



Chapter:	<b>Eastern State Hospital Safety</b>		
Policy:	<b>Workplace Safety Plan/Accident Prevention Program</b>		
Authorizing Sources:	WAC 296-800-140, RCW 49.19.020, RCW 72.23.400, RCW 72.23.451		
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## **1.0 PURPOSE:**

To provide a workplace safety plan for all state hospitals that incorporates federal and state laws including Occupational Safety and Health Administration (OSHA/Washington State Department of Occupational Safety and Health (DOSH), as well as Washington State law for the management of the environmental safety of patients, staff and others through proactive identification of safety risks and the planning and implementation of processes to minimize the likelihood of accidents and injuries. Also incorporated are standards of compliance required by The Joint Commission (TJC) and Centers for Medicare/Medicaid Services (CMS) accreditation and certification of hospitals.

## **2.0 AUTHORITY:**

Eastern State Hospital (ESH) is operated by the State of Washington under the auspices of the Department of Social and Health Services, (DSHS), and the Behavioral Health Administration (BHA) in accordance with state and federal law as applicable.

The CEO has delegated authority to the Safety Manager and leadership to stop any action that places the lives of employees, patients, contractors and visitors in immediate danger.

## **3.0 SCOPE:**

- Workplace Safety Plan: Applicable to all staff, including contract and support services employees, (i.e. Consolidated Support Services), interns, students and volunteers and includes prevention of risk related to the environment and provision of patient care.
- Accident Prevention Program (APP): Applicable to all ESH employees and encompasses any accidents, threats or acts of violence that may result in emotional or physical injury or otherwise places one's safety and productivity at risk. This includes supporting employees who are victims of domestic violence when requested, and assisting employees to access the Employee Assistance Program for counseling.
- Consolidated Support Services (CSS) employees utilize their own APP guidelines for employee safe work practices. Consolidated Support Services employees work in concert with ESH personnel to create a safe and healthful work environment by adhering to both CSS guidelines and ESH policies and programs. The ongoing interaction between agencies involves much more than just accident prevention; it also involves employee and patient interaction. In order to clarify this relationship, CSS employees and ESH staff cooperate utilizing the written Service Level Agreement (SLA) between CSS and ESH. The intent of the SLA is to describe the mutually agreed upon responsibilities, standards, and services obligation between agencies. Eastern State Hospital Safety staff collaborates with CSS safety personnel, management and employees to create an ongoing and effective safe and healthful working environment.

## **4.0 MANAGEMENT COMMITMENT:**

DSHS and ESH place a high value on the safety of its employees and are committed to providing a safe and healthy environment for all employees, patients and others entering the hospital's facilities. This policy has been developed for Workplace Safety and Injury Prevention and involves management, supervisors, and employees in identifying and eliminating hazards that may develop during work processes.

All hospital staff are responsible for preserving a safe environment regardless of duty of assignment, supervisory level or command. The Eastern State Hospital Safety Manager, Safety Committee Chair and members of the Safety Committee are responsible for this plan. The CEO

is responsible for ensuring the existence and the effectiveness of a comprehensive Workplace Safety/Accident Prevention Plan.

Employees are required to comply with all hospital safety rules and are encouraged to actively participate in identifying ways to make our hospital a safer place to work.

Management is committed to allocating resources necessary to implement all processes encompassed within this plan:

- Maintaining Safety Committees composed of management and elected employees;
- Identifying and taking action(s) to eliminate or mitigate hazards;
- Planning for foreseeable emergencies;
- Providing initial and ongoing training for employees and supervisors;
- Implementing a disciplinary policy to ensure that hospital safety policies are followed.

It is Management's assertion that no task is so important that an employee must violate a safety rule or take a risk of injury or illness in order to "get the job done".

***Safety is a team effort – Let us all work together to keep this a safe and healthy workplace.***

**We Believe**

- All incidents, injuries and illnesses have the potential to negatively impact quality of life and can be reduced through mitigation strategies
- Every day, every task can be completed in a safe manner.
- Everyone is responsible and accountable for their safety and the safety of the patients we serve and others entering ESH facilities.
- The quality of patient care services fosters a safe environment for staff.
- Accident prevention is a partnership between staff, management and Collective Bargaining Units.

**5.0 SAFETY AND HEALTH RESPONSIBILITIES:**

**5.1 Executive Leadership Responsibilities:**

- Ensure that the hospital maintains a safety committee that has both employee elected and employer-selected members in accordance WAC 296-800-13020.
- Ensure that the hospital Safety Committee meets monthly and provides all required documentation.
- Ensure that the Safety Committee carry out their responsibilities as described in this program.
- Ensure that sufficient employee time, supervisor support, and funds are budgeted for Personal Protective Equipment (PPE) equipment and training to implement the safety program.
- Ensure that incidents are fully investigated and appropriate corrective action implemented to mitigate risk and prevent reoccurrence.
- Ensure a record of injuries and illnesses is maintained and posted as described in this program.
- Ensure an annual review of the Workplace Safety Plan/Accident Prevention Program, including Workplace Violence Prevention, is conducted to ensure compliance with State/Federal law and hospital needs, Centers for Medicare and Medicaid (CMS)

certification and The Joint Commission accreditation standards of performance and develop Performance Improvement Activities, as indicated.

- Provide guidance and oversight to hospital personnel to ensure compliance with this program. This includes facility management, approval and purchase of equipment, authorization and payment for training, participation in workplace inspections, and evaluation of facility program needs.
- Responsible for the recruitment and retention of qualified staff to assure effective treatment and maintenance of a therapeutic milieu.
- Accountable for collection and review of data and implementation of quality improvement measures.
- Maintain a communication plan to promote a Culture of Safety.

## 5.2 Management/Supervisor Responsibilities:

All managers and supervisors are responsible for establishing and documenting appropriate site-specific policies and procedures, to ensure safe practices for their areas of operations.

- Managers and supervisors must maintain appropriate Workplace Safety procedural knowledge regarding practices, policies, procedures and emergency management plans and set a good example for employees by following safety rules and attending required training.
- Ensure each employee receives an initial, documented, site-specific Safety orientation/training that includes inherent hazards and safe practices *before* beginning work.
- Ensure each employee is competent to perform their duties safely and receives adequate/required training including prevention and intervention techniques, safe operation of equipment or tasks *before* starting work.
- Ensure that a hazard assessment is conducted on each job class and that each employee receives proper training in the use of the required personal protective equipment (PPE) *before* starting work.
- Ensure staff accounts for the safety and location of patients and monitor environmental factors that affect patient and staff safety ensuring that clinical, environmental and security needs are met. Ensure staff completes ward checks while respecting patient privacy and dignity (i.e. knocking on door before opening). This process may reflect clinical, environmental, and security differences among units. Staff assigned to ward check continuously circulate through the ward and intervene with patients as needed. They are not assigned any other duties during that time.
- Ensure that supervision is sufficient to identify unsafe work practices and that employees are provided additional training or disciplinary action is conducted as needed. Formal corrective action is documented according to Human Resources Policy.
- Ensure all employee injuries are investigated and all required documentation is properly completed and submitted to the Safety Office.
- Work with the hospital Safety Manager/Officer and DSHS Enterprise Risk Management Office (ERMO) to identify and evaluate changes to work practices or equipment that improves employee safety.

### **5.3 Employee Responsibilities:**

All employees are required to follow established safety policies and procedures and encourage co-workers by their words and example to use safe work practices including but not limited to:

- Following Washington State Safety and Health Core Rules (WAC 296-800) as described in this program/plan, and referenced in hospital policies, protocols and training.
- Reporting all injuries and near miss incidents to your supervisor promptly regardless of how serious.
- Reporting unsafe conditions or actions to your supervisor or safety committee representative promptly.
- Using personal protective equipment (PPE) as required
- Ensuring that PPE is maintained and in good working condition prior to use and any malfunctions or need for service or replacement are promptly reported to your supervisor.
- Not removing or interfering with any PPE or equipment safety device or safeguard provided for employee protection.
- Making suggestions to your supervisor, safety committee representative or management about changes you believe will improve employee safety.
- Hold themselves and their colleagues to be attentive to their environment and to maintain a safe and respectful environment.

## **6.0 EMPLOYEE PARTICIPATION**

### **6.1 Employee Safety Committee**

Eastern State Hospital maintains a safety committee to help employees and management work together to identify safety problems, develop solutions, review incident reports and evaluate the effectiveness of the Workplace Safety/Accident Prevention Program. The committee consists of employee-elected representatives and management-designated representatives, in an amount equal to or less than employee-elected representatives, from the facility. Guests (Adhoc members) are invited as needed. A chairperson is selected by majority vote of the committee. Membership is re-appointed or replaced at least annually. The committee meets the second Tuesday of each month in the West Conference room (or alternate location).

Ensure recommendations or concerns are reviewed and status of the recommendation is documented in the Safety/EOC minutes or written feedback provided to initiator within 60 days of Safety Committee review.

### **6.2 Environment of Care (EOC) Committee:**

The EOC Committee membership consists of COO, Safety Risk Manager, Security, Infection Control Director, Quality Management Director or designee, Consolidated Support Services Safety Officer, Medical Equipment Committee chair, Patient Safety Committee Chair, Medical staff representative, Rehab Services Representative, Nursing Representative, Food Services Representative, Housekeeping and Pharmacy Representative. This committee has oversight responsibilities for the Workplace Safety Plan/Accident Prevention Program and the Life Safety, Environment of Care, and Emergency Management chapters of The Joint Commission and related Centers for Medicare and Medicaid Services (CMS) standards and regulations.

Minutes for each Safety Committee meeting are documented and copies are posted on the ESH SharePoint the Safety folder under Committee Minutes Employee Safety Committee minutes are also posted on the designated ESH safety bulletin boards (*see below for locations*).

### **6.3 Safety Bulletin Board**

Eastern State Hospital has two bulletin boards that are specifically devoted to safety. The bulletin boards are located near the Eastlake and Westlake Switchboards where all employees have access. Required postings:

- Notice to Employees – If a job injury occurs (F242-191-000);
- Job Safety and Health Protection (F416-081-909);
- Your rights and a Non-Agricultural Worker (F700-074-000);
- OSHA 300A Summary of Work Related Injuries and Illnesses (required from February 1 through April 30 of each year);
- Safety meeting minutes.
- Other safety items suitable for posting on these boards includes: Safety Committee membership, time/date/location of safety meetings, Safety Newsletters, Safety training schedules.

