

# **Report to the Legislature**

## **Workplace Safety in State Hospitals**

Chapter 187, Laws of 2005, Section 1

September 2013

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## Executive Summary

Chapter 72.23 RCW requires each state hospital to develop a plan to reasonably prevent and protect their employees from violence at those hospitals, and directs the Department of Social and Health Services (DSHS) to provide an annual report to the legislature on efforts to reduce violence in the hospitals. Specific statutory language states:

### **RCW 72.23.400(1) (4) – Workplace safety plan**

- (1) By November 1, 2000, each state hospital shall develop a plan for implementation by January 1, 2001 to reasonably prevent and protect employees from violence at the state hospital. The plan shall be developed with input from the state hospital's safety committee, which includes representation from management, unions, nursing, psychiatry and key function staff as appropriate. The plan shall address security considerations related to the following items:
  - (a) The physical attributes of the state hospital;
  - (b) Staffing, including security staffing;
  - (c) Personnel policies;
  - (d) First aid and emergency procedures;
  - (e) Reporting violent acts, taking appropriate action in response to violent acts, and follow-up procedures after violent acts;
  - (f) Development of criteria for determining and reporting verbal threats;
  - (g) Employee education and training; and
  - (h) Clinical and patient policies and procedures.
- (2) Before the development of the plan required under subsection (1) of this section, each state hospital shall conduct a security and safety assessment to identify existing or potential hazards for violence and determine the appropriate preventive action to be taken. The assessment shall include, but is not limited to, analysis of data on violence and worker's compensation claims during at least the preceding year, input from staff and patients such as surveys, and information relevant to subsection (1)(a) through (h) of this section.
- (3) In developing the plan required by subsection (1) of this section, the state hospital may consider any guidelines on violence in the workplace or in the state hospital issued by the department of health, the department of social and health services, the department of labor and industries, the federal occupational safety and health administration, Medicare, and state hospital accrediting organizations.
- (4) The plan must be evaluated, reviewed, and amended as necessary, at least annually.

## **RCW 72.23.451 – Annual report to the Legislature**

By September 1<sup>st</sup> each year, the Department of Social and Health Services (DSHS) shall report to the Legislature the Department's efforts to reduce violence in state hospitals.

### **Overview**

This report updates last year's report by adding data for May 2012 through April 2013 and includes activities related to the three state psychiatric hospitals as follows:

**Western State Hospital:** located in Lakewood, Washington, has a capacity of 827 beds; 557 for civil commitments and 270 for forensics patients.

**Eastern State Hospital:** located in Medical Lake, Washington, has a capacity of 287 beds; 192 for civil commitments and 95 for forensics patients.

**Child Study and Treatment Center:** located on the grounds of Western State Hospital in Lakewood, has a capacity of 47 beds.

Initial workplace safety plans from the three state hospitals were submitted to the legislature in November 2000 and have been evaluated, revised and updated at least annually. These plans provide a safety assessment, detailed security activities undertaken, and identify further plans of action. These plans are attached as appendices to this report.

Creating a safe working environment in state hospitals remains a top priority for the Governor's office, the Department of Social and Health Services, the Department of Labor and Industries (L&I), leadership of all three state hospitals (Western State Hospital [WSH], Eastern State Hospital [ESH] and Child Study & Treatment Center [CSTC]) and local labor unions.

Implementing a Continuous Quality Improvement Plan (CQI Plan) is a top priority for DSHS leadership, including implementation of a strategic plan to improve risk management outcomes related to state hospitals. Strategies are being employed to improve patient care, quality management, data management and workplace safety, as well as increased individualized treatment planning, active psychosocial rehabilitation treatment and training, monitoring and adequate staffing. Each hospital is applying strategies to improve care and services, and ultimately safety, as part of their individual Continuous Quality Improvement Plans.

The Central Safety Office's current initiatives regarding workplace violence and assaults are as follows:

1. **Mental Health First Aid training.** The Department is in the process of obtaining funding to bring National Council for Community Behavioral Healthcare trainers out from Washington DC to train 30 staff as certified instructors of Mental Health

First Aid (MHFA). MHFA is an internationally recognized program designed to help people respond appropriately to a mental health emergency and offer support to others who appear to be in emotional distress.

Our intent is to then task these instructors to train existing DSHS staff and newly hired staff in MHFA in order that they better identify and manage: the increasing client population who are seeking services displaying varying degrees of mental illness; an increasing drug-affected client population seeking our services; and the situational emotional disturbances that commonly can erupt among our staff and client populations. While many of the facilities staff are already professionally and locally trained in similar issues, significant numbers of non-patient direct staff (administrative, CMO, CIBS, etc.) have limited or no training experience of this nature.

2. Assault Benefits Workgroup. RCW authorizes the Department to provide employees who are victim to client assault at the facilities additional extended benefits (e.g., added funds to maintain 100% salary in time loss periods, and no use of earned leave during time loss periods) above and beyond routine Worker's Compensation benefits. The Department recently put together an Assaults Benefits Workgroup to work toward building more standardization and consistency in the assault benefits program. While this began as primarily a claims initiative, the key focus of the group has turned to focus on effective reporting and investigation of assault events. The group is in the process of changing key safety forms: the 03-133, Personal Incident Report, the 03-391, Employee Report of Assault, and 03-389A, Assault Benefits Witness Statement. The changes require the employee, supervisor and witnesses to: lend more consistency to the reporting/investigation process; more thoroughly describe all aspects of the event in order to better derive root causes and eventual mitigation strategies; provide more complete documentation and historical data; and avail more comprehensive information to CEO's and the Central Claims unit for making assault benefits determinations. The Assault Benefits Workgroup has representatives from every facility program.
3. Safety Investigators. A concern noted from the Assault Benefits Group was the determination that the DSHS lacked any consistent safety (or assault) investigation standard. While altering the forms to be more informative will help drive consistency to a degree, safety reviews of assault incidents rely significantly on the experience, knowledge, will, objectivity, and motivation of direct supervisors/managers. One way to drive consistency and objectivity is to have objective experts perform the serious event reviews. Accordingly, the Enterprise Risk Management Office (ERMO) initiated a Decision Package to hire three FTE's whose role would be to investigate/review any serious assault event that were to meet a set criteria or series of thresholds, or when requested by executive managers. A means of triage is necessary due to the number of events identified as assaults each year. Following the reviews, executive managers would be debriefed

as to root cause and recommended mitigation strategies, plus as time allows, provide consultation/monitoring assistance for mitigation implementation.

Discussions at the Assault Benefits Workgroup led to a proposal to seek additional safety investigators to review assaults throughout the Department. The group thought that having a cadre of objective, trained investigators looking into the more serious assaults, the Department may be able to better determine root causes and affect more effective preventative best practices. The current method of relying on supervisor reviews is adequate for minor events, but significant assaults require trained investigators with the time and resources to conduct proper reviews.

4. Annual Loss Control Evaluation (ALCE) focus. Historically, the ALCE process conducted by Central Safety staff has focused predominantly on general safety and occupational health program elements. Observational/walk-around inspections during the evaluations were keyed to routine OSHA/WISHA and The Joint Commission (TJC) program items. While those areas continue to remain points of attention for future ALCEs, recent L&I compliance visits have demonstrated the need for increased focus on safety management documentation, and more importantly, workplace violence concerns. Beginning in July, Medical Lake ALCE visits to Eastern State Hospital, Lakeland Village, and Consolidated Support Services, increased attention was placed on potential workplace violence issues, including but not limited to: employee blind-spots/concealed areas, potential weapons, potential suicide environment, lighting, staff team monitoring, staff communications/alerts, hazard and risk assessment/identification (including patient behavior), staff training, monitoring equipment (cameras, metal detectors, etc.), 1:1 monitoring and the use of pulled staff. The points of contact for the ALCE are the Safety Managers at each of the facilities.

The Return to Work (RTW) Program provides employees, who have either an occupational injury or illness and are unable to return to full regular duties immediately, a safe, timely transition back to work. The program involves monitoring an injured employee's progress and identifying temporary modified duties that are suited to physical capacity guidelines established by the designated physician or medical provider.

The goal of the RTW Program is to reduce the cost of Labor and Industry (L&I) premiums for the state hospitals and reduce costs for L&I compensation for injuries. Premiums and experience ratings are determined by L&I on a three year rolling average and based on the combined performance of all DSHS institutional staffs. In 2012, the state hospitals paid premiums based on the cost of claims for all DSHS institutions that occurred from 7/1/2007 through 6/30/2010.

Safety programs, other than increased challenges related to back filling for staff on light duty or attending safety training, remain intact at all three hospitals.

## **Summary**

The state hospitals continue to collaborate on several projects:

- Workplace Safety Initiatives
- Reduction of Seclusion and Restraint Initiatives
- Standardized policies and procedures

The state hospitals are planning to collaborate on new projects:

- Evidenced Based Practice treatment interventions for medication management.
- Creating a Tobacco-Free Campus
- Participating with L&I's SHARP program in a research project through an approved grant to assist the hospitals with workplace violence prevention

## **Challenges**

Recent budget reductions make maintaining past gains a challenge. At CSTC, RTW FTE's provide injured staff a funded, light duty position, to return to on a temporary basis as prescribed by their healthcare provider. The positions allow current positions to participate in safety training without impacting patient care by assigning a RTW FTE to backfill during the training. ESH has maintained a dynamic RTW Program, offering Transitional Return to Work utilizing existing funded positions while backfilling critical positions during an injured worker's recovery. The current economic climate will impact ESH's ability to maintain its program at the current level, resulting in increased time loss.

# Western State Hospital

## Summary of Accomplishments

Western State Hospital (WSH) has initiated a number of performance improvement initiatives to enhance staff safety.

- Joint Labor and Management Safety Committees to review injury incidents, patterns, and trends.
- Joint Labor Security Committee in the Center for Forensic Services, (CFS).
- Continued efforts to reduce seclusion/restraint
- Continued collaboration with the SHARP program from Department of Labor & Industries (L&I) to survey staff regarding safety and develop staff training.

## Projects

- Refine and simplify the hospital’s debriefing process for all serious incidents to determine precipitating factors, learn from our responses, celebrate and share successes and change practices as needed.
- Focus on behavioral consultation from Medical Director and expert psychologists to provide consultation to treatment teams for challenging patients.
- A key control system called “Key Watcher” was implemented in CFS for better access control to the area. This system has been very successful with zero keys lost from CFS since its implementation.
- Established a Key Control Department that is separate from Central Maintenance Operations for oversight of the hospital’s key control.
- A Capital Programs safety and security project was completed taking into consideration our patient population. Recent staff/patient safety projects include the following:
  - Anti-ligature door handles on all ward area doors
  - 1 – 2 Safe rooms identified on each ward to be used for high risk patients with self-harm behavior
  - Patient locker doors were modified in all patient rooms to decrease the opportunity for self-harm behavior
  - Enclosed exposed plumbing fixtures on wards
  - Installed new anti-ligature faucets in high risk areas
  - Modified or installed grab bars and toilet paper holders that are anti-ligature
- A new camera system was installed in CFS to assist staff with visual issues in the building. The new system allows staff to view more areas in CFS that was not possible with the old system.
- Upgraded our radio system to a digital narrow banded system with 3 channels (Security channel, Maintenance Channel, and Emergency management (EM) channel). The hospital has also added repeaters throughout the hospital for improved communication.
- A lighting project was completed for enhanced, more efficient interior and exterior lighting throughout the hospital.

- Security staffing was analyzed as part of an overall effort to identify risk of violence and address security needs. As a result of the analysis, two additional staff were added to the Security Department.

### **Performance Improvement Activities**

- SAFE Team continues to provide training in New Employee Orientation; 471 employees have received TEAM training which is a 2 day course covering patient interventions. In addition, a multitude of trainings continue to be offered that cover the spectrum of violence prevention. For example, 550 employees were trained on the SAFE Team Module "Understanding Behavior"; 745 employees were trained in the "Safety Movements and Mechanics" Module; 1062 employees have had the "Use of Padded Shields to Manage Assaultive Behavior" Module; and 969 employees have had Seclusion and Restraint competency. The SAFE Team also continues to assist Nursing with Behavioral Crisis Drills that occur quarterly per ward and the Bi-Annual Nursing Competency Fair has been changed to annual trainings to ensure staff are up-to-date with their core competencies. The SAFE Team Director and Safety Manager developed an accident investigation training for supervisors regarding how to do a thorough accident investigation so that effective prevention recommendations can be implemented for safer outcomes for both patients and staff. This training included how the debriefing process can help bridge the gap for better prevention recommendations to be used in the future. By April 30, 2013, 103 supervisors had been trained in the Accident Investigation Process and its importance in assisting the hospital with preventing future like kind occurrences.
- WSH revised its Code of Conduct Policy (1.7.2) to promote compliance with the WSH Code of Conduct. In addition, WSH created and distributed a new "Culture of Safety" Policy (3.4.13) and booklet to promote a hospital-wide safety culture which ensures the safety of all. An on-line training was developed to go along with these policies which focused on civil behavior in the workplace. By April 30, 2013, close to 100% of staff had taken the on-line course.
- A new staff scheduling software program has been implemented for nursing staff; its use is now being expanded hospital-wide. The program coordinates call-ins with the float pool and those willing to work overtime. Use of this program has reduced the amount of time it takes to schedule nursing staff for a given shift on a given day by many hours, and ensures that those who are willing to work are given the opportunity to do so rather than forcing others to work beyond their safe ability.
- Initiatives to reduce seclusion and restraint continue to be implemented, including improved debriefing procedures and emphasis on the completion of patient safety plans.
- A leadership academy was developed for WSH managers and supervisors. 108 managers and supervisors completed the academy. The leadership training series included training for managers and supervisors on; Introduction and Leader Skill Set; Leadership Styles and Strategies; Leadership and the Environment of Care; Leadership and Labor Relations; Leadership and Human Resources Information; and Violence and Civil Behavior in the workplace.

- A follow-up Culture of Safety Survey was administered to staff for the second time. The results were much the same as for the previous administration—indicating that the exchange of information about patient behavior at shift change remains problematic. The hospital is exploring a training developed by the federal Agency for Health Care Quality and Research and the Department of Defense to assist treatment teams in communicating about a patient’s condition. (Team STEPPS).
- Clinical leaders continue to meet each morning to review clinical reports for patients to determine ways to help treatment team’s deal with challenging patients.

### **Future Planning**

- Continue to refine and simplify the debriefing process to provide staff with vital information that will assist with interventions for staff to use with patients.
- Continue to focus on behavioral consultation from Medical Director and expert psychologists to provide consultation to treatment teams for challenging patients.
- Improve the Culture of Safety among staff.
- Expand use of Critical Incident Stress Management (CISM) team in response to events
- Decrease overtime.
- As budget allows:
  - Replace furniture in patient care areas with safe furniture.
  - Install additional camera systems to improve sight lines in patient care areas.
  - Expand and improve the key management system.
  - Expand the personal alarm system.
  - Improve building and grounds PA systems.
  - Increase the use of Transitional Return to Work opportunities to assist injured workers back to work as soon as possible

### **Risk Assessments**

- An annual Proactive Environmental Risk Assessment was done in the fall of 2012 to identify safety and security risks associated with the environment of care. Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts.
- A Capital Programs project was submitted in the amount of \$3.1 million dollars for WSH in early 2013 to help make the environment safer and more secure for all. Some of the items requested in this package include but are not limited to, purchasing SAFE furniture to be distributed throughout the hospital, expanding the personal alarm duress system, Closed circuit Television installation in South Hall, completing the anti-ligature project and expanding the “Key Watcher” system hospital-wide.

- The Hazard Vulnerability Analysis (HVA) was reviewed with the Emergency Management Committee in February, 2013, and results used for future Emergency Management response and recovery planning.

### **Work Groups**

- The safety committee structure at Western State Hospital includes 4 patient-care area sub-committees and 1 support area sub-committee. Membership includes management and labor representatives from each area. Co-chairs are elected to each sub-committee; one from management, one from labor. The sub-committees have increased representation and input at the ward level and support area level and allow very specific safety issues to be discussed and acted on. The WSH Central Safety Committee is comprised of the co-chairs of each of the sub-committees. Additional members include the COO, SAFE Team Director and WFSE Local 793 representation. Resource members include the safety manager, infection control/employee health representative. Each committee meets on a monthly basis to review injuries and trends, and resolve safety issues.
- The Environment of Care Committee meets on a bi-monthly basis to monitor and manage the Joint Commission Environment of Care, Life Safety and Emergency Management Chapters. Committee members provide annual environment of care rounds throughout the hospital and a physical risk assessment of all patient areas. This committee also develops management plans for Safety, Life Safety Utilities, Hazard Communication Medical Equipment Management and Emergency Management. The management plans are provided to WSH's Governing Body annually.
- The WSH Emergency Management Committee meets on a monthly basis to ensure protection of our patients, staff, community and property through increased readiness, training and guidance
- The Safety Manager actively participates in the Region 5 Pierce County Coalition for Healthcare in Emergencies committee to develop regional healthcare response plan during disasters. The Coalition participates in functional drills twice a year to evaluate the effectiveness of the plan.  
The Joint Labor/Management CFS Security Committee meets on a weekly basis to discuss and resolve security issues within CFS.

### **Challenges**

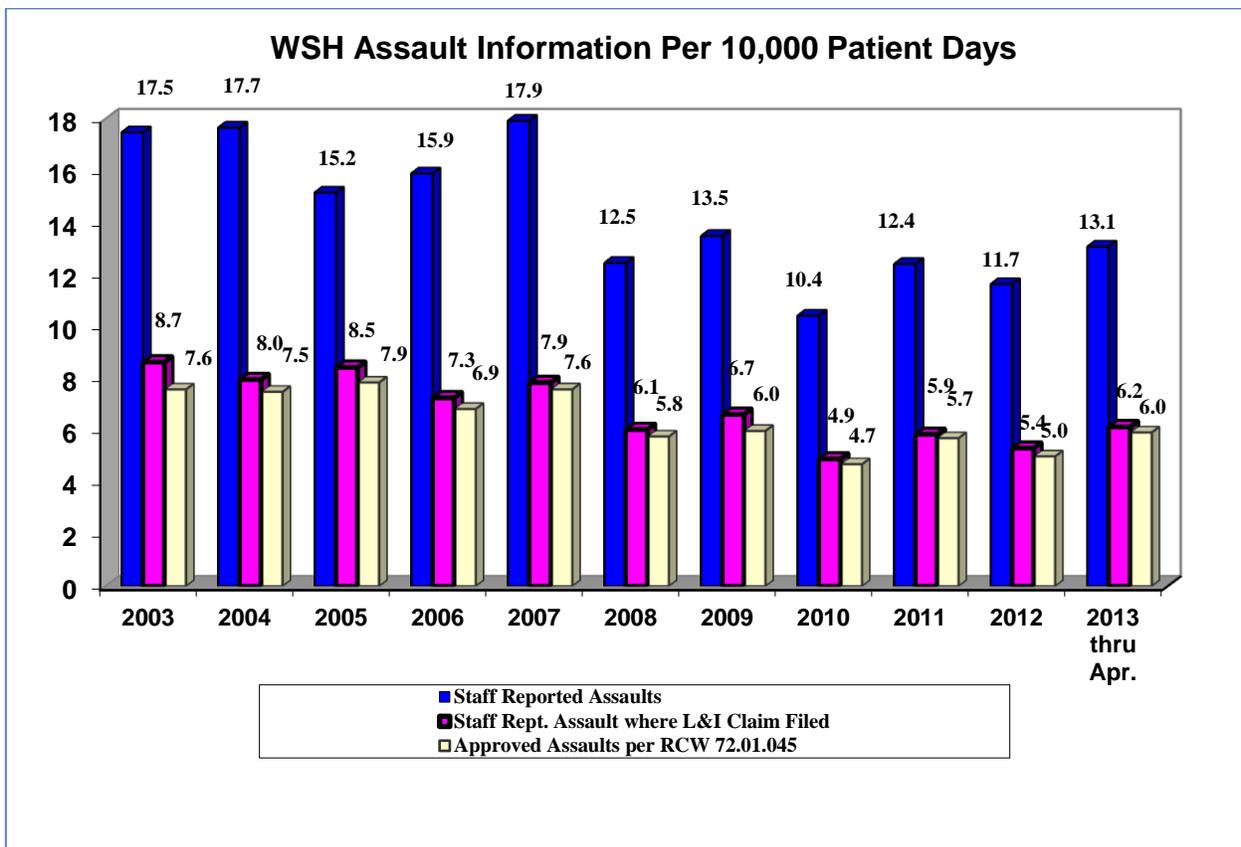
- Budget constraints mean we are unable to purchase some items or upgrade current systems (i.e. safe furniture, camera systems, personal alarm systems) and backfilling for Return to Work FTE's and mandatory safety training. In addition, the purchase of safety equipment needs to be weighed against purchases for direct care needs.
- An open campus results in an increase for possible unauthorized leaves and security concerns from the outside community.

