

Washington State Department of Social and Health Services

Eastern State Hospital

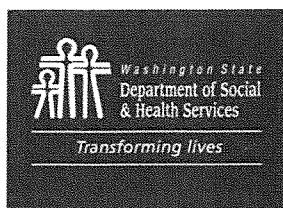
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Transforming
Lives

EASTERN STATE HOSPITAL
WORKPLACE SAFETY PLAN




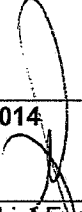
			
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APPENDIX A. SECURITY AND SAFETY ASSESSMENT

APPENDIX B. CIBS SPECIFIC PROCEDURES

APPENDIX C. CSS SPECIFIC PROCEDURES

1.0 PURPOSE

The purpose of the Workplace Safety Plan is to improve and maintain workplace safety at Eastern State Hospital by providing information, policies and guidance for the proactive identification of safety risks and implementation of processes and mitigation actions to prevent accidents, injuries, illness and workplace violence.

2.0 SCOPE

The Workplace Safety Plan (WSP) is applicable to all hospital staff, DSHS CIBS staff, DSHS Consolidated Support Services (CSS) staff, contract staff, interns, students and volunteers. CSS employees work collaboratively with ESH personnel to create and maintain a safe work environment through the use of a Service Level Agreement (SLA) to identify hospital and CSS responsibilities and service obligations. DSHS CIBS Commissary staff work with ESH staff to provide needed resources based on hospital and patient care needs.

The WSP incorporates:

- Applicable federal and state laws and rules including the Occupational Safety and Health Administration (OSHA), Washington State Department of Occupational Safety and Health (DOSH), WAC 296-800-140 Accident Prevention Program, WAC 296-800-130 Safety Committees and 72.23.400 RCW Workplace Safety Plan.
- Applicable accreditation standards of The Joint Commission (TJC) and Centers for Medicare & Medicaid Services (CMS) regulations.
- DSHS Administrative Policy No. 18.67 Workplace and Domestic Violence.

3.0 HOSPITAL LEADERSHIP COMMITMENT

Hospital leadership places a high value on workplace safety and is committed to providing a safe environment by devoting resources for staff training, safety committees, emergency management, facilities maintenance and incident reporting and investigation systems. Hospital leadership is also committed to providing support to injured employees and victims of workplace violence by devoting resources for debriefings and Critical Incident Stress Management (CISM).

The hospital 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.

4.0 SAFETY AND HEALTH RESPONSIBILITIES

Workplace safety requires ongoing vigilance, communication and collaboration by managers, supervisors, and employees to identify and eliminate workplace hazards and prevent workplace violence.

4.1 Executive Leadership Responsibilities

Executive Leadership responsibilities to create and maintain workplace safety include:

- Maintaining a safety committee in accordance WAC 296-800-13020 and providing employees sufficient time to participate on the committee.
- Ensuring injuries and illnesses are recorded and reported and an OSHA Summary is signed by the highest ranking official at the facility and posted per WAC 296-800.
- Reviewing workplace safety data and implementing prevention and mitigation measures to improve workplace safety.

- Providing guidance and supervision to hospital personnel to ensure compliance with the WSP.
- Recruitment and retention of qualified staff to ensure effective patient care and maintenance of a safe workplace.
- Creating, maintaining, and promoting a Culture of Safety

4.2 Manager and Supervisor Responsibilities

Managers and supervisor responsibilities to create and maintain workplace safety include:

- Employees receive a documented site-specific safety orientation and training to ensure employee perform their duties safely.
- Providing supervision to identify unsafe employee work practices and to provide training or disciplinary action when needed.
- Ensuring employee injuries are reported and investigated and all required documentation is properly completed and submitted to the ESH Safety Office.
- Working collaboratively with the hospital Safety Office and DSHS Enterprise Risk Management Office (ERMO) to identify changes to work practices or equipment that improves workplace safety.
- Employees understand the expectations of a violence free workplace and support is provided to employees who are victims of workplace violence by facilitating debriefings and making referrals to the Critical Incident Stress Management (CISM) team and/or Employee Assistance Program (EAP), as indicated.

4.3 Employee Responsibilities

Employee responsibilities to create and maintain workplace safety include:

- Immediately reporting to supervisors any unsafe conditions, injuries, near miss incidents and threats or acts of violence.
- Using personal protective equipment (PPE) as required and immediately reporting equipment malfunctions or need for service or replacement to supervisors. In addition, removing or interfering with any PPE or equipment safety device or safeguard is prohibited.
- Utilizing situational awareness to maintain a safe and respectful work environment and behaving respectfully to patients and co-workers at all times, reinforcing a culture of safety.
- Understand and follow patient treatment and safety plans to improve patient care outcomes and decrease safety risks.
- Understand and comply with safety policies, procedures and training and encourage co-workers to use safe work practices.

5.0 SAFETY COMMITTEES AND SAFETY INFORMATION

5.1 Employee Safety Committee

The purpose of the Employee Safety Committee is for employees and management to mutually

address safety and health issues, in compliance with WAC 296-800-130. The committee is responsible for evaluating the effectiveness of the Workplace Safety Plan and for developing, implementing and overseeing action plans in order to create and maintain a safe workplace.

The Employee Safety 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 required. 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 from 1300-1430 in the West Conference room.

Recommendations or concerns brought to the committee by employees are reviewed and the status of action plans are documented in the Employee Safety committee minutes. Written feedback is provided to the initiator, if known, within 60 days of Safety Committee review.

Meeting minutes are documented and copies posted on the ESH SharePoint in the Safety folder under Committee Minutes and posted on the designated ESH, CSS and CIBS Commissary safety bulletin boards (see 5.3 below for locations).

5.2 Environment of Care Committee

The Environment of Care Committee (EOC) performs retroactive and proactive safety reviews, performs risk assessments of the Environment of Care, makes safety recommendations and develops action plans to improve workplace safety. The EOC has oversight responsibilities for the Life Safety, Environment of Care, and Emergency Management standards of The Joint Commission and related regulations under the Centers for Medicare and Medicaid Services (CMS).

EOC membership consists of the Chief Operating Officer, Director of Facilities, Safety Manager and representatives from Security, Infection Prevention, Quality Management, Consolidated Support Services, Medical Equipment Committee, and Medical staff, Rehab Services, Nursing, Food Services, Housekeeping and Pharmacy.

5.3 Safety Bulletin Board

Eastern State Hospital has two core bulletin boards that are maintained with all OSHA required postings and three unit safety boards for posting Safety Committee meeting minutes and other safety related information and announcements.

Locations of Physical Safety Bulletin Boards	
<i>Eastlake Core Bulletin Board</i>	<i>Eastlake Administration Building Main Entrance Near Switchboard Office</i>
<i>Westlake Core Bulletin Board</i>	<i>Westlake Main Entrance in Corridor Next to Work Center Adjacent to the 782 Union Board</i>
<i>GPU</i>	<i>Corridor Outside of Copy Room</i>
<i>APU</i>	<i>0N3 Corridor Near Loading Dock Entrance</i>
<i>FSU</i>	<i>FSU Administration Entrance</i>

<i>CSS</i>	<i>Building M in Corridor Across from the Conference Room</i>
<i>CIBS Commissary</i>	<i>Commissary Office Near Entrance</i>

Required OSHA Postings Include:

- 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.

6.0 REPORTING AND RECORDKEEPING – INJURY, ILLNESS AND NEAR MISS

6.1 Employee Responsibilities

- Employees involved in an **on-the-job injury** or a **near miss incident** must immediately report the injury or incident to their supervisor and complete a current Safety Incident/Near Miss Report (DSHS 03-133), located on the ESH SharePoint in the Safety folder. Employees must then submit the form to their supervisor and they will fill out a current Supervisors Review of the Safety Incident/Near Miss Report (DSHS 03-133A). Completed forms must be scanned and emailed or forwarded in the hospital mail to the ESH Safety Office within three (3) working days of the injury or near miss.
- The Employee Report of Possible Client Assault (DSHS 03-391) form must be completed for all incidents resulting from a potential client assault as outlined in DSHS Administrative Policy 9.02 and attached to the Injury and Illness Incident Report.
- A Post Exposure Packet must be completed by employees in cases resulting in an exposure incident or blood borne 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.
- A Labor and Industry (L&I) Form 242-130-1111 is initiated at the healthcare provider's office, urgent care or emergency room when receiving medical or emergency treatment for a work-related incident/injury or exposure. The physician completes the form with the employee and mails a copy to Labor & Industries for processing.

6.2 Supervisor Responsibilities

Supervisors are responsible to investigate all injury, illness and near-miss occurrences and complete DSHS 03-133A Supervisors Review of Safety Incident/Near Miss Report. The report must be forwarded to the Safety Office within three (3) working days of the incident.

Supervisor investigations must include:

- Gathering all necessary information.
- Recording the sequence of events.
- Listing all causative factors as they occur in the sequence of events.
- Interviewing and collecting statements from witnesses as indicated.