## **7.0 HAZARD RECOGNITION**

### **7.1 Injury Record Keeping and Review**

Employees are required to report any injury or work related illness to their immediate supervisor regardless of how serious. Minor injuries such as cuts and scrapes shall be reported as well. The employee must use an Injury and Illness Incident Report (DSHS 0 3-133 rev. April, 2014) to report all injuries.

#### **The supervisor:**

- Investigates an injury or illness using procedures in the "Accident Investigation" section below;
- Completes the "Supervisors Review of Injury and Illness Incident Report" (DSHS 03-133a) form with the employee;
- Forwards the report to the Safety Officer.

#### **The Safety Manager:**

- Reviews the incident form to ensure all pertinent information has been collected;
- Provides additional comments or investigation results, if indicated, will be included on the form;
- Forwards all paperwork to Enterprise Risk Management Office (ERMO) claims department.

#### **DSHS Enterprise Risk Management Office (ERMO) Claims Unit:**

- Inputs and tracks all reports of injury through the RiskMaster system;
- Determines from the Employee Report, Injury Investigation Report, and any L&I claim form associated with the accident, whether it must be recorded on the OSHA Injury and Illness Log and Summary according to the instructions for that form;
- Enters a recordable injury or illness within six days after the hospital becomes aware of it;
- If the injury is not recorded on the OSHA log, it is tracked through the Risk Master System (non-OSHA recordable injuries and near misses);
- Provides each month, before the scheduled ESH safety committee meeting, any new injury/claim data. The safety committee reviews the data for trends and develops recommendations for performance improvement to mitigate or prevent future occurrences, as indicated.

The Safety Manager is responsible for posting a completed copy of the OSHA Summary for the previous year on the safety bulletin board each February 1 until April 30. The Summary must be signed by the highest ranking official at the facility. The Summary is kept on file for at least five years. Any employee can view an OSHA log upon request at any time during the year.

## **7.2 Incident Reporting and Investigation Procedure**

### **Near Miss**

Whenever there is an incident that could have resulted in serious injury to an employee (a *near-miss*), the near-miss is reviewed by the supervisor and additional investigator(s) depending on the seriousness of the injury that could have occurred. The "Injury and Illness Incident Report (DSHS 03-133) or ESH's Unusual Occurrence report form is used to report and investigate near-misses. The form is clearly marked to indicate that it was a near-miss and that no actual injury occurred. The report will be used to document the near miss and correct the hazards to reduce and/or eliminate the possibility of an injury.

### **Employee Injury**

When an employee is involved in an on-the-job injury, they must report it to their supervisor immediately and follow the procedures for reporting injuries. When the supervisor becomes aware of an employee injury, the supervisor completes:

- Injury and Illness Incident Report (DSHS 03-133) with the employee to insure all required information is complete. The injury is investigated by the supervisor and additional investigator(s) depending on the seriousness of the injury that occurred. In conducting an investigation, it is important to:
  - a) Gather all necessary information.
  - b) Record the sequence of events.
  - c) List all causative factors as they occur in the sequence of events.
  - d) Interview and collect statements from witnesses as indicated.
  - e) Closely review the employee's statement and description of the incident and identify any discrepancies between employee's statement and actual findings.
  - f) Make determination based on the findings:
    - (1) Unsafe Act
    - (2) Unsafe Conditions
    - (3) Unsafe Acts/Conditions
- The Employee Report of Possible Client Assault (DSHS 03-391) is completed for all incidents resulting from a potential client assault. Attach to the Injury and Illness Incident Report.
- ESH Form 1-28 "Confidential Report of Unusual Occurrence" (UOR). Unusual Occurrence Reports are also completed when any incident of unusual nature occurs and involves patients, visitors, employees, equipment, property, etc.
- A Post Exposure Packet is completed in all cases resulting in an exposure incident or bloodborne pathogen exposure. This is defined as an eye, mouth, other mucous membrane, non-intact skin, or contacts with blood or other potentially infectious materials that results from the performance of an employee's duties.
- The Labor and Industry Employee Report of Accident form is completed by the employee if receiving medical or emergency treatment for a work-related incident/injury or exposure. This form is to be initiated at the physician's office or emergency room.

The physician completes the form with the employee and mails a copy to Labor & Industries for processing.

### **Hospitalization or Fatality Reporting Requirements (WAC 296-27-031 and 296-800-320)**

- (1) The CEO (or designee) must report to DOSH within eight hours of becoming aware of a work-related incident that results in:
  - (a) A fatality; or
  - (b) An inpatient hospitalization of any employee. (Unless it involves only observation or diagnostic testing).
- (2) The CEO (or designee) must report to DOSH within twenty-four hours of becoming aware of a work-related incident that results in either an amputation or the loss of an eye that does not require inpatient hospitalization.

Note:

1. Staff must secure the scene of work-related events that result in the death or inpatient hospitalization of any worker. (WAC 296-800-320).
2. Staff must not move equipment involved (e.g. personal protective equipment (PPE), tools, machinery or other equipment ), unless it is necessary to remove the victim or prevent further injuries.(WAC 296-800-320-10)

NOTE:

1. If the amputation or loss of an eye requires inpatient hospitalization, staff must follow the eight-hour requirement in WAC 296-27-031 (1)
  2. Inpatient hospitalization that involves only observation or diagnostic testing is not a reportable inpatient hospitalization.
- (5) The CEO (or designee) reports the following information to DOSH:
    - a) The employer name, location and time of the incident;
    - b) The number of employees involved and the extent of injuries or illness;
    - c) A brief description of what happened and;
    - d) The name and phone number of a contact person.

- **DO NOT DISTURB the scene except to aid in rescue or make the scene safe.**

In the event of employee work-related hospitalization or fatality:

- Block off and secure area. If in a room, close and lock the room and post a guard, if in a common area, mark off with tape or ribbon and post a guard.
- Do not clean up bodily fluids or pick up other items.
- Keep unnecessary persons out of the area before and after securing it.
- Record the names of persons who have entered the area during and after the incident.
- Record the names of persons who have witnessed the incident.
- Keep records of any items leaving the area before investigators arrive, i.e. clothing, bloody items and weapons.

These points are particularly important for an unwitnessed incident; they may be able to tell investigators what transpired.

Whenever there is an employee accident that results in death or serious injuries that have immediate symptoms, a preliminary investigation is conducted by the immediate supervisor of the injured person(s), a person designated by ERMO, and/or any other persons whose

expertise can help with the investigation. The investigator(s) takes written statements from witnesses, photographs the incident scene and equipment involved. The investigator(s) must also document as soon as possible after the incident, the condition of equipment and any anything else in the work area that may be relevant. The investigator(s) makes a written report of their findings. The report includes a sequence of events leading up to the incident, conclusions about the incident and any recommendations to prevent a similar incident in the future.

### **7.3 Patient and Visitor Injuries**

All patient injuries are reported to the Quality Management Department through the Unusual Occurrence Reporting (UOR) system.

### **7.4 Hazardous Materials and Waste Spills and Exposures**

Processes for reporting and investigating hazardous materials and waste spills and exposures are described in the Hazardous Materials Management Plan.

### **7.5 Fire/Safety Management Deficiencies and Failures**

Processes for reporting and investigating fires are described in the Fire/Safety Management Plan.

### **7.6 Product Safety Recalls**

All equipment hazard notices and recalls are coordinated through the Safety Office and forwarded to identified departments for review and action as indicated.

### **7.7 Utility System Failure or User Errors**

Failures or user errors related to utility systems are reported Consolidated Support Services as described in the Utility Systems Management Plan.

### **7.8 General Hazards**

Every employee has the right and responsibility to identify hazards and to report them for corrective action. This must be done by immediately notifying the immediate supervisor and/or the supervisor of the area where the hazard has been identified. The following procedures apply when reporting identified hazards:

- Notify supervisor immediately.
- If no action is taken, notify the Safety Manager by telephone and/or complete an ESH Internal Hazard Reporting Form. Complete this form with as much detail as possible. Reports may be anonymous; however, providing a name and telephone number will assist in obtaining additional information that may be necessary to rectify the hazard.
- Hazard reports are evaluated by the Safety Manager to determine causative factors and implement corrective actions.
- All reports and action(s) taken are reviewed by the Safety Committee during regular monthly meetings. Copies of reports are submitted to all concerned parties and to the initiator if identified.

### **7.9 Interim Life Safety Measures (ILSM)**

Potential hazards related to construction, renovation or maintenance activity are assessed through the Infection Control Risk Assessment (ICRA) process that identifies potential new or altered risks related to infection control, utilities or building systems, fire safety or interim life safety, general safety issues, emergency preparedness or response, and security. The

ICRA is reviewed and monitored by the COO, Safety Manager, Security and Infection Control Coordinator and reported to the Safety Committee.

Projects that could significantly impact life and/or fire safety result in the development of an interim life safety plan, which includes specific training materials and information, the implementation of expanded fire drills, daily/weekly inspections/documentation and compliance of all contractors with ILSM during the construction period. The Safety Manager coordinates the planning, implementation and monitoring of all interim life safety measures in coordination with other departments (e.g. CSS) as indicated.

Interim Life Safety Measures (ILSM) are a series of operational activities that must be implemented to temporarily reduce the hazards posed by:

- 1) Construction activities (in or adjacent to all construction areas)
- 2) Temporary Life Safety Code deficiencies including but not limited to the following:
  - a) Fire, smoke or sprinkler systems temporarily out of service
  - b) Exit(s) blocked
  - c) Access for emergency response team is blocked
  - d) Fire walls/doors are breached
  - e) Fire doors/windows are missing
  - f) Other

Interim Life Safety Measures (as identified during planning phase)

1. Ensure free and unobstructed exits. Staff must receive additional training when alternative exits are designated. Buildings or areas under construction must maintain escape routes for construction workers at all times. Staff or designees must inspect means of exiting from construction areas daily.
2. Ensure free and unobstructed access to emergency services for fire, police and other emergency forces. Fire hydrants, fire lanes, etc. must be readily available for immediate fire department use.
3. Ensure fire alarm, detection and suppression systems are in good working order. Provide a temporary but equivalent system when any fire system becomes impaired. Inspect and test temporary systems monthly. Immediately initiate and document a fire watch whenever a fire alarm or sprinkler system is being tested, serviced, and/or repaired or there has been a system failure. If the fire alarm system or required automatic sprinkler system is out of service for more than four (4) hours in a 24-hour period, the Authority Having Jurisdiction (AHJ) must be notified.
4. Ensure temporary construction partitions are smoke-tight and built of noncombustible or limited combustible materials that will not contribute to the development or spread of fire.
5. Provide additional firefighting equipment and train staff in its use.
6. Prohibit smoking throughout buildings as well as in, and adjacent to, construction areas.
7. Develop and enforce storage, housekeeping and debris removal to reduce the building's flammable and combustible fire load to the lowest feasible level.
8. Conduct a minimum of two fire drills per shift per quarter.
9. Increase hazard surveillance of buildings, grounds and equipment, with special attention given to excavations, construction areas, construction storage and field offices.
10. Train staff to compensate for impaired structural or compartmental fire safety features.