**Data Summary**

**Staff Reported Assault Information:** When looking at data for 2008 through 2012, staff reported assault rate significantly decreased during these years when compared to 2007 (17.9 per 10,000 patient days, down to 12.5, 13.5, 10.4, 12.4 and 11.7). When looking at early 2013 data, (through April), the rate of staff reported assaults has remained steady since 2008.

When looking at data for 2008 through 2012, staff reported assault rates for L&I claims and approved assault claims also significantly decreased when compared to 2007. Assault claims filed decreased from 7.9 per 10,000 patient days in 2007 down to 5.4 in 2012 per 10,000 patient days. Approved assault claims decreased from 7.6 per 10,000 patient days down to 5.0 per 10,000 patient days. When looking at early 2013 data, (through April), both indicators have remained steady since 2008.

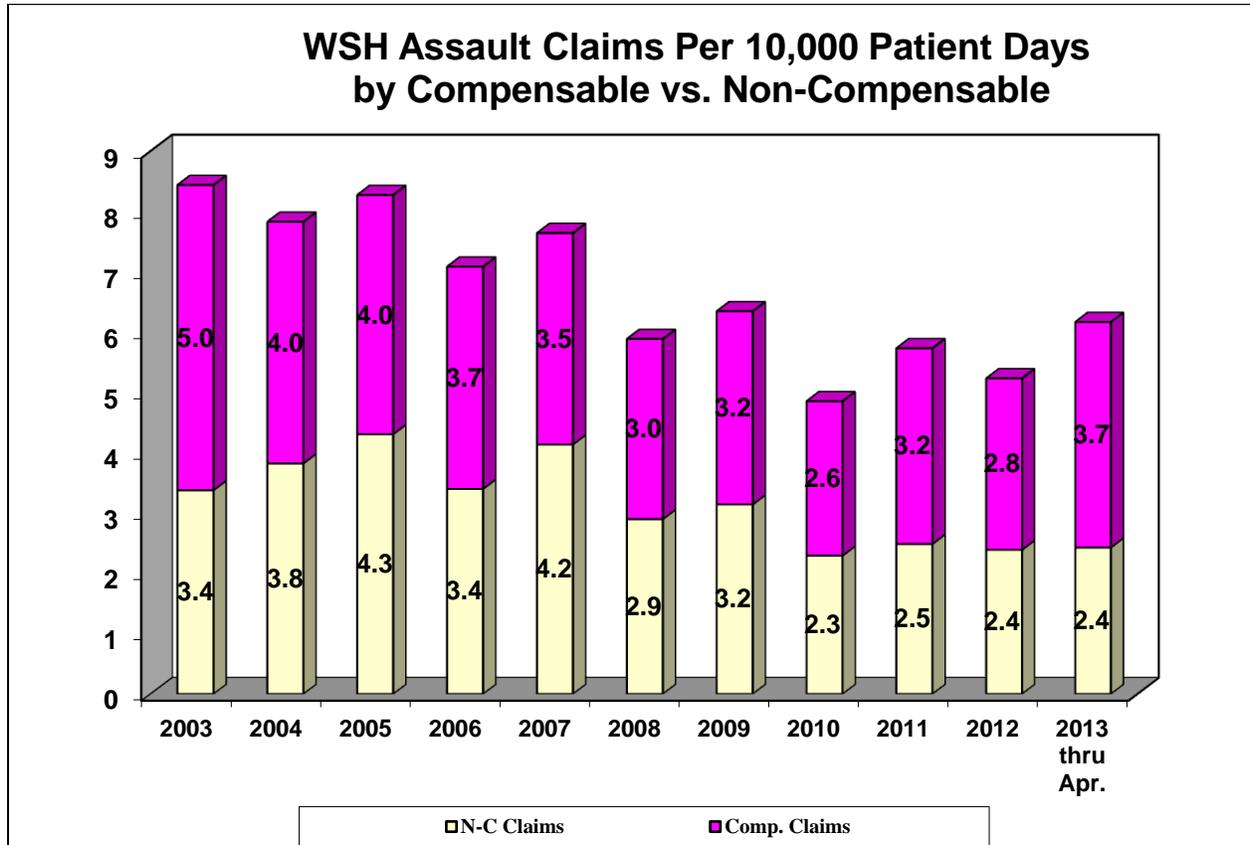
These decreases are due to the many programs that have been implemented since 2007.



**Compensable vs. Non Compensable Assault Claims:** Measuring the ratio between compensable (payable) and non-compensable claims is important as more non-compensable claims result in lower industrial insurance premiums and is an indicator of injured employees returning to work. Non-compensable claims should make up 50% or

greater of claims filed. The most direct way to increase non-compensable claims is by having effective Return-to-Work (RTW) and Claims Management Programs. However, safety prevention efforts by an organization can also decrease compensable claims as less serious injuries allow employees to return to work more quickly.

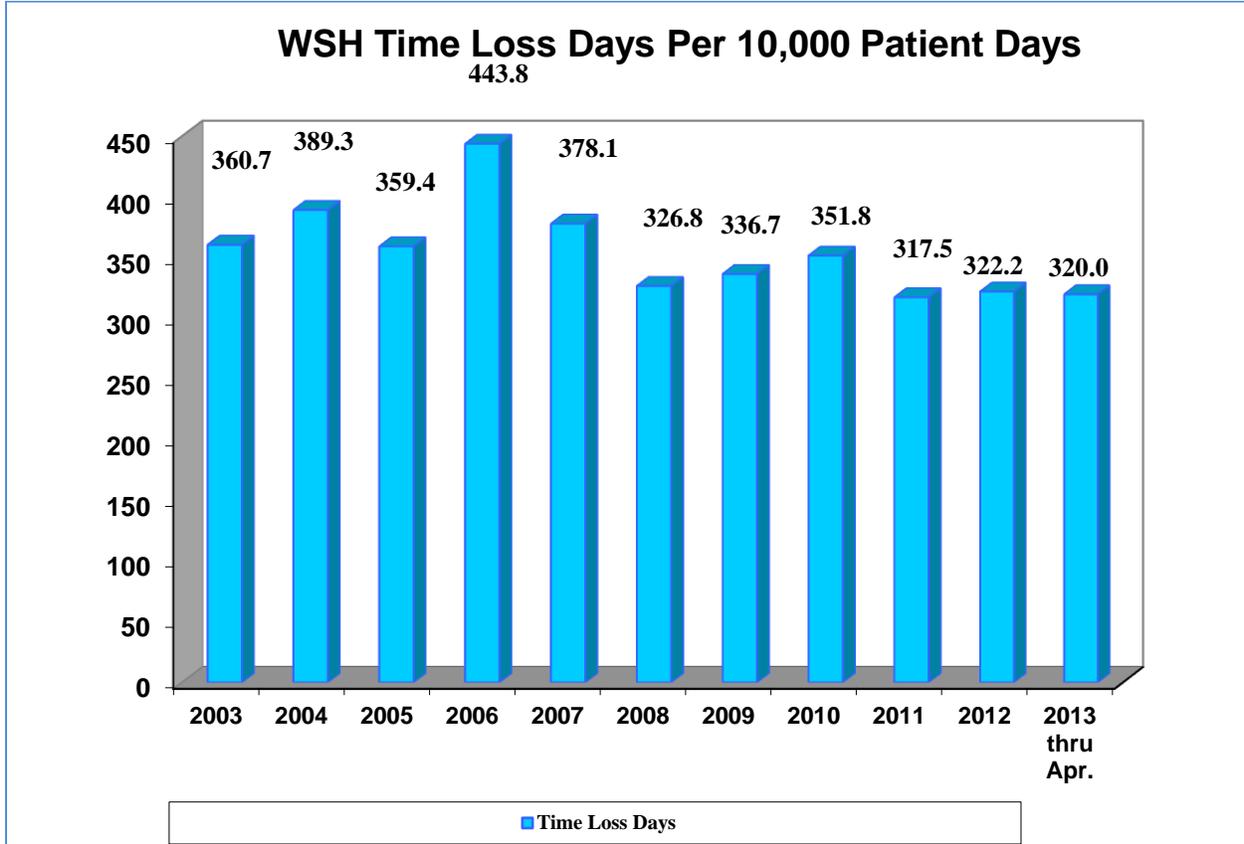
At WSH, 2008 and 2009 data indicate that the compensable to non-compensable ratio for assault claims were at about 50/50. When looking at 2010 thru present, the trend is reverting back to a less favorable ratio of 60/40.



**Time Loss Days:** are directly related to frequency and how many claims are compensable verses non-compensable. An effective Safety program reduces the number of claims filed, and an effective Return-to-Work Program directly reduces the number of days an employee misses work by returning employees back to work as soon as possible after an injury negating the need for Labor and Industries to pay time loss.

A compensable claim means time loss (wages) had to be paid to an employee on their claims due to an on-the-job injury. At WSH, 2008 showed a dramatic decrease in days employees missed from work when compared to 2006 and 2007. This is directly attributable to the implementation of the funded RTW program at WSH beginning July 1,

2007 through June 30, 2009. Since 2008 the time loss days due to assault at WSH has remained steady. This is due to the many different safety and claims programs that have been implemented at WSH since 2007.



# Eastern State Hospital

## Summary of Accomplishments

- The total number of reported staff injuries in 2012 was 201 compared to 224 in 2011. The total number of incidents resulting in a claim being filed decreased from 120 in 2011 to 117 in 2012. The largest proportion of total incidents continues to be patient-to-staff assaults but has decreased with 99 reported in 2012 compared to 105 in 2011.
- Performance Improvement activities were initiated in 2012 to reduce employee injuries related to Patient Handling Activities (lifting, re-positioning, transferring, preventing patient falls). As a result, six patient handling injuries were reported in 2012 compared to 17 in 2011; a 65% decrease.
- Unauthorized leaves decreased from four in 2011 to one in 2012; a 25% decrease. Unauthorized leaves continue to be monitored and reported to Safety and Patient Safety committee quarterly to assess effectiveness of Security improvements.
- ESH continues to make significant improvements in Seclusion and Restraint reduction.

## Projects

- A Capital Programs project, Phase 1, for patient safety hardware improvements (door handles, closet rods, grab bars, mirrors) is 90% complete. Phase 2 (continuous hinges, faucet and shower handle replacement, covering of exposed sink and toilet plumbing, toilet paper holder replacement, and corridor handrail replacement) is targeted to be installed in all high-risk locations; August 30th, 2013. Until funding is received and identified issues are abated, bath/shower rooms are either locked when not in use or patient/room checks are being conducted every 15 minutes.
- Capital Programs funding was requested and approved for FSU security upgrades (replacement of existing cameras and access control and installation of additional cameras (38 locations). Target for completion; July, 2013.

## Performance Improvement Activities

- The Security Department implemented a performance improvement activity involving monitoring of high risk door locations for trends (unsecured) to evaluate need for snap-lock and/or door replacement.
- Security continues to track unauthorized leave (UL) by time and source of elopement and reports to the Safety Committee for identification of trends and drill downs as needed. Unauthorized leaves decreased from four in 2011 to one in 2012. Unauthorized leaves will continue to be monitored and reported to Safety and Patient Safety committee quarterly during 2013 to assess effectiveness of Security improvements.
- Level of compliance with control of equipment and materials stored in corridors continues to be monitored. Target compliance of 90% for control of equipment and materials in corridors to ensure a clear means of egress (exit) for patients, visitors or staff leaving the building under emergency conditions was met for 2012. Daily

compliance will continue to be monitored in 2013 and additional Performance Improvement activities developed to increase compliance as indicated

- Environmental surveys are conducted in both patient and non-patient care areas, hospital-wide, and are used to evaluate staff knowledge of, and ability to access, Material Safety Data Sheets (MSDS) with a focus on Housekeeping, Rehab & Food Service in 2012 based on a 2011 performance improvement assessment.
- A 2012 PI activity was developed to decrease the number of cannot-locate equipment identified during preventative maintenance checks; target decrease 10%. There were 13 reports of equipment that could not be located by Consolidated Support Services during preventive maintenance checks in 2012 compared to 21 in 2011. A 62% decrease.
- A 2012 PI activity was developed to decrease number of user errors identified during preventative maintenance checks and/or service calls; target decrease 20%. There were two user errors in 2012 compared to eight in 2011. A 30% decrease.
- Security staffing increased to two per shift to provide back up. ESH Security Guard staff is primarily responsible for the security and safety of the external campus, including patrolling the campus, watching for trespassing, ensuring vacant buildings are secure, and that hospital entrances are safe and secure. They are not assigned to patient care wards but are available to go to the wards if requested by Nursing Staff.
- Nursing, in conjunction with the accounting office, finalized a contract with Maxim Staffing Solutions; complete 1.29.13. This contract is utilized to secure additional RNs prior to activating requests for mandatory overtime.
- The FSU security training was reviewed to assess whether gaps occur and to include a plan for conducting individual patient and room searches and training revised as indicated. Training includes a requirement to ensure refresher security training is an annual mandatory requirement. Training is divided into two sections, one for the nursing staff and the second for non-nursing staff.
- New and Revised Policies Implemented:
  - Minimal Personal Care Criteria (new FSU policy) outlines the twice daily room inspections, checking for any unauthorized items, and that authorized items are stowed in the patient's lockers and patient's lockers are locked.
  - Patient Property Authorized and Unauthorized policy developed to identify items that are safe for patients to have in their possession based on patient's category level (all units).
  - FSU Environmental Safety Check out System to identify a process to safely monitor and check out/in items to patients. Items include those that they may have in their possession during that specific shift only.
  - FSU Staffing Plan; identified specific positions such as the Security Desk position.
- Senior leadership conducts safety rounds on a monthly basis. Senior leaders meet with front line staff and discuss safety concerns and develop plans of action based on the input of staff.
- The Nurse Executive is completing Intentional Leadership Rounding at least quarterly on all shifts with the agenda of focusing on safety and improving communication.

- A 2012 culture of safety survey was completed and reviewed by senior leadership; March 4, 2013. Culture of Safety is included in all Executive Committee and Governing Body meeting discussions including treatment errors that have occurred, reports from various providers and inviting front line staff to discuss safety concerns from their perspective.
- Senior Level Management received training on Quality and Safe Patient Care February 2013 to bring awareness of safety to the forefront and promote a culture of safety.
- Four emergency response activities were conducted and evaluated during 2012; three planned exercises and one real life occurrence:
  - 4.18.12 Table Top Region 9 Healthcare Coalition.
  - 5.9.12 Drill; Armed Assault/All-Hospital Lockdown.
  - 10.30.12; Structure/Wildfire Resulting in Evacuation
  - 11.2.12; Real-life occurrence, Telephone Failure

A Plan for Improvement was developed for all emergency activities (staged and actual) in response to identified issues related to internal/external communication, availability of and access to materials, safety & security of patients and staff, staff roles & responsibilities (assignment and performance), managements of critical utilities, managements of clinical and support activities. Improvement activities include, but are not limited to:

- Development of a flow chart to outline process/procedures for tracking patients and staff and how and who to communicate the information to including how ESH will notify families when patients are relocated to alternative care sites.
- Installation of a base station for Eastlake Kitchen & Campus Café (1 base housed in a mutual location) for alternate communication capability.
- Development of improved guidance/direction for initiating emergency announcements with a quick reference for Incident Command Center to decrease confusion and increase response time; all-hospital overhead announcement versus two-way radio or phone, determining need for announcement to affected area only and/or all-hospital, communication by Switchboard or other designee. It is understood that making emergency notifications via overhead announcement and/or two-way radio is not always prudent depending on nature of emergency e.g. hostage, bomb threat, etc.
- A Plan for Improvement was initiated to improve tracking of patients and staff movement during an evacuation to initial staging/off-site care location(s) (how to report & who to report information to).

### **Future Planning**

- DSHS and 1199 SEIU worked together to bring a nationally recognized safety consultant to ESH in March 2013 to review the existing workplace violence prevention program. Benchmarks for the review included compliance with state laws and regulations as well as best practices in violence prevention in the inpatient psychiatric setting. The evaluation goal is to identify program and system gaps and opportunities for improvement and document them in a written report summarizing key findings, with a

table of recommendations for management and labor representatives to consider. The key objectives of this consult are to provide assistance to the labor and management leadership at each hospital to:

- 1) Improve processes and systems for identifying and addressing workplace violence,
  - 2) To identify specific improvement projects that may reduce the incidence, severity, and impact of workplace violence; and
  - 3) To develop a pathway to improve support to assaulted or traumatized staff.
- ESH brought a Psychiatrist and Psychiatric RN to consult specially on safety issues at ESH April 2013. Several issues were identified throughout the three visits by the consults. Executive Committee along with nursing and medical staff will identify areas to target for improvement – knowing that these are recommendations and we need to focus resources on those within our means to complete.
  - Governing Body and Administration will re-design their meeting agendas to focus on Culture of Safety, Creating a Just Culture, and team building.
  - Completion of the patient safety/suicide prevention stratified risk reduction Capital improvements.

### **Risk Assessments**

- The Safety/Risk Management Manager and representatives of Safety & Patient Safety Committee, Administration, and CSS conduct an annual pro-active risk assessment to identify and rate all known physical plant deficiencies and problems determined to present a threat of physical injury to persons; damage to property, or a threat to general safety. Plans of Action to minimize and/or eliminate identified risks in clinical areas are developed and implemented. This proactive risk assessment is in addition to routine Environmental Surveys. Recommendations for improvement include, but are not limited to:
  - Replacement of phone cord on patient phones with a shortened cord (12” or less) between the base and hand set (Lengths quoted in the Design Guide for the Built Environment of Behavioral Health Facilities, National Association of Psychiatric Health Systems, are 12” or less). Currently evaluating replacement with "armored", wall mount phones with stainless steel cord to prevent use as weapon or removal of cord to use as ligature.
  - Installation of Patient Safety Hardware (anti-ligature)
  - Replacement of remaining patient bathroom glass mirrors with stainless steel in all locations
  - Unit management teams have conducted risk assessments and developed Authorized/Unauthorized patient property lists; December, 2012. All rooms on wards with unsupervised patient use have been hardened to eliminate access to equipment cords (TVs), minimizing risk(s). Risks in unsupervised areas are monitored on 15 minutes checks and documented until patient safety hardware improvements made to mitigate hardware risks. GPU conducts 15 minute patient checks instead of 15 minute room checks, due to the large quantity of equipment on this unit, to mitigate cord risks that cannot be secured or removed i.e. medical equipment, electric beds.

- The Westlake kitchen break room door lock was changed to a “snap lock”; October, 2012 as part of Failure Mode Effectiveness Analysis (FMEA) completed for Westlake unauthorized leave risks.

The Security Department conducted a Pharmacy risk assessment, 9.11.12, associated with medication security to include:

- Number and severity of medication security incidents.
- Level of access.
- Security hardware present (alarms, locks, video surveillance).
- Public traffic and degree of isolation.
- Potential degree of loss.
- Community risks.
- Security risks associated with particular times of day.

As a result of that assessment, the following improvements were made:

- The entry access alarm was updated 10.2.12 to provide individual passwords for each Pharmacy employee. This provides documentation of employee access; dates/times. A duress alarm is in place and monitored by Switchboard.
- The medication courier was provided with a portable radio for use in an emergency; 3.11.13.

### **Workgroups**

- The Safety/Risk Management Program Specialist and Infection Control Coordinator continue to actively participate in the Region 9 Healthcare Coalition. ESH staff with designated Incident Command Center roles participated in a coalition functional drill, 4.8.12, in response to a request for mental health disaster recovery activities.