- Closely reviewing the employee's statement and description of the incident and identifying any discrepancies between employee's statement and actual findings.
- A determination based on the findings:
 - (1) Unsafe Act
 - (2) Unsafe Conditions
 - (3) Unsafe Acts/Conditions

Whenever there is an employee accident that results in death or serious injury the supervisor must ensure a preliminary investigation is conducted.

- This may include participation by union representation, Safety Manager, ERMO staff and others.
- The investigator(s) take written statements from witnesses, photographs the incident scene and equipment involved, if applicable.
- The investigator(s) must also document as soon as possible after the incident, the condition of equipment, if applicable, and any anything else in the work area that may be relevant.
- The investigator(s) make a written report of their findings and forwards the report to the Safety Office. The report includes a sequence of events leading up to the incident, conclusions about the incident and any recommendations to prevent a similar incident.

6.3 Safety Manager Responsibilities

The Safety Manager or designee reviews DSHS 03-133 and 03-133A incident forms to ensure all required and pertinent information has been collected. Additional comments or investigation results, if indicated, are included on the form by the Safety Manager or designee. All documentation is forwarded to Enterprise Risk Management Office (ERMO) claims department and inputted into the Risk Master database. Documentation including recommended corrective actions are reported to the Safety Committee.

The Safety Manager is responsible for posting a completed copy of the OSHA Summary for the previous year on the ESH and CIBs Commissary designated safety bulletin boards each February 1 until April 30. 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.

6.4 DSHS Enterprise Risk Management Office (ERMO) Responsibilities

Enterprise Risk Management Office investigators complete a secondary review of serious assaults with an injury that requires medical treatment beyond first aid. A report is provided to hospital leadership and the Safety Manager and recommendations are provided to the Employee Safety Committee.

The ERMO claims unit inputs and tracks injury and illness reports through the RiskMaster database system and determines whether the incident must be recorded on the OSHA Injury and Illness Log and Summary. All recordable injuries and illnesses must be entered on the OSHA log within six days after the hospital becomes aware of incident.

ERMO provides data reports to the Employee Safety Committee on at least a monthly basis and prior to each meeting. The committee reviews incident reports and ERMO data and may decide to conduct separate incident investigations and/or develop action plans as indicated.

6.5 Reporting Requirements - Hospitalizations, Fatalities, Amputations, and Loss of an Eye (WAC 296-27-031 and WAC 296-800-320)

Chief Executive Officer (CEO) or Designee Responsibilities:

- 1) The CEO or designee must report to the Department of Occupational Safety and Health (DOSH) within eight hours of becoming aware of a work-related incident that results in a fatality or 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.
- 3) The CEO or designee must report 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.

Staff Responsibilities:

In the event of an employee work related inpatient hospitalization, fatality, amputation or loss of an eye with or without inpatient hospitalization, the following rules apply:

Staff must not:

- Disturb the scene except to aid in rescue or make the scene safe.
- Clean up bodily fluids or pick up other items.
- Move equipment involved (e.g. personal protective equipment, tools, machinery or other equipment) unless it is necessary to remove the victim or prevent further injuries (WAC 296-800-32010).

Staff must:

- Block off and secure the area. If in a room, the room must be closed and locked, and a guard posted. If in a common area, the area must be mark off with tape or ribbon and a guard posted.
- Keep unnecessary persons out of the area before and after securing the area.
- 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 (e.g. clothing, bloody items, equipment and weapons).

6.6 Patient and Visitor Injuries

All patient and visitor injuries are reported to the Quality Management Department through the Unusual Occurrence (UOR) reporting system. Reports are analyzed by Quality Management and the Safety Office. Monthly reports are provided to EOC and Employee Safety Committee and quarterly to Quality Council and action plans are developed as required.

7.0 HAZARD PREVENTION AND CONTROL

Eastern State Hospital policies and practices conform to State and Federal safety standards and rules for hazards or potential hazards in the workplace. Facilities are designed and equipment chosen to eliminate or at a minimum, limit employee exposure to hazards. Work rules are written to effectively prevent or mitigate employee exposure to the hazard and employees are required to use personal protective equipment (PPE) such as safety glasses and hearing protection.

7.1 Statement of Conditions

The Director of Facilities is responsible for the Statement of Conditions and the document is maintained in the Director of Facilities Office. The Director of Facilities maintains building Life Safety plans, coordinates the identification and resolution of facility deficiencies and provides oversight for the initiation and completion of Survey Related Plans for Improvement (SPFI) or Time Limited Waivers as required in response to TJC and CMS survey findings. The Director of Facilities is responsible for identifying any corrections that require special funding or scheduling and communicating this information to Leadership and others as required.

7.2 Basic Safety Rules for Employees

Basic safety rules have been established at ESH to promote workplace safety. These rules are in addition to safety rules that must be followed when performing specific duties or operating specific equipment. Failure to comply with the following rules may result in disciplinary action:

- Always use safe work practices in performing duties including understanding and using proper lifting techniques, using personal protective equipment (PPE) when required, following safety warning signs and reading and following product labels.
- Manufacturer's instructions must be followed when using or operating equipment. Unsafe equipment must not be operated and equipment shall only be operated when trained and authorized. Supervisors must document training before an employee is considered competent to perform duties of the job.
- Unsafe work conditions, practices and hazard conditions must be immediately reported to supervisors and may be reported to safety committee representatives.
- Understand and follow the procedures for reporting accidents (section 7.0).
- Staff must comply with applicable collective bargaining agreements and DSHS Administrative Policy 18.75 Drug and Alcohol-Free Workplace.
- Firearms or explosives may not be on hospital property.
- Smoking inside the building or within 25 feet from any entry or ventilation intake is prohibited in accordance with DSHS Administrative Policy No. 18.65 and RCW 70.160.
- Refrain from behavior that is distracting to other employees.

- Maintain good housekeeping and keep emergency exits, aisles, walkways and working areas clear of slipping or tripping hazards. Replace all tools and supplies after use, and do not allow debris to accumulate where it will become a hazard. Clean up spills immediately.
- Refrain from horseplay, fighting and distracting fellow employees
- 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

7.3 Discipline for Failure to Follow Basic Safety Rules

Employees are expected to use good judgment when performing work duties and must follow established safety rules. Appropriate actions are taken by supervisors for failure to follow established safety rules. The discipline process is addressed in the applicable collective bargaining agreements and DSHS Administrative Policy 18.40.

7.4 Environment of Care (EOC) plans

ESH has developed detailed Environment of Care (EOC) plans required by rules and regulations set by DOSH and CMS. These plans are located in the Facilities Coordinator's Office and the Director of Facilities office and are updated annually. The EOC plans address:

- Safety Management
- Security Management
- Hazardous Waste Management
- Fire Safety Management
- Medical Equipment Management
- Utility Systems Management

7.5 Equipment Maintenance

The hospital is responsible for inspecting and servicing equipment following manufacturers' recommendations. DSHS Consolidated Maintenance & Operations is responsible for maintaining all equipment and buildings within the facility. All records are kept in the ESH Maintenance Office and maintenance documentation is kept on file for the life of the equipment.

All equipment is required to be examined prior to use to ensure good working condition. Medical equipment is maintained in accordance with the Medical Equipment Management Plan. Equipment hazard notices and recalls are coordinated through the Safety Office and forwarded to appropriate departments for review and action as indicated.

7.6 Interim Life Safety Measures, Infection Control Risk Assessment, Job Hazard Analysis and Personal Protective Equipment

Interim Life Safety Measures (ILSM)

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 interim life safety plans in coordination with the Director of Facilities and others (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

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
4. 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, and construction storage and field offices.
10. Inspects and tests temporary systems monthly. The completion date of the tests is documented. The need for these inspections and tests is based on criteria in the hospital's interim life safety measure (ILSM) policy.

11. Train staff to compensate for impaired structural or compartmental fire safety features.
12. 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.

Infection Control Risk Assessment (ICRA)

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, Director of Facilities, Security and Infection Preventionist and reported to the Safety, Infection Control and Environment of Care Committee.

Job Hazard Analysis and Personal Protective Equipment

A Job Hazard Analysis (JHA) form is utilized to evaluate each type of job task employees perform. The JHA 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.

Each JHA has a section in which Personal Protective Equipment (PPE) is identified related to a particular hazard. Employees are trained during their New Employee Orientation on both the JHA for their particular job class and PPE as it applies to hazards. If a new PPE is identified, a description is added to the corresponding JHA and employees who are affected are trained.

Each job task is analyzed at least once every two years and whenever there is a change in how the task is performed or if there is a serious injury while performing the task. JHA results are reported to the Employee Safety Committee.

8.0 HAZARD RECOGNITION AND REPORTING PROCEDURES

Every employee has the right and responsibility to identify hazards and to correct or report them for corrective action. This must be done by immediately notifying the direct supervisor and/or the supervisor of the area where the hazard has been identified.