11. Conduct organization-wide safety education programs to promote awareness of LSC deficiencies, construction hazards and ILSMs. During periods of temporary Life Safety Code deficiencies, Attachment A - Interim Life Safety Measures (ILSM) Evaluation Sheet will be the tool used to determine if ILSMs are required.

### **7.10 Statement of Conditions**

The Safety Manager has the primary responsibility for the electronic Statement of Conditions. The Safety Manager maintains building floor plans and coordinates the identification and resolution of facility deficiencies and provides oversight for the initiation and completion of Plans for Improvement (PFI). The Safety Manager is responsible for identifying any corrections that require special funding or scheduling and ensuring that a PFI is developed, when indicated.

### **7.11 Safety Inspection Procedures**

Eastern State Hospital is committed to aggressively identifying hazardous conditions and practices which are likely to result in injury or illness to employee and takes prompt action to eliminate any identified hazards. In addition to reviewing injury records and investigating accidents for their causes, management and the safety committee regularly check the workplace for hazards as described below:

#### **Environmental Safety Inspections**

Environmental safety inspections are conducted weekly to ensure that all patient care areas are inspected for hazards, at a minimum, bi-annually and all non-patient care areas, at a minimum, annually to evaluate staff knowledge and skill, observe current practice, and evaluate environmental conditions/hazards. These inspections are conducted by Safety Committee, Safety, Infection Control and Housekeeping representatives. These inspections are in addition to documented hourly environmental checks completed by nursing staff in all patient care areas. Representatives discuss with co-workers any safety concerns and report any hazards or concerns to the Safety committee for consideration. The results of the area inspections and any action taken are reported to the area supervisor(s), department manager, Safety Committee and CEO.

#### **Periodic Change Process**

A team is formed to look at any significant changes the hospital makes to identify safety issues that may arise because of these changes. Examples of when this is necessary could include new equipment, significant changes to processes (i.e. Non-smoking campus, or anti-ligature changes) or a change to the building structure. This team is made up of affected staff and safety representatives and will examine the changed conditions and make recommendations to eliminate or control any hazards that were or may be created as a result of the change.

#### **Proactive Risk Assessment**

The Safety Manager in coordination with hospital leadership, Security, Department Managers, Consolidated Support Services and Safety Committee members conducts comprehensive risk assessments to proactively evaluate risks associated with buildings, grounds, equipment, occupants, and internal physical systems that have the potential to impact the safety of patients, staff and visitors coming to the hospital's facilities. Results of the risk assessment process are used to create new or revise existing safety policies and procedures, hazard surveillance elements in the affected area, safety orientation and education programs or safety performance improvement standards. Risks are prioritized to

assure appropriate controls are implemented to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people coming into the hospital's facilities. The prioritized risks are then either addressed immediately or integrated into the planning objectives and performance improvement processes for the respective management plan. Specific findings, recommendations, and opportunities for improvement are documented in Safety Committee meeting minutes and reported to the Executive Committee and Governing Body.

### **Annual Loss Control Evaluation (ALCE)**

Each year staff from ERMO conducts an annual courtesy inspection of the facility. This gives the facility an opportunity to have an outside inspector walk-through the facility and look for hazards that may be missed during routine inspections. Inspections follow a formalized inspection process that is shared with staff. All inspections have corrective measures with due dates to ensure each hazard is corrected in a timely manner.

### **Job Hazard Analysis**

As a part of Eastern State Hospital's on-going safety program, a "Job Hazard Analysis" (JHA) form is used to look at each type of job task our employees perform. This analysis is completed by a supervisor and/or safety committee member along with an employee familiar with the task. The JHA defines the steps of the task, what hazards may be present during the task and what can be done to eliminate or protect workers from those hazards. Employees are trained if there are changes to current procedures or PPE. The results are reported to the safety committee. Each job task is analyzed at least once every two years, whenever there is a change in how the task is performed or if there is a serious injury while performing the task.

## **8.0 HAZARD PREVENTION AND CONTROL**

Eastern State Hospital is committed to eliminating or controlling workplace hazards that could cause injury or illness to our employees or patients. We meet the requirements of State/Federal safety standards where there are specific rules about a hazard or potential hazard in our workplace. Whenever possible we design our facilities and equipment to eliminate employee exposure to hazards. Where these engineering controls are not possible, work rules are written that effectively prevent or mitigate employee exposure to the hazard. When the above methods of control are not possible or are not fully effective we require employees to use personal protective equipment (PPE) such as safety glasses, hearing protection, foot protection etc.

### **8.1 Basic Safety Rules**

The following basic safety rules have been established to help make our facility a safe and efficient place to work. These rules are in addition to safety rules that must be followed when doing particular jobs or operating certain equipment. Always refer to manufacturer's instructions when possible. Failure to comply with these rules may result in disciplinary action.

1. Never do anything that is unsafe in order to get the job done. If a job is unsafe, report it to your supervisor or safety committee representative. We will find a safer way to do that job;
2. Report hazardous conditions to your supervisor or safety committee immediately. Do not operate unsafe equipment;
3. Understand and follow the procedure for reporting accidents (section 4);
4. Never operate a piece of equipment unless you have been trained and are authorized. Supervisors must document training before an employee is considered competent to perform duties of the job;

5. Use your personal protective equipment (PPE) whenever it is required;
6. Obey all safety warning signs;
7. All employees must comply with applicable collective bargaining agreements and DSHS Administrative Policy 18.75 entitled Drug and Alcohol-Free Workplace. Working under the influence of alcohol or illegal drugs or using them at work is prohibited. Use of prescription drugs that may impact judgment or work performance must be disclosed to your supervisor.
8. It is a felony to bring firearms or explosives onto Hospital property;
9. Smoking is only permitted outside the building, 25 feet away from any entry or ventilation intake in accordance with DSHS Administrative Policy No. 18.65 and RCW 70.160. ;
10. Follow appropriate work habits:
  - Read and follow product labels
  - Refrain from horseplay, fighting and distracting fellow employees
  - Understand and use proper lifting techniques
  - Maintain good housekeeping
  - Keep emergency exits, aisles, walkways and working areas clear of slipping/ tripping hazards
11. Know the location and use of:
  - First aid supplies
  - Emergency procedures (chemical, fire medical, etc.)
  - Emergency telephone numbers
  - Emergency exit and evacuation routes
  - Firefighting equipment
12. Clean up spills immediately. Replace all tools and supplies after use. Do not allow scraps to accumulate where they will become a hazard. Good housekeeping helps prevent injuries.

## **8.2 Job Related Safety Rules**

Eastern State Hospital has established safety rules and personal protective equipment (PPE) requirements based upon the job hazard assessment for the common workplace hazardous tasks. *All JHA's and SOP's for specific information regarding the requirements are located in the PPE manual located in the Safety Office.*

## **8.3 Discipline for Failure to Follow Basic Safety Rules:**

Employees are expected to use good judgment when doing their work and to follow established safety rules. Appropriate action will be taken for failure to follow established safety rules. The discipline process is addressed in the applicable collective bargaining agreements and DSHS Administrative Policy 18.40.

## **8.4 Equipment Maintenance**

Each facility is responsible for servicing and inspecting their equipment following manufacturers' recommendations. Consolidated Support Services (CSS) is responsible for maintaining all equipment and buildings within the facility. All records are kept in the maintenance office. A checklist/record to document the maintenance items is maintained and kept on file for the life of the equipment.

All medical equipment preventative maintenance and repair is completed and documented by Sacred Heart MC Engineering with the exception of hospital beds which are maintained by

Consolidated Support Services (CSS) Electrical Shop employees. Consolidated Support Services Electrical Shop employees assist ESH Central Supply staff manage the medical equipment inventory and maintains documentation of all service and preventative maintenance.

All equipment is required to be examined daily prior to being placed into service.

## **9.0 EMERGENCY PLANNING**

### **9.1 In case of emergency**

Evacuation maps for the facility are posted in all ESH buildings; patient care and non-patient care areas. Evacuation maps show the location of exits, fire alarm pull stations and fire extinguishers. Fire evacuation drills are conducted at least annually for all buildings and one drill per shift for each quarter of the year.

#### **Hazard Vulnerability Analysis**

A hazard vulnerability analysis (HVA) is completed to determine which hazards require special attention. The HVA provides a systematic approach to recognizing hazards that may affect demand for the hospitals services or its ability to provide those services. The risks associated with each hazard are analyzed to prioritize planning, mitigation, response and recovery activities. The hazard vulnerability analysis is evaluated annually to assess the hospital's current emergency management activities and to identify necessary changes, additional planning activities and specific exercise scenarios. Contingency plans are developed as the result of a hazard vulnerability analysis and are designed to guide personnel in the initial stages of specific emergency situations that may seriously impact or threaten routine capabilities of the hospital. The HVA and emergency procedures are located in the Safety manual in the Emergency Management Plan. Emergency procedures outlined in this plan include:

- All Hospital Lockdown
- Hostage Situation
- Labor Action
- Major Utility Failure
- Crisis Debriefing
- Telephone Failure
- Severe Weather Warning
- Fire
- Evacuation
- Earthquake
- Armed Assault
- Fire Watch
- Bomb/Telephone Threat
- Volcanic Eruption
- Bio-Terrorism/Hazardous Substance in the Mail
- Bio-Terrorism/Infected Patient or Staff

### **9.2 If an injury occurs**

- First aid supplies are maintained in all patient care locations. If you are injured, promptly report it to any supervisor.
- All direct care staff are required to have CPR training. Other employees may also have certification in CPR.

- In case of serious injury, do not move injured person unless absolutely necessary. Only provide assistance to the level of your training. Two codes have been identified for use at ESH:
  - Code Blue is initiated for all cardiopulmonary arrests (no pulse and/or not breathing) involving a patient, staff person, or visitor.
  - Code Rapid Response Team is initiated when a patient, staff or visitor experiences a sudden, abrupt, critical emergency other than cardiopulmonary arrest (i.e., person is responsive, breathing and moving) or a progressive deterioration in physical condition that requires immediate medical assessment. Examples include, but are not limited to, serious fall, fainting, seizures, and symptoms associated with low blood pressure, hypoglycemia, etc.