### **Challenges**

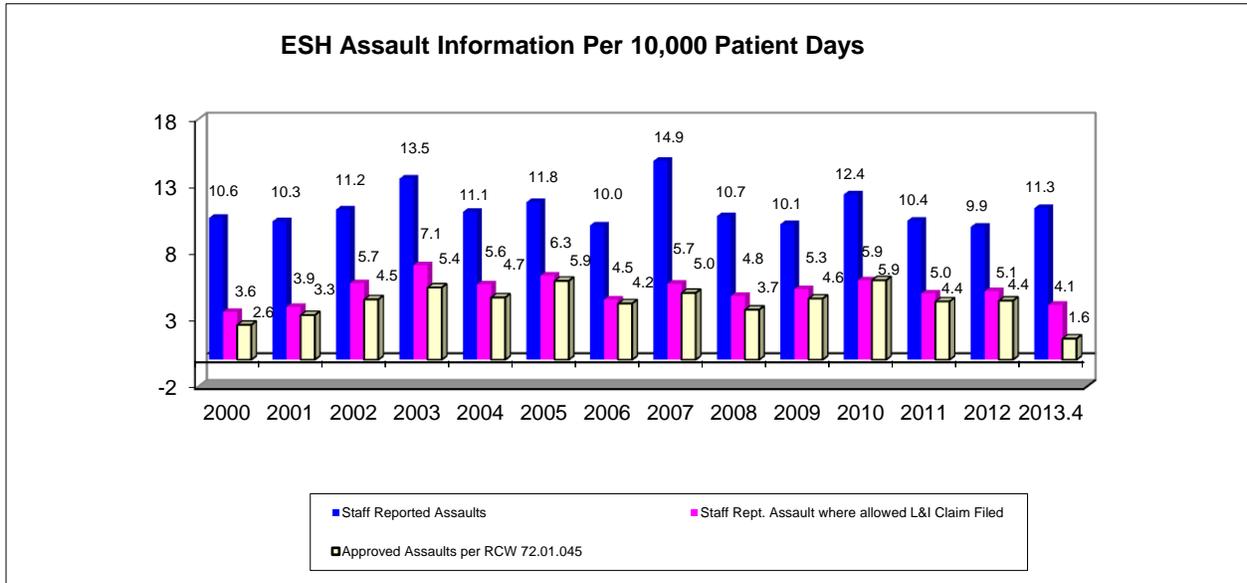
- Maintaining current level of Transitional Return to Work opportunities.
- Weighing purchases of safety equipment against purchases for direct care needs.
- Staffing:  
The hospital is increasing the staffing on evening and night shift (Mental Health Technicians and Psychiatric Security Attendants); however, increased overtime is currently being used due to unscheduled leave and patient acuity. The Registered Nurses are now being supplemented with contracted nurses and on-call positions to offset the unscheduled leave, patient acuity and vacation back-fills.
- Hiring:  
The added directives (reference checks) on hiring staff have slowed the hiring process. It continues to be difficult to acquire candidates for Psychiatrists, Psychologists, and Recreation Therapists due to the low compensation package in comparison to what is

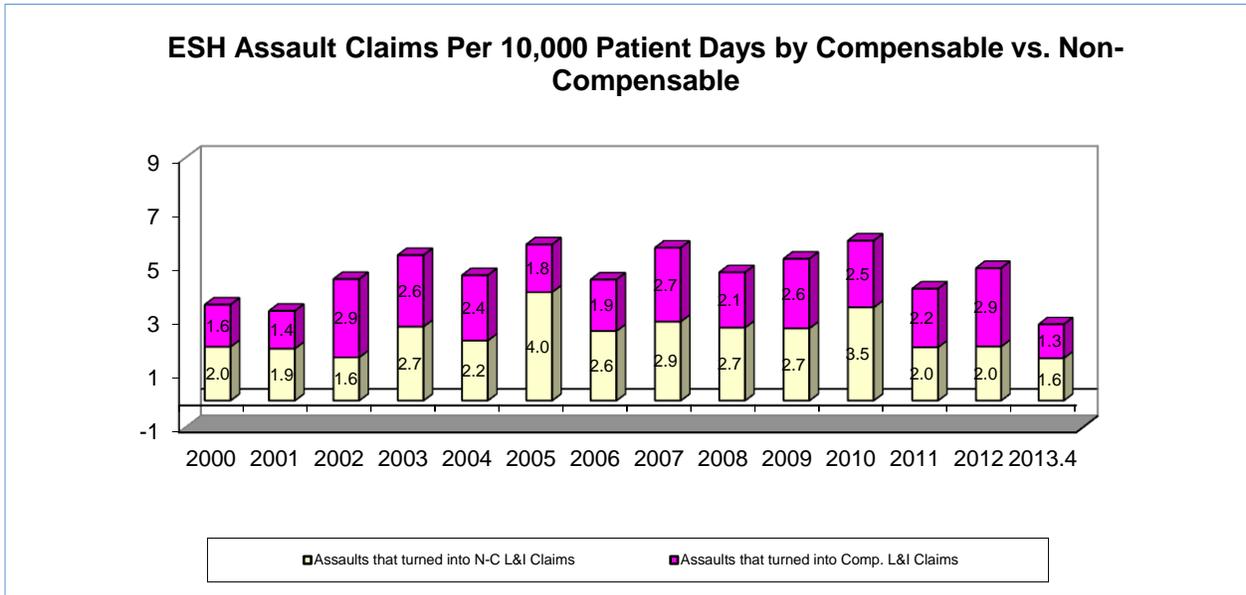
offered in the private sector. ESH continues to hire candidates in Nursing; however, Nursing staff resignations and retirements have created a consistent turnover.

**Data Summary**

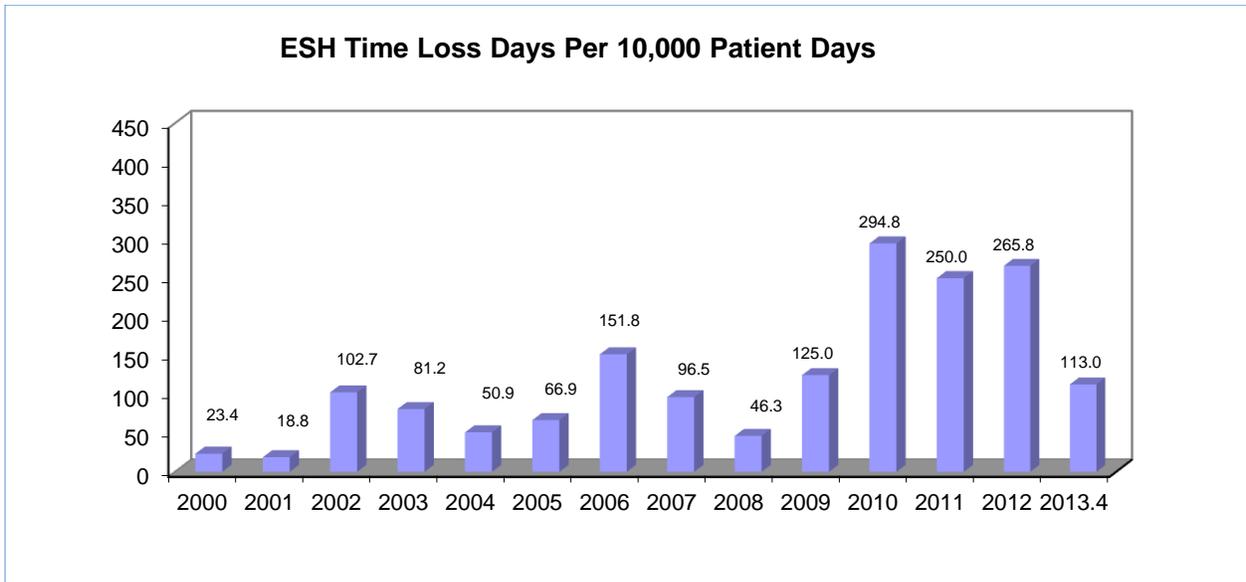
**Important Data Notes pertaining to this report:** This report continues to use RCW 72.01.045 to define assaults and represents assaults per 10,000 bed days for all three hospitals. The data in this report is consistent with prior year Workplace Safety reporting with the exception of time loss days. Cumulative time loss for ESH incidents that occurs in a subsequent year is now being reported in the data for the year the time loss is **accrued** instead of the year the injury **occurred** to be consistent with WSH and CSTC reports. Due to the change in ESH time loss reporting, time loss comparisons to years prior to 2010 cannot be made in this year’s report.

**Staff Reported Assault Information:** At ESH, data indicates that 2012 had a lower staff reported assault rate than in 2011 from 10.4 to 9.9. This trend appears to be continuing in the early 2013 data for assaults that turned into L&I claims and approved assaults with a slight increase in staff reported assault rate from 9.9 to 11.3 due to 2012 incidents that accrued time loss in 2013 (253 days). Sixty-five percent (1074 days) of the total time loss in 2012 was due to six incidents that occurred in 2012.





**Compensable vs. Non-Compensable Assault Claims:** At ESH, the annual data through April 2013 shows that there is a slight decrease in the rate of non-compensable and compensable claims. The ratio of compensable to non-compensable claims indicates a slight decrease with compensable claims accounting for approximately thirty-one percent of the total claims.



**Time Loss Days:** As stated in the “Staff Reported Assault Information”, 65% (1074 days) of the total time loss in 2012 was due to six incidents that occurred across all three units. Of the total (1074 days), 69% (746 days) were the result of four incidents occurring on the Forensic Services Unit across all three wards; 17% (179 days) occurred on one civil commitment ward and 14% (149 days) occurred on another civil commitment ward and

was due to the inability to accommodate the worker's restrictions. The remainder of time loss due to "staff reported as assault" incidents *by location* occurring in 2012 indicates 35% (229 days) was the result of assaults that occurred on a single Habilitation Mental Health (HMH) ward serving patients with dual diagnoses (Developmental Disability and Mental Health) across day and evening shifts. Five of the 11 HMH incidents (45%) were the result of assaults involving two patients. Time loss due to "staff reported as assault" incidents *by shift* in 2012 shows 71% (1170 days) were the result of incidents that occurred during day shift. Early 2013 data reflects 101 days of time loss for four incidents occurring across all three units with the majority occurring on evening shift.

## Child Study & Treatment Center

### Summary of Accomplishments

CSTC serves children and youth ages 6 to 18 and is the only public facility providing psychiatric care to children under 12 in Washington. CSTC is one of the state's three Children's Long-Term Inpatient Programs (CLIP) providing evidence-based inpatient treatment for the most psychiatrically complex youth in Washington State. Our manual, "Principles of an Effective Treatment Milieu" continues as the cornerstone of treatment philosophy at CSTC. Originally based on the successful model of integrated treatment offered through the Juvenile Rehabilitation Administration, this philosophy has evolved into a nationally recognized model of a successful public sector mental health collaboration with the University of Washington, the medical faculty to which our three child psychiatrists belong. CSTC is also a valued site for post-doctoral psychologists and psychiatric residents, nursing and recreational therapy students to intern. Our professional staff are involved in clinical research and are active nationally in developing standard of care guidelines and practices for diagnosing and treating youth with serious emotional disturbances. The following paragraphs describe key aspects of the programs at CSTC along with safety efforts and progress accomplished over the last year.

- Effective milieu-based treatment strategies at CSTC are grounded in the philosophy and practices described in the manual "Principles of an Effective Treatment Milieu" (available on request). This resource translates principles of effective treatment into day to day treatment strategies to address the complex clinical pictures that our client population presents. Symptoms commonly include aggression and poor impulse control resulting in self injurious, destructive and often violent behavior. Complicating psychosocial stressors such as state dependency, family turmoil, histories of trauma, co-existing substance abuse, chronic medical conditions, developmental disability and justice system involvement for criminal behavior are important contextual issues in understanding the treatment challenges these children and youth present, including aggression towards peers and staff assault. At the core of our approaches lies vigilant observation to effect early intervention which can help avoid physical assault. Functional Behavior Analysis and Positive Behavior Support (a form of Applied Behavioral Analysis) are regularly used as part of the treatment approach on patient units (cottages) and in the school settings at CSTC. Such approaches help identify triggers / antecedents that improve staff ability to prevent acting out and/or intervene early when behavior is disregulated and escalating. Understanding the function of the aggressive behavior in the child's life and in the treatment milieu supports treatment approaches to reduce and extinguish it. Coupled with other evidence-based practices employed at CSTC, effective intervention by a trained and well-functioning treatment team can make the difference between problem resolution and a serious injury.
- Environment of Care: Quarterly audits by the CSTC Safety Committee identify any physical safety issues that are remedied on the spot by the Consolidated Maintenance

Operations (CMO). This along with an in-depth annual safety audit by the leadership team ensures that risks to safety in the physical environment are kept to a minimum. An “Anti-Ligature” project in 2012 involved the installation of upgraded hardware to reduce risk of self-harm / suicide from hanging. The DSHS Enterprise Risk Management Office conducted an annual loss control evaluation (ALCE) in October. This audit had minimal findings which were remedied prior to the end of the year. L&I conducted an investigation on Orcas Cottage in 2012. Although CSTC successfully appealed the findings, (resulting in a reduction of the fine from \$11,000 to \$1,000), L&I recommendations for increased safety were put into place. Safety expenditures for 2012 totaled \$44,646. (Detailed in appendix).

- **Staffing:** Clinical leadership recognizes the impact a strong and stable workforce has on the treatment milieu and our ability to more safely manage assaultive patients. Staffing and security protocols ensure shift make-up that is effective in number and mix to address the specific needs of the patient environment that can change on a day to day (or shift-to-shift) basis. In the spring of 2013, the CEO at CSTC was able to identify funding through a state “Buy Back” initiative to add a Psychiatric Child Care Counselor position. This position is designed as a “float” or flexible position that will be knowledgeable about all units across both day and swing shifts in order that she/he can be deployed where most needed. Staffing has remained stable over the last several years due to successful efforts to reduce vacancies, such as review of vacancies, hiring strategies and progress updates in the weekly Leadership Meeting.
- **Crisis Intervention:** In March, 2013, CSTC began transitioning to a new behavioral crisis intervention program – “CPI”. The Crisis Prevention Institute’s Nonviolent Crisis Intervention program trains to the basic elements of violent behavior. It identifies how a crisis may escalate, and, conversely, de-escalate. The program identifies strategies that have been proven successful for millions of human service professionals throughout the world. The training for direct care staff includes situational applications, formal refreshers, and policy discussions. Participants must demonstrate CPI’s Principles of Personal Safety to avoid injury if behavior escalates to a physical level while continuing to provide for the care, welfare, safety, and security of all of those involved in a crisis situation. Three senior staff including the Acting Director of Nursing are certified by CPI as trainers and will continue to train new staff and provide regular refreshers and updates. As of August 1, all direct care staff and some administrators have been trained in this \$14,000 investment which replaces the “Pro-Act” program that was previously in place.
- **Workplace Safety Policies, Plan, and Initiatives:** In 2013, CSTC revised Personnel Policy 200 Safety and Health Program to address workplace violence related to patient aggression. We also developed a separate Policy 209, Preventing and Responding to Workplace Violence which provides guidelines for defining and responding to potential or actual psychological or physical violence by visitors, employees or patients. The policy includes verbal threats or physical assault emphasizing a zero tolerance policy. The policy also makes the distinction about population characteristics of the patients

and the importance of proactive non-violent patient intervention practices. Thirdly, we updated our Safety Plan for 2013 and developed a freestanding Workplace Violence Prevention Plan. This targeted plan is modeled on information and guidelines contained in the OSHA publication “Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers” (OSHA 3148-01R2004). CSTC’s Safety Committee, Annual Safety Plan and safety policies operate dynamically with aforementioned treatment modalities, evidence-based practices, active treatment planning, individualized patient safety plans, routine communication and supervision, inter-shift meetings, staffing and CPI training to maintain a safe environment and achieve client outcomes.

- CSTC Strategic Plan- The Workplace Safety Workgroup: In December 2012 as part of our ongoing strategic plan to reduce staff injuries, and in response to a rise in claims in 2012 (see data discussion to follow); the CEO at CSTC chartered the Workplace Safety Workgroup as a sub-group of the Safety Committee. The workgroup is made up of a cross-section of staff including Psychiatric Child Care Counselors, Recreation Therapy, Nursing, Administration and cottage leadership and is chaired by the Director of Quality Management. The goal of the workgroup is to understand trends and risk factors leading to employee injury in order to identify actions by which CSTC will continually improve and sustain a safe environment for staff and patients. These are intended to reduce employee workplace injuries related to patient assault and create a work atmosphere where employees feel confident and safe in their work environment. Launched in January, the group identified and explored a variety of factors and developed a staff survey around causal categories. The voluntary survey response was good and revealed an array of concerns, suggestions and training interests. The second tool developed by CEO with input from the workgroup and our partnership with DSHS Enterprise Risk Management is the Violent Acts Log. This access data base stores data collected from Employee Personal Incident Reports (03-133) and the Patient Assault Report (03-391) and cross references information from the related Patient Incident Report (CSTC 30-37). The combination offers a rich and relatively deep analysis of violent acts from which we can formulate hypotheses about staff injury and develop strategies for reduction in violent acts and injury. Together with the insight gained from staff survey input, we will develop strategies for reduction in staff injury due to patient aggression and assault. Claims information gleaned from DSHS ERMO RiskMaster data base will be utilized to track and trend injuries over the next several years.
- Emergency Preparedness: In June, 2013, CSTC conducted successful emergency preparedness training. 75% of the staff were trained in the Incident Command Center approach in the one-day event oriented to interactive, experiential learning. The remainder of the staff will receive training via the Learning Management System. Staff evaluations were very positive and management at CSTC plans to make this an annual event. Two days following the training CSTC held a Level II Major Disaster Drill using an earthquake scenario to test the Incident Command Center, evacuation, Medical Response and Communication. The drill was observed and evaluated by DSHS

Enterprise Risk Management (ERMO), WSH Security, and community partners West Pierce Fire and Rescue. A number of recommendations were generated resulting in purchase of emergency related equipment, supplies and specific guidance to staff as well as training curriculum for future incorporation into the DSHS Learning Management System to complement our existing safety training. With the assistance of an injured worker returning to work on light duty, the CSTC disaster manual was fully updated and distributed to replace existing copies campus wide as well as WSH Security, Consolidated Maintenance Operations and Office of Safety Management. Collaboration with our close neighbor, WSH, around emergency preparedness is critical to making the most of shared resources, particularly in any prospective event that would affect both hospitals.

- Evidence-Based Practices (EBP's): CSTC has long been a proponent of utilizing state of the art intervention and evidence-based practices. Effective treatment is active and achieves outcomes readily. The sooner patients are engaged and aligned with their own objectives in treatment; the less likely they will be to act out in aggressive and violent ways. Among the EBP's incorporated into the treatment program at CSTC are:
  - Cognitive Behavioral Therapy (CBT), based on learning and behavioral principles is one of the most effective psychotherapy interventions for treating childhood psychiatric disorders. CBT effectively addresses a variety of problems including depression, anxiety, self-injurious behaviors, post-traumatic stress and conduct problems. CBT strategies are also an important component of our parent training offerings.
  - CSTC also has trained numerous staff over the last several years in Trauma-Focused-CBT an evidence-based practice that addresses trauma and post-traumatic stress. CSTC contracts with a TFCBT expert at University of Washington Harborview to provide bi-weekly case consultation. CSTC is exploring ways to adapt the principles of TFCBT across the milieu setting as a trauma informed approach to care.
  - Dialectical Behavior Therapy combines CBT techniques with distress tolerance, mindful awareness and acceptance. It is a balanced approach to living responsibly, accepting limitations and building a life worth living. It is especially well suited to the older youth at CSTC.
  - Parent-Child Interaction Therapy is an empirically-supported treatment for conduct disordered young children that engages parents in learning new skills to establish a secure relationship while increasing their child's pro-social behavior and decreasing negative behavior. Parents learn to use specific behavior management techniques as they play with their child and receive coaching.
  - Multi-family Group Therapy occurs twice monthly in the evenings and includes a monthly Saturday psychoeducation meeting. Cottage staff and one of the child psychiatrists facilitate this popular practice that enables families to provide support to each other and learn valuable parenting tools, enabling them to participate actively in treatment and continue successful approaches with their children post-discharge.

- Finally, Motivational Interviewing is a goal oriented, person-centered direct method of communication that enhances the client’s intrinsic motivation by exploring and resolving ambivalence about change and aligning behavior with higher personal motives and values.

DSHS is currently investing in wide scale training at leadership and practice levels in motivational interviewing (MI). A major implementation at the Department of Vocational Rehabilitation (DVR) has demonstrated impressive outcomes in increased performance, increased timeliness, reduced costs, and increased customer and staff engagement and satisfaction. More to the point of this report, applications of MI in psychiatric and correctional settings have shown a distinct reduction in claims for workplace injury due to assault. In July of 2013, members of the leadership team including the Chief Executive Officer, the Director of Quality Management and Program and the Director on the older youth cottage, Orcas, completed the DSHS training for system leaders. Wide-scale training of DSHS staff will commence in October. CSTC will develop a plan to train clinical staff and direct-care staff to systematically adapt and employ MI with fidelity in our treatment array and milieu environment.

### **Challenges**

Analysis of the data of assaults toward staff demonstrates the significant impact a few, highly acute patients can have on the overall milieu. This is revealed repeatedly when we look closely at the “spikes” in data on staff injury. This was clearly operating in 2012 as noted last year and continues to show up when we analyze data in the Violent Acts Log data base. Patients admitted to CSTC are youth whose psychiatric challenges most often present with violent / unsafe behavior. CSTC also admits a forensic population and has a secure “Close Attention Program” where youth who are committed on RCW 10.77 court orders and older youth who are severely assaultive are placed. The balance of positive relationship-building treatment approaches with containment is at times a delicate one. This is a treatment center and not a correctional facility. Even when youth are violent, it is rarely possible or necessarily appropriate to pursue placement in a JRA facility. At the same time, there are occasions when youth who have been violent face charges and leave the facility for juvenile detention; and they most often come back and resume their treatment. In understanding trends, particularly spikes in data it is important to recognize that the CSTC population is in comparison, small. The number of episodes relative to a relatively small number of patient days can result in a greater variance, appearing more dramatic than at a larger facility.