Supervisors must ensure that corrective measures are taken which may include completion of a work order or immediate correction of the hazard. If the employee or supervisor is unable to resolve the hazard, the Safety Manager must be notified and/or an ESH Internal Hazard Reporting form must be completed. 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 and reporting corrective action(s) taken.

All hazard reports are evaluated by the Safety Manager to determine causative factors and implement corrective actions and reported to the EOC and Employee Safety Committee during regular monthly meetings. Actions, as required, are documented in Safety Committee minutes.

8.1 Environmental Safety Inspections

Eastern State Hospital is committed to identifying and eliminating hazardous conditions and practices. In addition to reviewing injury and illness records and investigating accidents for

their causes, members of the EOC and Employee Safety committees along with management and supervisors regularly check the workplace for hazards.

Environmental safety inspections are conducted weekly to ensure that all patient care areas are inspected for hazards at least bi-annually and all non-patient care areas are inspected at least annually. The inspections evaluate staff knowledge and skill, observe current practice and evaluate environmental conditions/hazards. The inspections are conducted by members of the EOC and Employee Safety Committees, safety staff, the Infection Preventionist and housekeeping and leadership representatives as available. These inspections are in addition to documented hourly environmental checks completed by nursing staff in all patient care areas. The results of the inspections and any action(s) taken are reported to the area supervisor(s), department manager, EOC and Employee Safety Committee and the CEO. CSS and CIBs Commissary environmental inspections are conducted in accordance with procedures outlined in the Workplace Safety Plan/APP (refer to Attachments for guidance). Results of these inspections are reported to the ESH Safety Committee.

8.2 Periodic Change Process

A team is formed by Executive Leadership 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 may include new equipment, significant changes to processes (e.g. non-smoking campus, anti-ligature changes) or a change to the building structure. This team is made up of safety office representatives and staff affected by the changed conditions. The team examines the changed conditions and makes recommendations to eliminate or control any hazards that are or may be created as a result of the change.

8.3 Proactive Risk Assessment

The Safety Manager, in coordination with the Director of Facilities and hospital leadership, security, department managers, Consolidated Support Services, CIBS and EOC/Employee Safety Committee members, as applicable, 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. 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 ensure appropriate controls are implemented to mitigate potential adverse impact on the safety and health of patients, staff and others. The prioritized risks are addressed immediately or integrated into planning objectives and performance improvement processes. Specific findings, recommendations, and opportunities for improvement are documented in EOC and Employee Safety Committee meeting minutes and reported to the Quality Council and Governing Body.

8.4 Annual Loss Control Evaluation (ALCE)

Safety staff from DSHS ERMO/Safety conducts an annual inspection of the hospital to include all associated buildings on the ESH campus and the workplace safety program to ensure compliance with applicable regulations, DSHS policies and hospital policies. The inspection provides the hospital with information about hazards that may be missed during routine inspections. Action plans are developed for all inspection findings with identified target dates to ensure each hazard is corrected in a timely manner.

9.0 EMERGENCY PLANNING

9.1 Evacuation Maps

Evacuation maps for the facility are posted in all patient care and non-patient care buildings. 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 a quarterly drill is conducted in all patient care areas. Documentation of all ESH and CIBs Commissary fire drills are maintained in the ESH Safety Office. All CSS drill documentation is maintained by the CSS Administrative Assistant.

9.2 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 hospital's 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, at a minimum, to assess the hospital's emergency management activities and to identify necessary changes, additional planning activities and specific exercise scenarios if required.

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 Operations Plan.

9.3 Response to Injuries

First aid supplies are maintained in all patient care locations. The Emergency Medical Response policy outlines procedures for response to non-patient care areas including movement of medical supplies and equipment. Injuries must be promptly reported to a supervisor. All direct care staff are required to have CPR training and other employees may also have CPR certification. In case of serious injury:

- Injured persons must not be moved unless absolutely necessary
- Assistance must only be provided to the level of training

Procedures outlined in the Emergency Medical Response policy must be followed. To initiate an emergency medical response, employees call 4333 on a hospital phone or 565-4333 by cell:

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 medical 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, falling, fainting, seizures and symptoms associated with low blood pressure or hypoglycemia.

9.4 Infectious Disease Exposure Hazard

Infectious diseases are a risk with some job tasks at the facility. The Eastern State Hospital exposure control plan is designed 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 ESH SharePoint. 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 patients, 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 is the best defense.

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 the common cold and influenza. Depending on the specific strain, these annually occurring contagions can have the greatest impact on ESH staff and productivity.

Employees should also expect to occasionally be conducting business with patients, other staff, contractors, or general members of the public who may be infected with more severe, though less common, contagions, including: Human Immunodeficiency Virus (HIV), Hepatitis B virus (HBV).

Employees at ESH have little potential for exposure to extreme infectious diseases such as Viral Hemorrhagic Fever (Ebola). Possible staff introduction to these more fervent contagions in the course of performing routine work 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 patient or staff member who has a family member who may have been exposed to a contagion). Employees should review the Washington State Department of Health website for the most current and factual information available.

As a 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 it is learned during the course of routine work that: 1) a patient, staff member, or anyone in a patient 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, a supervisor and the Infection Preventionist should be notified. As required, the local county public health department will be notified.

10.0 SAFETY AND HEALTH TRAINING AND EDUCATION

10.1 Safety Training

Safety training is essential to provide a safe workplace at Eastern State Hospital. The Safety Manager or designee conducts New Employee Orientation addressing all required Safety information including, but not limited to, Accident Reporting, Workplace Violence Prevention, Ladder Program, emergency response, LOTO and Asbestos Awareness and voluntary respirator use (refer to Staff Education Services for mandatory training requirements and assignments for departments and/or job assignment) The supervisor is responsible to verify that each employee has received an initial, site-specific orientation and any additional training required to perform job safely. All training is documented and maintained in the employee file. The Safety Manager in conjunction with Staff Education Services is responsible for developing and maintaining New Employee, Annual Safety/Accident Prevention, Emergency Management and Supervisor Safety training materials.

10.2 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 prevention, Infection Control and other required training. Training includes procedural knowledge regarding practices, policies, procedures, use and maintenance of personal protective equipment, behavioral intervention techniques, safe operation of equipment and emergency management and response plans. All ESH training curriculum is maintained by the ESH Staff Development Department. CSS and CIBs training requirements and curriculum is maintained according to their Workplace Safety Plan/APP.

10.3 Orientation for Clinical and Nursing Staff

Upon completion of the basic NEO, clinical and 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 patient care, and advanced skills in managing escalating situations with patients.

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 as required. All training is documented and maintained in the employee file.

10.4 Site-Specific Training for CSS/CIBS Commissary

CSS staff receives site-specific training prior to working at the facility e.g. TEAM. CIBs Commissary staff are required to complete ESH Safety and Emergency Response training via LMS.

11.0 WORKPLACE VIOLENCE PREVENTION

Eastern State Hospital mitigates the risk of workplace violence by providing effective evidenced based patient care combined with staff training and safety related policies to promote a safe physical environment and Culture of Safety.

Prevention of workplace violence is based on principles of:

- Zero tolerance for workplace violence
- A proactive patient centered approach leads to a reduction in violence
- Prioritizing quality and effective patient care creates a safe environment
- Increasing safety and respect for patients creates safety for staff
- Utilizing non-violent crisis intervention when faced with escalating verbal or physical patient behavior prevents injury or assault.

11.1 Definition of Workplace Violence

The National Institute for Occupational Safety and Health (NIOSH) defines workplace violence as “violent acts directed toward persons at work or on duty.”¹ 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).

11.2 Workplace Safety and Security Assessment

The annual Workplace Safety and Security Assessment required under RCW 72.23.400 addresses safety and security considerations related to the following items (Appendix A):

- 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

11.3 Risk Assessment and Treatment Planning

Patients with an increased risk for assault have treatment plans formulated to address the risk and includes safety plans to identify triggers and prevention and de-escalation. Violent acts are tracked to identify frequency and severity of assaults. Weekly inter-shift meetings include the interdisciplinary team and psychiatric consultation to develop treatment strategies, tailor responses, develop staff safety strategies and examine and debriefing interventions or critical events.

Effective patient care requires accurate analysis of behavior and consideration of the patient's predisposing and co-existing conditions, circumstances and 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 side-effects of medication.

Risk assessment continues throughout a patient's hospital stay and has a dynamic relationship with the patient's individualized treatment plan. Different tools may be utilized to determine risk. A behavior chain analysis is one tool that examines the links of a behavior chain, including, triggers, emotional, cognitive and behavioral responses, and outcomes that reinforce or support behavior. Communication of risks and new or current information about patients' vulnerabilities and effective treatment responses must be communicated during treatment plan reviews and daily shift changes and report for ongoing situational awareness and tools to mitigate the risk of patient and staff injury.