To initiate emergency response, call 4333 on a house phone, 565-4333 by cell phone, or use a radio on channel 1 to report “Code Blue or Code Rapid Response (state location)” and then immediately follow the procedures outlined in the Emergency Medical Response policy.

- Infectious diseases are a risk with some job tasks at the facility. Eastern State Hospital has developed an exposure control plan to mitigate the risks of Bloodborne Pathogens and infectious diseases. All information regarding Bloodborne Pathogens and infectious diseases can be found in the ESH Infection Control Manual located on the Public Computer Drive (“P” Drive) under ESH Manuals in the Infection Control folder or on the ESH SharePoint. The Exposure control plan covers HIV/AIDS and Hepatitis B; the primary infectious diseases of concern in blood. Universal precautions, work policies, and PPE are covered under the plan as well as how to report any exposure to infectious diseases. All reports are kept confidential as required by HIPAA and other DOSH regulation.

As a matter of routine, DSHS employees come in daily contact with a high volume and broad range of clients, residents, other staff, contractors, and general members of the public. Accordingly, employees should anticipate being regularly exposed to any number of infectious diseases. In all cases, taking universal precautions and being constantly vigilant will be the best defense.

- A. The most frequent contagions employees can expected to be exposed to in the course of their daily official duties are common infectious agents that include such things as the common cold and influenza. Depending on the specific strain, these annually occurring contagions can have the greatest impact on ESH staff and productivity. To reduce the likelihood of spreading these virus’ or becoming infected, all employees are highly encouraged to:
- Perform frequent hand-washing using plain soap and hot water throughout the day, to include the tops of hands;
  - During the course of performing daily business be sure to keep hands away from the face. Avoid touching your eyes, nose and mouth with unwashed hands;
  - Maintain a respectable, professional distance from others in the workplace to help prevent the easy passage of contagions;
  - Do not cough or sneeze directly into the hand. Use proper etiquette around others by coughing/sneezing into disposable tissues, or, in the absence of tissues, using the crook of the elbow instead;
  - Get an annual flu shot;

- If you have obvious symptoms, remain home from work to help keep from potentially exposing others.
- B. Employees should also expect to occasionally be conducting business with clients, residents, other staff, contractors, or general members of the public who may be infected with more severe, though less common, contagions, including such things as: Human Immunodeficiency Virus (HIV), Hepatitis B virus (HBV). While that may be troubling, in most cases an employee's exposure will be no greater at work than what they might reasonably expect to experience visiting a grocery store, attending a movie, or walking through a shopping mall.

Nevertheless, employees should conduct official business with others always keeping Universal Precautions in mind. Universal Precautions refer to the generally accepted preventative practice to treat blood and all other potentially infectious bodily fluids as if they contain blood-borne pathogens, whether the blood or fluid has been identified as having blood-borne pathogens or not. Employees are encouraged to:

- Actively participate in initial and annual refresher Blood-Borne Pathogen training appropriate to position, duties and responsibilities;
  - Maintain a respectable, professional distance from others in the workplace to help prevent easy passage of any contagion;
  - Wash hands frequently, and between washings use alcohol-based sanitizers or waterless hand cleaner;
  - Wear gloves appropriate to the task whenever there is any possibility of coming into contact with potentially infectious fluids (e.g. performing first aid, handling SHARPS containers, cleaning up bodily discharges, removing trash, etc.);
  - If there is a possibility of fluids being splashed onto an employee performing clean-up or a rescue, they should wear gloves, full body gowns, face masks and eye protection;
  - At locations with an increased possibility for exposure to blood or other potentially infectious bodily fluids (e.g., hospitals, 24-hour facilities), employees should be certain to review and become very familiar with their site's specific Infectious Disease Exposure Control Plan.
- C. Employees in DSHS have little potential for exposure to extreme infectious diseases such as Viral Hemorrhagic Fever (Ebola). Possible DSHS staff introduction to these more fervent contagions in the course of performing state business is extremely remote. The most likely means of any sort of exposure would be through some form of second or third-hand contact with the general public (e.g., exposure to a client or staff member who has a family member who may have been exposed to a contagion). DSHS employees should review the Washington State Department of Health website for the most current and factual information available.

As precaution, it is important all staff know what to do if a potential exposure is suspected and factually supported through verifiable context and presentation of symptoms. If you learn during the course of business that: 1) a client, staff member, or anyone in a client or staff member's immediate circle has recently returned from visiting, working, or volunteering in a known outbreak area of the world; and, 2) the returning person is reporting or presenting symptoms of an illness, then:

- As with all circumstances, practice Universal Precautions while performing your duties;
- Notify the local county public health department, and take the directions they provide;
- If the local health department directs you call 911, do so, and have the person wait in a separate room to keep them excluded from others until Emergency Medical Services arrives;
- Notify the chain of command through normal incident reporting procedures.

## 10.0 SAFETY AND HEALTH TRAINING AND EDUCATION

### 10.1 Safety Training

Safety training is an essential part of our plan to provide a safe work place at Eastern State Hospital. The Safety Manager and supervisors conduct a basic orientation to ensure that all employees are trained *before* they start a task that requires training. The supervisor is responsible to verify that each employee has received an initial, site-specific orientation and any training required to do the job safely. All training is documented and maintained in the employee file. The Safety Manager is responsible for developing and maintaining New Employee, Annual Safety/Accident Prevention, Emergency Management and Supervisor Safety training materials.

#### Basic Orientation

On the first day of hire, and annually or as required by job class and training type, employees are required to attend New Employee Orientation (NEO) that includes all OSHA required Safety, Accident Prevention, Workplace Violence, Infection Control and other required training i.e. training related to the interaction with patients that are specific to their job tasks as outlined in the JHA. All training curriculum is maintained by the ESH Staff Development Department.

#### Orientation for Nursing Staff:

Upon completion of the basic NEO, nursing staff completes additional training, utilizing a Competency Based Evaluation Tool, related to working with people with mental illness, violence prevention, safety policies specific to nursing and patient care, and advanced skills in managing escalating situations with patients using.

Other training required by job class and/or based on JHA is conducted prior to an employee performing the task using a Competency Based Evaluation Tool. All training is documented and maintained in the employee file.

CSS staff receives site-specific training prior to working at the facility. Other required training topics are conducted by the CSS Safety Officer and may include:

- Confined Space Entry training for employees that may participate in confined space entries;
- Lockout\Tagout training for all authorized employees;
- Respirator use and fit testing;
- Hearing audiograms for affected employees;
- Hazard Communication specific training for chemicals used;
- Fall Protection training for fall arrest and fall restraint at heights four feet or higher;
- Basic power tool safety;
- Hand tool Safety;
- Specific Mobile Equipment training for mowers, forklifts, tractors, etc.;
- Heavy equipment training will be provided prior to operation of equipment;
- Basic welding safety;

- Ladder use and inspection;
- Other training specific to the facility

## **10.2 Other Hazard Control Programs**

In addition to this basic Workplace Safety Plan/Accident Prevention Program, Eastern State Hospital has developed detailed written programs and Environment of Care (EOC) plans required by The Joint Commission. These plans are located in the Safety Manual, hospital-wide. The Safety Office maintains all required documentation related to these program/plan requirements.

- Fire Safety Management Plan
- Security Management Plan
- Utility Systems Management Plan & Documentation
- Medical Equipment Management Plan
- Hazardous Waste Management Plan
- Emergency Management/COOP Plan
- Safe Patient Handling Program
- Chemical Hazard Communication Program
- Personal Protective Equipment (PPE)/JHA and SOP
- Facility Inspections

Consolidated Support Services maintains documentation linked to their APP and related programs.

## **11.0 WORKPLACE VIOLENCE PREVENTION**

### **11.1 Purpose**

The Eastern State Hospital Workplace Violence Prevention Plan demonstrates the hospital's commitment to reduce and eliminate workplace violence. Eastern State Hospital recognizes that as a psychiatric hospital our patients create an additional risk of violence in the workplace. The hospital mitigates this additional risk through a continuous commitment to providing effective treatment to our patients combined with staff training and support, ensuring a safe environment and promoting a Culture of Safety. At the foundation of our Workplace Violence Prevention Plan is the recognition that:

- Management is committed to “Zero Tolerance for Workplace Violence”;
- A proactive patient centered approach leads to a reduction in violence;
- Increasing safety and respect for our patients creates safety for our staff;
- Prioritizing good clinical care and patient engagement creates a safer environment for all

As a high risk industry, all efforts are taken to integrate clinical understanding of adverse patient behaviors to develop behavior and treatment plans designed to proactively minimize risk. Staff is trained to employ non-violent crisis intervention when faced with escalating verbal or physical patient behavior to prevent injury or assault.

This plan guides the state hospitals' implementation of 49.19.020 RCW and 72.23.400 RCW requiring public and private facilities for the mentally ill to develop, implement and plan to reasonably protect employees from violence at the health care setting and to address and report security considerations related to identified hazards.

## 11.2 Scope

The Eastern State Hospital Workplace Violence Prevention Plan applies to all employees, contract staff, interns, students and volunteers, buildings and property and to any acts of violence that might be perpetrated on an employee. Such violent acts may include assault, threatening behavior or harassment that results in emotional or physical injury or otherwise places one's safety and productivity at risk.

This plan also addresses support to employees who are victims of domestic violence mirroring DSHS Administrative Policy No. 18.67 in its commitment to work with employees to prevent abuse, stalking and harassment from occurring in the workplace and offering employees who are victims of domestic violence referral to appropriate resources.

## 11.3 Definition

The National Institute for Occupational Safety and Health (NIOSH) defines workplace violence as "violent acts directed toward persons at work or on duty."<sup>1</sup> Washington State Department of Social and Health Services (DSHS) defines workplace as any location, permanent or temporary, where an employee performs work-related duties, including but not limited to buildings and surrounding perimeters, parking lots, field locations, home and community activities, alternate work locations, agency vehicles, and travel to, from and during work assignments (DSHS Administrative Policy No.18.67).

Workplace violence takes several forms, including verbal threats, threatening behavior, or physical assaults. It may be further differentiated as:

- Stranger violence: an assailant who has no legitimate business relationship to the workplace, or the worker (stranger violence),
- Domestic violence – an assailant who has a personal relationship with the victim
- Workplace violence: an assailant who either receives services from or is under the supervision of the affected workplace or the victim or by co-workers

Each of these involves different risk factors and means of prevention / response. A risk factor is a condition or circumstance that may increase the likelihood of violence occurring in a particular setting. Health care settings are high risk environments for the occurrence of workplace violence, particularly those that provide services to persons with unstable or volatile conditions and/or behaviors (see footnote 1).