### **Data Summary**

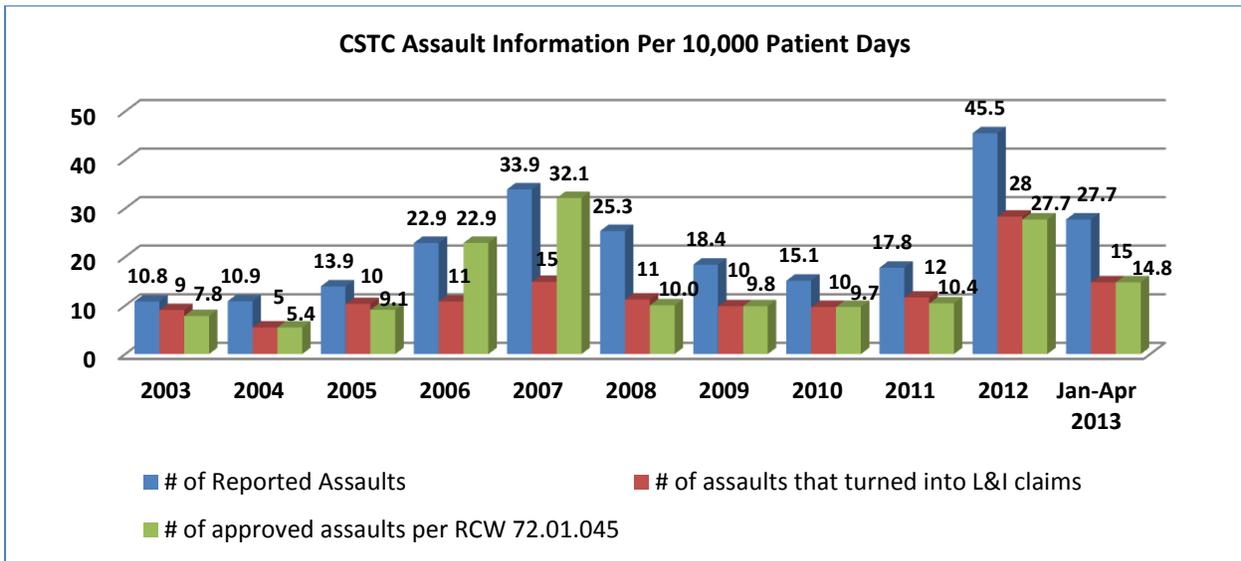
**Number of reported assaults, assaults that turned into L&I claims and approved assaults per 10,000 patient days.**

Of obvious concern is the rise in assaults leading to injury of staff during 2012. As stated in last year’s report, 58% (14 of the 25) reported assaults in the first quarter of 2012 involved

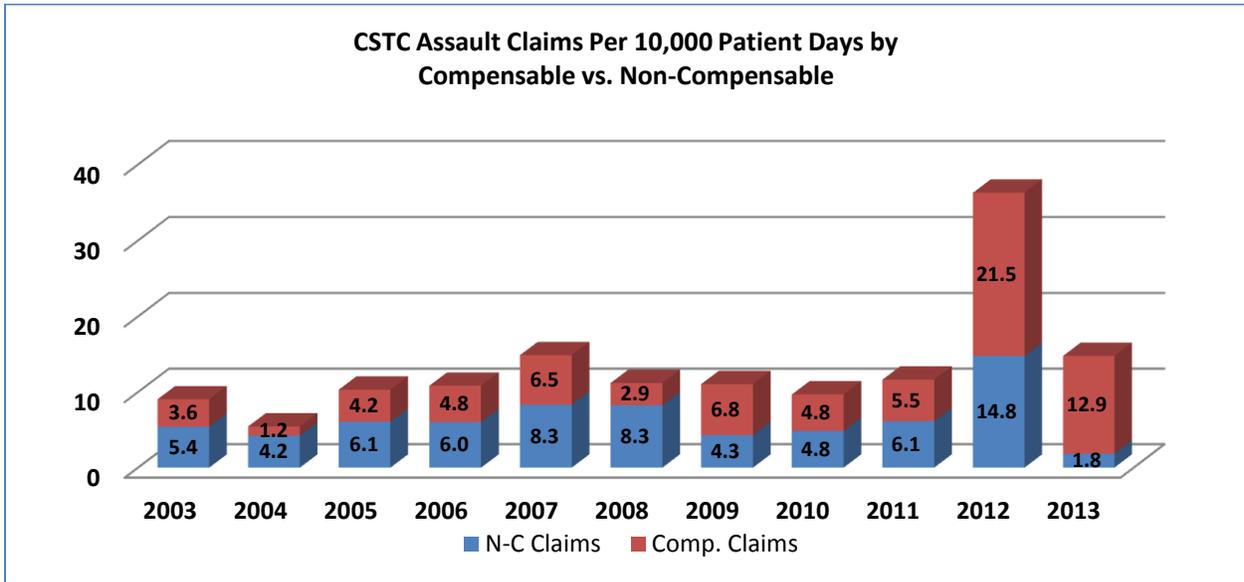
2 patients. The trend of a very few being responsible for a disproportionate number of assaults continued through the end of 2012. During this 8 month period, 59% of the assaults occurred on Orcas Cottage (older teens) which has a general population program and a separately secured area for the Close Attention Program (CAP) serving highly aggressive youth and those adjudicated for mental competency restoration (10.77).

For the entirety of 2012, one youth was responsible for 26% of all assaults at CSTC. While other youth were responsible for multiple assaults, the next highest was responsible for half as many, 13% of the total.

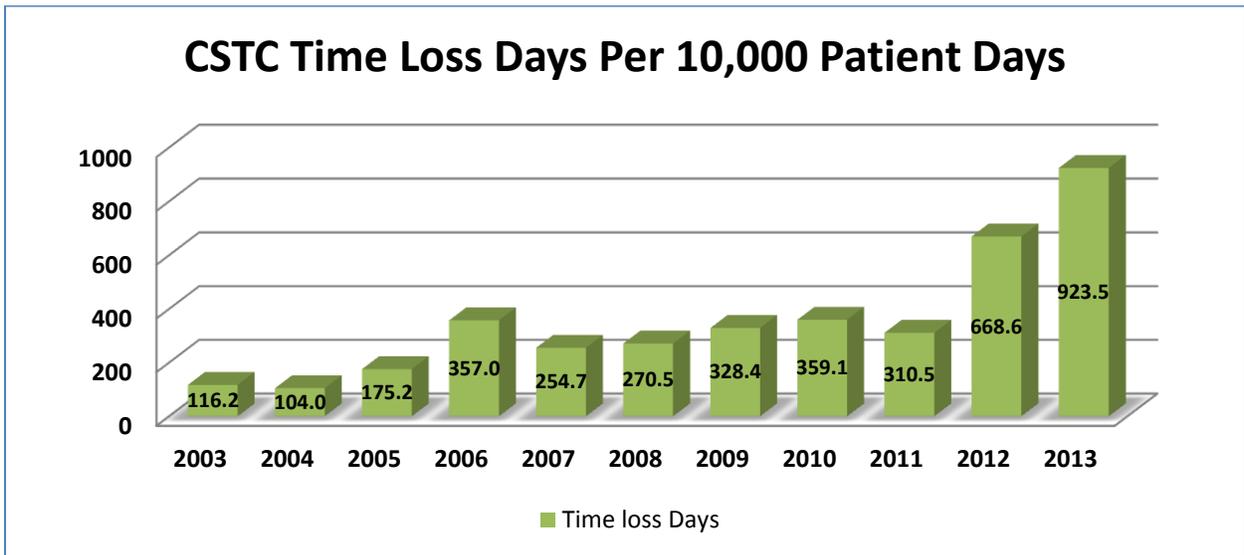
Many hours go in to strategizing on treatment approaches for youth with this severity of aggression. Despite the number of assaults he had committed, this one youth did not meet the legal threshold required to enter the juvenile rehabilitation system. This particular youth was discharged in February of 2013. While we have seen a reduction in assaults in the first quarter, (13 as opposed to 17 in the 4<sup>th</sup> Quarter of 2012), data for the quarter identifies another single youth who is responsible for 30% of the assaults campus-wide and half of the assaults on Orcas. This lays some perspective on assaultive behavior among the treatment population served at CSTC.



**Compensable vs. Non-Compensable Assault Claims:** CSTC monitors the severity of employee assault injuries based on the proportion of compensable claims to non-compensable claims. From 2009 through 2011, the number of compensable claims (representing injuries that result in greater than 3 days of time loss) was either slightly greater or equal to the number of non-compensable claims. However, in 2012, the rate of compensable claims to non-compensable was 47% higher. In the first four months of 2013, we see a notable increase in the proportion of compensable claims.



**Time Loss Days:** The number of time loss days per 10,000 patient days in 2012 doubled the number in 2011. Time loss in the first four months of 2013 is also higher than the previous year, reflecting not only injuries that occurred in 2013, but also ongoing time loss from injuries occurring in the last 2 quarters of 2012. We expect with our growing Workplace Safety Workgroup, injury and assault analysis and introduction of expanding evidence-based practices, we will be able to curb this trend and reduce the number of compensable claims in the coming year.



# APPENDIX A

<h2 style="margin: 0;">Workplace Safety Plan</h2> <h3 style="margin: 0;">Child Study and Treatment Center (CSTC)</h3> <p style="margin: 0;">ANNUAL UPDATE April 2013</p>
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RCW 72.23.400 requires each state hospital (WSH, ESH, CSTC) to develop a plan to reasonably prevent and protect employees from violence. The law requires completion of a security and safety assessment to identify existing or potential hazards for violence in the workplace. Using the results of the assessment, each state hospital must develop a plan to prevent and protect employees from violence and provide an update to the legislature annually. The following table lists the elements of both the assessment and the updated plan as required by law. It then provides a summary of the results of the assessment as well as the plan derived from that assessment.

<b>Elements of the plan per law. (Items a through h are part of the security &amp; safety assessment)</b>	<b>Assessment – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence.</b>	<b>Plan – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence.</b>
<p>a. The physical attributes of the state hospital including:</p> <ol style="list-style-type: none"> <li>1. Access control</li> <li>2. Egress control</li> <li>3. Door locks</li> <li>4. Lighting</li> <li>5. Alarm systems</li> </ol>	<p>Physical safety and security reviews of Child Study and Treatment Center (CSTC) campus buildings and grounds revealed the following:</p> <ul style="list-style-type: none"> <li>• Access, egress control and door locks were found to be in good order.</li> <li>• Lighting is adequate on all wards, offices, and shop areas. Outdoor lighting is adequate.</li> <li>• Alarms have undergone routine inspection and are in working order.</li> </ul>	<p>Physical safety and security is assessed at a minimum of a quarterly basis through audits conducted by CSTC’s Safety Committee. These “walk-throughs” assess access and egress, door locks, fire extinguisher check documentation and lighting in addition to other elements. These audits are managed by CSTC’s Safety Committee Chair and results are communicated to the Environment of Care committee which is held once per month. Any findings are corrected immediately upon discovery by submitting the appropriate work order which is routed through the CEO for advisement and signature. <b>Ongoing</b></p> <p>CSTC Leadership Team, including the CEO, Director of Quality Management and Director of Nursing conducts a detailed annual safety review of all patient care areas that identifies any concerns, assigns level of risk and takes immediate action to correct and/or mitigate. This audit is directed toward both patient and staff safety with care taken to observe for any risk of injury, accident or entrapment as well as patient risks such as self-harm suicide or unauthorized leave. <b>Ongoing</b></p> <p>Since the last report to the legislature, CSTC instituted an “Anti-Ligature Project” installing upgraded hardware on the two units with the greater risk of patient self-harm or suicide by hanging. Boilers on two units were replaced, the sport court was resurfaced with a non-skid material and new basketball standards, hoops and backboards were installed. One of the patients on Orcas kicked out the lock on the Orcas Sport Court leading to a new lock reinforced by chains and a secondary lock. Heavy weighted chairs were also installed on the Close Attention Program (CAP). The above improvements were implemented to improve safety and maintain upkeep on equipment subject to wear and tear.</p> <p>The DSHS Enterprise Risk Management Office conducts an “Annual Loss Control Evaluation (ALCE). This audit is conducted every Fall. It covers elements 1-5 under “a” as they relate to standards for: Environment of Care, Emergency Management, Life Safety and Training related to</p>

		<p>Safety , Security, Dealing with Assaultive Behavior, Accident/Injury Reporting, Hazard Communication (including MSDS) and Emergency Action Procedures.</p> <p>Following a staff injury in 2012, L&amp;I conducted an investigation which focused on one cottage (not related to the injury). Upon L&amp;I recommendations \$4200 was invested in safety improvements on Orcas Cottage. CSTC levied a successful appeal of the L&amp;I findings and which was reduced from \$11,000 to \$1,000.</p> <p>Expenditures for the biennium 2011-2013 totaled \$44,646 of which \$20,000 was for the anti-ligature capital improvement program. Miscellaneous expenditures covered the purchase of additional safety mirrors, door alarms, security camera, mirrors and sheets, 2-way radios, disaster and first aid supplies, weighted furniture, replacement of safety supplies and medical equipment (defibrillators) and new eye washing stations.</p> <p>Alarm systems are tested and monitored by the Consolidated Maintenance Operations headquartered at WSH. CSTC has a Maintenance Supervisor who is responsible for conducting and coordinating maintenance and life safety operations at CSTC including all preventive maintenance and overseeing contracted projects. The Lakewood Fire Marshall and a team from comprised of the Safety Manager, the Maintenance Supervisor, and the Director of Quality Management conduct the annual fire inspection at CSTC. This inspection evaluates fire safety issues and satisfies accreditation. Shortcomings are identified and corrected to preclude a fire emergency. All areas are inspected on an annual basis. <b>Ongoing</b></p>
<p><b>Elements of the plan per law. (Items a through h are part of the security &amp; safety assessment)</b></p>	<p><b>Assessment – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence.</b></p>	<p><b>Plan – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence.</b></p>
<p>b. Staffing, including security staffing</p>	<p>Nursing management constantly monitors staffing for safe staffing levels.</p>	<p>As part of the “Buy Back” program, CSTC retrieved an FTE to enable the hiring of a PCCC1 (psychiatric care counselor) to work as a float on the cottages on a flexible shift schedule. This added resource will augment staff safety and additional coverage for acuity. .</p> <p>CSTC Personnel Policy 310 addresses Staffing Levels for Patient Care and delineates variables that are important to modification of staff levels in response to fluctuating acuity. Some of these variables are staff experience and skill mix, diagnoses and co-occurring conditions of the patients on each cottage, patients requiring “close observation” or “maximum precautions (1:1) circumstances around new admissions, developmental age of patients off campus activities including need for transport. The CEO authorizes staffing levels outside the usual range, overtime and call back. CSTC Policy 410 governs Levels of Observation, whereby patients with active high risk behavior that threatens safety to self or others are identified and actions taken to mitigate risk. To maintain safety and security for CSTC patients, staff visually check each patient on the cottage every 30 minutes and document findings on the security check sheet for each shift. Timing of checks is varied to enhance reliability. Staff also check the environment for potential hazards at the same time. Patients who require more intensive observation may be assigned by their doctor to one of three levels, each with specific time intervals and restrictions.</p>

		<p>An annual competency check list is conducted for all staff at CSTC, in particular Nursing, Supervisors, Psychiatric Child Care Counselors, Dietary and Maintenance. The core treatment philosophy at CSTC is captured in the booklet and training “Principles of an Effective Treatment Milieu” which emphasizes early intervention, behavior management techniques and treatment philosophy of respect and care designed to reduce the need for restrictive interventions. CSTC regularly assesses potentially violent or exceptionally aggressive patients designing treatment and safety plans to reduce risk to other patients and staff that may include additional staffing such as “1-1”. <b>Ongoing</b></p> <p>CSTC relies on WSH Security to respond to security incidents, including those patient incidents which require additional staff to intervene with a violent patient or involve an elopement off of the property. WSH provides CSTS with security incident reports that are reviewed by the QM Director and at the monthly Safety Committee. <b>Ongoing</b></p>
<b>Elements of the plan per law. (Items a through h are part of the security &amp; safety assessment)</b>	<b>Assessment – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence.</b>	<b>Plan – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence.</b>
c. Personnel policies	All safety-related policies have been reviewed and updated Sunset review dates will be monitored for completion by the Director of Quality Management who chairs the Policy Committee.	<p>Updated and new policies are made available to staff hospital-wide via Intranet with hard copy distribution and/or Staff Development Department training. CSTC requires new staff to review of all policies as part of New Employee Orientation, <b>Ongoing</b></p> <p>CSTC revised Personnel Policy 200 Safety and Health Program to address workplace violence related to patient aggression and references new Policy 209 Preventing and Responding to Workplace Violence which provides guidelines for defining and responding to potential or actual psychological or physical violence by visitors, employees or patients. The policy includes verbal threats or actual physical behavior emphasizing a zero tolerance policy. The policy also makes the distinction about population characteristics of the patients and the importance of proactive non-violent patient intervention practices. These two policies are supported by CSTC’s revised Safety Plan for 2013 and the new Workplace Violence Prevention Plan that is modeled on information and guidelines contained in the OSHA publication “Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers” (OSHA 3148-01R2004). Annual plans and policies at CSTC operate dynamically with treatment modalities, treatment and safety plans, intershift meetings, staffing and CPI training to be addressed below. <b>Ongoing</b></p>
d. First aid and emergency procedures	CSTC Policy 203 covers “Responding to Medical Emergencies for patients, staff and visitors at CSTC.	In a medical emergency at CSTC, the individual(s) on the scene with the most medical training and experience will assume the role of first responder. Child Study and Treatment Center provides nursing coverage on campus at all times. First Aid supplies are located in the nursing office on each cottage, in the schools and the administration building. Sufficient numbers of employees are trained in First Aid, CPR and every two years, recertified. Staff is also trained on the use of 2 Automated External

	CSTC actively plans/ prepares and participates with the Community for disasters.	Defibrillators (AED) on campus. CSTC activates the local emergency medical services system for emergency medical care beyond basic life support. <b>Ongoing</b>  CSTC updates the Emergency Management Plan annually. The Emergency Planning and Response Team Committee meets regularly to plan and organize disaster drills which occur twice a year. Since the last report, CSTC conducted a desktop drill (December 2012), a campus wide emergency preparedness training “fair” and a Level 2 Disaster Drill to test the Incident Command Center. The latter involved WSH Security, DSHS ERMO, and the Lakewood (West Pierce) Fire Department as evaluators. Much was learned from the successful training which will be repeated annually and the drill findings from which will be incorporated into additional staff feedback and future training. The drill also prompted purchase of additional safety and emergency food supplies and a large outdoor container in which to store non-perishable items.
<b>Elements of the plan per law. (Items a through h below are part of the security &amp; safety assessment)</b>	<b>Assessment – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence</b>	<b>Plan – Security considerations and action already taken or planned – based on the hazards identified in the assessment –to prevent and protect employees from violence.</b>
e. Reporting violent acts, taking appropriate action in response to violent acts, and follow-up procedures after violent acts: Analysis of data on violence and workers compensation claims during at least the preceding year	CSTC Policy 204 – Employee and Volunteer Injuries and Accidents  Patient Incident Reporting  Violent Acts Log	CSTC Policy 204 governs full documentation for internal risk management and the processing of industrial insurance (L&I) claims. The Employee / Volunteer Personal Incident report (DSHS 03-133) is completed within 24 hours whenever an injury occurs while the individual is working. All reports are reviewed by the CEO and may warrant additional investigation. In addition when an injury is caused by a patient assault report form 03-391 is submitted. Information about aggressive behavior by patients is also tracked via the patient incident report form information from which is entered into the Incident Report Data Base. When a staff injury occurs information is entered from both data bases into the “CSTC Violent Acts Log”. This log is instrumental in analysis of staff injuries, causes, location, patients involved, type and seriousness of injuries and care needed. <b>Ongoing</b>  In December, 2012 CSTC CEO chartered the Workplace Safety Workgroup as a subgroup of the Safety Committee. The workgroup is chaired by the Director of Quality Management and includes cottage, recreational therapy, nursing and administration staff. The group conducted a cause and effect analysis based on collective experience from which a staff survey was conducted. The results of this survey are being analyzed to identify themes of concern and indicators for mitigation. . Internal injury tracking is conducted by the Director of Quality Management on a monthly basis utilizing staff personal incident reports (03-133), and reports from ERMO/Riskmaster. This data is reviewed at the monthly Safety Committee. Data for previous 2 years has been updated in the body of this report. <b>Ongoing</b>
f. Development of criteria for determining and reporting verbal threats.	CSTC Incident Report Form (CSTC 30-37(A) is utilized to report both verbal and physical aggression.	Verbal aggression is defined as “...makes clear threats of violence toward others or self (e.g. “I’m going to kill you.”). This includes verbal aggression directed at staff, other patients and families of other patients or staff whether or not the patient has the current means to carry out the threat.  CSTC considers verbal and physical behavior a reflection of internal states and the ability (or lack thereof) to constructively use communication and other means to reduce anxiety, depression, and

