

# **Report to the Legislature**

## **Workplace Safety in State Hospitals**

RCW 72.23.451  
September 1, 2015

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## Background

The Behavioral Health and Service Integration Administration (BHSIA) within the Department of Social and Health Services (DSHS) provides prevention, intervention, inpatient treatment, outpatient treatment and recovery support to people with addiction and mental health needs.

BHSIA operates three state psychiatric hospitals. Eastern State Hospital and Western State Hospital deliver high quality inpatient psychiatric care to adults who have been committed through the civil or criminal court system for treatment and/or competency restoration services. The Child Study and Treatment Center provides high quality inpatient psychiatric care and education to children ages 5 to 17 that cannot be served in less restrictive settings in the community due to their complex needs. As of July 1, 2015, the hospital locations and bed capacities are:

Child Study and Treatment Center (CSTC): located on the grounds of Western State Hospital in Lakewood, Washington, has a capacity of 47 beds

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

Western State Hospital (WSH): located in Lakewood, Washington, has a capacity of 837 beds; 557 for civil commitments and 280 for forensics patients.

Creating a safe working environment in the state hospitals is a top priority for DSHS, BHSIA and leadership of all three state hospitals. The state hospitals are committed to engaging in collaborative partnerships with stakeholders including the Department of Labor and Industries (L&I), local labor unions and our staff in efforts to prevent and reduce workplace violence and protect employees.

The following statutes bear on workplace safety at the state hospitals:

**Chapter RCW 72.23.400 -Workplace Safety Plan** requires each state hospital to develop a plan to reasonably prevent and protect their employees from violence and directs the Department of Social and Health Services (DSHS) to evaluate, review and amend the plans as necessary, at least annually, and to include specified security considerations.

**Chapter RCW 72.23.451 – Annual report to the Legislature** requires that by September 1<sup>st</sup> each year, the department shall report to the House Committee on Commerce and Labor and the Senate Committee on Commerce and Trade, or successor committees, on the department's efforts to reduce violence in state hospitals.

## Annual Report Overview

Initial workplace safety plans from the three state hospitals were submitted to the legislature in November 2000 and have been evaluated, revised and updated annually. This report updates the state hospitals efforts to reduce violence for the time period of July 2014 through June 2015 and

updates the workplace safety success measures tracked in the BHSIA Strategic Plan. Security considerations specified under RCW 72.23.400 are found in Appendix A (WSH), Appendix B (ESH), and Appendix C (CSTC).

### BHSIA 2013-2015 Strategic Plan and Success Measures

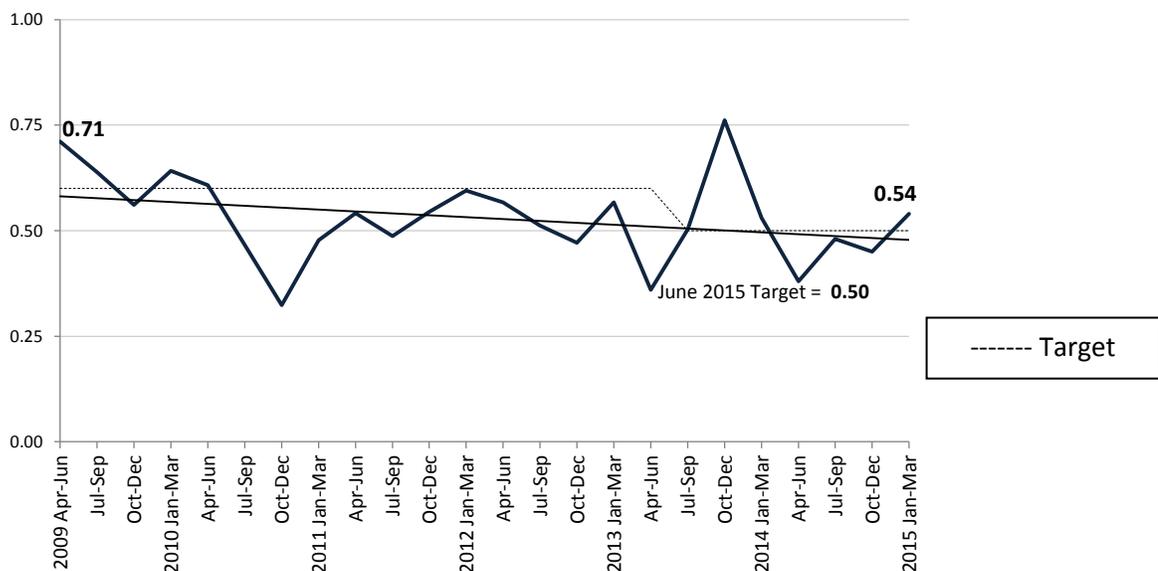
The BHSIA 2013-2015 Strategic Plan includes strategic objectives and success metrics designed to improve safety at the state hospitals and to reduce and prevent workplace violence. The following success measures are tracked by the Behavioral Health and Service Integration Administration (BHSIA) and reported to the Secretary of DSHS in support of the DSHS Goals of Health, Safety, Protection, Quality of Life and Public Trust:

#### Strategic Objective 1.7: Decrease the number of patient-to-staff assault claims filed at Eastern State Hospital, Western State Hospital, and the Child Study and Treatment Center

Reducing patient-to-staff assaults will increase staff safety and well-being, as well as reduce expenditures for workplace related injury claims. The success measure for this objective is to decrease the number of patient-to-staff assault claims filed at the three hospitals from the third quarter FY 2013 rate of 0.57 assaults per 1,000 patient days to 0.50 assaults per 1,000 patient days by June 30, 2015.

The following chart shows the rate of patient-to-staff assault claims filed at the three hospitals.

**Patient-to-staff assault claims filed at Eastern State Hospital, Western State Hospital, and the Child Study and Treatment Center per 1,000 patient days**



\* January 2015 performance level is based upon performance in the October - December 2014 quarter  
 \*\* Change in target starting January 2013

The hospitals continue their trend of decreasing the number of patient-to-staff assault claims filed from the third quarter FY 2013 rate of 0.57 assaults per 1,000 patient days to the second quarter FY 2015 rate of 0.54 assaults per 1,000 patient days.

**Strategic Objective 1.8: Decrease the quarterly rates of patient seclusion hours at Eastern State Hospital and Western State Hospital; and**

**Strategic Objective 1.9: Maintain the quarterly rates of restraint use at Eastern State Hospital and decrease the quarterly rates of restraint use at Western State Hospital**

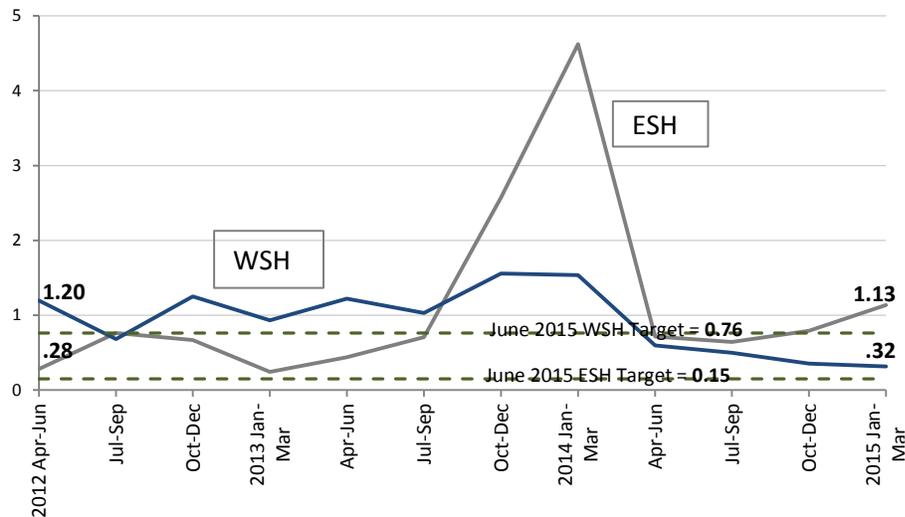
Reduced use of patient seclusion and restraint lessens the need for physical interaction between the staff and patients thereby reducing the likelihood of injury.

The success measures for **Strategic Objective 1.8** are to decrease the quarterly rates of seclusion hours at Eastern State Hospital from the fourth quarter FY 2013 rate of 0.24 per 1,000 patient hours to 0.15 by June 30, 2015, and to decrease the rates of seclusion at Western State Hospital from the fourth quarter FY 2013 rate of 1.05 hours per 1,000 inpatient hours to 0.76 by June 30, 2015.