## 11.4 Background:

Washington State House Bill 2899 passed in 2000 and incorporated into law as 49.19.020 RCW requires each health care setting in the state to:

- Develop and implement a plan to reasonably prevent and protect employees from violence at the setting.
- Conduct a security and safety assessment to identify existing or potential hazards for violence and determine the appropriate preventive action to be taken.

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<sup>1</sup> In its report "Prevent Workplace Violence in Psychiatric Settings, Washington's Department of Labor and Industries states that the health care sector leads all other industry sectors in incidence of nonfatal workplace assaults with 48% of all nonfatal injuries from violent acts against workers occurring in this sector. According to the National Crime Victimization Survey, mental health workers experienced the highest rate of simple assaults in the health care sector. The National Occupational Safety and Health Administration's publication "Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers" (OSHA 3148-01R, 2004) identifies common risk factors and offers guidelines for workplace violence prevention programs which have been incorporated in this plan including practical corrective methods to help prevent and mitigate the effects of workplace violence.

- Consider for incorporation guidelines on violence in the workplace or health care settings 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 health care setting accrediting organizations.

72.23.400 RCW relating to Public and Private Facilities for the Mentally Ill further delineates this law for state hospitals, requiring input to the plan from management, unions, nursing, psychiatry and key function staff as appropriate and requiring that the plan be evaluated, reviewed and amended as necessary at least annually.

The plan is to address security considerations related to the following items, as appropriate to the particular state hospital, based on identified hazards:

- a) Physical attributes including access control, egress control, door locks, lighting and alarm systems
- b) Staffing including security staffing
- c) Personnel policies
- d) First aid and emergency procedures
- e) Reporting violent acts, taking appropriate actions 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 including those related to smoking, activity, leisure, and therapeutic programs; communication between shifts; and restraint and seclusion

Additionally, 72.23.451 RCW requires the Department of Social and Health Services (DSHS) to report to the House Committee on Commerce and Labor and the Senate Committee on Commerce and Trade on the department's efforts to reduce violence in state hospitals. This report, "Workplace Safety in State Hospitals" is written in collaboration by all three state hospitals, Eastern State, Western State and Child Study and Treatment Center and submitted to the Legislature by September 1 of each year.

Finally, the Workplace Violence Prevention Plan reflects Eastern State Hospital's Safety Policies and is additionally grounded in accreditation requirements of The Joint Commission.

The Joint Commission (TJC) standard LD 03.01.01 identifies that leadership must work to create and maintain a culture of safety and quality ("CAMH," 2012).

#### **11.5 Executive Leadership Responsibilities:**

- Create and maintain a culture of safety and a means for employees to report issues without fear of reprisal.
- Annually review the Workplace Violence Prevention Plan in accordance with RCW 72.43.400
- Provide an annual Workplace Safety Report to the legislature outlining our efforts to reduce workplace violence in each of the state hospitals
- Recruit and retain qualified staff to ensure effective treatment
- Review and communicate Quality Improvement data to enhance accountability for workplace safety

### **11.6 Management/Supervisor Responsibilities:**

- Ensure employees understand the expectations of a violence free workplace.
- Conduct employee competency evaluation annually
- Hold staff accountable for participation and competency in key skills and abilities related to workplace violence prevention
- Identify employee needs for knowledge and skills refresher in non-violent crisis intervention techniques
- Fully investigate all occurrences of workplace violence and implement corrective action(s) to eliminate or mitigate issue.
- Support employees that are victims of workplace violence facilitating debriefing, Critical Incident Stress Management (CISM) or referral to Employee Assistance Program (EAP), as indicated.
- Ensure accurate reporting of incidents (e.g. AROI) and Employee injuries (DSHS Form 31-133)

### **11.7 Employee Responsibilities:**

- Be respectful to patients and co-workers at all times, reinforcing a culture of safety
- Follow the patient's safety plan addressing any questions to supervisor
- Sign, acknowledging their annual review of the Workplace Violence Plan and DSHS Policy 18.67
- Report threats or acts of violence to supervisor and document immediately
- Utilize least restrictive interventions when responding to escalating patient behavior
- Follow training recommendations related to de-escalation and containment
- Maintain constant awareness of the environment

### **11.8 Risk Assessment**

Effective treatment requires the accurate analysis of behavior and consideration of the patient's predisposing and co-existing conditions and circumstances often identified in the admission assessment. It is important to identify vulnerabilities that increase the potential for maladaptive behavior. Vulnerabilities can be episodic (e.g. specific triggers or stressors), short-term (e.g. sleep patterns), long-term or permanent in nature such as developmental disorders, type of mental illness, substance abuse or even side-effects of medication. Risk assessment continues throughout a patient's admission and has a dynamic relationship with the patient's individualized treatment plan. Different tools may be utilized to determine risk. Communication of risks and new / current information about patients' vulnerabilities and effective treatment responses must be communicated during treatment plan reviews and daily shift changes and report.

### **11.9 Treatment Plans and Milieu:**

A primary focus of treatment is mitigation of unsafe behavior, behavior change, skills building and personal growth resulting in the ability to resume safe and effective community and/or family living. Preventing and constructively dealing with unsafe and violent behavior is therefore a priority for patient care as well as workplace violence prevention. Eastern State Hospital's treatment protocols are grounded in the philosophy of the "therapeutic milieu". Training guides staff in the components of cognitive behavioral treatment and the recovery model and how these are utilized to inform individual treatment plans and the achievement of short and long-term goals. The multidisciplinary treatment team works proactively with clients to reduce incidents of unsafe behavior, including assault. All direct care staff are trained in the principles of effective treatment, establishing a common language and a common understanding of the behavioral strategies employed across the campus.

Eastern State Hospital conducts team debriefings of incidents of seclusion, restraint and assaults utilizing post incident as well as structured inter-shift meetings to support staff as well as identify effective interventions employed and opportunities for improved awareness or skill development. Effective team process and communication is essential to managing an environment with inherent risks for disruption.

#### Special Population Considerations

There are often special risk considerations for specific populations. Such risks, vulnerabilities and corresponding tailored approaches are included in training and orientation to the patient unit. Special populations include, but are not limited to:

- Geriatric
- Forensic
- Developmental Disabilities
- Civil commitments,
- Habilitation Mental Health
- Co-occurring diagnoses

#### Patient Treatment Planning

Patients' treatment plans address their risk factors and safety plans which clearly identify triggers and effective prevention / de-escalation. The ward specific clinical rounds, inter-shift reports and safety huddles enable the interdisciplinary team to develop treatment strategies, tailor responses and examine / debrief interventions or critical events daily.

### **11.10 Training to Reduce Workplace Violence**

Staff development and supervisors at each state psychiatric hospital are responsible for ensuring that all staff completes mandatory training.

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-violent crisis intervention training program.

Eastern State Hospital utilizes Therapeutic Options, 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.

### **11.11 Quality Management**

#### Data Review

Workplace violence of any kind is reported through administrative channels and tracked in incident data bases. Administrative forms (Injury and Illness Incident Report (DSHS 03-133) and ESH's Unusual Occurrence report form) are utilized to document assaults and are reviewed by leadership.

Eastern State Hospital tracks all workplace injuries due to assault in the RiskMaster data base maintained by ERMO and internal database (UOR) providing the capacity to compile data for analysis of frequency, severity and circumstances contributing to a deeper understanding of

workplace violence among our patient population and staff and the potential for a systemic solution:

- Staff involved
- Assailant identifier (patient, employee, visitor, other)
- Incident date, time, shift
- Use of restraint
- Use of seclusion
- Cause of injury
- Patient assault involved
- Object used in assault
- Staff-initiated contact
- Injury severity rating
- Type of injury
- Body part affected
- Description of precipitating event(s)

Data is analyzed at the monthly Safety Committee Workgroup meeting and reported quarterly to the Quality Council. A narrative summary with recommended action plans is presented to Quality Council and at quarterly Governing Body meetings.

#### Workplace Safety Surveys

Employee surveys (i.e. Culture of Safety) are used on a strategic basis at Eastern State Hospital to obtain feedback on perceived personal safety, communication, teamwork and leadership effectiveness related to safety. Surveys are a valuable tool in identifying or confirming the need for improved security measures, training, supervision or management responsiveness. Surveys and follow-up focus groups also convey management's interest and concern for staff safety and acknowledgement of the importance of employee feedback.

#### Support to employees

Management recognizes that victims of workplace violence suffer a variety of consequences that may include physical injury, psychological trauma, reduced confidence, and concerns about returning to work.

All employees injured at work have access to first aid measures as indicated. Most injuries that result from hands-on containment or workplace violence are easily remedied by cleansing, applying comfort item such as ice to reduce swelling, bandage, etc. In the event that an employee sustains a more serious injury the supervisor assists the employee to obtain additional medical attention if indicated.

All levels of leadership at Eastern State Hospital communicate personal interest in employees who have been injured by an episode of Workplace Violence. Direct supervisors provide support as 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. Critical Incident Stress Management (CISM) is also available as indicated on a voluntary basis for groups or individual team members who have been impacted.

Employees who self-identify as victims of domestic abuse may access the employee assistance program for referral to special resources.

### **11.12 Administrative, Engineering Controls and Work Practices**

Eastern State Hospital complies with Labor and Industry and OSHA regulations that apply to workplace violence hazards and accident prevention including mandatory employment practices such as background checks, primary source verification of qualifications, reporting of employee work-related hospitalization and/or fatality and provision of safety orientation and training tailored to our specific hospital environment and population.

Other environmental controls employed at Eastern State Hospital include entrance security (locks), a system of visitor or contractor access control, identification or security badges worn by all Eastern State Hospital employees, contractors and visitors, alarm systems on the units, strategically placed convex mirrors for heightened visibility, hand held radios carried by direct care staff, closed circuit video, and the use of “quiet/comfort rooms” for de-escalation when patients are escalating or unsafe.

Furnishings are purchased and the physical milieu is designed with safety in mind. Care is taken to avoid an institutional appearance to the extent possible. Patient risk to self and others requires heightened staff awareness and due attention to any prospect of utilizing objects as weapons against themselves or others.

The Joint Commission (TJC) accreditation standards address all aspects of patient care and the environment. TJC audits are conducted every three years and self-assessments are required at intervening cycles to ensure that all aspects of the environment and treatment are in compliance.