11.4 Special Population Considerations

There are often special risk considerations for specific populations. Special population 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
- Children and Adolescents

- Developmental Disabilities
- Civil commitments,
- Habilitative Mental Health
- Co-occurring diagnoses

11.5 Effective Patient Care

Preventing and constructively addressing with unsafe and violent behavior is a priority for patient care and leads to a safe work environment for staff. The multidisciplinary treatment team works proactively with patients to reduce incidents of unsafe behavior, including assault. All direct care staff are trained in the principles of effective treatment and behavioral management strategies.

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

11.6 Administrative and Engineering Controls, Work Practices, Security

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.

11.6.1 Administrative Controls

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. Controls include:

- DSHS Policy 18.67 Workplace and Domestic Violence.
- Prohibition of actual or potential weapons on campus grounds.
- 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.

11.6.2 Environmental Controls

Environmental controls include:

- Entrance security (locks)
- A system of visitor or contractor access control
- Identification 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
- Use of quiet/comfort rooms for de-escalation when patients are escalating or unsafe.
- Safe furniture appropriate for a psychiatric setting

11.6.3 Work practices

The Psychiatric Emergency Response Team (PERT) is designed as a first-responder system to promote a culture of safety for patients and staff. This highly skilled team, comprised of Institution Counselor 3s, and Registered Nurses (RN), and a Supervisor, are trained in crisis intervention skills, incident management skills, analysis of the antecedents for violence and aggression, and de-escalation techniques.

When containment is necessary, this team will facilitate seclusion and restraint if necessary and work with floor staff to re-integrate the patient back to the ward environment, utilizing appropriate evidence-based practice. When not active, team members provide direct, hands-on therapeutic engagement of patients, often modeling best practices for staff. A secondary benefit of PERT is enhanced staffing on the more volatile patient treatment units throughout the hospital. PERT is not included in the staffing count.

11.6.4 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.

11.7 Support to Employees

Victims of workplace violence may 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 and emergency medical response. In the event that an employee sustains a more serious injury, the supervisor assists the employee to obtain additional medical attention if indicated.

Supervisors provide employees who are victims of workplace or domestic violence information regarding resources including access to the Employee Assistance Program for counseling and referral on an individual and confidential basis. A Critical Incident Stress Management (CISM) team is in place and may be initiated to provide assistance to staff on a voluntary basis to individuals or team members, as a group, who have been impacted by workplace violence (refer to ESH Policy 2.15).

11.8 Annual Report to the Legislature – Workplace Safety in State Hospitals

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

11.9 Training to Reduce Workplace Violence

Patient care staff are trained at hire and annually in prevention practices that range from situational awareness of the environment, ongoing risk assessment, effective documentation, individual and group patient education to a formal non-violent crisis intervention training program.

Eastern State Hospital utilizes a crisis intervention program that is evidence based, and provides staff with the tools to keep themselves and patients safe while maintaining a 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. Staff are also trained in approved procedures for physical intervention should a patient become assaultive or engage in self-harm and less restrictive interventions have been unsuccessful. This training includes: evasion techniques, the hierarchy of physical intervention, physical containment procedures and application of mechanical restraints. All physical skills require return demonstration and documentation of competency.

11.10 Data and Surveys Addressing Workplace Violence

Data Review:

Workplace violence is tracked utilizing incident data bases. Administrative forms (DSHS 03-133 Injury and Illness Incident Report and ESH's Unusual Occurrence report form) are utilized to document assaults and are reviewed by leadership in daily morning meetings.

Eastern State Hospital tracks workplace injuries due to assault in the RiskMaster data base maintained by ERMO and in the hospital database (UOR). RiskMaster provides the capacity to compile data for analysis of frequency, severity, precipitating event(s) and other circumstances contributing to a deeper understanding of workplace violence increasing the potential for a systemic solution.

Data is analyzed at the monthly EOC and Employee Safety Committee meetings and reported quarterly to 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 are used to obtain feedback on communication, teamwork and leadership related to safety. The surveys identify or confirm the need for improved security measures, training, supervision or management responsiveness. Action plans are developed, as required, to improve the overall Culture of Safety.

12.0 WORKPLACE SAFETY GOALS AND PERFORMANCE IMPROVEMENT

The Safety Manager, Employee Safety Committee and other subject matter experts, as identified, are responsible for the development of annual Safety Committee goals and performance improvement (PI) initiatives. Safety goals and PI initiatives are based on priorities identified by the Employee Safety Committee through data and incident reviews and are documented in the Employee Safety Committee minutes.

The EOC Committee is responsible for EOC PI initiatives that are based on priorities identified by the EOC Committee through evaluation of risks associated with Safety, Security, Utility Systems, Medical Equipment, Fire Safety and Hazardous Materials Management. Performance improvement activities are documented in the EOC Committee minutes.

Quality Council is responsible for approving Workplace Safety goals and PI initiatives, including performance measurements. Activities and progress related to goals and PI initiatives are reported

quarterly to the Employee Safety Committee and/or EOC Committee and provided to Quality Council and Governing Body.

13.0 WORKPLACE SAFETY PLAN – ANNUAL EVALUATION

The Safety Manager, EOC and Employee Safety Committee evaluates the Workplace Safety Plan annually for its scope, objectives, performance, and effectiveness, as required under RCW 72.23.400. A year-end workplace safety summary is presented to the EOC Committee, Employee Safety Committee, Quality Council and Governing Body.

Appendix A: Workplace Safety Plan – 2017 Security and Safety Assessment

Eastern State Hospital

RCW 72.23.400 requires each state hospital to develop a plan (Workplace Safety Plan) to reasonably prevent and protect employees from violence at the state hospitals. The Plan must address security and safety considerations related to specified items under RCW 72.23.400(a) through 72.23.400(h), as appropriate to the particular state hospital, in order to identify existing or potential hazards for violence and to determine the appropriate preventative action to be taken. The Plan must be evaluated, reviewed, and amended as necessary and at least annually, to include an annual Security and Safety Assessment.

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
<p>a) The physical attributes of the state hospital including:</p> <p>a) 1. Access Control</p>	<p>An Employee Safety Committee assessment of the visitor access and metal detector use policies for each unit found they are inconsistent in addition to inconsistencies with nursing staff compliance; ward to ward, shift to shift. 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 the detectors in alternate locations is not feasible due to egress requirements (APU/GPU). Hand held detectors available on all wards. There is an increased potential for visitors to bring contraband onto the ward when visiting if metal detector not utilized.</p> <p>It is problematic to obtain keys when staff quit via telephone or employment separation is initiated by ESH via letter.</p>	<p>The Administrative Directors for FSU, APU, and GPU) have evaluated individual unit visitor access and metal detector use policies and revised them to reflect consistency across the hospital units, wards and shifts. Security implemented training regarding use of hand-held metal detectors at hire; March, 2017. Educational Services staff took over NEO wand training in November 2017. Unit education coordinators are arranging/providing refresher training to current staff.</p> <p>All Security events involving campus or building access are reviewed by the EOC and Employee Safety committee for development of recommendations or action plans as required.</p> <p>Access to the hospital campus is controlled primarily through the use of identification badges, personal identification and advance notification of authorized visitors. Campus-wide key control is 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 key returns from employees when leaving ESH employment.</p>

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
a) 1. Access Control	There are occurrences of stolen, misplaced, lost or not turned in employee identification badges and/or keys assigned to individual employees.	A Capital Program request has been made for funding to install an electronic "Key Watcher" issuance and tracking system for internal building keys and a card access building entry system. This will require Legislative approval and funding.
a) 1. Access Control	Security reports and security related Unusual Occurrence reporting have identified interior and exterior building doors found unlocked. These occurrences are potentially related to the door not closing properly (HVAC air pressure related), door lock malfunction or the door being left unsecured by staff. Some doors require manual locking and some locks are self-locking.	<p>Quarterly and annual door inspections are completed by CSS to ensure proper function. Quarterly reports of these inspections are forwarded to the Safety Office for monitoring.</p> <p>Doors at required egress exits must have panic hardware in place by Fire Code. This requirement prevents use of self-locking mechanisms at these locations.</p> <p>Door security checks are completed by Security staff after hours and unsecure locations documented and reported to responsible area supervisor for follow-up. Data is reviewed by the Environment of Care (EOC) and Employee Safety committee for trend analysis and recommendations for performance improvement activities as indicated.</p> <p>Capital Programs funding has been obtained and assessment completed for all fire doors hospital-wide. All fire doors, including exterior and interior entrances, will be replaced, as indicated by assessment, to ensure proper function and compliance with Life Safety code requirements and TJC/CMS standards compliance; 2017-2019 biennium. Currently there is a capital project in the design phase to replace/repair/recertify the doors. Estimated completion date is June, 2019.</p>
a) 1. Access Control	Assessment of the Eastlake and Westlake Switchboard locations was completed by the Spokane County Sheriff's Department prior to December 2016 Armed Assault emergency drill. This post-drill evaluation, and After Action Planning have identified that Switchboard staff are vulnerable to	Assessment of the Eastlake and Westlake Switchboard locations was completed by the Spokane County Sheriff's Department prior to December 2016. Based on this assessment, in addition to after action planning from Active Threat drills conducted at ESH, have identified that the PBX staff are vulnerable to workplace violence. Both locations contain critical alarm system,