		<p>aggression. As with any self-destructive, socially inappropriate and abusive behavior, the reduction of verbal aggression is a therapeutic goal and dealt with through the individualized treatment plan. As an outcome, the reduction of verbal aggression demonstrates improvement in the patient's ability to manage internal states and impulses. <b>Ongoing</b></p> <p>The CSTC Workplace Safety Workgroup is currently developing recommendations based on input from staff (2013 Employee Workplace Safety Survey) and data from the Violent Acts Log. Continuous efforts to develop and reinforce a culture of safety at CSTC address all violent acts, including verbal aggression.</p>
g. Employee education and training	<p>New Crisis Intervention Program implemented March 2013.</p> <p>Curriculum was developed for a campus-wide interactive emergency preparedness training that was held 6/11/13. It was well received by staff, ¾ of whom were trained in one day. The emphasis was on the incident command center and included multiple stations with staff trainers representing the roles of incident command as well as training in logistics, supplies and direct care and education staff roles.</p> <p>All employees are required to complete comprehensive mandatory DSHS training that occurs at the time of hire (new employee orientation) and annually. This includes Workforce and Domestic Violence and Sexual Harassment. In addition, CSTC requires the following:</p>	<p>CSTC implemented a new Crisis Intervention Program in March 2013. All direct care and selected administrative staff have been trained as of August 1, 2013. This \$14,000 investment replaces the "ProAct" program that was previously in place. A brief description of this new program follows: The Crisis Prevention Institute's Nonviolent Crisis Intervention program clarifies the basic elements of violent behavior. It proceeds to identify how a crisis may escalate, and, conversely, de-escalate. The program identifies strategies that have been proven successful for millions of human service professionals throughout the world. The Nonviolent Crisis Intervention Training for direct care staff includes situational applications, formal refreshers, and policy discussions. Participants must demonstrate CPI's Principles of Personal Safety to avoid injury if behavior escalates to a physical level while continuing to provide for the Care, Welfare, Safety, and Security of all of those involved in a crisis situation. <b>Ongoing</b></p> <p>The Acting Director of Nursing is responsible for the CPI implementation and training. There are two senior staff that have been trained as trainers as well. This has greatly facilitated the transition to the new program and the accomplishment of having all staff trained within 4 months.</p> <p>Annual Safety Training, Assessment of Patients in Seclusion, Compliance, CPI, Cultural Competency in Health Services and Care, Documentation Training, Recognizing change in a patient's behavior, Ethics, Patient Rights, Principles of an Effective Treatment Milieu, Reporting Suspected Abuse and Neglect, Safe Patient Handling, Suicide Prevention, HIPAA, Incident Reporting, Infection Control, Policy Review. Custodians are required in addition to some of the non-clinical selections above to take Ladder Safety, Personal Protective Equipment; nurse, PYXIS training and Assessment of Patients in Seclusion. In addition, direct care staff are required to take CPR and First Aid, CPR AED, <b>Ongoing</b></p>
<b>Elements of the plan per law. (Items a through h below are part of the security &amp; safety assessment)</b>	<b>Assessment – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence</b>	<b>Plan – Security considerations and action already taken or planned – based on the hazards identified in the assessment –to prevent and protect employees from violence.</b>
h. Clinical and patient policies and procedures including those related to: 1. Smoking 2. Activity, leisure and	CSTC Policy 306 – Smoking Restrictions	CSTC promotes an environment of health and wellness. Policy 306 defines restrictions of the use of tobacco products on CSTC grounds by all employees, visitors and patients. Patients are not allowed to smoke or use tobacco products at CSTC or while in the custody of CSTC staff. Employees and visitors are required to restrict their smoking or tobacco use to designated areas having proper

<p>therapeutic programs 3. Communication between shifts 4. Restraint and seclusion</p>	<p>Activity, leisure and therapeutic programs – CSTC Policy 406 Recreation Therapy Services (RT)</p> <p>Improved communications between shifts may lead to fewer violent incidents. Other safety precautions as part of milieu management. (CSTC Policy 438)</p> <p>Restraints and Seclusion</p>	<p>receptacles and situated outside of the 25 foot rule in compliance with Washington State law. In addition, smoking areas are placed where the smoking is not observable by patients. CSTC makes available resource materials on wellness and smoking cessation to employees and patients requesting such information. <b>Ongoing</b></p> <p>Recreation Therapy Services provide opportunities for patients to develop skill generalization through participation in activities, leisure education and recreation groups and classes. The benefits include increased social skills, improved problem solving, improved frustration tolerance, enhanced health and physical fitness and increased safety awareness. RT Plans are based on initial assessment within 14 days of arrival. Each client sets recreational goals and RT therapists motivate and engage clients, introducing new leisure opportunities. Activities are designed to be developmentally appropriate and are identified on the patient’s interdisciplinary treatment plan. The RT staff promote a positive social community through planning and facilitating cottage-wide and all-center activities. Before new activities are conducted with patients, a RT Risk Assessment must be conducted to ensure that appropriate safety precautions and conditions of participation are established. Outings with patients include such things as the YMCA, museums, camping and hiking and are sufficiently staffed for numbers and patient vulnerabilities. Only patients who are able to manage behavior and have demonstrated a level of confidence are able to go on outings. Decision making about participation depends on team collaboration and coordination. <b>Ongoing</b></p> <p>The structure and schedule of the cottage milieu is carefully designed to maintain a safe environment. Shift reports occur at the time of transition from one shift to the next. Each patient currently in the program and their current emotional and behavioral status, changes in treatment planning / response, observation status restrictions and precautions. Significant incidents are discussed as well as restrictive interventions and injuries. Potential stressors are identified and updates in individualized interventions to more effectively manage patient behaviors are explained. Supervision hand off is as carefully managed. Radios are assigned to patient care staff and any staff leaving the cottage with a patient is required to carry a radio. Staff conducts their own activity to ensure that they can safely observe the milieu. Motion detectors and door alarms are utilized during quiet time, after bed times and before wake up to augment supervision of patient movement. Staff will knock on a patient’s door and identify themselves before entering the room when conducting 30 minute check or at other times when entry is indicated. Searches for contraband are conducted routinely and as indicated and governed by Policy 439. <b>Ongoing</b></p> <p>In addition to daily shift change meetings and treatment plan updates which involves team process, each cottage team is designed to have a 2-hour period of time weekly for ongoing inter-shift dialogue and clinical consultation. These meetings allow time for updates along with education and training in key concepts and models in use on the cottage. It is a time that the attending psychiatrist and psychologist, program director, social worker, supervisors and psychiatric child care counselors to give and receive information necessary for the effective implementation of treatment plans. This is also a time that center-wide feedback (for example safety information, debriefing from emergency preparedness drills, etc., or quality improvement projects can be shared. <b>Ongoing</b></p> <p>Restrictive interventions are used only when clinically necessary and adequately justified to protect the safety of the patient and/or others. Restrictive interventions generally refer to the use of seclusion and restraint (Policies 444 and 445) but when a less restrictive, or preventive alternative is possible, such as “Time Out (Policy 443) it is the first option used to manage escalating behavior. Seclusion and/or</p>
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		<p>restraint may be used only for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or others. Neither are used as a punishment or discipline or convenience to staff or conducted in a way that causes undue physical discomfort, harm, or pain to the patient. A physician's order is required. Staff enforcing a seclusion or restraint have documented training the management of out-of-control, combative and assaultive behavior. Patients in seclusion or in a restraint are continually monitored, 15 minute checks are documented and the patient is returned to the milieu as soon as the behaviors are no longer in evidence and/or documented behavioral outcomes are attained. The use of seclusion and restraint are routinely evaluated and trends reviewed by the leadership team. <b>Ongoing</b></p> <p>Preventing the use of seclusion and restraint and the risk of injury to staff and patients is CSTC's goal. Immediate debriefing with the patient following each event is mandatory to identify ways to avoid future incidents. CSTC does not use physical restraint as a therapeutic intervention for dangerous or assaultive behavior, but only to physically intervene in crisis situation to stabilize and or physically escort or re-direct the patient. It is the general policy of CSTS to NOT use mechanical (leather) restraints for behavioral control of patients. Given the nature of CSTC's clinical population, episodes of non-behavioral restraint are rare. The most likely indication would be the physical restraint of a patient with an eating disorder to place a nasogastric tube. But all strategies would be employed to be able to use an alternative course for anxiety reduction when conducting medical procedures. Policies governing the use of seclusion and restraint delineate specific guidelines and procedures by staff. <b>Ongoing</b></p>
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# APPENDIX B

## Workplace Safety Plan Eastern State Hospital UPDATE June, 2013

RCW 72.23.400 requires each state hospital (WSH, ESH, CSTC) to develop a plan to reasonably prevent and protect employees from violence at the state hospital. The law requires completion of a security and safety assessment to identify existing or potential hazards for violence in the workplace. Using the results of the assessment, each state hospital must develop a plan to reasonably prevent and protect employees from violence. The following table lists the elements of both the assessment and the plan as required by law. It then provides a summary of the results of the assessment as well as the plan derived from that assessment.

<b>Elements of the plan per law.</b> (Items a through h below are part of the security & safety assessment)	<b>Assessment</b> – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence.	<b>Plan</b> – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence.
a) The physical attributes of the state hospital including: <ol style="list-style-type: none"> <li>1. access control</li> <li>2. egress control</li> <li>3. door locks</li> <li>4. lighting</li> <li>5. alarm systems</li> </ol>	<ul style="list-style-type: none"> <li>• Potential risks associated with the Environment of Care and high-risk processes that present a threat of physical injury to persons, damage to property, or a threat to general safety</li> </ul>	<p>The Safety/Risk Management Manager and representatives of Safety &amp; Patient Safety Committee, Administration, and CSS conduct an annual pro-active risk assessment to identify and rate all known physical plant deficiencies and problems determined to present a threat of physical injury to persons; damage to property, or a threat to general safety. Plans of Action to minimize and/or eliminate identified risks in clinical areas are developed and implemented. This proactive risk assessment is in addition to routine Environmental Surveys.</p> <p>Proactive Risk Assessment team was established November, 2012 to complete annual assessment (prior to November incident on FSU). The team reviewed the 2011 Risk Assessment (current status of Performance Improvement Activities), review of 2012 data, and developed team assignments for individual unit assessments related to blind</p>

spots and treatment room sharps. Assessment related to the November, 2012 incident on FSU was conducted by management and separate from this annual review. Recommendations for improvement include, but are not limited to:

- Identify drawers/cabinets for sharps storage in all treatment rooms & post signage.
- Replace phone cord on patient phones with a shortened cord (12” or less) between the base and hand set (Lengths quoted in the Design Guide for the Built Environment of Behavioral Health Facilities, National Association of Psychiatric Health Systems, are 12” or less). Consider "armored", wall mount phone with stainless steel cord to prevent use as weapon or removal of cord to use as ligature.
- Installation of Patient Safety Hardware (anti-ligature)
- Replacement of remaining patient bathroom glass mirrors with stainless steel in all locations
- Identify “ in use cover” similar to what is used on an outside outlet were the cover can be closed and locked. That would allow cords to be plugged into the outlet and still prevent the patients from accessing the outlet itself.
- Unit management teams have conducted risk assessments and developed Authorized/Unauthorized patient property lists; December, 2012. All rooms on wards with unsupervised patient use have been hardened to eliminate access to equipment cords (TVs), minimizing risk(s). Risks in unsupervised areas are monitored on 15 minutes checks and documented until patient safety hardware improvements made to mitigate hardware risks. GPU is conducting 15 minute patient checks instead of 15 minute room checks to mitigate cord risks that cannot be mitigate i.e. medical equipment, electric beds due to large quantity of equipment on this unit.
- The responsibility of determining what items/possessions a patient is permitted to have is

determined by the patient's Treatment Team, Psychiatrist or the RN (Interdisciplinary Suicide Plan of Care/Assessment). Suicide monitoring policy #1.94 indicates any materials/possessions that could be used in a suicide attempt are removed from patient access to the extent possible (preventing access to items belonging to other patients on the ward is problematic without 1-to-1 monitoring).

- Install full dome security mirror in identified locations

**See Proactive Risk Assessment for Complete Details**

Individual unit risk assessments were conducted in response to December 21, 2012 Joint Commission survey and integrated into the all-hospital assessment and additional performance improvement activities developed by the team, as indicated. Assessments were presented to Safety, Patient Safety and Executive committees.

**COMPLETE: March 29, 2013**

All items that could be used as ligatures (strings, electrical cords, etc.) and heavy items that could be used as weapons were removed from two forensic wards, 3S1 and 2S1.

**COMPLETE: 12. 21.2012/February, 2013 (All Remaining Wards)**

Plant facility shortened and secured all cords (tvs are mounted to the wall) hospital-wide. Items that are not secured have been removed and only available when staff is monitoring the room.

**COMPLETE: 12.21.2012 (2S1 and 3S1)/February, 2013 (All Remaining Wards)**

Monitoring of the electrical cords that run the length of the beds, underneath the bed, is monitored visually every 15 minutes (FSU and APU) to ensure they are intact whenever the rooms with these beds are unlocked. Due to the large quantity of medical equipment on GPU, patients are visually monitored every 15 minutes versus electrical cords.

**ON-GOING**

	<ul style="list-style-type: none"> <li>• <b>Access control</b> <ul style="list-style-type: none"> <li>• Risks associated with medication security to include: <ul style="list-style-type: none"> <li>• Number and severity of medication security incidents.</li> <li>• Level of access.</li> <li>• Security hardware present (alarms,</li> </ul> </li> </ul> </li> </ul>	<p>All units; Forensic Services (FSU), Adult Psych (APU) and Geropsych (GPU) have developed and implemented new policies regarding items that must not be allowed in the hospital environment and must remain permanently removed from patient access (unauthorized) in addition to items that will be allowed to be utilized via a check-out process, items that can be used only when monitored by staff in a 1:1 setting, and patient property that can be maintained on the ward (authorized).</p> <p><b>COMPLETE: February, 2013</b></p> <p>RN3's/designees complete audits of the observation/monitoring described above on every shift, every day and retains them in a notebook. Nurse Managers spot check to assure these audits are being completed daily by the RN3's/designees, tracks the outcomes and provides follow-up as needed with staff.</p> <p><b>COMPLETE/ON-GOING</b></p> <p>All visitors are notified of what items constitute contraband and must walk through the metal detector. Visitors have the option to leave these belongings in their vehicles or they can lock them up in the lockers provided outside of the ward. Once this is done they are allowed into the visitor's room (FSU separate from the ward) or on the ward to join the patient they are here to visit.</p> <p><b>ON-GOING</b></p> <p><b>Access control</b></p> <p>The Security Department conducted a Pharmacy risk assessment.</p> <p><b>COMPLETE: 9.11.12</b></p> <p>Tamper-proof, numbered Armorite security bags are in place to prevent occurrences of theft of patient</p>
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	<ul style="list-style-type: none"> <li>• There are occurrences of stolen, misplaced, lost or not turned in employee identification badges and/or keys assigned to individual employees.</li> </ul>	<p>All occurrences reported to Security and Unusual Occurrence Report completed.</p> <p><b>ON-GOING</b></p> <p>Develop an automated versus current manual tracking system &amp; corresponding database for the return and issuing of keys/identification badges to/from employees when transferred to other areas/departments or leaving ESH employment.</p> <p><b>TARGET DATE: 12.31.13</b></p> <p>Identify exterior doors that do not close properly and place work orders to repair or replace.</p> <p><b>Monitoring Ongoing - weekly environmental surveys (worksite inspections), Security rounds (24/7)</b></p>
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<p><b>Elements of the plan per law.</b> (Items a through h below are part of the security &amp; safety assessment)</p>	<p><b>Assessment</b> – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence.</p>	<p><b>Plan</b> – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence.</p>
	<ul style="list-style-type: none"> <li>• Increased potential hazards at Westlake Switchboard due to limited visibility of in-coming visitors, patients and staff.</li>   <li>• The parking areas on the north side of Eastlake Administration building are not under surveillance of the main building and are bordered by woods and an unsecured road/access trail.</li> </ul>	<p>Turn Switchboard/reception desk 180 degrees to increase visibility of parking lot and in-coming visitors, patient and staff.</p> <p><b>Due to the location of utilities/infrastructure, it has been identified that this will not be feasible. The current plan is to install wireless cameras so that Switchboard staff can monitor the parking lots and main entrances.</b></p> <p><b>ESTIMATE REQUEST SUBMITTED TO CSS: 6.13</b></p> <p>Identify high-risk areas and install surveillance cameras.</p> <p><b>Capital Programs project lost partial funding for Phase I installation of exterior cameras that have been prioritized by Safety &amp; Security.</b></p> <p><b>TARGET: Will re-submit a Capital Programs request for additional cameras identified for future planning. Target for installation pending funding approval.</b></p> <p>As a component of a Capital Programs project, thirty eight additional cameras are being installed in FSU including in the hallways on all three wards as part of the FSU Security Enhancement project.</p> <p><b>TARGET FOR COMPLETION: July, 2013</b></p>

<p><b>Elements of the plan per law.</b> (Items a through h below are part of the security &amp; safety assessment)</p>	<p><b>Assessment</b> – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence.</p>	<p><b>Plan</b> – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence.</p>
	<ul style="list-style-type: none"> <li>• The area between the Therapy Pool and the unused Interlake building has no surveillance and is not well lit.</li>   <li>• <b>Egress Control</b> No physical control over egress (visitor/staff) on campus. Remedy would essentially require a security fence around entire perimeter of hospital and this is not consistent with hospital mission, vision, or values.</li>   <li>• Potential for equipment and materials to be stored in corridors impacting emergency egress.</li> </ul>	<p>Install eight foot high chain link fence to block access to this area. <b>There is no funding currently available. Funding will be requested for future Capital Programs project.</b></p> <ul style="list-style-type: none"> <li>• <b>Egress Control</b> Security personnel log daily activity and report trends monthly &amp; quarterly to the Safety Committee and department managers for follow-up and plans for improvement as indicated. <b>ON-GOING</b></li>   <li><b>The Westlake kitchen break room door lock was changed to a “snap lock” as part of FMEA completed for WL UL risk.</b> <b>COMPLETE: October, 2012</b></li>   <li>Level of compliance with control of equipment and materials stored in corridors continues to be monitored and documented daily by designated ward staff. The hospital reviews the results of the monitoring and documents compliance on the quarterly Environment of Care Performance Improvement Activities Report. <b>ON-GOING</b></li> </ul>

<p><b>Elements of the plan per law.</b> (Items a through h below are part of the security &amp; safety assessment)</p>	<p><b>Assessment</b> – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence.</p>	<p><b>Plan</b> – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence.</p>
		<p><b>There is a system in place were the CEO/COO has the ability to restrict visitors from the campus due to history and/or current behavior.</b> <b>ON-GOING</b></p>
	<ul style="list-style-type: none"> <li>• There is a potential for violence when apprehending patients that have gone on unauthorized leave.</li>   <li>• <b>Door Locks</b> <ul style="list-style-type: none"> <li>• Current employee key control and tracking system with regard to change of employee need/status is inadequate.</li> </ul> </li>   <li>• <b>Outside Lighting</b> <ul style="list-style-type: none"> <li>• Burned-out/malfunctioning outside lighting.</li> <li>• Amount of time for replacement.</li> <li>• The parking lot to the north of the Therapy Pool is dimly lit and cannot be seen from any building that is typically occupied at night.</li> <li>• The Linden Hall parking lot is poorly lit.</li> <li>• Upper terrace and the north side of the Westlake parking lot are dark despite the</li> </ul> </li> </ul>	<p>Increase Security staffing to two per shift to provide back up. <b>Additional security guard positions established for all shifts, seven days per week, to ensure two per shift.</b> <b>COMPLETE: February, 2013</b></p> <p>Unauthorized leave data tracked and reported monthly to Safety and Patient Safety Committees for trend analysis and drill downs to identify Plans for Improvement. <b>ON-GOING</b></p> <ul style="list-style-type: none"> <li>• <b>Door Locks</b> Develop an automated versus current manual tracking system &amp; corresponding database for the return and issuing of keys/identification badges to/from employees when transferred to other areas/departments or leaving ESH employment. <b>Safety/Risk Mgmt will take to Executive Committee for Plan: TARGET DATE: 8.13</b></li>   <li>• <b>Outside Lighting</b> Security provides a monthly report to Consolidated Support Services regarding their submission and CSS’s completion of campus lighting work orders to ensure timely replacement. <b>ON-GOING</b></li> </ul> <p>All lighting work orders are prioritized based on overall lighting requests/needs.</p>

	<p>presence of several pole lights.</p> <ul style="list-style-type: none"> <li>• <b>Radios</b> <ul style="list-style-type: none"> <li>• Low/dead battery</li> </ul> </li> </ul>	<p><b>ON-GOING</b> Forensic Services Unit perimeter lighting has been increased and is immediately replaced when not working. <b>ON-GOING</b></p> <p>Prioritize areas for installation of additional lighting <b>There is no funding currently available for additional lighting. Funding will be requested for future Capital Programs project</b></p> <p>Initial training is provided by the ESH Safety Officer and Security personnel and reinforced by supervisors. Annual competency of staff in the use and maintenance of radio equipment is evaluated by supervisors. <b>ON-GOING</b></p> <p>Radio distribution, maintenance &amp; ordering are now coordinated by Security, hospital-wide. <b>ON-GOING</b></p>
		<p>Patients are escorted by staff to dining areas during meal times &amp; staff is equipped with portable radios for communication. <b>ON-GOING</b></p> <p>Access to FSU Administration is controlled and communication capabilities increased via portable radios. <b>ON-GOING</b></p>
	<ul style="list-style-type: none"> <li>• Subject to malfunction and accidental activation.</li> </ul>	<p>The duress alarm is currently tested daily on all wards by ward staff (APU &amp; FSU) per ESH manual. <b>ON-GOING</b></p>