Precautions against workplace violence at Eastern State Hospital include Administrative Policy 18.67 (Workplace and Domestic Violence), prohibition of actual or potential weapons on campus grounds, and a state-of-the-art patient behavior intervention program and non-violent crisis response that include verbal and physical de-escalation techniques and training in team communication. Eastern State Hospital establishes clear lines of authority and responsibilities, requires annual competency assessment, review of policies and procedure and annual safety training. Direct access to Leadership is available to express concerns or advise of safety risks.

#### Security

ESH Security is the authorized liaison with local police authorities and readily responds to Eastern State Hospital needs for heightened security or containment of a violent incident.

### **12.0 Workplace Safety Plan/Accident Prevention Program Planning Objectives**

The Safety Manager, Safety Committee and identified staff is responsible for the development of annual Planning Objectives. Some objectives include measurable outcomes and establish performance improvement standards for the specific plan. Assessment of effectiveness and performance is accomplished by evaluating the progress made toward stated objectives. The Safety Committee selects one to three of the planning objectives for routine reporting at Safety Committee meetings. The objectives chosen for monitoring are those identified as having the highest priority for the hospital.

### **13.0 Workplace Safety Plan /Accident Prevention Program Performance Improvement (PI)**

The Safety Manager, Safety Committee and identified staff is responsible for the development of performance improvement indicators, which are based on priorities identified by the Safety Committee. The Safety Committee and Executive Leadership have the responsibility for approving the indicators, including monitors and thresholds. All PI activities are reported quarterly to the Safety Committee and provided to the Executive Committee and Governing

Body. All elements of the PI process are subject to change at any time based on Administrative input.

#### **14.0 Workplace Safety Plan /Accident Prevention Program Annual Evaluation**

The Safety Manager evaluates the Workplace Safety/Accident Prevention Plan annually for its scope, objectives, performance, and effectiveness. Any changes in scope are addressed during the annual update of the plan. Annual planning objectives are developed collaboratively with the Safety Committee and hospital administration. These objectives address the primary operational initiatives for maintaining and enhancing the “safety” of the Environment of Care. A year-end summary of the effectiveness in accomplishing these objectives is presented to the Safety Committee, Executive Committee and Governing Body. The performance of the plan is assessed through progress in achieving the Performance Improvement Standards defined within the plan. The annual evaluations, updates, and planning efforts are presented for committee review and action during the first quarter of the new calendar year.

**Appendix  
Eastern State Hospital  
Workplace Safety Plan – Annual Update  
June, 2016**

RCW 72.23.400 requires each state hospital to develop a plan to reasonably prevent and protect employees from violence at the state hospitals. The plan must address specified security and safety considerations (RCW 72.23.400(1)(a.-h.)), as appropriate to the particular state hospital, and must be evaluated, reviewed and amended as necessary, at least annually.

<b>Security and Safety Elements (RCW 72.23.400 (1))</b>	<b>Assessment</b>	<b>Plan Update</b>
<p>a) <b>The physical attributes of the state hospital including:</b></p> <ol style="list-style-type: none"> <li>1. <b>access control</b></li> <li>2. <b>egress control</b></li> <li>3. <b>door locks</b></li> <li>4. <b>lighting</b></li> <li>5. <b>alarm systems</b></li> </ol>	<p><b>Physical Attributes (Environment of Care)</b></p> <p>There are 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> <p>A comprehensive Environmental Proactive Risk Assessment is utilized, and updated annually, in addition to individual assessments initiated as a result of any Sentinel Events or drill downs, data from hazard reports, environmental safety surveys, unusual occurrence and injury reporting, and individual building evaluations. A Plan of Action(s) and/or interim measures are identified and implemented.</p> <p>The Environmental Proactive Risk Assessment is reviewed by Employee Safety committee, Environment of Care committee, Patient Safety committee, Quality Council, and Governing Body.</p>	<p>The Environmental Proactive Risk assessment was updated June, 2016.</p> <p>Recommendations for improvement include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• 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 loopable restroom shelves and toilet paper holder replacement on all remaining wards hospital-wide. Replacement of electrical outlets with GFCI “tamper-resistant” or covering outlets to prevent tampering in all patient accessible areas, replacement of overhead reading lights on APU wards to prevent use for concealment of contraband, remodeling the 1N1 “safe room” to provide improved patient monitoring and ease for staff in executing seclusion/restraint activities, replacement of cross corridor smoke doors on all APU wards, installation of tamper-proof soap dispensers, and installation of cameras for patient monitoring and incident investigation on all APU wards.</li> </ul>

	<p><b>Physical Attributes (Environment of Care)</b></p> <p>Environment Checks:</p> <p>Inspected and documented hourly on all ward and incorporates risks identified on Environmental Proactive Risk assessment.</p> <p>Weekly environmental Safety surveys conducted. Findings reported to department/area supervisor and Leadership for action as identified. Survey tool revised to enable quick identification of high-risk findings and incorporation of any identified survey deficiencies. Analysis of all findings is conducted and reported to EOC, monthly and annually, for development of performance improvement activities.</p>	<p>Recommendations for improvement include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• 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 loopable restroom shelves and toilet paper holder replacement on all remaining wards hospital-wide. Replacement of electrical outlets with GFCI “tamper-resistant” or covering outlets to prevent tampering in all patient accessible areas, replacement of overhead reading lights on APU wards to prevent use for concealment of contraband, remodeling the 1N1 “safe room” to provide improved patient monitoring and ease for staff in executing seclusion/restraint activities, replacement of cross corridor smoke doors on all APU wards, installation of tamper-proof soap dispensers, and installation of cameras for patient monitoring and incident investigation on all APU wards.</li> <li>• Purchases of additional Norix furniture for newly renovated FSU competency restoration ward and Psychiatric Intensive Care Unit (PICU). This furniture consists of molded vinyl chairs, molded cubicles for patient storage, one-piece dining room tables and chairs specifically manufactured for Behavioral Health and Correctional facilities. The molded vinyl furniture is “sand-ballasted (weighted) or bolted to floor to prevent being thrown as weapon.</li> <li>• The Authorized Patient Belongings list is updated at least annually or as indicated and/or the results of a Sentinel Event root cause analysis.</li> <li>• Lighting for patient monitoring in the north patient yard was</li> </ul>
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		<p>assessed. Additional lights installed and replacement of existing fixtures with LED has been completed.</p> <ul style="list-style-type: none"> <li>Window security assessed, hospital-wide, on all patient wards and plan for improvement developed to reinforce window security based on assessment.</li> </ul> <p>Environment Checks</p> <ul style="list-style-type: none"> <li>Inspected and documented hourly on all ward and incorporates risks identified on Environmental Proactive Risk assessment.</li> </ul> <p>Weekly environmental Safety surveys conducted. Findings reported to department/area supervisor and Leadership for action as identified. Survey tool revised to enable quick identification of high-risk findings and incorporation of any identified survey deficiencies. Analysis of all findings is conducted and reported to EOC, monthly and annually, for development of performance improvement activities.</p>
	<p><b>a) 1. Access Control</b></p> <ul style="list-style-type: none"> <li>Unit Metal Detector and Visitor Policies: 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; hand-held detectors only. Walk-through detector on 1N1 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</li> </ul>	<p>Security Management 2016 performance improvement activity was approved by Environment of Care committee. The goal is to conduct an A3 LEAN project to evaluate metal detector and visitor policies for development and implementation of recommendations for improvement.</p> <p>All visitors are notified of what items constitute contraband (signage posted at Switchboard locations). 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 (APU/FSU).</p>

	<p>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>	<p>Existing lockers located near the Westlake Switchboard are being utilized for visitor use until permanent lockers are installed at each GPU ward entrance and GPU Management committee develops a policy and procedure for use.</p>
	<ul style="list-style-type: none"> <li>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.</li> </ul>	<p>Capital Programs has developed a long-range plan for demolition of vacant buildings to decrease attraction and trespassing on campus but is dependent on Legislative funding.</p> <p>A Capital Programs request has been initiated for installation of additional cameras in high-risk, campus-wide, locations based on usage and restricted access requirements e.g. Pharmacy.</p> <p>All Security incidents are investigated and appropriate follow-up actions taken. A monthly report of all Security activities is provided to Environment of Care (EOC) Committee for review and recommendations for performance improvement.</p>
	<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> <li>Problematic to obtain keys when staff quit via telephone or employment separation is initiated by ESH via letter.</li> </ul>	<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 maintained by the Security Department. Access to FSU is controlled through the use of proximity cards approved and issued by FSU Administration, ward access control panels and cameras. Pharmacy access is alarmed after hours and reports to the Eastlake Switchboard for Security response. Security controls key issuance, retrieval from employees when transferred to other areas/departments and returns from employees when leaving ESH employment and tracks utilizing a database. All keys are stamped for tracking purposes.</p>

		A Capital Program request has been made for funding to install an electronic “Key Watcher” issuance and tracking system.
	<ul style="list-style-type: none"> <li>Potential for exterior building doors to not close or lock properly.</li> </ul>	<p>Quarterly and annual door inspections completed by CSS to ensure proper function.</p> <p>Door security checks completed by Security staff after hours and unsecure locations documented and reported to responsible area supervisor for follow-up. Data is reviewed by EOC committee for trend analysis and recommendations for performance improvement activities as indicated.</p> <p>A Capital Programs request to assess all fire doors, including exterior doors, has been funded to ensure compliance with Life Safety code requirements and TJC/CMS standards compliance.</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>	Scope of 2016 Capital Programs project to replace the Westlake nurse call system includes relocating the Switchboard/reception desk 180 degrees, installing cameras at entrance doors and enclosing desk area to increase visibility of parking lot and in-coming visitors, and Switchboard security.
	<ul style="list-style-type: none"> <li>The parking areas, hospital-wide, are not under surveillance and some locations are bordered by wooded areas or vacant buildings.</li> </ul>	A Capital Programs request has been initiated for installation of additional cameras in high-risk, campus-wide, locations based on usage and restricted access requirements e.g. Pharmacy.
	<ul style="list-style-type: none"> <li>The exterior area between the Therapy Pool and the vacant Interlake building difficult to monitor and access not controlled.</li> </ul>	A 2016 Capital Programs project has been funded and initiated to demolish the Interlake building; June, 2016.
	<p><b>a) 2. Egress Control</b></p> <ul style="list-style-type: none"> <li>No physical control over egress (visitor/staff) on campus.</li> </ul>	ESH policy 1.8, Patients’ Visitors, outlines procedures for visitor restriction from ward or campus by