The success measures for **Strategic Objective 1.9** are to maintain the quarterly rates of restraint hours at Eastern State Hospital at 0.17 per 1,000 patient hours and to decrease the quarterly rates of restraint hours at Western State Hospital from the fourth quarter FY 2012 average of 3.02 per 1,000 inpatient hours to 2.18 by June 30, 2015.

The following chart shows rates of patient seclusion at the two adult hospitals.

**Seclusion hours per 1,000 patient hours at Eastern State Hospital and Western State Hospital**

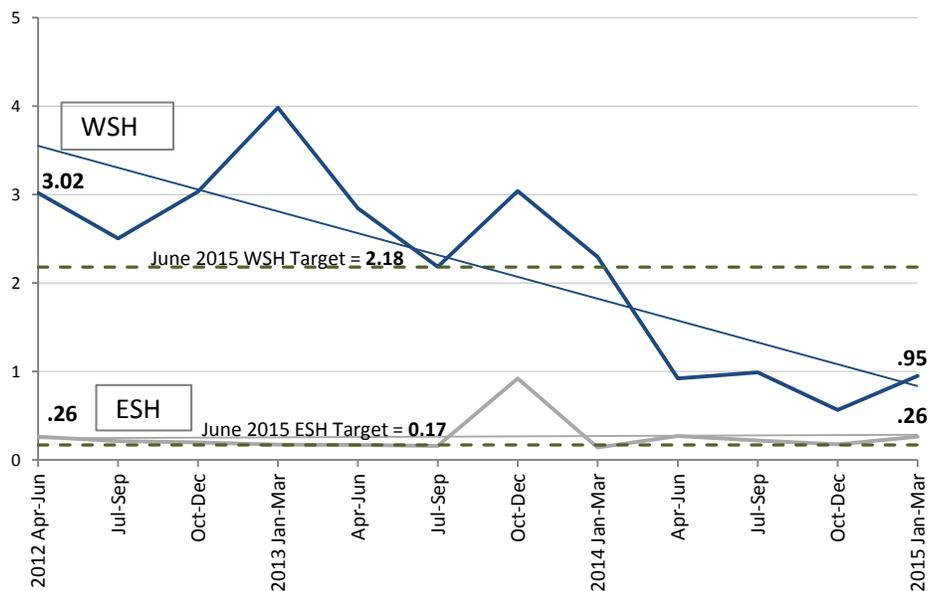


\*January 2015 performance level is based upon performance in the October - December 2014 quarter.

was primarily attributable to a single patient subsequently discharged in March 2014. In the most recent quarter, there has been a slight increase in seclusion rates. This is a reflection of the increasing acuity of several newly admitted patients who have been admitted directly to ESH escorted by law enforcement, with the patient in restraint. This has necessitated the use of seclusion at admission. De-escalation techniques to address patients' increased levels of aggression and agitation have not been successful. Accordingly, ESH staff have been using multidisciplinary team meetings to discuss alternative treatment approaches for challenging individuals. Further data will show that the use of seclusion does not carry over for the same patients from month to month, indicating successful implementation of strategies by treatment teams.

The following chart shows rates of patient restraint at the two adult hospitals.

**Restraint hours per 1,000 patient hours at Eastern State Hospital and Western State Hospital**



\*\*January 2015 performance level is based upon performance in the October - December 2014 quarter

Eastern State Hospital continues to maintain the target for the timeframe noted and Western State Hospital has met its target; rates dropped considerably in January 2014 - March 2014 and the trend continues through 2014.

**Strategic Objective 1.10: Decrease the quarterly rates of seclusion hours and restraint hours at the Child Study and Treatment Center**

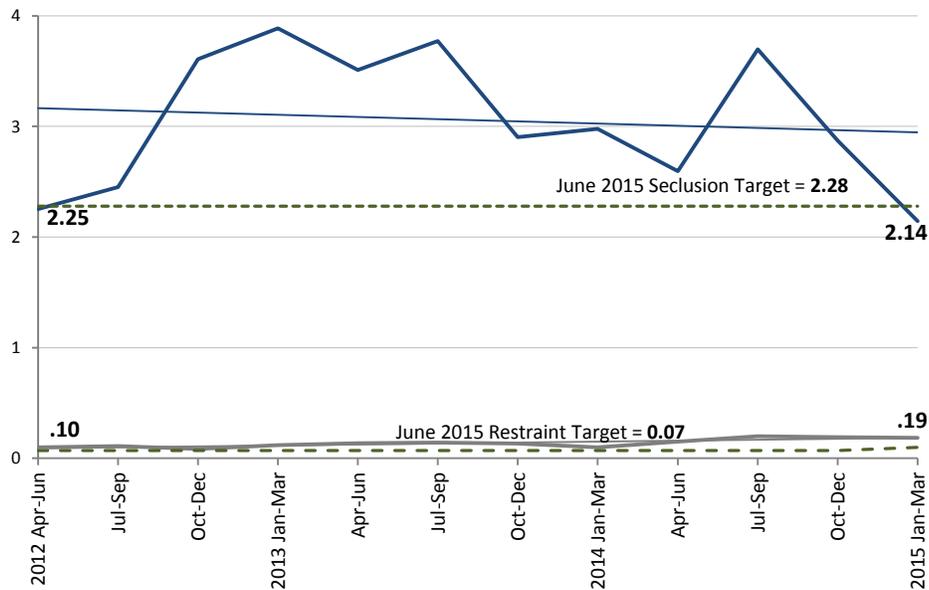
As with the adult hospitals, reduced rates of patient seclusion and restraint lessens the need for physical interaction between staff and patients thereby reducing the likelihood of injury.

The success measure for Strategic Objective 1.10 is to decrease the quarterly rate of seclusion hours from the fourth quarter FY 2013 rate of 3.69 per 1,000 patient hours to 2.28 per 1,000 patient hours by June 30, 2015; and maintain the quarterly rate of restraint hours at the third

quarter FY 2013 rate of 0.07 per 1,000 patient hours.

The following chart shows rates of patient seclusion and restraint at the Child Study and Treatment Center.

**Seclusion and restraint hours per 1,000 patient hours at the Child Study and Treatment Center**



\*\*January 2015 performance level is based upon performance in the October - December 2014 quarter

The rate of seclusion and restraint hours at CSTC continues to drop, with a sharp decrease beginning in the first quarter of 2015 due to several improvements elaborated upon below. CSTC is currently below the June 2015 target.

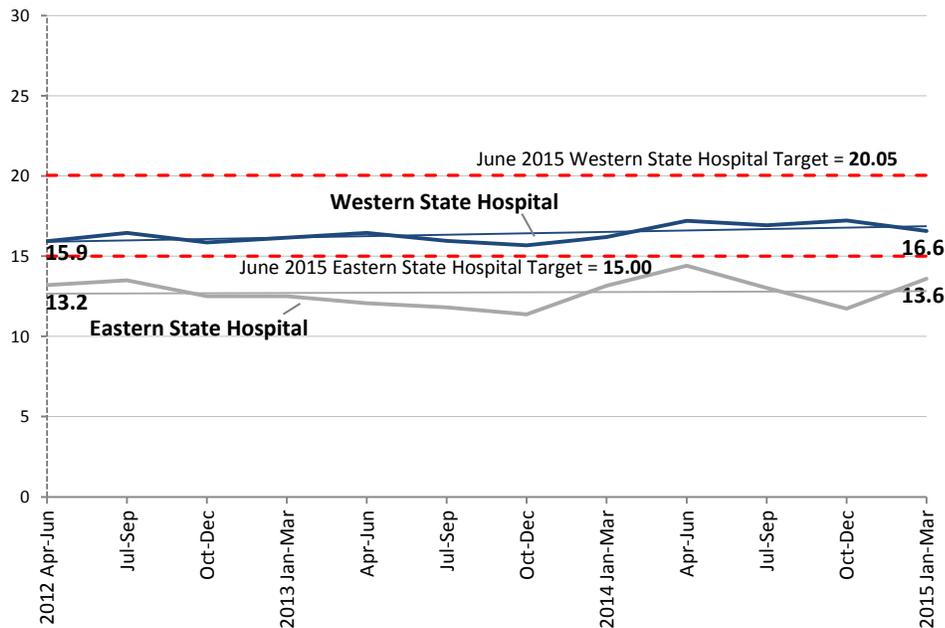
**Strategic Objective 1.11: Increase the rates of active treatment hours delivered at Eastern State Hospital and Western State Hospital**

Active treatment includes cognitive behavioral therapy, daily living skills, recreational activities and other programs and interactions which assist patients in achieving recovery. Active treatment contributes to a safe work environment and the reduction and prevention of workplace violence at the state hospitals.

