three month post**
		10. a. Plan developed to implement "Hooligan" bar (emergency tool used by fire dept.) for immediate access to doors if barricaded and/or if key breaks, lock unable to be opened. These Hooligan tools located in the following unit locations: ***Tyler 1: Clean Utility Closet** ***Tyler 2: Back of report room** ***Tyler 3: Report room in art supply closet** ***Osgood 1: Staff bathroom/ break area**	**10.a. 6/17/14**	**10.a. Director of Facilities**	**10.a. plan completed**
		b. general Staff training on use *** OSGOOD 1 Child Unit** *** TYLER 3 Adolescent Unit**	**b. 6/26/14** *** 8/18/14** *** 7/18/14**	**b. Director of Facilities**	**b. > 90% active staff complete**
		c. incorporation into CPI training	**c. 8/18/14**	**c. CPI coordinator**	**c. included in 100% CPI training**
		11. Director of facilities investigated door enhancements on T3 to include safety features to alert to any object over door. Executive team	**11. 7/15/14**	**11. Director of Facilities**	**11.Order placed**

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		approved.			
A 701	482.41 (a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observations and staff interviews, the hospital failed to ensure that the overall hospital environment was maintained in a manner that assured the safety of patients in all areas. Findings include: During the initial tour of the Tyler 3 Unit on 6/16/14, commencing at 11:30 AM and ending at 12:20 PM, a plastic ceiling light cover panel in the elevator was observed to have multiple cracks and 2 holes, approximately 1.0- 1.5 inches in diameter, posing a potential safety hazard related to possible patient self-harming behavior. Patients (accompanied by staff) use the elevator multiple times daily and could potentially pull down the panel and use it to injure themselves or another person. The broken ceiling cover in this elevator was observed by surveyors at various times on all three days of the survey. On the morning of	**1. On all inpatient units, MHWs will continue to perform EOC safety rounds once per shift (3 times per day) using established checklist to identify safety concerns. Unit managers will review daily checklists and will report trends to Quality and Facilities. Weekend Charge Nurses will review MHW weekend EOC checklist and report concerns to Supervisor** **2. Increase frequency of organization wide EOC rounds from quarterly to monthly for 6 months and re-evaluate frequency at 6 months.** **3. Develop a Retreat specific EOC checklist tool for EOC rounding.** **4. Vary membership of EOC rounding group to use a variety of perspectives/observations.** **5. Assign role of scribe to a staff member with a clinical background on the EOC rounding team** **6. Investigate feasibility of modifying the Electronic Incident reporting system to include an EOC sub category.** **7. Develop a more structured**	**1. 8/22/14** **2. 8/22/14** **3. 8/22/14** **4. 8/22/14** **5. 8/22/14** **6. 7/24/14** **7.**	**1.Director of Education** **2. Patient Safety Officer** **3. Patient Safety Officer** **4. Patient Safety Officer** **5. Patient Safety Officer** **6. Director Informatics** **7.**	**1. Review of 100% EOC MHW checklist by unit manager immediate concerns reported to facilities; trends reported at Pt Safety** **2.Reflected in EOC rounding schedule** **3. Tool utilized 100% in EOC rounds** **4. Reflected in EOC Rounding attendance sheet** **5. Role assigned.** **6. If able, include category in EMR** **7.**

