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September 3, 2015

Tracey Sessions, Administrator
State Hospital South
PO Box 400
Blackfoot, ID 83221

Provider #134010

Dear Ms. Sessions:

An unannounced on-site complaint investigation was conducted from August 19, 2015 to August 19, 2015 at State Hospital South. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006648

Allegation: The facility failed to ensure patients were adequately supervised, which resulted in a patient elopement and damage to a residence close to the facility.

Findings: An unannounced, on-site complaint survey was conducted on 8/19/15. Clinical records, facility policies and incident reports were reviewed. Interviews were conducted with staff and a current inpatient with multiple attempted elopements during his hospitalization. Additionally, observations of security measures were made.

Eight patient records were reviewed. Seven records included incident reports for elopement from the facility. Five of seven elopements occurred by patients going over the unit's fence. Two of seven elopements occurred when patients left a group they were walking with.

One patient was interviewed privately. He described jumping over the fence when he was out on the patio. He stated there were several staff around and they made him come back. He described several attempts at bolting for the door when staff were coming in or going out but that he was stopped from leaving. He reported more intense supervision after the elopements and that there has been a change in units, physicians and medications since the attempts.

One patient record reviewed included a elopement of a 21 year old male admitted with the diagnosis of paranoid type schizophrenia. He was in the patio unit yard, under the supervision of staff, when he ran and lept over the fence at 5:45 PM. The staff called a Code Green and all hospital staff were advised per radio comminication. The county law enforcement dispatch was notified of the patient elopement. The hospital staff maintained visual contact with the patient. The patient used his fists and arms and broke a window of a residential building. Hospital security spoke with the patient who laid on the ground and was returned to the hospital without further incident at 5:55 PM.

The hospital notified county law enforcement of the property destruction and patients return to the hospital. The hospital completed an unauthorized absence report to administration. The report included threats made by the patient towards staff after his return to the facility. The patient was placed into seclusion.

The Performance Improvement Director (PID) and the Director of Nursing Services (DNS) were interviewed on 8/18/15 at 9:35 AM.

The PID described the mission of the hospital to "provide all persons who have a serious mental illness a safe environment for growth, recovery and inclusion in their community." She stated it was the hospital's policy to protect patients from harm from self or others and to prevent unauthorized absence from the facility. She added elopement precautions, whenever possible, did not remove the patient from treatment milieu.

The PID provided a hospital's policy titled "Suicide, Elopement, Assault Precautions". The policy included precaution levels and their indicators for suicide, elopement and assault.

The DNS described the clinical necessity of precautions, the precautionary levels and interventions employed. He also described environmental controls which included supervision of the patient's freedom of movement within a defined area, staff escort, frequent patient observations, close staff monitoring and prompting the patient to remain in a designated safe area.

The DNS described 3 levels of supervision, based on clinical and behavioral indicators, which included, but was not limited to, 5, 10 or 15-minute checks on patient whereabouts by hospital staff. He provided an additional hospital policy titled "Daily Accounting for Patient Census," which included documentation of direct visualization of each patient at one-hour intervals.

A record review of 7 patients identified in incident reports as patients who had eloped, included a clinical evaluation for the level of supervision required, a Special Precautions Flowsheet with the appropriate frequency of checks and appropriate precautions noted for each patient's treatment plan. In addition, each patient's precaution level was noted to be changed to a higher level of interventions following an elopement or elopement attempt.

The PID provided a hospital policy, titled "Unauthorized Absence: Procedure and Notification". The policy included procedures to be followed after an unauthorized absence was discovered. The procedures included utilization of a Code Green which identifies an unauthorized absence, the unit involved, the gender of the patient, the direction of travel and a clothing description. The code system was implemented using a combination of a radio system and overhead paging system. The procedure included a delineation of staff assignments for responding to the recovery of the eloped patient while security of the unit was maintained.

The Unauthorized Absence Policy included, when appropriate, procedures for notification of community law enforcement agencies and judicial entities.

A tour of the hospital was provided by the Safety Risk Manager on 8/18/15 at 11:30 AM. The patio section of the unit was noted to be within a 5ft iron fence around the perimeter of the patio with a row of hedges outside the fence extending the height another 2ft. The gate of the fence was the only area without the hedge extension. The Safety Risk Manager indicated the addition of increased lighting and camera surveillance to areas outside of the patient housing areas in the past 12 months.

Additional observations of the patient residential unit included visualization of staff response when people entered and left through the unit's locked doors. Staff inside the unit provided access to the unit after a visual confirmation of identity was made using a camera and monitor system.

Although the allegation of patient elopement was substantiated, no deficiencies were cited. The hospital had implemented additional safety measures in the last year.

Conclusion: Substantiated. No deficiencies related to the allegation are cited.

As the allegation was substantiated, but was not cited, no response is necessary.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626, option 4. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Susan Costa/sc

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Health Facility Surveyor
Non-Long Term Care

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