The success measure for Strategic Objective 1.11 is to increase the average number of active treatment hours received per patient per week at Eastern State Hospital from the fourth quarter FY 2013 average of 12.01 to 15.00 hours by June 30, 2015; and increase the number of active treatment hours received per patient per week at Western State Hospital from the fourth quarter FY 2013 average of 15.85 hours to 20.05 by June 30, 2015.

The following chart shows rates of Active Treatment at the two adult hospitals.

## Average active treatment hours per patient per 7 days at Eastern State Hospital and Western State Hospital



The rate of active treatment hours at Eastern State Hospital steadily increased in 2014 and nearly reached the June 2015 target in the April 2014 - June 2014, quarter. The rate of active treatment hours at Western State Hospital gradually increased in 2014.

### Violence Reduction Efforts - Update

Over the last year, in collaboration with key stakeholders, significant efforts have been undertaken by the three state hospitals to reduce violence, including, but not limited to:

- Alignment of the comprehensive *Safety Management Plan/Accident Prevention programs encompassing Workplace Violence Prevention* programs across the three state hospitals. (ESH, WSH, and CSTC)
- Identification of existing “best practices” currently engaged by the three state hospitals to develop consistent training curriculums.
- Completion of *A Culture of Safety* survey by staff at the three hospitals in April 2015. Results were presented to executive leadership and are being utilized to develop a plan for improvement to increase overall patient and staff safety.
- Staff, management and union partners continue work together to develop recommendations to decrease violence at the hospitals based on independent safety evaluations completed.
- In 2013/2014, BHSIA established an Ad Hoc Safety Committee, made up of staff, management and union partners from each hospital, that created a list of

recommendations to decrease violence at the hospitals based on independent evaluations of safety done since 2000. The committee's recommendations were used to guide 2014 legislative decision packages and funded in the 2015-2017 budget to include:

- The creation of a Psychiatric Intensive Care Unit (PICU), a highly structured unit designed to stabilize patients who demonstrate the most violent behaviors. This unit will be located at ESH but also available to patients at WSH. The unit at ESH is currently being remodeled, program protocols are under development, and the unit is expected to open in early 2016.
- Expansion of the Psychiatric Emergency Response Team(s) (PERT), teams that use therapeutic interventions to de-escalate crisis situations involving violent or potentially violent situations. These teams will be deployed at both ESH and WSH. Currently there is a PERT function at the WSH Center for Forensic Services.
- Backfill FTEs for direct-care staff to attend an additional eight hours of annual safety training focusing on de-escalation techniques and best practices for interacting with patients.
- A safety training curriculum for staff based on a previous L&I settlement agreement (Citation No. 316455559) was approved, developed and deployed through the guidance of the Ad Hoc Safety Sub-Committee.

### **Western State Hospital – Key Efforts**

Communications System improvements at WSH include:

- Expansion of the Pendant Alarm System to cover additional buildings and outside courtyards.
- Installation of emergency broadcast speakers to every WSH building on campus to include exterior speakers for the future Central Campus quadrangle so that emergency information can be disseminated quickly throughout campus.
- Establishment of a Pendant Alarm System Failure reporting requirement, and communicating the requirement to all staff.

Initiatives in place at WSH:

- Purchase, receipt and distribution of additional behavioral health safe furniture at a cost of \$460,000.
- Funding is in place for the expansion of the Viacom Camera System in CFS, and completion of the expansion is anticipated by September 30, 2015.
- Funding is in place for the installation of secure outdoor fencing in the campus “Quadrangle area”. Completion is anticipated by October 31, 2015.

- Additional “Key Watcher” boxes will be installed in Building 29 and some buildings in Central Campus. Once installed, staff reporting to work in those areas will use this key control system, making the environment more secure.

### **Eastern State Hospital – Key Efforts**

- Establishment and implementation of a Competency Mall/Skills lab to provide enhanced staff training. Mock code training is offered as part of the skills competency fair as well as EKG and initial physical health assessment training.
- Implementation of TEAM Training incorporating physical interventions in addition to verbal de-escalation techniques. “TEAM” training is an evidence-based training that provides staff with tools to keep themselves and patients safe while maintaining staff commitment to positive approaches in serving patients whose behavior(s) may pose a danger to themselves or others.
- Additional training resources were purchased based on the Ad Hoc Safety Committee recommendations, including additional CPR mannequins to facilitate AHA CPR certification and a Mental Health Nursing video series which provides common scenarios for successful patient/staff interactions.
- Completion of “Phase 3 Patient Safety Hardware” improvements, based on an environmental proactive risk assessment and prioritized by risk of use for patient self-harm or use as weapons.
- New digital two-way radios and repeaters were purchased and deployed, replacing antiquated communication equipment and ensuring continuity with local emergency response agencies. This best practice approach improves signal quality, coverage, staff safety and security of patient healthcare information. The radios are equipped with an emergency alarm button that, once activated, alerts all radio carriers on that radio channel and switchboard of a staff emergency. Once the alarm is activated it initiates a 30 second “open mic” for staff to report their emergency type/location. The alarm reports the alarms radio number and can be associated with the staff member assigned to the radio.

### **Child Study Treatment Center – Key Efforts**

- CSTC expanded its supply of battery operated radios that direct care staff carry with them at all times. In 2015, CSTC provided radios to Clover Park School staff working alongside CSTC staff providing educational services to hospitalized youth. Additionally, WSH security radios have been installed in all cottages and both schools to increase campus-wide security response time.
- CSTC received legislative and budget support for renovations of Orcas Cottage, which houses the oldest youth and where most patient-to-staff injuries and/or assaults occur.

This capital improvement will enhance safety for staff by the strategic expansion of milieu space to treat highly aggressive youth. Work is scheduled to begin in April 2016. In 2015, safety improvements on Orcas Cottage focused on door replacement – from double doors to wider single doors to reduce the risk of blind spots.

- CSTC hired a Safety Manager, utilizing existing funds to replace a FTE Safety position lost in budget cuts four years ago.
- Additional refresher courses in Crisis Prevention Institute (CPI) training. CPI is CSTC's verbal and physical intervention model for prevention of patient violence/assault/harm to self or others were implemented in 2014-15 as part of the safety curriculum. In addition, targeted trainings have been conducted with cottage teams to enhance individual competency as well as team communication related to crisis intervention. Two additional staff members were certified in 2015 as CPI instructors at CSTC with plans to increase our training capacity further before the end of the fiscal year.
- Acknowledging that hands-on intervention increases the likelihood of staff injury, CSTC has reduced the use of Seclusion and Restraint through the increased use of evidence based practices such as Motivational Interviewing (MI) and Collaborative Problem Solving. Two Ph.D. Program Directors have been certified as MI trainers and have implemented a 16-hour course for direct care staff. Psychiatric Child Care Counselors are taught the basics of MI one month; are coached in its use and return a month later for a second 8-hour class to continue with training and coaching. The principles of MI are being integrated on all units, and work well with other evidence-based practices in use, such as Dialectical Behavior Therapy, and Cognitive Behavioral Therapy.

### **Summary**

Reducing workplace violence and staff injuries at the three state hospitals continues to be challenging due to the nature of the state hospital workplace environment, the complexities involved in preventing violence, funding limitations and competing resource needs.

Looking forward, the legislature provided funding to backfill ward based staff so that all direct care staff can participate in a minimum of eight hours of peer led safety training. While this is only half of the funding needed to fully implement the Ad Hoc Safety Committee's recommended training, it represents a significant investment in the safety of staff and patients. In addition the legislature has also provided funding for three FTEs in the DSHS Enterprise Risk Management Office. These staff will be dedicated to conducting root cause analysis on every assault that results in a staff member leaving the hospital for medical care. Information derived from the Root Cause Analysis will be used to develop training and preemptive strategies to improve staff safety. The two adult state hospitals are also committed to implementing Psychiatric Emergency Response Teams and a Psychiatric Intensive Care Unit to address the needs of patients who pose the greatest risk of violence and staff injury.

BHSIA and the state hospitals will continue to be actively engaged in developing and sustaining efforts to reduce workplace violence. BHSIA is committed to continuously improving

workplace safety and achieving targeted safety outcomes in collaboration with stakeholders including local labor unions and the Department of Labor & Industries.