	<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>	<p>clinical OD, AOD or CEO/COO due to history and/or current behavior.</p>
	<ul style="list-style-type: none"> <li>• <b>There is a potential for violence when apprehending patients that have gone on unauthorized leave.</b></li> </ul>	<p>Unauthorized leave data tracked and reported monthly to EOC and Patient Safety Committees for trend analysis and drill downs to identify Plans for Improvement. Unauthorized leaves decreased from four (4) in 2014 to two (2) in 2015.</p> <p>A LEAN project was completed related to escorting patients to off campus appointments 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. Policy revised to ensure consistency and ESH patient transportation vehicles were updated with a divider between the driver and patient areas.</p>
	<p><b>a) 3. Door Locks</b></p> <ul style="list-style-type: none"> <li>• 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.</li> </ul>	<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 utilizes a database to track key issuing &amp; return to/from employees when transferred to other areas/departments or leaving ESH employment. All keys are stamped for tracking purposes.</p> <p>A workgroup was formed including representatives from Educations Services, the COO, and Human</p>

		<p>Resources to clarify the process for assigning keys at hire.</p> <p>A Capital Program request has been made for funding to install an electronic “Key Watcher” issuance and tracking system on internal building keys and a card access building entry system.</p>
	<p><b>a) 4. Lighting</b>  <b>Outside Lighting:</b></p> <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> </ul> <p>Upper terrace and the north side of the Westlake parking lot are dark despite the presence of several pole lights.</p>	<p>Security monitors lighting during daily Security rounds and reports burned out exterior lighting to Consolidated Support Services for replacement. All lighting work orders are prioritized based on location risk.</p> <p>Lighting for patient monitoring in the north patient yard was assessed. Additional lights installed and replacement of existing fixtures with LED has been completed. CSS has replaced existing Westlake parking lot lighting with LED for improved visibility and cost savings. A Capital Programs request has been made to increase campus-wide parking and perimeter lighting based on risk assessment.</p>
	<p><b>a) 5. Alarm Systems</b></p> <ul style="list-style-type: none"> <li>• Radios:</li> <li>• Low/dead battery</li> <li>• Dead Spots (lack of repeater coverage)</li> </ul> <p>Not compatible with community emergency response agencies</p>	<p>ESH migrated to new digital radios in May of 2015. The newly purchased digital are 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; there is no ability to electronically track location at this time.</p> <p>These replaced antiquated communication equipment and to ensure continuity with local emergency response agencies. This best practice approach improves signal quality, coverage, staff safety and security of patient healthcare information (PHI).</p>

		<p>Additional performance improvement activities related to this transition include:</p> <ul style="list-style-type: none"> <li>• Battery and generator backup for the TurboVUi rack and repeaters utilized by the Eastlake switchboard to monitor all channels.</li> <li>• Additional training for the Security Department and Incident Command Center</li> <li>• (ICC) personnel for interim emergency operations and contingency plans.</li> <li>• Additional programming to better facilitate emergency operations with two redundancy capabilities.</li> <li>• Additional availability to non-nursing departments not previously provided e.g. Social Work</li> </ul> <p>Ability to communicate with community first responders is being re-evaluated to ensure compatibility.</p>
	<ul style="list-style-type: none"> <li>• Duress Alarms: <ul style="list-style-type: none"> <li>• Subject to malfunction and accidental activation.</li> </ul> </li> </ul> <p>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.</p> <p>The FSU alarm system requires use of a proximity card with readers located 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> <ul style="list-style-type: none"> <li>• Location makes the system difficult if not impossible for</li> </ul>	<p>The existing staff duress alarm is tested daily on all wards by ward staff (APU &amp; FSU) and weekly (GPU) per Nursing policy to ensure reliability.</p> <p>A Capital Programs has been made to replace the existing duress systems on the wards and install a “personal duress alarm” system in all locations with that provides wider coverage, ease of activation and electronic location tracking for quicker emergency response.</p> <p>A Capital Programs request submitted and funded to replace the GPU Nurse Call system; fiscal year 2016-2017.</p>

	<p>staff to use if involved in a patient-to-staff assault.</p> <ul style="list-style-type: none"> <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.</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> </ul> <p>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. The alarm notification only announces the ward location via automated overhead PA announcement; it does not identify specific/exact location of activation. 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. 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 Mal Locations – No Existing Duress Alarm</li> <li>• Activity Therapy Building/Eastlake Treatment Mall – No Existing Duress Alarm</li> </ul>	
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<p><b>b) Staffing, including security staffing</b></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> <li>• Use of contracted Nursing services.</li> </ul>	<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 Patient Safety committee, Quality Council, and Governing Body.</p> <p><u>Use of on-call staff</u> Eastern State Hospital has a pool of on-call employees for utilization when required.</p>
		<p><u>Pre-Arranged Overtime</u> The following steps are used to determine 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 to ensure equitable distribution on eligible shifts. 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</li> </ul>

		<p>greatest patient care/need is a priority.</p> <ul style="list-style-type: none"> <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><u>Voluntary Overtime</u> When Nursing has exhausted the on-call availability and pre-arranged overtime, they solicit volunteers currently at work to arrange voluntary overtime on the upcoming shift.</p> <p><u>Involuntary Overtime</u> When voluntary overtime does not meet patient care/workload demands, involuntary overtime is assigned based on a in-verse seniority rotational schedule in compliance with the Collective Bargaining Agreement.</p> <p><u>Agency Nurses</u> A contract with travel and local agencies in place and utilized to ensure staffing levels are suitable for provision of patient care and to avoid mandatory overtime; registered nurses only.</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>
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		<p>2015 Performance Improvement Projects - Staffing:</p> <ul style="list-style-type: none"> <li>• Decreasing the use of overtime.</li> <li>• Decreasing the occurrence of unscheduled leave.</li> <li>• Decreasing staff vacancy and turnover rate.</li> <li>• Implementing innovative recruitment strategies to decrease vacancies.</li> </ul> <p><u>Staff Location (FSU)</u></p> <ul style="list-style-type: none"> <li>• Staff is aware of each other's location and whereabouts at all times.</li> <li>• Ward location is monitored via cameras, radio and spot visual checks as required.</li> </ul> <p><u>Float Positions:</u></p> <p>Twenty PSA and MHT float positions and ten registered nurse positions were established to minimize the impact to daily staffing and patient care during the implementation of multiple initiatives currently in progress at ESH. These include Electronic Medical Records (EMR) implementation and resulting training requirements, Ad Hoc Safety training mandates, establishment of a Psychiatric Intensive Care Unit (PICU), opening of a new Forensic ward and expansion of competency restoration beds.</p>
<p><b>c) Personnel policies</b></p>	<p>DSHS, BHSIA, and ESH hospital, unit, and discipline specific policies, Workplace Safety/Accident Prevention plans and emergency response policies are in place and address the following (list is not all inclusive, refer to individual policy manuals for additional information):</p> <ul style="list-style-type: none"> <li>• Behavior Undermining the Culture of Safety</li> <li>• Seclusion/Restraint</li> <li>• Safety Huddles</li> <li>• Workplace Safety Plan, including Accident Prevention, and Workplace Violence Prevention</li> <li>• Crisis Prevention and</li> </ul>	<p>Environment of Care plans (Safety, Fire/Safety, Medical Equipment, Utility Systems, Security and Hazardous Waste Management) are assessed annually for objective, scope, performance and effectiveness. Data is reviewed by EOC and Employee Safety committee to identify trends and develop a plan for improvement, if indicated, to correct deficiencies and reduce the risk of injuries. The 2015 annual evaluation of the Safety Management/Accident Prevention Plan validates the plan is adequate and effective in practice. A standardized committee charters was developed and implemented to define scope, responsibilities, deliverables,</p>

	<p>Intervention training (TEAM)</p> <ul style="list-style-type: none"> <li>• Critical Incident Stress Management (CISM)</li> <li>• Disruptive And Intimidating Behavior By Staff</li> <li>• Workplace and Domestic Violence</li> <li>• Incident Reporting</li> <li>• Workplace Personnel Security</li> <li>• Emergency Operations and Specific Emergency Response Procedures</li> </ul>	<p>and data reviewed.</p> <p>ESH has improved the process for creating, reviewing, revising, communicating, distributing and posting of policies, protocols and procedures through development and implementation of an intranet/SharePoint site and the development and posting of communications boards throughout the hospital.</p>
	<p>All three (3) state hospitals (ESH, WSH, and CSTC) have collaborated to align their comprehensive <i>Safety Management Plan/Accident Prevention Programs encompassing Workplace Violence Prevention</i>.</p>	
<p><b>d) First aid and emergency procedures</b></p>	<ul style="list-style-type: none"> <li>• Infection Control Risk Assessment: 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>Personnel flu vaccination reports are in place and reported to Quality Council committee.</p>
	<ul style="list-style-type: none"> <li>• Medical Emergency Response: Medical Emergency Response Team in place. The Medical Emergency Response committee (MERC) reviews all emergency response events and develops and implements a Medical Emergency Response action plan, as indicated.</li> <li>• Emergency Medical Response Procedures are in place, Code Blue and Code Rapid Respond Team, and activated by contacting Switchboard for communicating request for nursing and medical provider response via two-way radio, overhead PA and radio paging channel alert.</li> </ul>	<ul style="list-style-type: none"> <li>• ESH transitioned to the use of national emergency response code names.</li> <li>• MERC has developed and implemented "Mock Codes", to improve medical emergency response preparedness.</li> <li>• 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</li> </ul>

		<p>and are stored in identified Westlake and Eastlake locations.</p> <ul style="list-style-type: none"> <li>• Medical providers are required to complete ACLS classes with biannual recertification. ECG rhythm and emergency response training is provided to shift nurses.</li> </ul>
	<ul style="list-style-type: none"> <li>• <b>Emergency Operations and 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, management of clinical and support activities, transportation and personal protective equipment.</li> </ul>	<p>Emergency procedures in place based on Hazard Vulnerability Assessment (HVA):</p> <ul style="list-style-type: none"> <li>• All Hospital Lockdown</li> <li>• Hostage Situation</li> <li>• Labor Action</li> <li>• Major Utility Failure</li> <li>• Crisis Debriefing</li> <li>• Telephone Failure</li> <li>• Severe Weather Warning</li> <li>• Fire</li> <li>• Evacuation</li> <li>• Earthquake</li> <li>• Armed Assault</li> <li>• Fire Watch</li> <li>• Bomb/Telephone Threat</li> <li>• Volcanic Eruption</li> <li>• Bio-Terrorism/Hazardous Substance in the Mail</li> <li>• Bio-Terrorism/Infected Patient or Staff</li> </ul> <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 at this time. 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</p>