		<p>Impervious laundry bags were removed from patient areas to locked storage. Porous bags were placed in laundry bins for patients to place their soiled laundry. Those bags are then placed into non-porous bags by staff and immediately removed from the ward to secure storage.  <b>COMPLETE: February, 2013</b></p>
<p>b) Personnel policies</p>	<ul style="list-style-type: none"> <li>• Systems for identifying variances in staffing and responding to these in a timely manner are in place and appear to be adequate in general.  Additional tools/systems used in nursing include <ul style="list-style-type: none"> <li>- policy/procedure on how to acquire staff</li> <li>- acuity based staffing plan</li> <li>- guidelines for safe staffing levels</li> </ul> </li> </ul>	<p>No additional actions required</p>
<p>c) Staffing, including security staffing.</p>	<ul style="list-style-type: none"> <li>• With only one Security staff member on duty most of the time, there is strong potential for an act of violence to overwhelm the Security staff's ability to contain or control it. This could subject the Security staff to injury and jeopardize others before local law enforcement could respond to provide assistance.</li> <li>• Systems for identifying variances in staffing and responding to these in a timely manner are in place and appear to be adequate in general.  Additional tools/systems used in nursing include <ul style="list-style-type: none"> <li>- policy/procedure on how to acquire staff</li> <li>- acuity based staffing plan</li> <li>- guidelines for safe staffing levels</li> </ul> </li> </ul>	<p>Security staffing increased to two per shift to provide back up. ESH Security Guard staff is primarily responsible for the security and safety of the external campus, including patrolling the campus, watching for trespassing, ensuring vacant buildings are secure, and that hospital entrances are safe and secure. They are not assigned to patient care wards but are available to go to the wards if requested by Nursing Staff.  <b>Additional security guard positions established for all shifts, seven days per week, to ensure two per shift.</b>  <b>COMPLETE: February, 2013</b></p> <p>Request and approval to hire 28 additional positions primarily for afternoon and night shift including additional security guards.</p> <p><u>Use of on-call staff</u>  Eastern State Hospital has a pool of on-call employees who work when required. These staff are utilized first to cover for permanent staff.  <b>ON-GOING</b>  <u>Voluntary Overtime</u></p>

		<p>At the beginning of shift, staff available for overtime on the following shift will notify the Nursing Staffing Office of their availability.</p> <p><b>ON-GOING</b></p> <p>In addition, the following steps are used to determine who is offered prearranged voluntary overtime:</p> <ul style="list-style-type: none"><li>• Staff notifies the staffing office in writing that they wish work voluntary overtime.</li><li>• Names are added to the rotation list in order received.</li><li>• The designated staffer adds the employee's name to the overtime rotation log, by classification and shift in the staffing computer system for use by those completing staffing.</li><li>• Staff will be offered overtime on a rotational basis by classification need and the employee's position on the rotational list. Skills, abilities, and competencies are considered and may be a reason to skip to the next qualified individual until the next available overtime (for example staff must meet the HMH training needs requirement to work on HMH, staff must have 2 years experience to work on FSU).</li><li>• When a staff member is contacted, a computerized record will be maintained noting the staff member's full name, title, date contacted, and the results of that call.</li><li>• Overtime is assigned where the greatest patient care/need is a priority.</li><li>• Staff is expected to work in the location assigned. Every attempt will be made to accommodate preferences, but may not always be possible.</li></ul> <p><b>ON-GOING</b></p>
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		<p><u>Involuntary Overtime</u> When voluntary overtime does not meet patient care/workload demands, involuntary overtime is assigned based on a senior rotational schedule in compliance with the Collective Bargaining Agreement. <b>ON-GOING</b></p> <p><u>Agency Nurses</u> Nursing, in conjunction with the accounting office, finalized a contract with Maxim Staffing Solutions. <b>COMPLETE: 1.29.13</b></p> <p><u>Hiring new employees</u> New Employee Orientation occurred in May, July, November and December of 2012 and January, March and May, 2013.</p> <p>FSU Staffing Plan; identified specific positions such as the Security Desk position. <b>COMPLETE: December 21, 2012</b></p>
<p>d) First aid and emergency procedures</p>	<ul style="list-style-type: none"> <li>• Infection Control Risk Assessment</li>   <li>• Emergency Management Assessment</li> </ul>	<p>Risk Assessment Tool completed and presented to the Infection Control Committee for approval. This tool assesses communicable diseases in the community as well as the prioritized risks within ESH bases on surveillance data. <b>Updated Annually/ON-GOING</b></p> <p>Four emergency response activities were evaluated during 2012; three planned exercises and one real life occurrence:</p> <ul style="list-style-type: none"> <li>• 4.18.12 Table Top Region 9 Healthcare Coalition.</li> <li>• 5.9.12 Drill; Armed Assault/All-Hospital Lockdown.</li> <li>• 10.30.12; Structure/Wildfire Resulting in Evacuation</li> </ul>

		<ul style="list-style-type: none"><li>• 11.2.12; Real-life occurrence, Telephone Failure</li></ul> <p>A Plan for Improvement was developed for all emergency activities (staged and actual) in response to identified issues related to internal/external communication, availability of and access to materials, safety &amp; security of patients and staff, staff roles &amp; responsibilities (assignment and performance), managements of critical utilities, managements of clinical and support activities. Improvement activities include, but are not limited to:</p> <ul style="list-style-type: none"><li>• Development of a flow chart to outline process/procedures for tracking patients and staff and how and who to communicate the information to including how ESH will notify families when patients are relocated to alternative care sites.</li><li>• Installation of a base station for Eastlake Kitchen &amp; Campus Café (1 base housed in a mutual location) for alternate communication capability.</li><li>• Development of improved guidance/direction for initiating emergency announcements w/quick reference for ICC to decrease confusion and increase response time; all-hospital PA versus two-way radio or phone, determining need for announcement to affected area only and/or all-hospital, communication by Switchboard or other designee. It is understood that making emergency notifications via overhead PA &amp;/or two-way radio is not always prudent depending on nature of emergency e.g. hostage, bomb threat, etc.</li></ul>
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<p><b>Elements of the plan per law.</b> (Items a through h below are part of the security &amp; safety assessment)</p>	<p><b>Assessment</b> – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence.</p>	<p><b>Plan</b> – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence.</p>
<p>e) Violent acts:</p> <ul style="list-style-type: none"> <li>• Reporting of violent acts</li> <li>• Taking appropriate action in response to violent acts</li> <li>• Follow-up procedures after violent acts</li> </ul>	<ul style="list-style-type: none"> <li>• All elements pertaining to reporting of violent acts appear to be covered and systems are working well.</li> <li>• All elements under this area appear to be currently covered and systems are working well.</li> <li>• All elements pertaining to follow-up procedures appear to be covered and systems are working well.</li> </ul>	<p>Maintain follow-up procedures and monitor compliance.</p> <p>Policies/procedures are implemented as directed. Critical Incident Stress Management procedure in place and team members identified for response.</p> <p><b>ON-GOING</b></p> <p>Maintain follow-up procedures.</p> <p><b>All incidents are investigated at time of occurrence &amp; findings reported monthly to the Safety Committee for review and analysis of trends/patterns.</b></p> <p>Psychiatric Security Attendants (PSA) and Psychiatric Security Nurses (PSN) staff is assigned to the Forensic Services Unit wards. In addition to providing psychiatric care and support to patients, these staff have additional security and safety responsibilities specific to the forensic population they work with. The job specifications for the PSA job classification include these duties:</p> <ul style="list-style-type: none"> <li>• Maintains order and discipline in housing and treatment area; protects employees and patients from acts of violence from recalcitrant patients;</li> <li>• Inspects patient quarters for cleanliness and order; searches quarters and persons for contraband; escorts patients on outside trips;</li> <li>• Observes patients for unusual or significant behavior; prepares reports to supervisor.</li> </ul>

<p><b>Elements of the plan per law.</b> (Items a through h below are part of the security &amp; safety assessment)</p>	<p><b>Assessment</b> – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence.</p>	<p><b>Plan</b> – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence.</p>
<p>f) Development of criteria for determining and reporting verbal threats</p>	<ul style="list-style-type: none"> <li>• ESH has been using criteria as identified in the MHD Quality Steering Committee definition for assault in the Unusual Occurrence Reporting System (UORS) for the past 10 years.</li> </ul>	<p>Verbal threats are tracked when reported. Staff determines risk potential. <b>ON-GOING</b></p>
<p>g) Employee education and training</p>	<ul style="list-style-type: none"> <li>• Not all new employees receive new employee orientation including the Therapeutic Options training class in a timely manner. Some are employed at ESH for months before receiving this training.</li> </ul>	<p>All new employees receive new employee orientation within the first month of employment. New Employee Orientation occurred in May, July, November and December of 2012 and January, March and May, 2013 <b>ON-GOING</b></p> <p>All current employees (dependent on position title) are required to take the initial 8-hour Therapeutic Options training and update every year. Current tracking system is in place to monitor compliance. <b>ON-GOING</b></p> <p>The FSU security training was reviewed to assess whether gaps occur and to include a plan for conducting individual patient and room searches and training revised as indicated. Training includes a requirement to ensure refresher security training is an annual mandatory requirement. Training divided into two sections, one for the nursing staff and other for non-nursing staff Nursing Staff:</p> <ul style="list-style-type: none"> <li>• A power point presentation to provide an overview that pertains to nursing staff <ul style="list-style-type: none"> <li>○ Safety and Security</li> <li>○ Specific positions with expectations and responsibilities</li> </ul> </li> </ul>

		<ul style="list-style-type: none"> <li>○ Equipment overview and radio use</li> <li>● Power point post test <ul style="list-style-type: none"> <li>○ After the power point and post test is completed there is hands on training <ul style="list-style-type: none"> <li>▪ Operation of the Control Panel</li> <li>▪ Swipe care use</li> <li>▪ Key check out</li> <li>▪ Specific positions and expectations</li> </ul> </li> <li>○ There are specific policies, procedures and work instructions that apply specifically to FSU that must be read (i.e. Contraband Search 1.39, FSU Safety and Security Checks 1.11, etc.)</li> </ul> </li> </ul> <p>Non Nursing Staff</p> <ul style="list-style-type: none"> <li>● A power point presentation to provide an overview that pertains to non nursing staff <ul style="list-style-type: none"> <li>○ Brief equipment overview including brief review of control panel</li> <li>○ Radio channels used by FSU</li> <li>○ Key check out system</li> <li>○ Swipe care and purpose</li> <li>○ Sally ports and expectations</li> </ul> </li> <li>● Power point post test</li> <li>● Hand on training of equipment, but to a lesser degree than nursing</li> <li>● A specific list of policies, procedures, and work instructions that would be helpful information for non nursing staff (i.e. Security Break 1.8, FSU Ward Guidelines 1.7, Program Descriptions 1.6, etc).</li> </ul> <p><b>COMPLETE: March, 2013</b></p> <p>All employees are required to review DSHS Administrative Policy 18.66 Discrimination and Harassment Prevention Policy.</p> <p><b>ON-GOING</b></p>
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		<p>There is revised training for clinical staff on increasing awareness of safety in the hospital. This includes the emphasis of a culture of safety that includes balance with the recovery environment.</p> <p><b>COMPLETE: 2.7.13 with senior leadership and Governing Body and selected nursing staff March 13, 2013.</b></p>
<p>h) Clinical and patient policies and procedures including those related to:</p> <ul style="list-style-type: none"> <li>• Smoking</li> <li>• Activity, leisure, and therapeutic programs</li> <li>• Communication between shifts</li> <li>• Restraint and seclusion</li> </ul>	<ul style="list-style-type: none"> <li>• Need more education in conflict management and classes in anger management, stress management and dealing with change in a positive manner.</li>   <li>• Limited Rehabilitation Services provided to patients may result in increased patient agitation due to limited activity, leisure and therapeutic programming.</li> </ul>	<p>Offer training in conflict management, stress management, anger management and dealing with change in a positive manner to ESH employees. Education to include various methods of instruction including classes, workbooks and videos.</p> <p><b>Eastern State Hospital is currently implementing a Recovery Model, tracking multiple outcomes; seclusion/restraint, staff injuries, patient-to-patient assault, patient-to-staff assault. This information is reported hospital-wide. INITIATED: 2006/ON-GOING</b></p> <p>Review data related to patient behavioral problem times, areas, etc., to identify increased needs for structured treatment programming.</p> <p>Evening and weekend programming in Therapeutic Recreation has been supplemented to decrease agitation and use of seclusion/ restraint during specific hours identified through review of data.</p> <p><b>ON-GOING</b></p> <p>Additional programs, treatment and care have been provided by additional rehabilitation department clinical staff focusing on anxiety and stress management, recovery focus, negotiating needs versus wants, processing loss and change, using methods including but not limited to</p>

exercise, relaxation, music and mood, socialization activities such as table games and activities, exercise, expressive arts and creativity.

**ON-GOING**

The assigned clinical security staff from the on-coming and off-going shifts together completes a security check and document on the Security Board.

**ON-GOING**

FSU Security Committee establishes reviews and makes recommendations for changes in unit security policies and procedures. This committee is composed of representatives of line staff from each ward and shift, representative from Rehabilitation Services, FSU MHT 5 and FSU Nurse Manager. This committee receives input from line staff (and others) to address safety and security issues. There is a Security Break Memo review process in place to address safety and security concerns.

**ON-GOING**

Additional Nursing observation is occurring by placing nursing staff mid-distance in each of the two hallways on the FSU wards. This allows the staff member to hear both ends of the hallway. The requirement to maintain this observation has been provided in writing and verbally to Nursing Staff. On the night shift, employees are assigned to these areas on the assignment sheets under different titles such as hall security north and hall security west. The purpose of these assignments is not only to be able to hear patients better throughout the ward, but also to make sure they aren't entering other patient's rooms. Staff is also there to provide the patients with a sense of safety by being visible out on the wards throughout the night.

**INITIATED: 12.21.12**

		<p>While the psychiatric security attendants are monitoring patients on Assault observation (AO), location observation (LO), or suicide observation (SO) they are doing this in an unpredictable manner (instead of every 15 minutes for example, they randomly complete the checks several minutes earlier).</p> <p><b>ON-GOING</b></p>
		<p>While out monitoring the environment if staff notices a patient who is having a difficult time, they alert not only the charge nurse, but all the staff who are present in hallways as described above. This assists staff in intervening in a timelier manner.</p> <p><b>ON-GOING</b></p>
	<ul style="list-style-type: none"> <li>• There is an increased risk for patient unauthorized leave and/or negative patient behavior during community outings.</li> </ul>	<p>A community outing planning tool has been developed and is utilized for all outings to identify potential risks and methods of managing/reducing these risks i.e. cell phones, personal protective equipment, patient-to-staff ratios.</p> <p><b>COMPLETE: 12.2009/ON-GOING</b></p> <p>Unauthorized leave data tracked and reported monthly to Safety and Patient Safety Committees for trend analysis and drill downs to identify Plans for Improvement</p> <p><b>ON-GOING</b></p>

<p><b>Elements of the plan per law.</b> (Items a through h below are part of the security &amp; safety assessment)</p>	<p><b>Assessment</b> – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence.</p>	<p><b>Plan</b> – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence.</p>
	<ul style="list-style-type: none"> <li>Placing patients in seclusion/restraint increases potential for employee injury.</li> </ul>	<p>Increase staff training in use of less-restrictive alternatives.</p> <p><b>In collaboration with the Substance Abuse Mental Health Services Administration (SAMSHA) Training Grant and Washington Institute for Mental Illness Research and Training (WIMIRT), ESH developed a plan to change from a Bio-Psycho-Social Model to a Recovery Model to reduce the number of seclusion/restraint events. Eastern State Hospital is currently implementing a Recovery Model, tracking multiple outcomes; seclusion/restraint, staff injuries, patient-to-patient assault, patient-to-staff assault. This information is reported hospital-wide. INITIATED: 2006/ON-GOING</b></p>
	<ul style="list-style-type: none"> <li>Non-therapeutic interactions with patients increases the potential for employee injury.</li> </ul>	<p>Consistent supervision &amp; corrective action to ensure therapeutic interactions. <b>See Above</b></p>
		<p>An additional assignment has been made to the Security Guard’s responsibilities to include regular rounds on all wards during their shift <b>COMPLETE: January, 2013</b></p>
		<p>Environment Checks</p> <ul style="list-style-type: none"> <li>Inspection of common areas for unauthorized items.</li> <li>No cords or any items which may pose a safety/security risk</li> <li>Designated rooms are always locked (tub rooms</li> </ul>

and any room that has been designated as safety/security risk

- Any item with a cord (electric beds, CPAP machines, etc) that is in patient areas is checked every 15 minutes.
- Rooms that have safety security risks (such as the shower room) are checked every 15 minutes.

**IMPLEMENTED: 12.21.12**

Staff Position (FSU)

- Staff is aware of each other's position and whereabouts at all times.
- Security desk position maintains constant contact (via radio or observation) of the person doing the ward security checks.
- The ward security check position maintains constant contact with the Security Desk position (via radio and checking to see that the Security Desk position is aware of his/her position)
- The Control Panel Operator position maintains constant contact with the Security Desk position and the Security Ward position (via radio and spot visual checks).

**COMPLETE: December 21, 2012**

New and Revised Policies:

- Minimal Personal Care Criteria (new FSU policy) outlines the twice daily room inspections, checking for any unauthorized items, authorized items are stowed in the patient's lockers and patient's lockers are locked.
- Patient Property Authorized and Unauthorized to identify items that are safe for patients to have in their possession based on patient's category level.
- FSU Environmental Safety Check out System to identify a process to safely monitor and check

		<p>out/in items to patients. Items that they may have in their possession during that specific shift only.</p> <ul style="list-style-type: none"> <li>• FSU Staffing Plan; identified specific positions such as the Security Desk position.</li> </ul> <p><b>IMPLEMENTED: January 2013</b></p> <p>The Nurse Executive will be completing Intentional Leadership Rounding at least quarterly on all shifts with the agenda of focusing on safety and improving communication.</p> <ul style="list-style-type: none"> <li>• APU/GPU: Assignment sheet completed</li> <li>• Staff assigned to the patient ward check knows where patients are at all times.</li> <li>• Environmental ward check staff are continuously circulating throughout the ward unless they are helping a patient or providing care</li> <li>• Safety monitoring is complete and accurate (SO, AO, LO, 1:1, etc)</li> <li>• Ward check staff verify the safety condition of the patient at assigned intervals</li> </ul> <p><b>IMPLEMENTED: January, 2013</b></p>
<p>i) Analysis of data on violence and workers compensation claims during at least the preceding year</p>	<ul style="list-style-type: none"> <li>• These records are on a database.</li> </ul>	<p>Data is analyzed and trended at least quarterly.  <b>All incidents are investigated at time of occurrence and any needed plan of correction taken. Findings are reported monthly to the Safety and Executive Committee for review and analysis of trends/patterns.</b>  <b>ON-GOING</b></p>
	<ul style="list-style-type: none"> <li>• ESH has been using criteria as identified in the MHD Quality Steering Committee definition for assault in the UORS for the past 10 years.</li> </ul>	<p>Continue current reporting, trending and analysis.  <b>ON-GOING</b></p>

<p><b>Elements of the plan per law.</b> (Items a through h below are part of the security &amp; safety assessment)</p>	<p><b><u>Assessment</u></b> – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence.</p>	<p><b><u>Plan</u></b> – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence.</p>
<p>j) Input from staff and patients such as surveys and info relevant to the lettered elements above.</p>	<ul style="list-style-type: none"> <li>• The Complaint Review Team has identified that trending of the nature of the complaints is an area that requires improvement.</li>   <li>• The Unusual Occurrence Reporting System is a component of the new employee orientation and department specific training.</li>   <li>• Culture of Safety</li> </ul>	<p>The Complaint Review Team is meeting at least two times a month to identify how to capture trends that would inform and be of benefit to ESH.</p> <p><b>The Complaint Review Team meets daily and reviews for trends monthly. Aggregate data is distributed for ward/unit management groups to make appropriate program changes. ON-GOING</b></p> <p>Current system assures all UOR’s are reported, reviewed by supervisors and analyzed by Quality Management and trended quarterly. Performance Improvement plans are developed to improve drill down analysis of patterns/trends, identified “outlier” occurrences and implement recommendations on a continuous basis. <b>IMPLEMENTED &amp; ON-GOING.</b></p> <p>A culture of safety assessment is completed, analyzed and monitored annually. Areas for improvement are identified from the assessment and plans of action created.</p> <p>Senior leadership conducts safety rounds on a monthly basis. Senior leaders meet with front line staff and discuss safety concerns and develop plans of action based on the input of staff. <b>INITIATED: 2.12.12.</b></p>