# Workplace Safety Plan (WSH) - Appendix A

## Western State Hospital

### ANNUAL UPDATE

#### July 2014 through June 30, 2015

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: <ul style="list-style-type: none"> <li>• Access, egress controls, and door locks were found to be generally in good order.</li> <li>• Lighting is adequate on all wards, offices, and shop areas. Outdoor lighting is adequate.</li> </ul> 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.	WSH continued with staff/patient safety projects in 2014 to include the following: <ul style="list-style-type: none"> <li>• Anti-ligature improvements:               <ul style="list-style-type: none"> <li>○ Removal of door closures in patient bedrooms (100% complete)</li> <li>○ Installation of piano hinges on doors (1,200 doors /100% complete)</li> <li>○ Plumbing fixtures replaced with anti-ligature type to include faucets, bathtubs, showers, and valves in all patient care areas as well as shrouding of exposed pipes and plumbing (70% Complete)</li> <li>○ Design phase of the anti-ligature bathroom partitions.</li> <li>○ Anti-ligature laundry bags purchased and distributed throughout the facility.</li> </ul> </li> <li>• Continued installation of security mirrors in high risk areas that were identified to help reduce blind spots throughout the hospital.</li> <li>• Key rings with locking key hubs were changed over for approximately 25% of all key rings throughout the hospital so that keys cannot be taken off of the ring and lost. The hospital will continue to work on this issue over the next year.</li> <li>• In 2014, WSH continued to purchase and deploy Safe furniture. The following items were purchased in the amount of \$470,000 and deployed throughout the hospital:               <ul style="list-style-type: none"> <li>○ 270 Norix Sleigh beds</li> <li>○ 202 Norix night stands</li> <li>○ 270 Sand filled Forte guest chairs to be used in patient rooms and treatment malls.</li> <li>○ 250 sand filled lounge chairs.</li> </ul> </li> </ul>

		<ul style="list-style-type: none"> <li>• In addition, WSH added the following features throughout campus to increase the safety/security for all: <ul style="list-style-type: none"> <li>○ Upgrade and expansion of the Key Watcher system</li> <li>○ Expansion of the Fire Power personal alarm system to buildings 6, 8, and 27 and the outside courtyards of buildings 9, 20, 21 and 29.</li> <li>○ Installation of emergency broadcast speakers to every WSH building on campus to include exterior speakers for future Central Campus quadrangle location so that emergency information can be disseminated quickly throughout campus</li> <li>○ Replacement of ward Public Address amplifiers</li> <li>○ A safety and security assessment was done for WSH's Communication Center. This assessment led to upgrading the locking mechanism to the front door so the door could be locked after hours and the installation of cameras and a monitoring station so staff would be able to view the front entrance of the building. In addition, an automatic metal rolling door was installed at the front window for protection</li> <li>○ Upgraded cigarette receptacles to be self-closing.</li> <li>○ Design and bid phase completed for the replacement of the fire alarm system in building 29</li> <li>○ Safety equipment and adjustable ergonomic furniture was purchased and received</li> <li>○ Emergency Management equipment and supplies were purchased and received</li> <li>○ Fire lanes and crosswalks repainted for safety</li> <li>○ Revised patient area guidelines were established to ensure a safer environment for all. These guidelines included cord management and a controlled system for electrical devices and personal items that could be used for self-harm or as a weapon. WSH is currently in the process of developing these guidelines into a hospital-wide policy.</li> <li>○ A surge plan was developed by Russell Phillips for WSH to assist the community with preparing for emergencies when a surge is necessary due to an emergency/disaster.</li> <li>○ A pendant Alarm System Failure reporting requirement has been established and communicated to all staff. In addition, an investigative team has been formed to examine any failure to determine the cause and follow-up with any findings. All Pendant Alarm System Failure investigations are tracked in the WSH Safety Office.</li> </ul> </li> </ul>
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<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>Nurse management constantly monitors staffing for safe staffing levels.</p> <p>Nurse staffing continues to be analyzed by the Psychiatric Nurse Executive (PNE), Nurse Managers and the Joint Nurse Staffing Committee. As treatment models, census and acuity changes, staffing levels are adjusted appropriately.</p> <p>WSH Nursing Department uses a program for staffing developed for WSH Nursing Department in 2012 called Scheduler. The program enables ward needs to be anticipated and tracked to ensure safety of patients and staff alike. The Nurse Manager responsible for staffing the hospital is able to review the needs of the hospital down to the individual wards enabling the Nurse Manager to deploy staff based upon ward needs.</p> <p>The Scheduler Program has a base staffing number for each skill level on every ward and every shift. The PNE and Center Nurse Managers review patient care needs of each individual ward in deciding the number of base staff needed per ward. The base staffing is reviewed periodically as needs of the wards change and base staffing numbers are adjusted accordingly.</p> <p>The base staffing level is also discussed at the Joint Nurse Staffing Committee co-chaired by labor and management and affords both parties the opportunity to share views and ideas. The Joint Nurse Staffing Committee is mandated by legislature, the guidelines can be found in RCW 70.41.420.</p>	<p>No deficiencies noted.</p>

	<p>The PNE and Nurse Managers also consider the OSHA guidelines preventing Workplace Violence for Healthcare and Social Service workers when establishing baseline staffing</p>	
	<p>An additional FTE was hired to provide for the investigation of assaults on employees that meet a certain criteria.</p>	<p>In April 2015, a temporary FTE was hired in Enterprise Risk Management Office (ERMO) to provide investigations on assaults on employees that result in employee's hospitalization or medical treatment beyond first aid. This investigation will use Root Cause Analysis to determine whether existing processes are effective or require modification. Data derived from the Root Cause Analysis will be used, as appropriate, to develop an action plan for process improvement. DSHS has employed two full time employees to do these investigations.</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>Security Staffing continues to be analyzed by 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 for the civil wards and safety/security within CFS.</p>	<p>As a result of this analysis the following areas were identified:</p> <p><b><u>Grounds/ Civil Wards Security:</u></b></p> <ul style="list-style-type: none"> <li>• In 2014, security at WSH had a major philosophy change. Previously, the security officers were divided into three divisions, patrol, CFS and Court and worked as if they were only assigned to one of the areas instead of all three. The philosophical change has them now reacting as one team where all officers can and do work in all areas as needed.</li> <li>• There is also a greater emphasis on customer service where officers are helpful and flexible when it comes to staff and patient issues and their ability to help.</li> <li>• The security staff is also clear on the responses to violence on the wards. They are to respond promptly and if an assault or fight is in progress they are to assist staff with getting the patient under control in as safe a manner as possible.</li> <li>• Security is now more involved with fire watch issues as well. Security staff provide the staffing for the fire watch for the duration of the fire system failures that occur at the hospital.</li> </ul> <p><b><u>Recent Activity in the Security Department includes:</u></b></p> <ul style="list-style-type: none"> <li>• Refresher training for security officers in the use of restraints and carry downs.</li> <li>• First aid training</li> <li>• Shift briefing at each shift change</li> <li>• There has been a significant change in the security staff and that has meant a lot of training of new officers. The training has involved a lot of staff as they interact with the new people.</li> <li>• A parcel scanner was purchased for the mail room where all packages received at WSH get put through the scanner for the safety and security of patients and staff. It also assists the hospital with keeping contraband from coming into the environment via the mail.</li> <li>• Additional Security/risk assessments are underway for the Communications Center and the Human Resources office.</li> </ul>