		<p>uses a standardized set of terms used by all state agencies.</p> <p>Psychiatric Emergency Response Team (PERT) established and implemented; December, 2015. This team was established to provide a safe, effective and immediate plan of response for patients during a psychiatric crisis or anticipated crisis. This is accomplished through a least to most intervention technique utilizing verbal de-escalation tactics while promoting and maintaining patient and staff safety within a plan of recovery.</p> <p>Existing ESH policy requires implementation of a “Code Gray” whenever a patient’s behavior is escalating and may require seclusion or restraint or whenever seclusion or restraint is initiated. A “Code Gray” is in response to a critical incident and immediate response is required. Debriefing with staff and an intensive analysis of the event is completed.</p> <p>Fire/Safety improvement activity implemented and completed in 2015 to develop and implement a system to replace staff fire keys with keys that are readily identifiable; hospital-wide.</p>
		<p>Executive staff reviews all seclusion/restraint incidents occurring over the past 24 hours during the following morning report. The 24 hour shift report is screened for patterns or trends with Code “Gray” responses.</p>
<p><b>e) Violent acts:</b></p> <ul style="list-style-type: none"> <li>• <b>Reporting of violent acts</b></li> <li>• <b>Taking appropriate action in response to violent acts</b></li> <li>• <b>Follow-up procedures after violent acts</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>Reporting of violent acts</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>Workplace violence of any kind is reported through administrative channels and tracked utilizing incident databases enabling compilation of data for analysis of frequency, severity and circumstances:</p> <ul style="list-style-type: none"> <li>• Staff involved</li> <li>• Assailant identifier (patient, employee, visitor, other)</li> </ul>

	<ul style="list-style-type: none"> <li>• <b>Taking appropriate action in response to violent acts</b></li> <li>• <b>Follow-up procedures after violent acts</b></li> </ul>	<ul style="list-style-type: none"> <li>• Incident date, time, shift</li> <li>• Use of restraint</li> <li>• Use of seclusion</li> <li>• Cause of injury</li> <li>• Patient assault involved</li> <li>• Object used in assault</li> <li>• Staff-initiated contact ; containment</li> <li>• Injury severity rating</li> <li>• Type of injury</li> <li>• Body part affected</li> <li>• Description of precipitating event(s)</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. Critical Stress Management Team members notified to initiate contact with employee(s) per Leadership, supervisor or other staff referral. 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>The UOR Performance Improvement Project was completed January, 2016. This resulted in increased accuracy of coding and data entry, consistent and documented distribution and posting and placing the UOR form on-line for better access. Patient Safety, Patient Rights and Patient Care dashboards have been created and are distributed monthly for review/analysis by the QA PI committees.</p>
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<p><b>f) Development of criteria for determining and reporting verbal threats</b></p>	<p>ESH utilizes Employee/Volunteer Incident Report and Possible Client Assault for reporting patient-to-staff assault per RCW 72.01.045 and 74.04.790.</p>	<p>Assaults are tracked as identified and reported by staff utilizing the RiskMaster program managed by the DSHS Enterprise Risk Management Office. Reporting staff determines risk potential. Assault data is monitored and analyzed by Quality Management, Safety/Risk Management and Executive Leadership during morning rounds. Actions are taken as indicated.</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><b>g) Employee education and training</b></p>	<p>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>A training plan is in place to ensure all staff are trained at-hire and annually. As part of the plan, ESH has adopted the LMS learning system, which provides better access to and record of participation in ongoing training. The LMS system training also enables improved post-testing and timely feedback to participants. Educational Services has developed a matrix of mandatory training, at orientation and ongoing which is utilized to compile compliance reports. New Employee Orientation is being offered monthly.</p> <p>Eastern State Hospital utilizes “TEAM” 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 for violence prevention; Understanding Needs, Safety</p>

<p><b>g) Employee education and training</b></p>		<p>Planning, De-Escalation, Evasion, Control, and Debriefing. Application of Restraints is also covered in conjunction with TEAM training including documented competency evaluations. Topics include best practices for interactions with patients, Trauma Informed Care, functional behavioral assessment, strategies for effective interactions during Difficult Situations, Situational Awareness and The I.N.S.E.R.T. algorithm:</p> <ul style="list-style-type: none"> <li>• <u>I</u>dentify Escalating Behavior – Hot or Cold Threat</li> <li>• <u>N</u>eeds Assessment – Hot or Cold Threat’s Origins &amp; Gains</li> <li>• <u>S</u>afely Approach – Tactical Movement/Thinking</li> <li>• <u>E</u>ngage the patient – V.D.S.P.</li> <li>• <u>R</u>einforce patient self-management and self-control</li> <li>• <u>T</u>eaching moment for patient, staff, and team</li> </ul> <p>CPR training is instructed per the American Health Association standards and results in certification of participants. This is required every two (2) years for medical, nursing, and security staff.</p> <p>A new competency mall is in development for hands-on training and competency certification. Mock code training is offered as part of the skills competency fair as well as EKG and initial physical health assessment training.</p> <p>Additional training resources utilized include a video series on Mental Health Nursing which provides common scenarios for successful patient/staff interactions including:</p> <ul style="list-style-type: none"> <li>• Depressed/suicidal client</li> <li>• Verbally and physically aggressive client with/without delusions</li> </ul>
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<p><b>g) Employee education and training</b></p>	<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-violent crisis intervention training program.</p>	<ul style="list-style-type: none"> <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> <p>A video with input from CSTC, ESH and WSH on additional de-escalation techniques is in the planning stages and will augment the TEAM training modules.</p> <p>Milieu Management training is provided to all RN's at hire (New Employee Orientation) in support of provision of active treatment.</p> <p>All three (3) state hospitals are working to identify existing "best practices" and develop consistent training curriculums.</p>
<p><b>h) Clinical and patient policies and procedures including those related to:</b></p> <ul style="list-style-type: none"> <li>• Smoking</li> <li>• Activity, leisure, and therapeutic programs</li> <li>• Communication between shifts</li> </ul> <p><b>Restraint and seclusion</b></p>	<ul style="list-style-type: none"> <li>• <b>Smoking</b></li> </ul>	<p>Smoking on ESH campus is allowed subsequent to Chapter 70.160 RCW, Smoking in Public Places, and Administrative Policy No. 18.65, Smoking In Department of Social and Health Services Facilities.</p> <p>Patient smoking is restricted to outside the building with staff monitoring. All wards have individual ward guidelines addressing patient smoking.</p>
	<ul style="list-style-type: none"> <li>• <b>Activity, leisure, and therapeutic programs</b> <ul style="list-style-type: none"> <li>• Limited Rehabilitation Services provided to patients may result in increased patient agitation due to decreased activity, leisure and therapeutic programming.</li> <li>• Inconsistency between ward and shift routines, ward guidelines, recovery levels, group offerings, etc. increasing patient frustration when transferring from ward to ward.</li> <li>• On-ward active treatment</li> </ul> </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 ongoing focusing on increasing the quality of active treatment offered, with better interface with the treatment teams and improved data capture and documentation.</p> <p>A LEAN performance improvement project was completed and</p>

	<p>during the afternoon shift is limited or cancelled conflicts with ward routines e.g. medication distribution, snacks, etc. Rosters for afternoon shifts are not consistently being completed to document occurrences of active treatment or reasons for group cancellation.</p>	<p>improvement activities implemented to address ordering and procuring of supplies for use in active treatment delivery.</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 dashboard has been created/implemented to review/analyze active treatment. This data is monitored monthly on a monthly basis with quarterly reporting reports to Quality Council. A feedback system has been developed to report to unit management teams and includes increasing weekend/evening activity provision.</p> <p>A group facilitation competency assessment has been developed and implemented February, 2016. An introduction to group facilitation training has been added to the New Employee Orientation.</p>
	<ul style="list-style-type: none"> <li>• <b>Activity, leisure, and therapeutic programs</b></li> </ul>	<p>Strategic goal target hours for active treatment are 15 hours. The average number of hours for 2015 was 14.5; year to date average for 2016 is 14.8.</p> <p>Data related to time of day, locations, antecedents, etc. related to escalation of patient behaviors is reviewed by the Safety Assault Prevention Workgroup, Employee Safety committee and Active Treatment Council to identify increased needs for structured treatment programming as indicated.</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 action plan to decrease patient frustration and potential increased agitation when transferred to another ward or when inconsistencies occur shift-to-shift.</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>
	<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 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>Unauthorized leave data tracked and reported monthly to EOC and Patient Safety Committees for trend analysis and drill downs to identify Plans for Improvement. Unauthorized leaves decreased from four (4) in 2014 to two (2) in 2015.</p> <p>A LEAN project was completed related to escorting patients to off campus appointments 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. Policy revised to ensure consistency and ESH patient transportation vehicles were updated with a divider between the driver and patient areas.</p>

	<ul style="list-style-type: none"> <li>• <b>Communication between shifts</b></li> </ul>	<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 for continuity between shifts.</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>Employee engagement has been improved through the use of a hospital-wide newsletter, employee recognition events and processes, development and implementation of an intranet/SharePoint site and the development and posting of communications boards throughout the hospital.</p>
	<ul style="list-style-type: none"> <li>• <b>Communication between shifts</b></li> </ul>	<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>Executive Leadership reviews data from previous evening during morning rounds. Actions are taken as indicated.</p>
	<ul style="list-style-type: none"> <li>• <b>Restraint and seclusion</b> Placing patients in seclusion/restraint increases potential for employee injury.</li> </ul>	<p>Refer to section “g”, “Employee education and training” and section “h”, “Clinical and patient policies and procedures”</p> <p>Seclusion/restraint documentation is reviewed each time an episode exceeds two (2) hours or there are three (3) or more episodes in a seven (7) day period. In addition, a root-cause analysis process is under development for review of outlier seclusion episodes.</p> <p>Existing ESH policy requires implementation of a “Code Gray” whenever a patient’s behavior is</p>

		<p>escalating and may require seclusion or restraint or whenever seclusion or restraint is initiated. A "Code Gray" 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 Gray" incidents (with or without seclusion/restraint) during the following morning report.</p> <p><i>A Statement of Caring &amp; Safety</i> is provided to all patients upon admission. The statement encourages patients to share their concerns with staff if they do not feel safe for any reason including if another patient tells them that he or she wants to harm him/herself or others.</p>
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