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	6/18/14, it was brought to the attention of the Director of Quality and the Director of Social Services during a meeting at 8:08AM and subsequently repaired by hospital staff. During an interview on 6/16/14 at 1:15 PM with the Vice President of Operations and the Director of Maintenance, the Director of Maintenance stated that safety rounds are done quarterly. They do half of the units every quarter, so the entire facility is done every 6 months. He/she stated that it was a lengthy check list that was developed and that they are "not checking the 50 different boxes on every single unit". They rely on reports from MHW and housekeeping staff as well as the rounding done by facilities staff every day to find problems. He/she discussed on-going review of MHW rounds reports, review of incident reports and asking staff directly about any particular safety concerns, as methods used to identify areas requiring some type of work and/or repair. He/she confirmed that they do not have a formal process in place to monitor the work order process to assure that all areas in need are completed timely. Regarding the event report (and work order) of the broken key in a patient door on the Tyler 3 during the first quarter of 2014, the Director confirmed this was a potential patient	**approach for quality review of incident reporting** **a. Include an EOC category at morning meeting M-F to identify those incidents with potential for systemic impact needing immediate follow up and intervention. (EOC incidents reviewed by the Nursing Supervisor with Administrator-on-Call (AOC) on weekends with the AOC and Nursing Supervisor determining whether immediate action on any safety related incident is necessary and reported at Monday meeting** **b. Facilities coordinator or designee will attend morning meeting for documenting reported EOC concerns** **c. Facilities coordinator or designee will enter the work order as type Safety Issue** **d. Facilities coordinator will report status of work orders at the morning meeting** **e. Director of Facilities will report the status of safety related work orders at the Patient Safety meeting** **f. Director of Facilities and Director of Quality will meet monthly to review EOC incident reports and completed work orders to ensure that data is analyzed and those systemic issues are identified and resolved. This data is reported at the Quality Performance**	**a. 7/14/14** **b. 7/9/14** **c. 7/15/14** **d. 7/10/14** **e. 7/24/14** **f. 8/ 18/14**	**a. Director Quality** **b. Director Facilities** **c. Director Facilities** **d. Director Facilities** **e. Director Facilities** **f. Director of Quality**	**a. Category included in 100% incident review at morning meeting** **b. Included on >95% attendance sheet** **c. Safety issue type included in work orders** **d. Included in minutes** **e. Included in 100% Pt Safety minutes** **f. reported at Safety Committee**

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	safety risk that he/she had not discussed at any monthly Safety Committee Meeting. It was noted that the same potential risk existed on the Osgood Unit, where the doors also lock automatically when closed. These safety risks were also reviewed with the Quality Committee during a meeting on 6/17/14 at 3:30PM, where the Director of Quality reported that he/she was not previously aware of the existence of the event report regarding the broken key and therefore, it had not been previously reviewed by the entire committee. The hospital does have a plan to replace this type of door used on Tyler 3 and Osgood Units with a non-barricade door, per the Director of Maintenance.	**Improvement Committee through Patient Safety Committee** **8. Include unit specific safety concerns as a standing agenda item on Safety Committee.** **9. Implement a "If you see something, say something" campaign to encourage all staff to report EOC safety concerns** **10. a. Plan developed to implement "Hooligan" bar (emergency tool used by fire dept.) for immediate access to doors if barricaded and/or if key breaks, lock unable to be opened. These Hooligan tools located in the following unit locations:** ***Tyler 1: Clean Utility Closet** ***Tyler 2: Back of report room** ***Tyler 3: Report room in art supply closet** ***Osgood 1: Staff bathroom/ break area** **b. general Staff training on use** *** OSGOOD 1 Child Unit** *** TYLER 3 Adolescent Unit** **c. incorporation into CPI training** **11. Director of facilities investigated door enhancements on T3 to include safety features to alert to any object over door. Executive team approved.**	**8. 7/24/14** **9. 7/28/14** **10.a. 6/17/14** **b. 6/26/14** *** 8/18/14** *** 7/18/14** **c. 8/18/14** **11. 7/15/14**	**8. Director of Quality** **9.Director of Informatics** **10.a. Director of Facilities** **b. Director of Facilities** **c. CPI coordinator** **11. Director of Facilities**	**8. Included in 100% Safety Agenda** **9.Increase in staff reported EOC safety concerns as evidenced by comparison pre implementation and three month post** **10.a. plan completed** **b. > 90% active staff complete** **c. included in 100% CPI training** **11.Order placed**