<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	All safety-related policies have been reviewed and updated. Sunset review dates will be monitored for completion by the WSH Policy Committee.	<p>A revised Active Shooter/Hostage/Lockdown policy and procedure has been developed to assist staff with managing this emergency if it may arise in the workplace. A live training component for all staff has also been developed to go along with the new policy and procedure. Adoption and training on this new policy will begin in 2015.</p> <p>The following WSH policies have been reviewed, and updated, as needed:</p> <ul style="list-style-type: none"> <li>• Policy 1.8.2 Rights and Responsibilities of a Volunteer: has been completely rewritten to standardize WSH volunteer orientation requirements, including New Employee Orientation of safety. Status: awaiting final Policy Committee Review.</li> <li>• Policy 3.7.2 Personal Alarm/Duress System has been modified to include campus map and fire power map. Status: awaiting final Policy Committee Review.</li> <li>• Policy 1.9.4 Possession and/or Use of Firearms, Weapons &amp; Explosives: has been modified to include adoption of the BSHIA Policy 3.19.15. Finalized.</li> <li>• Policy 3.2.3 Orientation &amp; Competency: is currently being rewritten to reflect current practice and clarification of new employee orientation and related requirements and obligations, including culture of safety. Status: in process.</li> <li>• Policy 2.3.9 Infectious-Regulated Waste Management has been completely rewritten, adopted and posted.</li> <li>• Policy 4.2.13 Culture of Safety has been completely re-written, adopted and posted.</li> <li>• Policy 1.9.2 Fire &amp; Evacuation Drills is currently under review</li> <li>• Policy 1.9.3 Fire Marshals is currently under review</li> <li>• Policy 3.5.4 Interim Life Safety Measures has been completely rewritten, approved and posted.</li> <li>• Existing Safety Management/Accident Prevention Program (APP) plan was enhanced. In May 2014 the revised APP aligned the hospital safety management plan to be consistent with OSHA’s APP and the Joint Commission Standards which accredits the hospital. The App includes a section on workplace violence reduction, including staff responsibilities, risk assessment, patient treatment planning, staff</li> </ul>

		training and data tracking. IN addition it has an individualized workplace violence prevention piece that is modeled on information and guidelines contained in the OISHA publication “Guidelines for Preventing Workplace Violence for health Care and Social Service Workers”.
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<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.
d. First aid and emergency procedures	WSH has Teams of clinical staff that will respond to Medical Emergencies to any person throughout the hospital	No deficiencies noted.
	WSH actively plans/ prepares/exercises for internal incidents/events and participates with the Community for disasters.	<p>In 2014, WSH participated in 10 drills/exercises total, internally and with the local community and organizations (See below):</p> <p><b><u>Exercise Name: WSH Dietary Loss, Tabletop Exercise, June 17, 2014</u></b>          WSH Executive Leadership Team. Scenario was to stress WSH Dietary Services for several days. Can WSH rapidly respond in an organized, safe and supported manner in the event of unforeseen closure caused by disaster and/or inoperability?  <b><u>Objectives:</u></b>  <u>ICS roles:</u> Recognize and demonstrate roles of ELT/Command Staff during an emergency response.  <u>Discussion:</u> Enable participation in real-time problem solving discussions related to response solutions.  <u>Challenge:</u> Improve coordination of response operations with their coworkers and staff.</p> <p><b><u>Washington State Department of Health and Disaster Medical Control Center (DMCC), Washington System for Tracking Resources, Alerting and Communications (WaTrac):</u></b>          The drills tested the hospitals ability to effectively utilize the WaTrac system during drills, exercises and real events/incidents and if they communicated with outside agencies and facilities in a timely manner. Date of drills listed below          April 4, 2014          May 7, 2014          July2, 2014          September 3, 2104</p> <p><b><u>Exercise Name: Private Medication Center Activation, October 16, 2014:</u></b>          This exercise is a full scale exercise with community partners, Anthrax exposure. Activate DRAFT PMC Plan  <b><u>Objectives:</u></b>          Activate the PMC to include:</p>

		<p>Receive pharmaceuticals from health dept. chain of custody &amp; safety of the pharmaceuticals  Determine type &amp; quantity of supplies needed to support a distribution of pharmaceuticals  Process actual persons (players) through the PMC  Demonstrate staff knowledge of the PMC plan  Demonstrate the ability to create &amp; distribute information to patients, staff and others</p> <p><b><u>Training:</u></b></p> <p><b><u>Disaster Preparedness for Hospitals and Healthcare Organizations within the Community Infrastructure.</u></b>  October 21 &amp; 22, 2014, WSH Executive Leadership Team attended 2 day course in conjunction with the DHS/FEMA National Training Program and presented by Texas A &amp; M Engineering Extension Service, Texas A&amp;M. The course focused on bringing together those individuals from WSH who are responsible for ensuring the resiliency of healthcare services during a high-consequence or catastrophic event within a jurisdiction. Focusing on preparedness processes and activities, this course provides hospital and healthcare personnel an opportunity to acquire the knowledge, skills and abilities necessary to help them ensure the sustainability of their facilities and organizations during all types of disasters.</p>
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<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>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>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</p>	<p>No deficiencies noted.</p>

	<p>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>WSH Safety Office continues to provide monthly data regarding staff injuries and L&amp;I claims information.</p>	
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<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>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 continue to be tracked using the Security Incident report and/or the Administrative Report of Incident.</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>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</p>	<p>ERMO created an on-line training to go along with the form for staff to review.</p> <p>WSH did provide an in service to nurse managers, supervisors and safety committee members regarding the changes, and does provide 1:1 training as issues come up. In addition, an all staff e-mail went out explaining the changes shortly after the new form came into place.</p>

	<p>employees' records are reviewed for compliance.</p> <p>Ward-based job classifications are required to receive annual update training in TEAM.</p> <p>All Nursing Department staff (RN, LPN, PSN, PSA, MHT, IC) are required to complete an annual all-day training including standards of care, personal and workplace safety, and SAFE TEAM practice.</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>	
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<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.
h. Clinical and patient policies and procedures including those related to: 1. Smoking 2. Activity, leisure and therapeutic programs 3. Communication between shifts 4. Restraint and seclusion	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.	No deficiencies noted.
	WSH continues to improve active treatment and leisure programs to provide patients more meaningful and recovery-oriented activities.	No deficiencies noted.
	WSH continues to place a major focus to reduce the use of seclusion and restraint.	No deficiencies noted.

# Workplace Safety Plan (ESH) - Appendix B

## Eastern State Hospital

### ANNUAL UPDATE

#### May 2015

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	<p>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</p> <ul style="list-style-type: none"> <li>• The Safety Office and representatives of Unit Management committees and CSS conducted an annual Environmental Proactive Risk Assessment, May, 2014, in addition to individual assessments initiated as a result of any Sentinel Events or drill downs, to identify 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 and associated risk.</li> <li>• <b>Unit Metal Detector and Visitor Policies</b>              Inconsistent policy and compliance ward to ward, shift to shift. Escort to ward is completed by Security or ward staff on APU dependent on availability. Walk-through detectors are not available on 2N, 3N, and all GPU locations. Walk-</li> </ul>	<p>Recommendations for improvement include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Phase 3, Patient Safety Hardware improvements (installation of continuous door hinges, faucet and shower handle replacement, shower diverter valve replacement, covering of exposed sink and toilet plumbing, removal of restroom shelves and toilet paper holder replacement) on all remaining wards was initiated in 2014 and was completed in June 2015.</li> </ul> <p><b>FUTURE PLANNING: Installation of Phase 4 Patient Safety Hardware Improvements (replacement of overhead reading lights on APU wards, remodel of 1N1 “safe room” to provide improved patient monitoring and ease for staff in executing seclusion/restraint procedures, replacement of cross corridor smoke doors on all APU wards, placement of soap dispensers, additional cameras for patient monitoring on all APU wards).</b></p> <ul style="list-style-type: none"> <li>• Revision and consistency between units</li> </ul> <p>Safety/EOC committee recommendation to initiate an A3 Lean project to evaluate process and develop recommendations for improvement.</p> <p><b>Initiation of all new Lean projects on hold until existing projects completed. The Safety office will re-initiate request pending completion of existing A3 Lean projects.</b></p>

	<p>through detectors on APU frequently alarms (false) due to physical location and metal building features in elevator sally port location. Relocation/installation of detectors not feasible due to egress requirements in alternate locations (APU/GPU). Hand held detectors available on all wards.</p> <ul style="list-style-type: none"> <li>GPU ward locations do not have visitor lockers to secure unauthorized items.</li> </ul>	<ul style="list-style-type: none"> <li>Utilize existing lockers located near Westlake Switchboard for visitor use. Safety to meet with GPU Management committee to develop policy and procedure for use of GPU visitor lockers including guidance when the Westlake Switchboard operator is not on duty.</li> </ul> <p><b>TARGET: August 2015</b></p>
	<p><b>Access Control</b> Eastern State Hospital's open campus and rural location provide easy access. The multitude of vacant buildings on campus, slated for demolition, continues to attract curious local youths, and on some occasions, thieves looking for copper, recyclables or other items of worth. Multiple areas are isolated after dark.</p>	<p>Capital Programs has developed a long-range plan for demolition of vacant buildings on campus but is dependent on Legislative funding.</p> <p>Install security cameras in high-risk locations (off-ward) based on usage and access.</p> <p><b>Prior year Capital Programs project lost partial funding for Phase I installation of exterior cameras. Re-submit a Capital Programs request for additional cameras identified for future planning. Target for installation pending funding approval.</b></p> <p>All Security incidents are investigated and appropriate follow-up actions taken. A monthly report of all Security activities is provided to Safety/EOC Committee for review and data analysis.</p>
	<p>There are occurrences of stolen, misplaced, lost or not turned in employee identification badges and/or keys assigned to individual employees.</p>	<p>Access to the hospital campus is controlled primarily through the use of identification badges, personal identification and advance notification of authorized visitors. Campus-wide key control is tracked by Security. Access to FSU is controlled through the use of proximity cards issued by FSU Administration and ward control panels and cameras. Pharmacy access is alarmed after hours and reports to the Eastlake Switchboard for Security response. Security tracks key issuing &amp; return to/from employees when transferred to other areas/departments or leaving ESH employment on a database. All keys stamped for tracking purposes.</p> <p><b>FUTURE PLANNING: Request Capital Program funding for installation of "Key Watcher" system.</b></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> </ul>	<p>Turn Switchboard/reception desk 180 degrees to increase visibility of parking lot and in-coming visitors, patient and staff.</p> <p>Due to the location of utilities/infrastructure, it has been identified that this will not be feasible. <b>FUTURE PLANNING: Install wireless cameras so that Switchboard staff can monitor the parking lots and main entrances.</b></p>