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
	workplace violence ; armed assailant, agitated visitor, etc. Vulnerabilities include, but are not limited to; limited visibility of in-coming visitors and staff, physical location is either unsecured or non-hardened (zero barriers between visitor and operator and/or barrier easily broken to access location, etc.).	communication and camera equipment for alerting and notification of hospital staff in an emergency. Preliminary design for relocating the Westlake Switchboard reception desk, installing cameras at entrance doors and enclosing the desk area to increase visibility of the parking lot and in-coming visitors has been completed. Recommendations for added security at the Eastlake PBX have also been identified. A 2017-2019 minor projects budget request has been submitted to address identified security and safety risks at these locations. A Capital Programs request was submitted in the 2017-2019 minor projects budget request. No funding approval at this time.
a) 1. Access Control	The parking areas, hospital-wide, are not under surveillance and some locations are bordered by wooded areas or vacant buildings.	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. No funding approval at this time. Existing exterior lighting has been improved with installation of LED lighting campus-wide.
a) 2. Egress Control	There is currently no physical control over egress (visitor/staff) on campus and outside of secured buildings or unit fenced yard for staff escorted activities or unescorted patient walks (patient levels and risk evaluated prior to unescorted campus access). Restricting egress would require a security fence around the entire perimeter of the hospital. This would be logistically difficult due to the physical location of the hospital and surrounding landscape.	Unauthorized patient leave data is tracked and reported monthly to EOC Committees and Patient Risk Manager for trend analysis and drill downs to identify action plans if indicated.

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
b) 2. Egress Control	<p>As the result of a root-cause analysis, the following performance improvement activities have been identified for 2017: Audit of source documents required for law enforcement notifications of UL, clarification of escort policy relating to escorting to/from and while within the yard and identifying how to monitor compliance.</p> <p>Recommendations also included installation of additional security fencing and gate latches to include investigation of an alert system when latches are not secured.</p>	<p>The escorting policy was reviewed and revised to clarify staffing ratios when escorting patients to the yard and Eastlake 0N and 0S basement floor. Communicate direction to staff reinforcing the use of clear language when communicating UL via radio e.g. "UL North Patient Yard. Target for completion; April, 2017.</p> <p>Additional fine mesh fencing was installed over the existing fencing at the non-smoking shelter inside the APU yard and at the building equipment fenced area adjacent to the APU yard; February, 2017. The pop machine shed and non-smoking shelter was subsequently removed from the APU yard. Additionally, fine mesh was installed where the sheds were located. Additional Capital Program funding has also been requested to upgrade the APU fencing as part of the 1N3 and 3N3 Forensic ward renovation projects.</p> <p>This will decrease a patient's ability to get a finger or toe hold in the fencing that would allow them to climb over the fence.</p> <p>A Capital Programs request has been submitted for installation of fencing around the baseball field adjacent to the Activity Therapy building to provide additional secured space for patient group activities; 2017-2019 biennium. This will require Legislative funding.</p>
a) 2. Egress Control	<p>Security reports and security related Unusual Occurrence reporting have identified interior and exterior building doors found unlocked. These occurrences are potentially related to the door not closing properly (HVAC air pressure related), door lock malfunction or the door being left unsecured by staff. Some doors require manual locking and some locks are self-locking.</p>	Refer to 1.c)

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
a) 3. Door Locks	<p>The current employee key control and tracking system is completed manually by Security staff. This system documents initial issue of keys at hire, changes in keys issued to an employee based on need (position and area worked), and return of keys when employees leave ESH employment. Manual tracking is labor intensive and leaves potential for employees to have access to keys that they are not authorized to have if changes not reported to Security by employee supervisor, information not entered into the Security database in a timely manner or not entered at all (human error).</p>	<p>A Capital Program request has been made for funding to install an electronic "Key Watcher" issuance and tracking system for internal building keys and to install an electronic card reader building access system throughout the hospital. This will require Legislative approval and funding.</p> <p>All FSU wards have ward-specific keys checked out by staff when they arrive on the ward using a "chit" system. Through security break memos forwarded to the FSU Security committee and via UOR, there have been reported incidents of staff leaving at the end of their shift and forgetting to turn in their ward keys.</p>
a) 4. Lighting	<p>Burned-out or malfunctioning outside lighting decreases staff ability to monitor outdoor patient activities in the evening, Security's ability to conduct campus surveillance and staff's ability to monitor parking lots or other campus areas for hazardous conditions when arriving or leaving. Monthly Security reports have revealed areas where the lighting has not been corrected for extended periods of time.</p> <p>The Linden Hall parking lot is poorly lit. Upper terrace and the north side of the Westlake parking lot is dark despite the presence of several pole lights.</p>	<p>Security monitors lighting during daily Security rounds and reports burned out exterior lighting to CSS for replacement. All lighting work orders are prioritized based on location risk. Delays in lighting repair impacted by extent of repair e.g. light bulb only or need for more extensive electrical repair and/or height of perimeter lighting requires use of a bucket truck to complete repair.</p> <p>Existing exterior lighting has been improved with installation of LED lighting campus-wide; 2016-2017. A Capital Programs request has been made to increase campus-wide parking and perimeter lighting based on risk assessment.</p>
a) 5. Alarms	<p>The 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 building renovations over 20 years ago. The APU system is beyond its life expectancy. The FSU alarm system was installed under Phase 4 building renovations but was</p>	<p>To ensure reliability, the existing staff duress alarms are tested daily on all wards by ward staff (APU & FSU) and weekly on GPU per Nursing policy. Alarm deficiencies identified during these tests are reported to CSS for immediate repair. Testing is monitored by the Safety Office.</p> <p>A Capital Programs request has been made to replace</p>

	<p>updated during a recent Capital Programs project to install additional cameras but must interface with the old APU system for reporting. Wiring, equipment inadequacies and failures, specific to the APU duress system, were identified during the FSU Security Enhancement project.</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 several feet apart throughout the corridor.</p>	<p>the existing antiquated staff duress systems on the wards and install a “personal duress alarm” system in all locations that provides wider coverage, ease of activation and electronic location tracking for quicker emergency response. This will require Legislative approval and funding.</p> <p>A Capital Programs project has been funded and initiated for replacement of the existing nurse call system at Westlake. This project includes installation of additional staff duress devices in GPU Treatment Mall locations. Project completion; October, 2017.</p>
a) 5. Alarms	<p>The alarm is relayed to “reader boards” on each ward and the Eastlake Switchboard denoting the ward activated on. These “reader boards” are old and prone to malfunction. Repair is problematic due to age of system.</p> <p>The existing APU, FSU and GPU systems do not provide a method of activation for off-ward and/or outdoor escort/activities i.e. yard group, etc. The GPU Treatment Mall locations and Activity Therapy Building (Eastlake Treatment Mall) do not have existing staff duress devices.</p> <p>The alarm notification only displays the ward; it does not identify specific/exact location of staff activating the alarm. The Eastlake Switchboard is currently unable to visually see the alarms at their panel due to malfunction and CSS is unable to repair due to age and inability to get parts. The alarm is audible only at the Switchboard and requires staff reporting by radio or emergency phone number which is not always feasible dependent on emergency.</p>	

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
b) 5. Alarms	<p>Daily tracking of staff assigned to radios is in place but there is no ability to electronically track the exact location of staff.</p> <p>The existing Westlake staff duress alarm consists on one location for activation; a "push to activate" button at each nurses station. The location of activation devices makes the system difficult if not impossible for staff to use if involved in a patient-to-staff assault.</p>	<p>ESH utilizes digital radios for staff communication on and off ward. These digital radios are equipped with an emergency alarm button that when 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. The alarm, radio number and staff assigned to that radio is reported all other radios on that channel, Switchboard and Security for response.</p>
a) The Physical Attributes of the State Hospital: Environment of Care	<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>There is the potential for patient property to be used for self-harm or as weapon e.g.</p>	<p>The comprehensive Environmental Proactive Risk assessment was reviewed and updated May, 2018. This is 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. Action plans are developed based on assessment and monitored by EOC Committee and Quality Council.</p> <p>A Capital Programs project funded to address the restroom ligature risks in the Activity Therapy Building (Treatment Mall). The restrooms will be remodeled and configured so there are no ligature risks. The project calls for creating 12 new individual/gender neutral/ handicap accessible (two per floor) bathrooms. Tentative completion date is February, 2019. This project was in response to a TJC citation. Currently patients are being monitored and restrooms are locked between uses as part of a mitigation plan.</p> <p>A Capital Programs project has been funded to replace handrails, install ceiling clips and replace cabinet hardware (ligature risks) in response to a TJC citation in May, 2018. The project is scheduled to be completed by December, 2018.</p> <p>An Authorized Patient Property policy is in place and identifies patient belongings, personal care item, etc.</p>