		<p>A drill down is conducted on every patient to patient assault to identify what happened, how it happened, what can be done to prevent it from happening again. The drill down report will be discussed in executive leadership meetings and there will be action items identified to make improvements. The data will be analyzed for patterns and trends so senior leadership is able to take action to prevent assaults from happening. This data will also be presented at each Governing Body meeting for improvement activities.</p> <p><b>ON-GOING</b></p> <p>The 2012 culture of safety survey was completed and reviewed by senior leadership.</p> <p><b>COMPLETE: March 4, 2013</b></p> <p>Culture of Safety is included in all Executive Committee and Governing Body meeting discussions including treatment errors that have occurred, reports from various providers and inviting front line staff to discuss safety concerns from their perspective.</p>
<p>k) Review of guidelines on violence in the workplace or state hospital issued by DOH, DSHS, L&amp;I, OSHA, Medicare, others. (Not required)</p>	<ul style="list-style-type: none"> <li>Utilize as resource</li> </ul>	<p>Reports to the Safety Committee routinely include updates on all pertinent guidelines and these are utilized in planning workplace violence prevention at ESH.</p>

<p><b>Elements of the plan per law.</b> (Items a through h below are part of the security &amp; safety assessment)</p>	<p><b>Assessment</b> – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence.</p>	<p><b>Plan</b> – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence.</p>
<p>1) Violence prevention training with consideration to 14 topics in the law</p>	<ul style="list-style-type: none"> <li>• Must be addressed in the plan.</li> </ul>	<p>In-services encompassing interpersonal communication skills in a hospital setting, sexual harassment and workplace violence are incorporated into new employee and mandatory annual staff and supervisor training.</p> <p>All current employees (dependent on position title) are required to take the initial 8-hour Therapeutic Options training and update every year. Current tracking system is in place to monitor compliance.</p> <p><b>ON-GOING</b></p>
<p>1) Record of violent acts including physical assault or “attempted” physical assault</p>	<ul style="list-style-type: none"> <li>• These records are on a database.</li> <li>• ESH has been using criteria as identified in the MHD Quality Steering Committee definition for assault in the UORS for the past 10 years.</li> </ul>	<p>Data is analyzed and trended at least quarterly.</p> <p><b>All incidents are investigated at time of occurrence &amp; findings reported monthly to the Safety Committee for review and analysis of trends/patterns.</b></p> <p><b>ON-GOING</b></p> <p>Continue current reporting/trending/analysis improvement implementation process.</p> <p><b>ON-GOING</b></p> <p>All patient, staff and visitor injuries are coded for severity. The Clinical Risk Manager (CRM) ensures hospital administration is notified of any critical UOR or other incidents determined to high risk.</p> <ul style="list-style-type: none"> <li>• A Risk Management Review and investigation report (RMRIR) is completed by the CRM if there is missing information, lack of information or if clarification is needed. This is designed to ensure the severity of the injury or other incident is appropriately coded. The CRM tracks all RRIR via a log. Any new information is communicated to those who received copies of the UOR via normal distribution.</li> </ul>

		<ul style="list-style-type: none"> <li>Each month the CRM reviews the previous months' UORs for trends/patterns. These trends/patterns are discussed with the QM Director. A report is provided to the Patient Safety Committee for communication of pertinent information to appropriate hospital departments/personnel.</li> </ul>
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**COMPLETED AND/OR RESOLVED ASSESSMENTS/IMPROVEMENTS/ISSUES TO DATE:**

<p>The physical attributes of the state hospital including:</p> <ol style="list-style-type: none"> <li>1. access control</li> <li>2. egress control</li> <li>3. door locks</li> <li>4. lighting</li> <li>6. alarm systems</li> </ol>	<ul style="list-style-type: none"> <li>Potential risks associated with the Environment of Care and high-risk processes that present a threat of physical injury to persons, damage to property, or a threat to general safety</li> <li>Access control <ul style="list-style-type: none"> <li>Open campus/ location (rural), multiple buildings &amp; locations (multiple areas isolated after dark). Problem identified with Security staffing (one per shift, hospital-wide).</li> </ul> </li> <li>Westlake Building exterior doors do not always remain locked (not all are self-locking).</li> </ul>	<p>Develop Environmental Proactive Risk assessment policy and procedure. This is an annual assessment. <b>COMPLETE: February, 2010</b></p> <p>Additional patrols of identified areas completed to reduce or eliminate trespassing. Additional camera surveillance initiated in one location with assistance of Spokane County Sheriff's Department; <b>March, 2010.</b></p> <p>Cameras installed in highest priority areas identified by both Safety and Security. <b>COMPLETE: 3/08</b></p> <p>Inventory of all campus door locks/keys. <b>COMPLETE: 2/08</b></p> <p>Security study of high-risk locations requiring security cameras completed and prioritized based on usage, access &amp; history of unsecured doors. <b>COMPLETE: 12/05</b></p> <p>Project for replacement of ten exterior doors at Westlake funded &amp; installed through Capital Programs. <b>COMPLETE: 7/0-9</b></p>
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		Identify high-risk exterior doors that do not have self-locking mechanisms and place work order for lock replacement. <b>High-risk doors have been identified and locks prioritized for replacement: COMPLETE.</b>
	<ul style="list-style-type: none"> <li>• APU wards currently using hand-held metal detectors, which are sometimes unreliable due to building construction (metal/rebar in floors/walls)</li> </ul>	Two walkthrough metal detectors purchased for 1N1/1N3 (admission wards) and 2N1. <b>COMPLETE: 3/08</b>  An upgraded walk-through metal detector was installed on the Forensic Services Unit. <b>COMPLETE: December, 2010.</b>
	<ul style="list-style-type: none"> <li>• There is a potential for violence when apprehending patients that have gone on unauthorized leave.</li> </ul>	Numerous Security improvements were implemented during the third quarter of 2009 through 2010, including, but not limited to: <ol style="list-style-type: none"> <li>1. Revision of the Unauthorized Leave Policy</li> <li>2. Campus Limit Revisions</li> <li>3. Securing of Additional Doors</li> <li>4. Eastlake Adult Psychiatric Unit (APU) Yard Security Upgrades</li> </ol>
	<ul style="list-style-type: none"> <li>• <b>Outside Lighting</b> <ul style="list-style-type: none"> <li>• Burned-out/malfunctioning outside lighting.</li> <li>• Amount of time for replacement.</li> <li>• The parking lot to the north of the Therapy Pool is dimly lit and cannot be seen from any building that is typically occupied at night.</li> <li>• The Linden Hall parking lot is poorly lit.</li> <li>• Upper terrace and the north side of the Westlake parking lot are dark despite the presence of several pole lights.</li> </ul> </li> </ul>	Post “no parking after dark” signs in lot. <b>Work order completed for installation of sign: COMPLETE: 4/13/07</b>  Attach flood lights to building. <b>Additional lighting installed in high priority areas. COMPLETE</b>
	<ul style="list-style-type: none"> <li>• Additional radios needed for new Treatment Mall</li> </ul>	Additional radios purchased and in place at Treatment Mall and in ICC locations.

	<p>and Emergency Operations Center (ICC).</p> <ul style="list-style-type: none"> <li>Not all existing radios and base stations comply with Federal Communications Commission (FCC) narrow banding requirements: All non-Federal radio licensees operating 25 kHz systems in the 150-174 MHz and 421-512 MHz bands (VHF and UHF) must migrate to more efficient 12.5 kHz (narrowband) channels by January 1, 2013.</li> </ul>	<p><b>COMPLETE</b></p> <p>Required licensing in addition to new radios and base stations were purchased to comply with FCC narrow-banding requirements.  <b>COMPLETE: December, 2010.</b></p>
	<ul style="list-style-type: none"> <li>Alarm system Subject to malfunction and accidental activation.</li> </ul>	<p><b>Replacement of the GPU nurse call system</b>  <b>COMPLETE: 5/09</b></p>
c) Staffing, including security staffing.	Staff needed to develop a consultation system so that treatment teams can ask for behavioral assistance	Hire PhD prepared psychologist with experience in behavioral intervention assumed the role of Behavioral Specialist assigned to the Quality Management Department and available for consultation to all treatment teams. <b>COMPLETE: 2008</b>
h) First aid and emergency procedures	<ul style="list-style-type: none"> <li>Defibrillators not located in all areas.</li> <li>Emergency response procedure does not provide a mechanism for notifying first responders of what type of emergency is occurring.</li> <li>No emergency landing site at Westlake facility for helicopter transport.</li> <li>Clarify and establish proper procedure for equipment use in hallways that provide an unobstructed means of exit egress in corridors for patients, visitors or staff leaving the building under emergency conditions.</li> </ul>	<p>Defibrillators &amp; AED's are located on all wards and in the Security vehicle for emergencies away from the ward.  <b>COMPLETE</b></p> <p>The procedure has been updated to include notification of first responders indicating either "Code Blue" or "Code Orange".  <b>COMPLETE: 9/05</b>  <b>Additional group pagers have been purchased.</b>  <b>COMPLETE: 5/08</b></p> <p><b>Installation of Helistop at Westlake facility.</b>  <b>COMPLETE: 7/09</b></p> <p>A policy and procedure for "Maintenance of Exits" was developed to clarify and establish proper procedure for equipment use in hallways that provide an unobstructed means of exit egress in corridors for patients, visitors or staff leaving the building under emergency conditions.  <b>COMPLETE: February, 2010</b></p>

	<ul style="list-style-type: none"> <li>• Lack of emergency equipment for evacuation of mobility impaired patients.</li> </ul>	<p>An interim plan for laundry cart storage was implemented and a Performance Improvement Team assigned to identify a permanent plan of correction. A permanent plan of correction was implemented <b>April, 2010</b> and compliance is monitored daily by area/department supervisors in addition to routine Environmental Surveys.</p> <p>Implement training for all Nursing staff in the use of mobility impaired evacuation equipment (Paraslydes). Effectiveness will be evaluated during emergency exercises  <b>COMPLETE: September, 2010.</b></p>
<p>i) Clinical and patient policies and procedures including those related to:</p> <ul style="list-style-type: none"> <li>• Smoking</li> <li>• Activity, leisure, and therapeutic programs</li> <li>• Communication between shifts</li> <li>• Restraint and seclusion</li> </ul>	<ul style="list-style-type: none"> <li>• Limited Rehabilitation Services provided to patients may result in increased patient agitation due to limited activity, leisure and therapeutic programming.</li> </ul>	<p>Additional Psychosocial Rehab programming in a treatment mall in the Activity Therapy Building has been implemented. Doors are secured and main entrances are continuously staffed.  <b>COMPLETE: 3/08</b></p> <p>Expanded Psychosocial Rehab Treatment Mall to include the space on a closed ward for two other programs (Connections and Preparations), enabling the most acute patients access to appropriate group treatments.  <b>COMPLETE: 4/09</b></p> <p><b>Psychosocial programs offered to patients:</b></p> <ul style="list-style-type: none"> <li>• <b>Anger Management</b></li> <li>• <b>Emotional Regulating</b></li> <li>• <b>Mindfulness</b></li> <li>• <b>Trauma Recovery</b></li> <li>• <b>Safety &amp; Coping</b></li> </ul>

	<ul style="list-style-type: none"> <li>• Lack of alternative interventions and staff skill to safely eliminate seclusion/restraint use.</li>   <li>• Increased patient agitation upon admission has been evaluated</li>     <li>• Limited adaptive equipment to increase patient mobility and decrease use of restraints.</li>                 <li>• Limited patient lifting/transferring devices to prevent staff injuries.</li> </ul>	<p>Revise program scheduling to increase use of therapy pool/aquatic therapy.  <b>IMPLEMENTED &amp; ON-GOING</b></p> <p>Eastern State Hospital has provided comfort rooms, sensory modulation and discontinued time-out intervention.  <b>COMPLETE: 1/07</b></p> <p>In collaboration with the Substance Abuse Mental Health Services Administration (SAMSHA) Training Grant and Washington Institute for Mental Illness Research and Training (WIMIRT), ESH has developed an individualized Patient Safety Plan tool for patients and staff to identify triggers to violence and successful techniques for agitation redirection.  <b>COMPLETE: 3/08</b></p> <p>Provide additional adaptive equipment to increase patient mobility and decrease use of restraints.</p> <ul style="list-style-type: none"> <li>- Hi-Low Beds</li> <li>- Mattresses (floor mats)</li> <li>- Ultimate Walkers</li> <li>- Broda Chairs</li> </ul> <p><b>Sixty new hi-lo beds have been purchased.</b>  <b>COMPLETE: 4/08</b></p> <p>A Safe Patient Handling Program was implemented January, 2007. Based on the original needs assessment Safe Patient Handling Program developed and implemented. Additional sit-to-stand lifts, portable lifts, height adjustable exam tables and overhead lifts have been purchased. The 2007 Annual Program Review shows a 60% decrease in total patient handling incidents, 62% decrease in L&amp;I claims filed due to patient handling and a 72% decrease in total time loss.  <b>COMPLETE</b></p>
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	<ul style="list-style-type: none"> <li>Placing patients in seclusion/restraint increases potential for employee injury.</li> </ul>	<p>Purchase Paraslydes (evacuation equipment for mobility impaired patients) to reduce risk of staff injury during emergency evacuation. <b>COMPLETE: 6/08.</b></p> <p>Protective body armor purchased for staff use during extremely high risk seclusion/restraint incidents. <b>COMPLETE: 5/08</b></p>
j) Input from staff and patients such as surveys and info relevant to the lettered elements above.	<ul style="list-style-type: none"> <li>A survey of staff that specifically addresses the elements of this Workplace Safety Plan is needed.</li> </ul>	<p>Survey has been developed and issued to all employees. Results have been reviewed and recommendations incorporated into the plan. <b>COMPLETE: 2000</b></p>
k)	<ul style="list-style-type: none"> <li>A survey of staff that specifically addresses the elements of this Workplace Safety Plan is needed.</li> </ul>	<p>Survey has been developed and issued to all employees. Results have been reviewed and recommendations incorporated into the plan. <b>COMPLETE: 2000</b></p>
m) Violence prevention training with consideration to 14 topics in the law		<p><b>Presentation by Sandra Bloom, MD “Creating Sanctuary” a non-violence program.</b> <b>COMPLETE: October, 2008</b></p>

# APPENDIX C

## Workplace Safety Plan (WSH)

### Western State Hospital

ANNUAL UPDATE

March 2013

RCW 72.23.400 requires each state hospital (WSH, ESH, CSTC) to develop a plan to reasonably prevent and protect employees from violence. The law requires completion of a security and safety assessment to identify existing or potential hazards for violence in the workplace. Using the results of the assessment, each state hospital must develop a plan to prevent and protect employees from violence and provide an update to the legislature annually. The following table lists the elements of both the assessment and the updated plan as required by law. It then provides a summary of the results of the assessment as well as the plan derived from that assessment.

<b>Elements of the plan per law.</b> (Items a through h are part of the security & safety assessment)	<b>Assessment</b> – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence.	<b>Plan</b> – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence.
a. The physical attributes of the state hospital including: 1. Access control 2. Egress control 3. Door locks 4. Lighting 5. Alarm systems	Physical security tour of Western State Hospital (WSH) campus revealed the following: • Access, egress control and door locks were found to be generally in good order.	The Environment of Care (EOC) Committee conducts a year-round assessment of access control, egress control, door locks and lighting during monthly walkthroughs. All areas are inspected at least once a year. In addition, every ward does their own (EOC) inspections on a monthly basis and produces work orders and/or follow ups based upon their findings. Each Safety Sub-committee reviews the EOC’s done by the ward and follows up on any unresolved issues. Ward staff also conduct safety rounds at least once per shift looking for important safety items (i.e. Unsecure exits/windows door, inadequate light in environment, broken furniture and/or broken glass, etc.) <b>Ongoing</b>  The EOC Committee also conducts an annual Physical Risk Assessment of every patient care area to look for other safety/security risks that take into consideration our patient population. Recent staff/patient safety projects include the following: <ul style="list-style-type: none"> <li>• Anti-ligature door handles on all ward area doors (<b>Completed</b>)</li> <li>• 1 – 2 SAFE rooms identified on each ward to be used for high risk patients with self-harm behavior. Norix beds and night stands were purchased and secured to floor and then sealed (<b>Completed</b>).</li> <li>• Patient locker doors were modified in all patient rooms to decrease the opportunity for self-harm behavior (<b>Completed</b>).</li> <li>• Enclosed exposed plumbing fixtures on wards (<b>Completed</b>)</li> <li>• Installed new anti-ligature faucets in high risk areas (<b>Completed</b>)</li> <li>• Modified or installed grab bars and toilet paper holders that are anti-ligature resistant (<b>Completed</b>).</li> </ul> In addition, in 2012, the Safety Office along with members of the Safety Committee conducted a Physical Risk Assessment as it pertains to staff safety only. Some of the items identified in this assessment were additional blind spots that needed mitigating,

		<p>miscellaneous safety issues and SAFE furniture needs in the amount of \$3.5 million. The blind spots and miscellaneous safety items have been completed. The SAFE furniture need has been prioritized, and the hospital has agreed to purchase some SAFE furniture every year. <b>Ongoing &amp; Budget Dependent</b></p> <p>In response to the L&amp;I citation, in March/April 2013, an additional physical risk assessment was done by the safety office and members of the safety committee throughout the hospital to identify any additional safety/security risks in the environment. Additional blind spots, window coverings furniture needs, and patient room standards issues were identified. Reminders, memos, and work orders were done for items that could be completed. The rest of the identified items will be placed on a priority list. <b>Ongoing &amp; Budget Dependent</b></p> <p>So far, WSH has spent \$1.2 million to mitigate the above and currently has a safety decision package for \$3.1 million on request with the legislature for additional safety mitigation.</p> <p>In January 2013, ELT distributed the new EOC committee patient room standards. These standards identified items on the wards that are now banned, allowed with treatment team approval, or allowed with a check in/out system. (i.e. belts, scarves, shoe laces, cords no longer than 6 inches, etc.) A cleansing of the wards was done in January/February 2013 to assist with safety of both staff and patients. <b>Completed, but will have to be periodically monitored for compliance by EOC &amp; Safety Committee Members.</b></p> <p>For better access control, WSH piloted a key control system called “Key Watcher” in the CFS in 2012. This system has been very successful with zero keys lost from CFS since it’s implementation. WSH has submitted a safety decision package in the amount of \$3.1 million dollars in 2013. Part of this package includes implementing the key watcher hospital-wide. In addition, WSH established a Key Control Department that is separate from Central Maintenance Operations for oversight of the hospitals key control. <b>Budget Dependent</b></p> <p>A new camera system is in the process of being installed in CFS to assist staff with visual issues of the building. This new system will allow staff to view more areas in CFS that were not possible with the old system. The new system includes cameras on all patios in CFS (F-1 through F-8) which the Security Control Station can view at all times. (F1 &amp; F2, (which are admission wards) will have camera view of patios at nurse’s station). <b>Anticipated completion date is May 16, 2013.</b></p> <p>WSH has upgraded our radio system to a digital narrow banded system with 3 channels, (Security channel, Maintenance Channel, and EM channel). We have also added repeaters throughout the hospital for improved communication.</p> <p>We are currently sending out to bid a new upgraded paging system for the hospital for better communication as well.</p> <p>A security assessment was done of our communications center to ensure a safe and secure environment for our the employees who work there. (i.e. automatic door lock at front door, camera system, strategic placement of breakable key box, etc.) We are currently in the</p>
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	<p>Annual Lakewood Fire Inspection is required.</p> <p>Lighting is adequate on all wards, offices, and shop areas. Outdoor lighting is adequate.</p>	<p>process of making the recommended modifications to the work area. <b>Target Completion date: 12/30/2013.</b></p> <p>Alarm systems are tested and monitored by the Maintenance Department. The Maintenance Department monitors and prioritizes work requests to maintain current condition. <b>Ongoing</b></p> <p>Since 2001, the annual Lakewood Fire Inspection has been conducted by the Lakewood Fire Marshall and a team from WSH comprised of the Safety Manager, a Facilities Representative, and others as needed. This inspection evaluates fire safety issues. Shortcomings are identified and corrected to preclude a fire emergency. All areas are inspected on an annual basis. <b>Ongoing</b></p> <p>An ESCO lighting project was completed in 2012 for enhanced, more efficient interior &amp; exterior lighting throughout the hospital. The Centralized Maintenance Operation (CMO) ensures lighting is maintained through regular inspections and in response to work orders. Selected trees and shrubs have also been removed. Ongoing monitoring will be conducted by the CMO ground maintenance crew. <b>Ongoing</b></p>
<p><b>Elements of the plan per law.</b> (Items a through h are part of the security &amp; safety assessment)</p>	<p><b>Assessment</b> – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence.</p>	<p><b>Plan</b> – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence.</p>
<p>b. Staffing, including security staffing</p>	<p>Nursing management constantly monitors staffing for safe staffing levels.</p>	<p>As treatment models, census and acuity changes, staffing levels will be adjusted appropriately. <b>Ongoing.</b></p> <p>WSH has a daily base staffing guide established for every ward, every shift that is determined by the Psychiatric Nurse Manager (PNE) and the Center Nurse Managers by the patient acuity level and ward needs. This guide is followed daily Per the attached white paper regarding Base Staffing, it states:</p> <ul style="list-style-type: none"> <li>• The PNE and Center Nurse Managers review patient care needs of the individual ward in deciding the amount of base staffing needed on a ward. The base staffing is reviewed periodically as needs of the wards change and base staffing numbers are adjusted accordingly.</li> <li>• The base staffing level is also discussed at the Safe Staffing Committee co-chaired by labor and management and affords both parties the opportunity to share views and ideas.</li> <li>• The PNE and Nurse Managers also consider the OSHA guidelines preventing Workplace Violence for Healthcare and Social Service workers when establishing baseline staffing.</li> </ul> <p>The process that is followed when there is not enough coverage is to exhaust over-time</p>