	<ul style="list-style-type: none"> <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>Identify high-risk areas and install surveillance cameras.</p> <p><b>Prior year 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>FUTURE PLANNING: Re-submit a Capital Programs request for additional cameras identified. Target for installation pending funding approval.</b></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> </ul>	<p>Install eight foot high chain link fence to block access to area between Therapy Pool and Interlake building.</p> <p><b>As part of a Capital Programs project, the Interlake building is currently in the second phase of asbestos abatement prior to demolition. Capital Programs has developed long range planning for demolition of numerous vacant buildings on campus; dependent on Legislative funding.</b></p>
	<ul style="list-style-type: none"> <li><b>Egress Control</b> No physical control over egress (visitor/staff) on campus.</li> </ul>	<p>Remedy would essentially require a security fence around the entire perimeter of hospital and this is not consistent with the hospital mission, vision, or values.</p>
	<ul style="list-style-type: none"> <li>There is a potential for violence when apprehending patients that have gone on unauthorized leave.</li> </ul>	<p>Unauthorized leave data tracked and reported monthly to Safety/EOC and Patient Safety Committees for trend analysis and drill downs to identify Plans for Improvement. Unauthorized leaves have decreased from seven (7) in 2013 to four (4) in 2014. The majority of unauthorized leaves occurred on campus grounds during staff escort; one UL occurred during an escort to a community medical appointment. All occurrences involved patients admitted to the Adult Psychiatric Unit; two each, 3N1 and 1N1.</p> <p>Establish an Escorting Policy workgroup to review consistency between unit policies and processes for escorting patients in unsecured areas and develop recommendations to prevent unauthorized leaves related to these processes.</p> <p><b>TARGET: 4<sup>th</sup> Quarter 2015</b></p>
	<p><b>Door Locks</b> Current employee key control and tracking system with regard to change of employee need/status and return at end of shift (FSU) is inadequate. Potential for lost or stolen keys and unauthorized access to keys and areas. Manual tracking versus automated system.</p>	<p>Access to the hospital campus is controlled primarily through the use of identification badges, personal identification and advance notification of authorized visitors. Campus-wide key control is tracked by Security. Access to FSU is controlled through the use of proximity cards issued by FSU Administration and ward control panels and cameras. Pharmacy access is alarmed after hours and reports to the Eastlake Switchboard for Security response. Security tracks key issuing &amp; return to/from employees when transferred to other areas/departments or leaving ESH employment on a database. All keys stamped for tracking purposes.</p> <p>A workgroup has been formed to clarify the process for assigning keys at hire. The workgroup includes representatives from Educations Services, COO, and Human Resources.</p>

		<b>FUTURE PLANNING: Request Capital Program funding for installation of “Key Watcher” system; hospital-wide.</b>
	<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 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>	<p>Security monitors during daily Security rounds and reports burned out exterior lighting to Consolidated Support Services for replacement. All lighting work orders are prioritized based on risk.</p> <p><b>There is no funding currently available for additional lighting. Submit funding request for future Capital Programs project.</b></p>
	<ul style="list-style-type: none"> <li>• <b>Radios</b> <ul style="list-style-type: none"> <li>• Low/dead battery</li> <li>• Dead Spots (lack of repeater coverage)</li> <li>• Not compatible with community emergency response agencies</li> </ul> </li> </ul>	<p>In June of 2014, ESH purchased new digital two way radios and repeaters to replace antiquated communication equipment and ensure continuity with local emergency response agencies. This best practice approach improves signal quality, coverage, staff safety and security of patient healthcare information (PHI). <b>Migration to the new radios including radio tracking, policy and training; complete May 30, 2015.</b></p>
	<ul style="list-style-type: none"> <li>• <b>Duress Alarms</b>  Subject to malfunction and accidental activation.  Existing staff duress alarms on Eastlake South (FSU) and Eastlake North (APU) were installed in two different phases with the APU alarm system installed during Phase 3, over 20 years ago. FSU was installed under Phase 4 .The system is beyond its life expectancy.</li> </ul> <p>The FSU alarm system requires use of a proximity card with readers located (need to verify how far apart) throughout the corridor. The APU system requires the system to be activated by “keying a box/switch” located (need to verify how far apart). The alarm is relayed to “reader boards” on each ward and the Eastlake Switchboard denoting the ward activated on.</p>	<p><b>Plan for Improvement developed based on staff feedback after migration and use in real event emergency response; power failure:</b></p> <ul style="list-style-type: none"> <li>• <b>Battery and generator backup for the TurboVUi rack and repeaters; in-process.</b></li> <li>• <b>Additional training for the Security Department and ICC personnel for interim emergency operations and contingency plans; in-process.</b></li> <li>• <b>Additional programming to better facilitate emergency operations with two redundancy plans; in-process.</b></li> <li>• <b>Ability to communicate with community first responders is being re-evaluated to ensure compatibility.</b></li> </ul> <p>The duress alarm is currently tested daily on all wards by ward staff (APU &amp; FSU) and weekly (GPU) per Nursing policy.</p> <p><b>Newly purchased digital radios are in place and equipped with an emergency alarm button that once activated alerts all radio carriers on that radio channel and Switchboard to a staff emergency. Once the alarm is activated it initiates a 30 second “open mic” for staff to report emergency type/location. Alarm reports radio number and can be associated with permanent assignment or daily tracking of staff assigned to radio; no ability to electronically track location.</b></p>