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
	<p>belts, large pieces of jewelry, CD's, drawstrings, etc.</p> <p>Furniture in patient care areas (chairs, tables, desks, beds) pose a risk for use as a weapon or ligature point.</p>	<p>and whether the item is not allowed or allowed. If the property is allowed, the policy/list identifies within what context (category based, staff supervision required, treatment team approval required, and other restrictions). The Authorized Patient Belongings list is updated at least annually or as indicated as the result of a Sentinel Event root cause analysis.</p> <p>Patient rooms on all APU wards are being systematically renovated for patient safety and include purchase and installation of additional Norix furniture. This furniture consists of molded vinyl beds and molded cubicles for patient storage which are specifically manufactured for Behavioral Healthcare. Health and Correctional facilities. The molded vinyl furniture is bolted to the floor/wall to prevent being thrown or broken apart and used as a weapon. The civil commitment admission ward patient bedrooms equipped with Norix beds; May, 2018. Target for installation of Norix molded vinyl beds and molded cubicles for patient storage on 2N1 (civil commitment ward); 2019.</p> <p>Assessment completed to identify all electric beds with six foot cords. All cords shortened to three feet and secured to the bed frame on all purchased and rental beds to mitigate risk of use for self-harm or as a weapon; July, 2017. The length of electric cords has been added to the EOC Audit Tool, monitored during the EOC rounds and reflected in the Environmental Proactive Risk Assessment.</p> <p>A checklist was created to document security and location of equipment utilized in the woodshop that present a staff and patient safety risk. This checklist is completed pre and post group. Compliance is based upon the completion of the checklist log and audited during EOC rounds to ensure log compliance.</p>

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
	<p>There is the potential for coat hangers (plastic hangers are currently in use in some locations) to be used for self-harm or as a weapon if broken.</p>	<p>Hangers on 2N3 remain in place. Patients on 2N3 are Level 8 and allowed on campus and into the community without escort on approved leave as outlined in the Treatment Plan; "No Risk, or Such Minor Risk as to be a serious consideration. All hangers have been removed from other high-risk locations; 2016.</p>
<p>a) The Physical Attributes of the State Hospital: Environment of Care</p>	<p>There is the potential for identified sharps drawers/cabinets to be left unlocked or for sharps not to be accounted for in patient accessible areas. Sharps in staff breakrooms that are not secured provide the potential for access by patients if they managed to push by staff and gain access into the room as staff are entering or leaving.</p> <p>There is a potential for metal and non-metal contraband /unauthorized items to be brought onto the ward by visitors that creates increased risk to patients and staff; illegal drugs, items that can be used for self-harm or as weapons, etc.</p> <p>Plastic tooth brushes, combs, and hairbrushes can be broken and used for self-harm or as a weapon. Alternative, flexible toothbrushes were identified and piloted on APU and FSU admission wards; February, 2017. The pilot was unsuccessful as patient(s) were able to create make-shift weapon with the toothbrush (identified during ward search).</p> <p>There is insufficient camera coverage on the Forensic admission ward for patient monitoring and investigation of incidents.</p>	<p>All sharps are required to be in locked drawers/cabinets in staff breakrooms and inventoried and/or shadowed in patient care areas to ensure they are secure, present and accounted for. Compliance is monitored during weekly environmental surveys and non-compliance reported to unit Administrative Directors and the unit Director of Operations for follow-up.</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 all wards (APU/FSU/GPU).</p> <p>An alternative toothbrush manufactured for use in Behavioral Health and Corrections facilities was implemented for use by all patients on APU and FSU wards; March, 2017. A "finger cot" type toothbrush used in DOC facilities has been identified for use on FSU admissions (1S1) for patients in seclusion or for patients at high-risk for use of the toothbrush as weapon or for self-harm; March, 2017.</p> <p>Capital Programs project funded and initiated for Installation of additional cameras on Forensics admission ward for patient monitoring and incident investigation. Completion; March, 2017.</p>

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		<p>Environmental checks are conducted and documented hourly on all wards and incorporates risks identified on the Environmental Proactive Risk assessment to mitigate risk. Weekly environmental Safety surveys conducted and findings reported to department/area supervisor and Leadership for action as identified. The survey tool enables quick identification of high-risk findings.</p>
b) Staffing, Including Security Staffing	<p>Variances (changes to staffing due to staff call in, vacations, ward acuity, etc.) in Nursing and Security staffing can potentially impact patient care and hospital-wide Security and emergency response.</p> <p>Systems for identifying variances in Nursing staffing and responding to these in a timely manner are in place.</p> <p>Systems for identifying variances in Security staffing needs are in place. 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 secure. Security personnel are not assigned to patient care wards but do respond to requests for staff assistance on the wards via radio communication initiated by ward staff or Nursing Management.</p> <p>Overtime YTD in 2018 is 6.0% compared to 2016 which maintained below 5.5%.</p>	<p>Additional tools/systems used in nursing include:</p> <ul style="list-style-type: none"> • Policy/procedure on how to acquire staff • Acuity based staffing plan • Guidelines for safe staffing levels • Use of contracted Nursing services. <p>During analysis of adverse patient safety events, an assessment is conducted to determine whether staffing played a role in the adverse event. A subsequent report is provided to the Patient Care committee, Quality Council, and Governing Body.</p> <p>Use of on-call staff Eastern State Hospital has a pool of on-call employees for utilization when required.</p> <p>Pre-Arranged Overtime Staff notifies the staffing office in writing when they want to work voluntary overtime. Staff is 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.</p>

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b) Staffing, Including Security Staffing		<p>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). When a staff member is contacted for overtime, a computerized record is maintained noting the staff member's full name, title, date contacted, and the results of that call. Overtime is assigned where the greatest patient care/need is a priority. Staff is expected to work in the location assigned. Every attempt will be made to accommodate preferences, but may not always be possible.</p> <p>Voluntary Overtime 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>Involuntary Overtime When voluntary overtime does not meet patient care/workload demands, involuntary overtime is assigned based on an in-verse seniority rotational schedule in compliance with the Collective Bargaining Agreement.</p> <p>Agency Nurses A contract with travel and local agencies is in place and utilized to ensure staffing levels are suitable for provision of patient care and to avoid mandatory overtime; registered nurses only.</p>

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c) Personnel Policies	<p>DSHS, BHA, and ESH hospital, unit, and discipline specific policies addressing workplace safety, security, emergency response and workplace violence are in place to mitigate risk.</p> <p>All three (3) state hospitals (ESH, WSH, and CSTC) have collaborated to align their comprehensive Workplace Safety Plans encompassing Workplace Violence Prevention.</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, "News Flashes", and posting of communications on safety and communication boards throughout the hospital. The Learning Management System (LMS) is utilized for ensuring employee compliance with mandatory training and changes to policies/procedures for employee awareness.</p> <p>Environment of Care plans (Safety, Fire/Safety, Medical Equipment, Utility Systems, Security and Hazardous Waste Management) are in place and assessed annually for objective, scope, performance and effectiveness. Data is reviewed by the EOC and Employee Safety committee to identify trends and develop a plan for improvement, if indicated, to correct deficiencies and mitigate risk. The 2016 annual evaluation of the Workplace Safety Plan validates the plan is adequate and effective in practice.</p>	<p>The following list is not all inclusive, refer to individual policy manuals for additional information:</p> <ul style="list-style-type: none"> • Behavior Undermining the Culture of Safety • Seclusion/Restraint • Safety Huddles • Workplace Safety Plan, including Accident Prevention, and Workplace Violence Prevention • Crisis Prevention and Intervention training (TEAM) • Psychiatric Emergency Response Team (PERT): A plan of response for patients during a psychiatric crisis or anticipated crisis • Code Grey Response (Escalating Patient Behavior Response) • Critical Incident Stress Management (CISM) • Disruptive And Intimidating Behavior By Staff • Incident Reporting • Key Control • Visitor Access • Background Checks • Law Enforcement Notification • Benefits for Employees Assaulted by Residents/Clients • Workplace Personnel Security Program • Emergency Operations and Specific Emergency Response Procedures <ul style="list-style-type: none"> ○ Active Threat ○ All Hospital Lockdown ○ Bomb Threat ○ Evacuation