	<p>The WSH Security Department assessment of staffing concluded that increased security presence on campus is beneficial to maintaining a safer environment for staff and patients.</p>	<p>wheel, and on call staff. When they have been exhausted, an RN3 must cover the wards to ensure there is adequate staffing on the floor. (Note: WAC 246-840-710, 5 c, states . . . Nurses cannot willfully abandon clients by leaving a nursing assignment when continued nursing is required by the condition of the client(s), without transferring responsibilities to appropriate personnel or care giver).</p> <p>WSH identified a need to change the system for scheduling direct care staff in 2012, and in Sept. 2012 a committee went through the lean process to establish a new electronic system that would meet the needs of the hospital, and on March 18, this new system went live.</p> <p>In addition all staff are required to attend the below training before reporting to their duty station. This training provides them with what is needed to work safely in our environment. The following is a listing of training required:</p> <ul style="list-style-type: none"> <li>• New Employee Orientation (1 – 3 weeks depending upon job class)</li> <li>• <b><u>Annual on-line updates:</u></b></li> <li>• DSHS - IT Security 2013 Version Online Training</li> <li>• DSHS Workplace &amp; Domestic Violence</li> <li>• WSH - 2013 Annual AROI Update</li> <li>• WSH - 2013 Annual Compliance Update</li> <li>• WSH - 2013 Annual DSHS Public Disclosure Update</li> <li>• WSH - 2013 Annual HIPAA Update</li> <li>• WSH - 2013 Annual Infection Control Update</li> <li>• WSH - 2013 Annual Safety and Claims Update</li> <li>• WSH - 2013 Security Essentials in CFS (All Staff)</li> <li>• WSH - Civil Behavior in the Workplace, Code of Conduct, Culture of Safety</li> </ul> <p>Nursing staff are also required to participate in an annual competency fair to ensure they are competent in procedures potentially impacting staff safety. Such as: (observing patients at risk for suicide, self-harm, therapeutic observation for patients deemed to be aggressive and patients assigned to 1:1 due to aggressive or injurious behaviors, competency for use of padded shield, med sled, and proper method of applying restraints.</p> <p>Security staffing was analyzed by the Chief Operations Officer and the Director of Security as part of an overall effort to identify risk of violence and address security needs. This included a review of needed safety/security on the grounds, court security, security response to the civil wards, and safety/security within CFS. <b>Ongoing.</b></p> <p>As a result of this analysis the following areas were identified: Grounds/ Civil Wards Security.</p> <ul style="list-style-type: none"> <li>• Because of the size of the WSH grounds and the need to provide safety/security related to patients, staff and visitors staffing levels were established as follows, minimum three on day shift, three on afternoon shift, and two on night shift. Two Security guards will approach any situation where there is a concern about violence.</li> <li>• Security guards assigned to grounds will respond to civil wards on an emergency basis</li> </ul>
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		<p>as part of an emergency response requested by the switchboard.</p> <p>CFS Security</p> <ul style="list-style-type: none"> <li>• Security Guards respond to all codes greens on the wards.</li> <li>• Escort of patients to outside medical appointments, court dates, visitations are staffed with one Security Guard and one nursing staff.</li> <li>• On grounds court security requires two Security Guards for escort as well as two Security Guards providing security with in the court room.</li> <li>• In CFS there will be a minimum security staffing levels of 9 on day shift, 9 on evening shift and 4 on night shift. There is also a supervisor assigned to each of these shifts.</li> </ul> <p>As a result of the analysis of these needs it was determined that additional staffing was required to cover all the posts to reasonably provide security and mitigate the risk of violence. To accommodate these identified needs 2 additional positions were added to the Security Department as of June 2012. In addition a complete review of all Security Department Standard Operating Procedures is currently underway.</p>
<b>Elements of the plan per law.</b> (Items a through h are part of the security & safety assessment)	<b>Assessment</b> – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence.	<b>Plan</b> – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence.
c. Personnel policies	<p>All safety-related policies have been reviewed and updated Sunset review dates will be monitored for completion by the WSH Policy Committee.</p> <p>Two policies have been either revised or created to promote Civil Behavior in the Workplace, a Code of Conduct and a culture of safety for the hospital.</p>	<p>Updated and new policies are made available to staff hospital-wide via Intranet with hard copy distribution and/or Staff Development Department training. The policies are presented in New Employee Orientation, during duty-site training or as stand-alone training. <b>Ongoing</b></p> <p>On 3/21/2013, WSH revised our Code of Conduct Policy (1.7.12) to promote compliance with the WSH Code of Conduct. (Attached). In addition, a new Culture of Safety Policy (3.4.13) was distributed to promote a hospital-wide culture which ensures the safety of all patients, and to reinforce the standards of staff’s conduct set for the in Admin policy 18.64, and eliminate staff behavior which interfere with psychiatric care and undermine patient safety. (Attached). On 4/1/2013 an on-line training for these policies went live, (Civil Behavior in the Workplace, Code of Conduct, Culture of Safety) and all staff are required to complete this training by 4/30/2013. <b>Complete 4/30/2013.</b></p>

<p><b>Elements of the plan per law.</b> (Items a through h below are part of the security &amp; safety assessment)</p>	<p><b>Assessment</b> – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence</p>	<p><b>Plan</b> – Security considerations and action already taken or planned – based on the hazards identified in the assessment –to prevent and protect employees from violence.</p>
<p>d. First aid and emergency procedures</p>	<p>WSH has Teams of clinical staff that will respond to Medical Emergencies to any person throughout the hospital.</p> <p>WSH actively plans/ prepares and participates with the Community for disasters.</p>	<p>WSH’s Code Blue (Medical Emergency of person presenting with respiratory distress) is requested when a person is found in cardiopulmonary or respiratory arrest.</p> <p>WSH’s Medial Rapid Response team will be initiated for all medical emergencies, Life threatening, accident, injury or illness to any person. <b>Ongoing.</b></p> <p>WSH participates with Department of Social and Health Services, the King &amp; Pierce County Health Care Coalition, Pierce County Department of Emergency Management, Tacoma Pierce County Department of Health, and the City of Lakewood Emergency management Community Work group to plan/prepare for emergencies as well and participate in community-wide drills. Currently, WSH is in the process of developing our Continuity of Operations Plan (COOP), and a plan with the Department of Health to run a Closed Point of Dispensing service for our patients, employees and their families during a health disaster, (i.e. pandemic, anthrax outbreak, etc.). <b>Ongoing.</b></p> <p>A 1-800 number and DSHS Wide Website are available for staff to use during emergencies to find out information about the hospital. <b>Complete.</b></p>
<p><b>Elements of the plan per law.</b> (Items a through h below are part of the security &amp; safety assessment)</p>	<p><b>Assessment</b> – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence</p>	<p><b>Plan</b> – Security considerations and action already taken or planned – based on the hazards identified in the assessment –to prevent and protect employees from violence.</p>
<p>e. Reporting violent acts, taking appropriate action in response to violent acts, and follow-up procedures after violent acts:</p>	<p>WSH has 5 different avenues for staff to report violent acts. (Administrative Report of Incident, Security Incident Report, 3-133 Employee injury report, Lakewood Police report, and the 1-888 Support our Safety Line.</p>	<p>WSH has an Administrative Report of Incident (AROI) form which is to be filled out for any unusual occurrence. Below is a section of the Hospital’s AROI policy:</p> <ul style="list-style-type: none"> <li>• All <b>serious and emergent incidents</b> . . . will be immediately reported (within 1 hour of becoming aware of the incident) to the nearest supervisor on duty. An Administrative Report of Incident (form DSHS20-192 will be initiated and hand delivered to the supervisor on duty no later than the end of the current shift.</li> </ul> <p>In addition, Security Incident Reports (SIR’s) are used to report incidences of violence as well as the DSHS - Report of Employee, Volunteer . . . Personal Incident Report (3-133), when an employee injury is involved.</p>

	<p>The Incident Management Office (IMO), Lakewood Police Department, Various Safety Committees and Safety Manager, ensures appropriate actions and follow up procedures are taken in response to violent acts</p> <p>A Critical Incident Stress Management Program is established at WSH to prevent or minimize stress reactions in staff exposed to a critical incident in the course of their duties at WSH.</p> <p>WSH provides debriefings for serious clinical incidents to help reduce serious clinical incidents, prevent violence, and promote a safe and healing environment.</p>	<p>Staff can also request police involvement for any patient to staff violent acts that are criminal in nature by completing a police report.</p> <p>Anyone can leave any type of safety issue anonymously on WSH Support our Safety Hot line as well. <b>Ongoing.</b></p> <p>The Incident Management Office is tasked with reviewing the AROI's and SIR's on a daily basis and is comprised of Investigators and Clinical Risk Review Specialists. A daily triage team is made up of at least one investigator a Clinical Risk Reviewer, IMO Manager, Security representative, Safety representative, Consumer Affairs Director and Chief of Medical Services. The team determines which incidents meet serious/emergent criteria for further review by someone outside of the Centers where the incident occurred. Decisions are also made to refer incidents to other agencies for investigation when needed.</p> <p>WSH has 5 Safety Sub-Committees that are made up of both Management and Labor employees and meet on a monthly basis. The Management &amp; Labor Co-Chairs from each Safety Sub-Committees Reports up to 1 Central Safety Committee. The Safety Sub-Committees are tasked with reviewing all 3—133 and other safety items and follow up on any unresolved issues. Issues that cannot be resolved at the Sub-Committee level are then brought to the Central Committee for Resolution. The WSH Safety Office also reviews all of the 3-133's and makes recommendations to the hospital for corrections needed.</p> <p>Lakewood Police Department will investigate and determine when cases area forwarded to the Prosecutors office for a charging decision. The IMO is responsible for monitoring all Lakewood police reports filed by staff for status of each case. Lakewood will inform WSH IMO of status of open cases on a weekly basis. If the cases are declined by LPD, IMO, HR, and hospital management will review to determine if further action is needed.</p> <p>The Safety Manager is responsible for monitoring the SOS Hot line Monday through Friday 8:00 am to 4:30 pm. All issues reported on this hotline, must be followed up on by Executive Management. <b>Ongoing.</b></p> <p>WSH has a team of individuals who are trained in crisis intervention to provide a one-time Stress Debriefing meeting designed to assist staff exposed to critical incidents. Stress Debriefing helps people to work quicker through acute stress reactions and return to normal functioning. Staff training in debriefing will sit down with the staff affected by the critical incident and as a group to process their reactions. Stress Debriefings are not public information. The entire process is confidential, Not mandatory. Participation is voluntary. Not a critique of job performance or part of an investigation. It is not open to outsiders. Only CISM team members.</p> <p>A Serious Clinical Incident is defined as including all episodes of seclusion and restraint, serious injuries which require medical attention, serious physical and serious property destruction. The debriefing process for Serious Clinical Incidents is a collaborative process in which staff and patients gather in a safe space to: assess immediate staff/patient needs;</p>
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<p>Analysis of data on violence and workers compensation claims during at least the preceding year</p>	<p>WSH Safety provides monthly data regarding staff injuries and L&amp;I claims information.</p>	<p>identify the facts; review how people responded as the serious incident unfolded. The intended outcome is to recommend specific, individualized treatment approaches, staff interventions and system changes that could reduce the likelihood of future serious incidents and promote safety. <b>Ongoing.</b></p> <p>WSH Governing Body Sub-Committee (quarterly) and Safety Committees (monthly) continue to review injury data and L&amp;I claims information on at least a quarterly basis to identify where the injuries are occurring and what can be done to reduce them. <b>Ongoing.</b></p> <p>All information required by law is collected and will be retained no fewer than five years to utilize in analysis of assault and injury due to assault. <b>Ongoing</b></p>
<p><b>Elements of the plan per law.</b> (Items a through h below are part of the security &amp; safety assessment)</p>	<p><b>Assessment</b> – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence</p>	<p><b>Plan</b> – Security considerations and action already taken or planned – based on the hazards identified in the assessment –to prevent and protect employees from violence.</p>
<p>f. Development of criteria for determining and reporting verbal threats.</p>	<p>Criteria has been identified within the Administrative Incident Reporting policy for reporting verbal threats.</p>	<p>Verbal threats are tracked using the Security Incident report and/or the Administrative Report of Incident. In 2003, the WSH Performance Measurement and Information Office added “threats” to its incident coding defined as follows:</p> <p>An alleged incident reported of any communication or interaction between (persons) that is patently dehumanizing or that places a (person) under excessive duress, including name calling, use of derogatory or uninvited nicknames, racial slurs, demeaning remarks, inappropriate shouting, imitating or mocking (the person’s) behavior, or threatening physical abuse (communicated orally, in writing, or with body language, with intent to do harm, coming from a (person) who is able to carry out the threat, resulting in the other (person) being afraid). This definition was an amalgamation from various sources. Counts are kept for patient-to-patient threats, patient-to-staff threats, staff-to-patient threats, and staff-to-staff threats, among others. <b>Ongoing</b></p>
<p><b>Elements of the plan per law.</b> (Items a through h below are part of the security &amp; safety assessment)</p>	<p><b>Assessment</b> – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence</p>	<p><b>Plan</b> – Security considerations and action already taken or planned – based on the hazards identified in the assessment –to prevent and protect employees from violence.</p>
<p>g. Employee education and training</p>	<p>Curriculum has been developed for identifying and reporting violence in the workplace, as well as supporting an environment of safety.</p> <p>TEAM Partnership for Violence Prevention is mandatory training for all new employees prior to reporting for assignment. All employees’ records are reviewed for compliance.</p>	<p>The Security Director provides training to all new employees in identifying and reporting violence in the workplace. <b>Ongoing</b></p> <p>TEAM (Training in Effective Aggression Management) is a mandatory requirement for all WSH new employees. TEAM training will be completed before reporting for duty at job assignment. TEAM training places emphasis on the creation of a safer, non-violent environment. <b>Ongoing.</b></p>

	<p>Ward-based job classifications are required to receive annual update training in TEAM.</p> <p>All new employees are required to complete Safety, Accident Reporting, Workplace Civility, Culture of Safety trainings.</p> <p>All existing employees are required to complete annual Safety, Accident Reporting, Workplace Civility, and Culture of Safety training.</p> <p>Supervisory staff receives training in safety and accident investigation and reporting</p>	<p>The SAFE TEAM director has provided an enhanced training schedule to ensure all current employees assigned to ward based patient care receive annual refresher in TEAM during the monthly nursing competency fair. Further monthly TEAM trainings are available on the key elements of; Therapeutic Relationships, Safety Movements and Mechanics, Understanding Behaviors, De-escalation. <b>Ongoing</b> .</p> <p>New employee orientation provides new employees receive live instructor led training in Safety, Industrial Hygiene, Accident Reporting, Infection Control and Blood-borne Pathogens, Security Awareness, Workplace Civility, and Culture of Safety by content experts in these areas. <b>Ongoing</b>.</p> <p>All existing employees receive annual mandatory training in Safety, Accident Reporting, Infection Control and Blood borne Pathogens, Security Awareness, Workplace Civility, and Culture of Safety. These trainings are available by attending live classes or online with testing to ensure comprehension. <b>Ongoing</b>.</p> <p>3-133 Employee Incident Investigations for Supervisors is a live instructor led training where safety personnel instruct and coach managers and supervisors how to examine and correctly handle employee reports of safety concerns, injuries or unwanted events. Completion is recorded in the employee training record. <b>Ongoing</b>.</p>
<p><b>Elements of the plan per law.</b> (Items a through h below are part of the security &amp; safety assessment)</p>	<p><b>Assessment</b> – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence</p>	<p><b>Plan</b> – Security considerations and action already taken or planned – based on the hazards identified in the assessment –to prevent and protect employees from violence.</p>
<p>h. Clinical and patient policies and procedures including those related to:</p> <ol style="list-style-type: none"> <li>1. Smoking</li> <li>2. Activity, leisure and therapeutic programs</li> <li>3. Communication between shifts</li> <li>4. Restraint and seclusion</li> </ol>	<p>WSH has improved communication regarding our smoking policy. WSH has also added covered sheds and visual markings around the hospital to assist patients and staff with complying with the WSH Smoking Policy .</p> <p>WSH continues to improved active treatment and leisure programs to provide patients more meaningful and recovery-oriented activities.</p>	<p>WSH Smoking Policy allows smoking in certain outdoor areas. (Areas in compliance with Washington state law prohibiting smoking within 25 feet of specified areas). To help patients and staff comply with the smoking regulations, WSH has provided outdoor storage areas for the patient cigarettes, matches, etc., covered smoking shed outside of the 25 foot rule, and periodic reminders sent to staff regarding our smoking policy. <b>Complete</b>.</p> <p>An additional item that WSH will be doing in the spring/summer (when the weather gets better), is to put a green stripe 25 feet away from the buildings so that everyone knows when they are outside the 25 foot rule. <b>Anticipated Completion date for this item only is June 30, 2013</b></p> <p>WSH provides active treatment to patients through our Treatment Malls. PTRC has 3 Treatment Malls that patients go to for active treatment Monday through Friday. Patients are encouraged to participate and provide feedback on their treatment planning. CFS continues with a Therapies and Recovery Center program of ongoing evaluation of patient treatment needs and updating of patient active treatment groups and activities. In addition, WSH provides approved patients opportunities to go to the Infinity and Art Centers as well as a gardening program for leisure activities. In 2012, the Rehabilitation Staff created some</p>

	<p>• Improved communications between shifts may lead to fewer violent incidents.</p> <p>WSH Policy 2.4.1 Restraint/ Seclusion was revised on 2/6/13. WSH continues to place a major focus to reduce the use of seclusion and restraint.</p> <p>WSH has developed 2012 through 2015 Strategic Initiatives for the hospital to assist with workplace safety and overall performance.</p>	<p>additional leisure activities for patients to participate in as well. All patients were able to participate in a carnival during the summer, as well as a couple of dances for patients during holiday times. <b>Ongoing</b></p> <p>In late 2012 early 2013, WSH Executive Leadership Team went around to all wards all shifts to elicit needs regarding safety. One of the repeated safety concerns that came up was the fact that there is not a good written ward orientation/safety information that was provided to staff coming on the ward to work. As a result a Ward Orientation sheet was developed called <b><i>“10 Essential Safety Practices you Need to know while on Ward_____”</i></b>. Every day a new Ward Orientation sheet will be developed by each ward’s treatment team with all shifts and disciplines giving input so that anyone coming onto the ward know what to understand about the ward and it’s patients. Examples of some of the items that can be put on this sheet are . . .</p> <ol style="list-style-type: none"> <li>1. Several E10 patients try to steal staff pens and use as weapons. If you bring your pen into patient care areas, keep it hidden.</li> <li>2. If you’re in the E10 Kitchen, keep the door closed at all times.</li> <li>3. Patient Sally Smith has been really agitated and not sleeping much these past few weeks. If you must wake Sally, open her bedroom door and stand back, softly asking her to get up.</li> <li>4. On Swings, when handing out evening snacks, ask for patients to sit in the dining room rather than line up at the kitchen window. This greatly reduces fights between patients.</li> <li>5. Always call patient John Doe by the name her prefers: “Peter.” ETC. <b>(SEE attached for more detailed information).</b></li> </ol> <p>The policy has been revised help reduce/eliminate the use of restraint and seclusion. <b>Complete.</b> Hospital management continues to promote a culture change which will encourage a more effective approach to patient care. This approach promotes hope and recovery and earlier intervention in behavior management and de-escalation techniques. It is anticipated this will result in a decrease in violent behaviors, and reduce restraint/seclusion usage. <b>Ongoing</b></p> <p>WSH’s strategic Initiatives are . . . . To promote recovery and well-being in partnership with the people we serve, we are responsible for:</p> <ol style="list-style-type: none"> <li>1. Service: Providing quality, patient-centered services that meet or exceed accreditation standards</li> <li>2. Safety: Ensuring a safe environment for all</li> <li>3. Staff: Supporting and developing our staff to be successful</li> <li>4. Stewardship: Improving processes to efficiently operate within our budget</li> </ol> <p><b>Ongoing</b> <b>(See attached for more detailed information).</b></p>
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