	<ul style="list-style-type: none"> <li>• Location makes the system difficult if not impossible for staff to use if involved in a patient-to-staff assault.</li> <li>• The alarm notification only displays the ward; it does not identify specific/exact location of activation.</li> <li>• Wiring/equipment inadequacies/failures were identified during the FSU Security Enhancement project (need to get specifics from Bill unless you can get me specifics)</li> <li>• The existing system does not provide a method of activation for off-ward and/or outdoor escort/activities i.e. yard group, etc.</li> <li>• The existing Westlake staff duress alarm consists on one location for activation; a “push to activate” button at each nurses station. Location makes the system difficult if not impossible for staff to use if involved in a patient-to-staff assault.</li> <li>• The alarm notification only announces the ward location via automated overhead PA announcement; it does not identify specific/exact location of activation.</li> <li>• The duress alarm is tied into the existing Simplex nurse call system which is frequently malfunctioning and potentially affects the duress alarm system, dependent on the issue. If impacted and requires Simplex service, historically, overall service support from Simplex has been poor. Once Simplex responds to troubleshoot a problem, which frequently takes a significant amount of effort to</li> </ul>	<p><b>A Capital Programs project is currently in planning stages to replace the existing duress systems on the wards and install a “personal duress alarm” system in all locations with a system that provides wider coverage, ease of activation and electronic location tracking for quicker emergency response. Installation dependent on Legislative funding</b></p>
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	<p>schedule, and the problem cannot be remedied by the technician the same day, it takes days or even weeks for Simplex to schedule additional service to complete the repair. The existing system does not provide a method of activation for off-ward and/or outdoor escort/activities i.e. yard group, dining room, etc.</p> <ul style="list-style-type: none"> <li>• GPU Treatment Mall – No Existing Duress Alarm</li> <li>• The existing Westlake duress system was not installed in the GPU Treatment Mall as it was not utilized as a patient care area at the time of the project.</li> <li>• Activity Therapy Building/Eastlake Treatment Mall – No Existing Duress Alarm</li> </ul>	
	<p>Hardware (environmental risk factors for use as weapon or for patient self-harm).</p>	<p>An Environmental Proactive Risk Assessments is conducted at least annually and in response to any Sentinel Event or patient to staff assault to mitigate identified environmental risk factors to prevent future occurrences of patient self-harm or suicide and use for patient-to-staff assault. A Capital Programs project, Phase 3, for patient safety hardware improvements (installation of continuous door hinges, faucet and shower handle replacement, shower diverter valve replacement, covering of exposed sink and toilet plumbing, removal of restroom shelves and toilet paper holder replacement) on all remaining wards was initiated in 2014 and is targeted for completion: September 2015. Phase 4 improvements include, but not limited to; replacement of cross corridor doors on all APU wards, replacement of existing reading lights in patient rooms on all APU wards with a tamper-proof assembly and renovation of an existing seclusion room and adjoining toilet room on 1N1 to increase visibility and staff ease of access in a seclusion/restraint event, installation of tamper-proof outlets or covering of electrical outlets on all APU wards.</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. Personnel policies</p>	<p>DSHS, BHSIA, and ESH hospital, unit, and discipline specific policies, Workplace Safety plans and emergency response policies are in place.</p>	<p>Policies are adequate and effective in practice. Overall number of reported incidents, incidents resulting in a claim being filed, claims that resulted in days away from work and total time loss decreased in 2014.</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>c. Staffing, including security staffing</p>	<p>Systems for identifying variances in Nursing staffing and responding to these in a timely manner are in place.</p> <p>Additional tools/systems used in nursing include</p> <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>	<p><b>Outside vendor, NASH, contracted to evaluate staffing effectiveness. Findings will be presented to Leadership for appropriate follow-up as indicated.</b></p> <p>During analysis of adverse patient safety events, an assessment is conducted to determine whether staffing played a role in the adverse event. A subsequent report is provided to the Governing Body, via the Quality Assurance/Performance Improvement committee reporting process.</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.</p>
		<p>Security staffs two positions per shift. Security personnel provides security and safety of the external campus, including patrolling the campus to monitor potential trespassing and ensuring ESH facilities, vacant buildings and 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 Management.</p> <p>Staff Position (FSU)</p> <ul style="list-style-type: none"> <li>• Staff is aware of each other’s position and whereabouts at all times.</li> <li>• Security desk position maintains constant contact (via radio or observation) of the person doing the ward security checks.</li> <li>• 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)</li> <li>• The Control Panel Operator position maintains constant contact with the Security Desk position and the Security Ward position (via radio and spot visual checks).</li> </ul>

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<p>d. First aid and emergency procedures</p>	<ul style="list-style-type: none"> <li>• <b>Infection Control Risk Assessment</b> Potential exposure to communicable diseases, BBP's, Hepatitis B/C, HIV, TB during provision of patient care.</li> </ul>	<p>An Infection Control Risk Assessment is completed annually to assess communicable diseases in the community as well as any prioritized risks within ESH based on surveillance data.</p> <p>Face shields were approved for use, ordered and distributed to protect staff from patient-to-staff spitting exposures.</p> <p>Personnel flu vaccination reports are in development. <b>TARGET: September 2015</b></p>
	<ul style="list-style-type: none"> <li>• <b>Emergency Response</b> A minimum of two (2) emergency drills are conducted annually. A Plan for Improvement is developed for all identified deficiencies related to emergency response activities (staged and actual) 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, transportation and personal protective equipment.</li> </ul>	<p>Emergency Medical Response Procedures are in place, Code Blue and Code Orange, and activated by contacting Switchboard for communicating request for nursing and medical provider response via two-way radio and paging channel.</p> <p>Emergency medical supplies, including an AED, now obtained from “jump bags” maintained in the security vehicles in the event of an outdoor (campus) medical emergency in lieu of wheeling on ward carts to outside location or placement of additional emergency equipment near the entry of ESH buildings. Security staff has been trained as first responders. Disaster kits are maintained for multiple casualty emergency response situations and are stored in identified Westlake and Eastlake locations.</p> <p>Medical providers scheduled for ACLS classes with biannual recertification. ECG rhythm and emergency response training provided to shift nurses. Mock codes are being developed and implemented once the ACLS course is completed in May, 2015 and nursing has completed their ECG/rhythm interpretation training.</p> <p>Newly purchased digital radios are in place and equipped with an emergency alarm button that once activated alerts all radio carriers on that radio channel and Switchboard to a staff emergency. Once the alarm is activated it initiates a 30 second “open mic” for staff to report emergency type/location. Alarm reports radio number and can be associated with permanent staff assignment or daily tracking of staff assigned to radio; no ability to electronically track location.</p> <p>The ESH Continuity of Operations Plans (COOP) is being revised to ensure adoption of federal terminology and definitions to replace DSHS antiquated terms (such as “vital services”). The purpose of these revisions is to ensure that ESH complies with state law and uses a standardized set of terms used by all state agencies. <b>TARGET: COMPLETED</b></p> <p><b>Establishment and implementation of a Psychiatric Emergency Response Team (PERT)</b> <b>TARGET: 4<sup>th</sup> Quarter 2015</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>e. Reporting violent acts, taking appropriate action in response to violent acts, and follow-up procedures after violent acts:</p>	<ul style="list-style-type: none"> <li>• <b>Reporting</b> All elements pertaining to reporting of violent acts are documented utilizing Employee Injury, Unusual Occurrence, Uniform Law Enforcement Notification and Internal Hazard reporting.</li> </ul>	<p>All incidents are investigated by the immediate supervisor, Security, Safety and/or other department(s) as indicated at the time of occurrence. All employees injured at work have access to first aid measures as indicated. In the event that an employee sustains a more serious injury, emergency medical response is initiated or the supervisor assists the employee to obtain additional medical attention if indicated. Staff is made aware of the services of the Employee Assistance Program and on an individual and confidential basis may request help from the Human Resource Department in accessing personal support.</p> <p>Employees who self-identify as victims of domestic abuse may access the employee assistance program for referral to special resources.</p> <p>Culture of Safety survey initiated 4/2015. Results from the survey will be presented to the ELT on 5/19/15.</p>
	<p>Critical Incident Stress Management policy/procedure in place. Inconsistency in initiation</p>	<p>Critical Incident Stress Management (CISM) is available as indicated on a voluntary basis for groups or individual team members who have been impacted by a violent act. Critical Incident Stress Management (CISM) team members have been identified for response. Critical Incident Stress Management (CISM) brochures developed and distributed to all wards departments to increase awareness and responsibilities for initiating response.</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>f. Development of criteria for determining and reporting verbal threats.</p>	<p>ESH utilizes criteria for reporting assault as outlined in the Unusual Occurrence Reporting procedure and identified in the MHD Quality Steering Committee definition.</p>	<p>Verbal threats are tracked when identified and reported by staff as a potential risk. Reporting staff determines risk potential. Actions taken as indicated.</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.
g. Employee education and training	<p>Not all new employees receive new employee orientation, or “at hire” mandatory training prior to working in assigned area or complete annual refresher training as required.</p> <p>Antecedents to assault injuries::</p> <ul style="list-style-type: none"> <li>• During patient re-direct;</li> <li>• When limit-setting;</li> <li>• During seclusion/restraint activities.(containment)</li> </ul>	<p>A training plan has been developed and implemented to ensure all staff are trained at-hire and annually. As part of the plan, ESH is adopting the LMS learning system, which will provide better access to and record of participation in ongoing training. The LMS system training will also enable improved post-testing and timely feedback to participants. Educational Services is also developing a matrix of mandatory training, at orientation and ongoing which will be utilized to compile compliance reports. New Employee Orientation is now being offered monthly, rather than quarterly</p> <p>Eastern State Hospital utilizes “<i>TEAM</i>” training, an evidence based training, that provides staff with the tools to keep themselves and patients safe while maintaining their commitment to positive approaches in serving patients whose behavior(s) may pose a danger to themselves or others. The program identifies how to provide services and support in a manner that does not promote patient need to resort to aggression or violence in order to participate in treatment, to be heard or to get his/her needs met. This training incorporates modules to address prevention, understanding needs, safety planning, de-escalation, evasion techniques, and debriefing. Application of Restraints is also covered in conjunction with TEAM training with competency tracked.</p> <p>CPR training is now instructed per the American Health Association standards and results in certification of participants.</p> <p>A new competency mall is being implemented for hands-on training and competency certification. Mock code training is now being offered as part of the skills competency fair as well as EKG and initial physical health assessment training.</p> <p>Additional training resources identified for purchase by the Ad Hoc Safety Committee and will be utilized for:</p> <ul style="list-style-type: none"> <li>• Purchase of additional CPR manikins to facilitate AHA CPR certification</li> <li>• Purchase of the video series: Mental Health Nursing which provides common scenarios for successful patient/staff interactions including:             <ul style="list-style-type: none"> <li>• Depressed/suicidal client</li> <li>• Verbally and physically aggressive client with/without delusions</li> <li>• Interactions with patients who have borderline personality disorder</li> <li>• Patients with dementia and agitation and/or anxiety</li> <li>• Patients experiencing mania</li> </ul> </li> </ul> <p>All direct care (milieu) staff is trained at hire and annually in prevention practices that range from constant awareness of the environment and milieu dynamics, ongoing risk assessment, effective documentation, individual patient and group psycho-education to a formal non-</p>