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d) First Aid and Emergency Procedures	<p>There is a potential for exposure to communicable diseases, Bloodborne Pathogens (BBP), Hepatitis B/C, HIV, and TB during provision of patient care.</p> <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. This risk assessment was last reviewed and revised February, 2017.</p>	<p>Infection prevention measures are implemented on wards as required based on daily shift reports.</p> <p>Vaccinations for Hepatitis B and TB testing are required at hire and assessed annually.</p> <p>Employees potentially exposed to a BBP must complete an Exposure Reporting form and all incidents investigated by the Infection Preventionist or Employee Health Nurse for follow-up as required.</p> <p>Flu vaccinations are available to staff at no cost.</p>
d) First Aid and Emergency Procedures	A Medical Emergency Response Team in place.	<p>The Medical Emergency Response Committee (MERC) reviews all emergency response events and develops and implements a Medical Emergency Response action plan, as indicated.</p> <p>Emergency medical response procedures for Code Blue and Code Rapid Respond are in place and activated by contacting Switchboard by radio or the emergency phone number (4333). Switchboard staff relays requests for nursing and medical provider response via two-way radio, overhead annunciation and radio paging alerts.</p> <p>The MERC has developed and implemented "Mock Codes", to improve medical emergency response preparedness. Seven Mock Codes were completed between August 2016 and March 2017; one on each unit, day and evening shift, and one at the Treatment Mall.</p> <p>Emergency medical supplies, including an AED, are maintained on all wards or can be 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 locations. Security staff has been trained as first responders.</p>

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d) 2. Medical Emergency Response	<p>A minimum of two (2) emergency response 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 & security of patients and staff, staff roles and responsibilities (assignment and performance), managements of critical utilities, management of clinical and support activities, transportation and personal protective equipment.</p>	<p>Medical providers are required to complete ACLS classes with biannual recertification. ECG rhythm and emergency response training is provided to shift nurses.</p> <p>Emergency procedures are in place based on a Hazard Vulnerability Assessment (HVA). The HVA is reviewed and updated annually or as required based on evaluation of staged or actual events. The HVA was last revised June, 2017.</p> <p>The following actual events, emergency response drills and Emergency Operations and Response participation with community partners occurred in 2017:</p> <ul style="list-style-type: none"> • Region 9 Healthcare Coalition (HCC) Situational Awareness: Community Influenza Outbreak; January, 2017 • Actual Event: DeVries Shredding Truck Fire; 4.5.17 • Actual Event: Eastlake Kitchen Steam Leak; 4.11.17 • Actual Event: Power Outage 5.16.17 • Unauthorized Leave (UL) Drill; 9.19.17 • Region 9 Healthcare Coalition Community Based HVA Workgroup Participation – November, 2017 • Actual Event: Outside Report of Potential Threat; 11.2.17 • Region 9 Healthcare Coalition Medical Surge Situational Awareness and low-notice functional drill Westlake Evacuation; 11.15.17 <p><i>Lessons Learned/Future Planning:</i></p> <ul style="list-style-type: none"> • Slow response by local volunteer fire department. Meeting held with Medical Lake Fire Department (MLFD) Fire Chief and facility Leadership including representatives from ESH, CSS, and Lakeland Village in order to clarify emergency response capabilities and

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
		<ul style="list-style-type: none"> • MLFD MOUs with other local departments; May, 2017. The Hazard Vulnerability Analysis was updated to reflect increased risk due to decreased MLFD resources and response capabilities. • Delayed steam shutdown in Eastlake kitchen. All CSS shop supervisors to ensure all staff are aware of utility system shutoff locations and that shut off locations/valves are identified/labeled. • Equipment and outlets in the Eastlake Dental Clinic were identified as not being on the critical circuit (emergency generator). The Eastlake Dental Clinic and other identified areas added to critical circuit during Capital Programs project that replaced the Eastlake north generator. <p>The ESH Continuity of Operations Plans (COOP) substantial completion September, 2017 with CEO signature; 10.13.17.</p> <p>A Communications Plan was developed and implemented November, 2017. This plan outlines the roles, responsibilities and protocols that guide the hospital in timely dissemination of information during an emergency. This plan is part of the Eastern State Hospital Emergency Operations Plan and administered by the hospital Incident Command. The plan is consistent with ESH's Region 9 Healthcare Coalition partners.</p> <p>Decision package submitted for 2018-2019 biennium for funding of additional repeaters to improve radio communication reliability in identified "dead spots" and in outside locations.</p>
		<ul style="list-style-type: none"> • ESH Social Worker staff upgraded from antiquated pagers to SL7550 radio/pager; 35% complete.

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	<p>There is the potential for radio communications to be compromised due to:</p> <ul style="list-style-type: none"> • Low/dead batteries • Dead spots (lack of repeater coverage) • Incompatibility with community emergency response agencies • Lack of assigned radio/pager for all staff 	<ul style="list-style-type: none"> • A daily digital radio assignment log is used daily by all wards and shift for assignment tracking enabling quicker emergency response if required. Rotating radio spares fielded on an as needed basis for inoperable radios.
e) 1. Reporting of Violent Acts	<p>All elements pertaining to reporting of violent acts are documented utilizing Employee Injury, Unusual Occurrence, Uniform Law Enforcement Notification and Internal Hazard reporting forms.</p>	<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"> • 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 ; containment • Injury severity rating • Type of injury • Body part affected • Description of precipitating events
e) 2. Taking Appropriate Action in Response to Violent Acts	<p>Policies, procedures, and training are in place to ensure appropriate actions and response to violent acts occurs.</p>	<p>All incidents are investigated by the immediate supervisor, Security, Safety and/or other department(s) as indicated at the time of occurrence and reported to the EOC and Employee Safety Committee.</p> <p>All seclusion/restraint, PERT, Code Grey, patient and staff injury incidents are reviewed by Leadership in daily morning rounds and actions implemented as required.</p> <ul style="list-style-type: none"> • The Psychiatric Emergency Response Team (PERT) responded to 2,445 staff calls for assistance in 2017. The PERT provides a safe, effective and immediate plan of response for

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
		<p>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.</p> <p>When not actively engaging patients the primary mission is primary prevention, and is accomplished by interacting with patients throughout the campus during the team member's daily shift.</p>
e) 2. Taking Appropriate Action in Response to Violent Acts		<p>A "Code Grey" is implemented whenever a patient's behavior is escalating and may require seclusion or restraint or whenever seclusion or restraint is initiated. A "Code Grey" is in response to an actual or anticipated critical incident and immediate response is required. Debriefing with staff and an intensive analysis of the event is completed.</p> <p>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 emergency response is initiated or the supervisor assists the employee to obtain additional outside medical attention if indicated. Refer to section d) First Aid and Emergency Procedures for additional information.</p> <p>The Critical Incident Stress Management (CISM) policy was revised January, 2018. Critical Incident Stress Management (CISM) is an adaptive, short-term psychological helping-process that focuses solely on an immediate and identifiable problem. It can include pre-incident preparedness to acute crisis management to post-crisis follow-up. Its purpose is to enable employees to return to work quicker with less likelihood of experiencing post-traumatic stress disorder (PTSD). The program is <i>peer-driven</i>, designed to help employees deal with their trauma by allowing them to talk about the</p>

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		<p>incident when it happens without judgment or criticism. New Critical Incident Stress Management (CISM) team members were selected and trained, April, 2017. The team is comprised of two groups providing 24/7 coverage. CISM members are notified to initiate contact with employee(s) per Leadership, supervisor or other staff referral. A new referral request mechanism has been added to the ESH SharePoint.</p> <p>In addition, staff is made aware 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>A LEAN workgroup was initiated to develop and implement process improvements related to injury/illness reporting and the Labor and Industries (L&I) clam process. Improvements included creation of a communication site on the ESH SharePoint to include link to L&I and DSHS Enterprise Risk Management (ERMO) safety and claims webpage; trained Subject Matter Experts, all shifts, to assist injured workers with accurate information related to the reporting process and how to access additional information and resources at time of occurrence; created and posted/distributed process communication posters and name badge cards for improved employee awareness. LMS training outlining all LEAN improvements was created and implemented 10/1/17.</p>
e) 3. Follow-up Procedures after Violent Acts		<p>Safety Huddles are conducted prior to morning report on each ward to share potential safety concerns/issues.</p> <p>A risk management review and investigation report (RMRIR) is completed daily by the Patient Safety Manager. This is designed to ensure the severity of an injury or other incident is appropriately coded, reported to appropriate individual for follow-up and actions taken.</p>

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		<p>The Employee Safety Committee meets monthly and conducts in-depth reviews of patient-to-staff assault occurrences and develops prevention strategies to mitigate future occurrences as identified. A narrative summary (dashboard) with recommended action plans is provided to the Employee Safety and EOC Committee, Quality Council and Governing Body for review and monitoring.</p>
<p>e) 3. Follow-up Procedures after Violent Acts</p>		<p>Employees who self-identify as victims of domestic abuse may access the employee assistance program for referral to special resources. Victims of domestic violence are supported under 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.</p> <p>The DSHS-Enterprise Risk Management Office (ERMO) conducts investigation, in addition to facility investigation, of any assault on a DSHS employee which results in an employee's hospitalization or medical treatment beyond first aid. A drill down of the event is conducted to determine whether existing processes are effective or require modification. Data derived from the drill down is used by ESH, as appropriate, to develop an action plan for process improvement and reported to Employee Safety Committee and Quality Council.</p>

