

# FINAL BILL REPORT

## SHB 2426

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Synopsis as Enacted

**Brief Description:** Protecting patient safety in psychiatric hospitals and other health care facilities.

**Sponsors:** House Committee on Health Care & Wellness (originally sponsored by Representatives Cody, Robinson, Kilduff, Tharinger, Davis, Macri, Riccelli and Pollet; by request of Department of Health).

**House Committee on Health Care & Wellness**

**House Committee on Appropriations**

**Senate Committee on Health & Long Term Care**

**Senate Committee on Behavioral Health Subcommittee to Health & Long Term Care**

**Senate Committee on Ways & Means**

### **Background:**

#### Licensing of Establishments.

The Department of Health (Department) regulates "establishments" which are private, county, or municipal facilities that receive or care for persons with mental illness or a substance use disorder. To become licensed to operate an establishment, a person must receive a certificate of need for the project, obtain approval of facility plans under the construction review process, obtain approval from the State Director of Fire Protection, and successfully complete a Department survey of the facility. Establishments must operate in compliance with Department regulations regarding clinical facilities, patient care services, staffing, patient safety, clinical records, and pharmacy and medication services.

The Department may conduct inspections at any time to determine compliance with establishment standards. The Department may issue a statement of deficiencies if it finds that the establishment is not in compliance with operating standards.

#### Sanctions for Health Care Facilities.

The Department licenses several types of health care facilities, including hospitals, establishments, and ambulatory surgical facilities. In the event that an inspection or survey identifies noncompliance with health care facility standards, the Department may require the facility to submit a plan of correction to address each of the deficiencies. For these facilities, the Department has the established authority to deny, suspend, revoke, or modify a license or

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provisional license. In the case of ambulatory surgical facilities, the Department may assess civil monetary penalties up to \$1,000 per violation. In addition, the operation of an establishment without a license may result in imprisonment and a fine of up to \$1,000.

#### Adverse Health Event Reporting.

Certain types of health care facilities, including some establishments, must report adverse health events to the Department. Under the reporting system, an initial notification must be filed with the Department within 48 hours of confirmation of the adverse event. Full reports must be submitted within 45 days of confirmation. Adverse health events include the 29 serious reportable events identified by the National Quality Forum in 2011. These are categorized among surgical or invasive procedure events, product or device events, patient protection events, care management events, environmental events, radiologic events, and potential criminal events.

#### **Summary:**

#### Licensed Psychiatric Hospitals.

For newly licensed psychiatric hospitals or existing psychiatric hospitals that change ownership after July 1, 2020, the Department of Health (Department) must provide enhanced oversight through inspections and technical assistance for the first 24 months.

"Psychiatric hospitals" are defined as establishments caring for any person with mental illness or substance use disorder. The term does not include acute care hospitals, state psychiatric hospitals, or residential treatment facilities.

#### Enforcement of Health Care Facility Licensing Standards.

If a licensed psychiatric hospital fails or refuses to comply with state licensing standards, the Department may take one or more of several actions.

The Department may either impose conditions on a psychiatric hospital, including training or the hiring of a consultant, or assess a civil fine of up to \$10,000 per violation, for a total of no more than \$1 million. These actions are available if the psychiatric hospital is in violation of licensing standards and has been previously subject to an enforcement action for the violation, has been given a previous statement of deficiency for the violation, or has failed to correct the noncompliance by an established date. The Department may impose civil fines of up to \$10,000 for each day that a person operates a psychiatric hospital without a license. Civil fines collected by the Department may only be used to provide technical assistance to psychiatric hospitals and to offset the cost of psychiatric hospital licensing activities.

The Department may suspend admissions to a psychiatric hospital by imposing a limited stop placement on one or more categories of patients or a stop placement on the entire facility if it finds practices or conditions that constitute an immediate jeopardy. The term "immediate jeopardy" means a situation in which the noncompliance has placed the health and safety of patients at risk for death or serious injury, harm, or impairment. Before imposing a limited stop placement or stop placement, the Department must give the psychiatric hospital notification of the practices or conditions that constitute an immediate jeopardy and allow the psychiatric hospital 24 hours to develop a plan to correct the violation. If the Department does not verify within 24 hours that the violation has been corrected, then the limited stop

placement or stop placement may be issued. If the Department issues a limited stop placement or stop placement, it must conduct a follow-up inspection within five business days or a longer period if the psychiatric hospital requests more time. The stop placement order or limited stop placement order must be terminated if the violations have been corrected or addressed through an intermediate action and the psychiatric hospital is able to maintain the corrections. Lastly, the Department may suspend, revoke, or refuse to renew a license.

Before imposing immediate conditions or an immediate license suspension, the Department must find that noncompliance will result in immediate jeopardy. When the Department takes such immediate actions, the psychiatric hospital is entitled to a show cause hearing within 14 days of making a request. At a show cause hearing the Department has the burden of demonstrating that an immediate jeopardy exists. Standards for the consideration of evidence are established. If the show cause hearing sustains the Department's immediate action, the psychiatric hospital may request an expedited full hearing to occur within 90 days.

Beginning with psychiatric hospitals and residential treatment facilities, the Department must make health care facility inspection and investigation statements of deficiencies, plans of correction, notice of acceptance of plans of correction, enforcement actions, and notices of resolution available to the public on the Internet, to the extent that resources allow.

The Department is directed to evaluate the appropriate levels of oversight for the health care facilities that it licenses and identify opportunities to consolidate and standardize licensing and enforcement standards across facility types. The types of facilities subject to the review include birthing centers, pharmacies, hospitals, medical test sites, in-home services agencies, ambulatory surgical facilities, establishments, and behavioral health service providers. The Department must work with stakeholders to create recommendations to develop a uniform health care facility enforcement act.

#### Elopement and Death Reporting by Psychiatric Hospitals.

Psychiatric hospitals must report to the Department every patient elopement that occurs on their grounds. An "elopement" is defined as any situation in which a patient admitted to the psychiatric hospital who is cognitively, physically, mentally, emotionally, or chemically impaired leaves the psychiatric hospital or its grounds unsupervised, unnoticed, and without the staff's knowledge prior to scheduled discharge. In addition, psychiatric hospitals must report to the Department every patient death associated with elopement, suicide, medication error, falls, and the use of physical restraints or bedrails. Psychiatric hospitals must also report patient or staff member death resulting from a physical assault. The reports must be made within three days of the elopement or death.

#### **Votes on Final Passage:**

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|--------|----|----|-------------------|
| House  | 84 | 14 |                   |
| Senate | 48 | 0  | (Senate amended)  |
| House  | 96 | 0  | (House concurred) |

**Effective:** March 25, 2020