		<p>violent crisis intervention training program.</p> <p>Milieu Management training is provided to all RN's at hire (New Employee Orientation) in support of provision of active treatment.</p>
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<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>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>	<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> <li>• Inconsistency between ward and shift routines, recovery levels, group offerings, etc. increasing patient frustration when transferring from ward to ward.</li> <li>• On-ward active treatment during the afternoon shift is limited or cancelled. Rosters are not consistently being completed to document occurrences of active treatment or reasons for group cancellation.</li> </ul>	<p>Eastern State Hospital uses a Recovery Model, tracking multiple outcomes; seclusion/restraint, patient-to-staff assaults, patient-to-patient assault, and active treatment. This information is reported hospital-wide and to Governing Body.</p> <p>A performance improvement plan is underway focused on increasing the quality of active treatment offered, with better interface with the treatment teams and improved data capture and documentation; target December 31, 2015</p> <p>A Lean performance improvement project is underway to address ordering and procuring of supplies for use in active treatment delivery; target December 31, 2015.</p> <p>An active treatment planning council has been formed to develop/implement additional methods to improve active treatment data capture and increase average hours of active treatment per patient. Active treatment data is monitored monthly by ward, day of week, and hour of day. A feedback system has been developed to present to unit management teams and includes increasing weekend/evening activity provision.</p> <p>Data related to problem times, locations, etc. related to escalation of patient behaviors is reviewed by the Safety Assault Prevention Workgroup and QC Committee to identify increased needs for structured treatment programming.</p> <p>It was recognized that some variances between wards occurs based on acuity, etc. and cannot be altered. Unit management teams are reviewing ward guidelines and shift inconsistencies and implementing actions plan to decrease patient frustration and potential increased agitation when transferred to another ward.</p> <p>Toolboxes for use by Nursing staff in support of provision of on-ward active treatment opportunities during afternoon shift, weekends or for patients unable to go to mall have been provided by the assigned Recreation Therapists; 1N1 and HMM. In addition, group outlines/structure for staff to choose from and educating staff on the toolbox availability and use has been provided.</p>

		<p>Recreation Therapist schedule changed to Tues.-Sat 12:00-8:15pm- increasing provision of programming during the hours of 3pm-8pm on 2N &amp; 3N.Recreation Therapist schedule changed to add another 3pm-6pm programming time on 2N1.</p> <p>Reassigned Recreation Therapist to cover vacant Recreation Therapist position on HMH (on hold) M, W, F; 10:00am to 6:15 pm and Tue/Thurs; 9:00 am to5:15pm. Leadership and Nursing Management responsible for ensuring resources are available and groups occur and are documented along with reasons for cancellation to identify trends and develop a plan of action to prevent.</p> <p>Programs, treatment and care are provided by 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 exercise, relaxation, music and mood, socialization activities such as table games and activities, exercise, expressive arts and creativity.</p>
	<p><b>Communication between shifts</b></p>	<p>The assigned FSU clinical security staff from the on-coming and off-going shifts together completes a security check and documents on the Security Board.</p> <p>FSU Security Committee establishes reviews and makes recommendations for changes in unit security policies and procedures. 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.</p> <p><i>Safety Huddles</i> are conducted prior to morning report on each ward to share safety concerns and provide information regarding potential safety issues.</p> <p>Existing ESH policy requires implementation of a “<i>Code Green</i>” whenever a patient’s behavior is escalating and may require seclusion or restraint or whenever seclusion or restraint is initiated. A “Code Green” is in response to a critical incident and immediate response is required. Debriefing with staff and an intensive analysis of the event is completed. The CEO, Medical Director, Quality Management Director, and Nurse Executive review all Code Green incidents (with or without seclusion/restraint) during the following morning report</p>
	<p>There is an increased risk for patient unauthorized leave and/or negative patient behavior during community outings.</p>	<p>No deficiencies noted.</p>
	<p>Placing patients in seclusion/restraint increases potential for employee injury.</p>	<p>Refer to section “g”, “Employee education and training” and section “h”, “Clinical and patient policies and procedures”</p> <p>Eastern State Hospital uses a Recovery Model, and is tracking multiple outcomes; seclusion/restraint, patient-to-staff assaults, patient-to-patient assault, and active treatment. This information is reported hospital-wide and to Governing Body.</p>



# Workplace Safety Plan (CSTC) - Appendix C

## Child Study and Treatment Center

### ANNUAL UPDATE

#### May 2015

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.
<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>A proposal to make floor plan improvements to Orcas cottage was funded in the 2015 Supplemental Budget (SHB 1105).</p> <p>Security was tightened in the administration building by instituting a new policy of keeping all external doors locked and installing a buzzer/camera system to alert reception staff of visitors. All staff and Clover Park School Personnel keys were upgraded to support authorized access.</p>
<p>b. Staffing, including security staffing</p>	<p>Nursing management constantly monitors staffing for safe staffing levels.</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. 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”.</p>
<p>c. Personnel policies</p>	<p>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>	<p>CSTC implemented a comprehensive Accident Prevention / Safety Management Plan that is aligned with OSHA requirements and TJC standards. Internal policies support the APP which also includes the CSTC 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 non-violent crisis intervention (CPI) training to be</p>

		addressed below.
d. First aid and emergency procedures	<p>CSTC Policy 203 covers “Responding to Medical Emergencies for patients, staff and visitors at CSTC.</p> <p>The DSHS Enterprise Risk Management Office conducts an “Annual Loss Control Evaluation (ALCE). This audit is conducted every Fall.</p> <p>CSTC updates the Emergency Management Plan annually. The Emergency Preparedness Committee meets regularly to plan and organize disaster drills which occur a minimum of twice a year.</p>	<p>CSTC maintains emergency supplies which are inventoried annually. This year major expenditure was approved for purchase of emergency preparedness supplies and equipment.</p> <p>As result of this audit, improvements were made to the Infection Control manual.</p>
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	<p>CSTC Policy 204 – Employee and Volunteer Injuries and Accidents - governs full documentation for internal risk management and the processing of industrial insurance (L&amp;I) claims.</p> <p>Patient Incident Reporting</p> <p>Violent Acts Log</p>	The CSTC Workplace Safety Workgroup, a subgroup of the Safety Committee continues to meet twice monthly. A second annual safety survey was conducted in the summer of 2014. At the time of this report, the analysis and action planning process has just begun.
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.	Additional refresher courses in CPI CSTC’s verbal and physical intervention model for prevention of patient violence / assault / harm to self or others were implemented in 2014-15 as part of the safety curriculum
g. Employee education and training	<p>Non-Violent Crisis Intervention Program (CPI)</p> <p>Curriculum was developed for a campus-wide interactive emergency preparedness training that was held 7/24/14. The emphasis was on the incident command center, employee home preparedness and individual responsibility at work during a major crisis.</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

<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>Acknowledging that hand's on intervention increase the likelihood of staff injury, CSTC has reduced the use of Seclusion and Restraint through the increased use of evidence based practices such as Motivational Interviewing (MI) and Collaborative Problem Solving.</p>	<p>Two Ph.D. Program Directors have been certified as MI trainers and have implemented a 16-hour course for direct care staff. Psychiatric Child Care Counselors are taught the basics of MI one month; are coached in its use and return a month later for a second 8-hour class to continue with training and coaching. The principles of MI are being integrated on all units, and work well with other evidence-based practices in use, such as Dialectical Behavior Therapy, and Cognitive Behavioral Therapy.</p>
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