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f) Development of Criteria for Determining and Reporting Verbal Threats	<p>ESH utilizes Unusual Occurrence (UOR) forms for reporting verbal threats, per RCW 72.01.045 and 74.04.790. Reporting staff determines risk potential.</p> <p>Definition and coding of UOR for verbal threat is identified as: "To express (orally, in writing, or by action) a specific intent to cause another person harm, trouble, or inconvenience". An abuse code is utilized if the threat is made by a patient or other to staff. An anti-safety culture code is utilized if the threat is made by a staff to another staff. 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>Workplace violence, including verbal threats, is monitored and analyzed daily by Quality Management, Safety/Risk Management and Executive Leadership during morning rounds. Monthly reports are provided to EOC and Employee Safety Committee and quarterly to Quality Council. Action plans are developed as required.</p>
f) Development of Criteria for Determining and Reporting Verbal Threats	<p>All direct care (milieu) staff is trained at hire and annually in prevention practices that range from situational awareness of the environment and milieu dynamics, ongoing risk assessment, and effective documentation to a formal non-violent crisis intervention training program.</p>	
g) Employee Education and Training	<p>A training plan is in place to ensure all staff is trained at-hire and on an ongoing basis as required. As part of the plan, ESH has adopted the LMS learning system, which provides better access to and recordkeeping of participation in ongoing training. The LMS system 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 conducted monthly.</p>	<p>Eastern State Hospital utilizes a crisis intervention program that is evidence based, and provides staff with the tools to keep themselves and patients safe while maintaining a 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.</p>

<p>g) Employee Education and Training</p>		<p>Application of Restraints is also covered in conjunction with the crisis intervention program covering therapeutic relationship and boundaries, best practices for interacting with patients, effective interactions during difficult situations, functional behavioral assessment, trauma-informed care, situational awareness, culture of safety, de-escalation techniques, and the INSERT Algorithm</p> <ul style="list-style-type: none"> • Identify Escalating Behavior – Hot or Cold Threat • Needs Assessment – Hot or Cold Threat's Origins & Gains • Safely Approach – Tactical Movement/Thinking • Engage the patient – V.D.S.P. • Reinforce patient self-management and self-control • Teaching moment for patient, staff, and team • Planning, De-Escalation, Evasion, Control, and Debriefing. <p>Staff are also trained in approved procedures for physical intervention should a patient become assaultive or engage in self-harm and less restrictive interventions have been unsuccessful. This training includes: evasion techniques, the hierarchy of physical intervention, physical containment procedures and application of mechanical restraints. All physical skills require return demonstration and documentation of competency.</p> <p>Following the classroom portion of NEO, Nursing staff, MHT's, PSA's, LPN's, PSN's and RN's are assigned to precept on the wards for an additional three weeks to complete New Nursing Orientation. This is designed to intermix mental health theory content with core competency training required for different levels of nursing practice.</p>
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g) Employee Education and Training		<p>CPR training is instructed per the American Heart Association Basic Life Support for Healthcare Providers standards and results in certification of participants. This is required every two (2) years for all clinical staff.</p> <p>Nursing skills training events are held two times a year to provide retraining /review of required nursing skill competencies. Education Services department, In conjunction with nursing services leadership determines the content of the skills fair based on whether a skill is required to be reviewed annually, or every 2 or 3 years.</p> <ul style="list-style-type: none"> • Additional training resources utilized include a video series on Mental Health Nursing which provides common scenarios for successful patient/staff interactions including: Depressed/suicidal client • Verbally and physically aggressive client with/without delusions • Interactions with patients who have borderline personality disorder • Patients with dementia and agitation and/or anxiety • Patients experiencing mania <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 clinical staff and staff having significant patient contact are being scheduled for re-training in Physical Skills and Application of Restraints training; target calendar year 2018. This training will supplemented with the Enhanced Safety online training to cover the non-physical portion of Crisis Intervention. This is planned for late summer or fall, 2018, in conjunction with the nursing skills fair.</p>

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<p>h) Clinical and Patient Policies and Procedures Including Those Related to:</p> <p>1. Smoking</p>	<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>A workgroup was initiated to develop guidelines and associated timelines for ESH to move to a tobacco-free campus for patients. Guidelines implemented November, 2017.</p>
<p>h) 2. Activity, Leisure, and Therapeutic Program</p>	<p>Limited Rehabilitation Services may result in increased patient agitation due to decreased activity, leisure and therapeutic programming opportunities.</p> <p>On-ward active treatment during the afternoon shift is limited or cancelled due to 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>Inconsistency between ward and shift routines, ward guidelines, recovery levels, group offerings, etc. increasing patient frustration when transferring from ward to ward.</p> <p>Many patients are diagnosed with substance a use disorder which often leads to recidivism and acuity upon admission.</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. An Active Treatment Planning Council is in place and develops/implements additional methods to improve active treatment data capture and increasing average hours of active treatment per patient. An Active treatment dashboard is in place and utilized to monitor and analyze active treatment data. This data is monitored monthly and reported quarterly to Quality Council. A feedback system has been developed to report to unit management teams and includes increasing weekend/evening activity provision.</p> <p>It was recognized that some variances between wards occurs based on patient acuity, etc. and cannot be altered. The ESH Safety office will be implementing a 2017 PI activity, working with Unit Administrative Directors, to crosswalk ward guidelines and identify shift inconsistencies and implement action plans to decrease patient frustration and potential increased agitation when transferred to another ward or when inconsistencies occur shift-to-shift. The APU Ward Guidelines were revised May, 2018 to ensure greater consistency between wards.</p> <p>In April 2018, ESH obtained a Washington State Substance Use Disorder (SUD) Assessment License. This license enables the SUD staff to complete assessments necessary for patients to be placed in SUD treatment</p>

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
		<p>upon discharge from ESH. ESH is working to decrease recidivism due to substance use issues. The SUD counselors work in conjunction with the treatment teams and patients to provide SUD assessments, individualized treatment planning and individual counseling. ESH hired three SUD counselors; 1st quarter, 2018.</p>
<p>h) 2. Activity, Leisure, and Therapeutic program</p>	<p>There is an increased risk for patient unauthorized leave and/or negative patient behavior during unsecured or community outings.</p>	<p>An introduction to group facilitation training has been added to the New Employee Orientation utilizing a facilitation competency assessment tool. 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. Strategic goal target hours for active treatment are 15 hours. The average number of hours for 2015 was 14.5; 15.9 for 2016; and 15.78 for 2017.</p> <p>There has been an increase in the number of groups offered during the day on the civil commitment wards for patients who are unable and/or refuse to attend and participate in the Treatment Mall. A Westlake float Recreation Therapist was hired April, 2018 whose primary responsibility is facilitating groups on the wards.</p> <p>A community outing planning tool is utilized for all outings to identify potential risks and methods of managing/reducing these risks i.e. radios carried by escorting staff, personal protective equipment, patient-to-staff ratios policies. Community outings for Civil Commitment patients, policy # 1.124, was approved in March, 2018. This policy includes safety and security procedures/protocols to ensure community outings are implemented safely and securely while still keeping the integrity of the purpose for the outing.</p>

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h) 2. Activity, Leisure, and Therapeutic program		<p>Unauthorized leave data tracked and reported monthly by EOC and Employee Safety Committees for trend analysis and drill downs to identify need for action plan(s).</p> <p>All ESH patient transportation vehicles are equipped with a divider between the driver and patient seating for patient and staff safety during transport to/from patient activities, medical appointments, etc.</p> <p>An Unauthorized Patient Leave policy is in place and addresses internal response and external communications and notifications. (UL drill conducted (refer to emergency response for details)</p>
h) 3. Communication Between Shifts.	There is the potential for patient information including changes in recovery levels, acuity and identified safety risks to not be relayed to oncoming shifts/staff.	<p>Safety Huddles are conducted prior to morning report on each ward to share safety concerns and provide information regarding potential safety issues.</p> <p>All wards have introduced a patient "quiet/reflection" time during shift change between day and evening shift. This strategy encourages patients to spend time in their bedrooms during the fifteen minute shift change report allowing staff to focus on critical patient information and relay of potential safety risks.</p> <p>Executive Leadership reviews ward report data from the previous evening during daily morning rounds and initiates actions or requests for additional investigation as indicated.</p> <p>The 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. All unit safety/security committee minutes are reviewed by the all-hospital Employee Safety</p>

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
		<p>committee for implementation of hospital-wide recommendations as required.</p> <p>Hospital-wide communication is conducted through the use of a hospital-wide “news flashes”, newsletter, development, use of an intranet/SharePoint site and postings on communications boards throughout the hospital.</p>
h) 4. Restraint and Seclusion	<p>Seclusion and restraint activities are high-risk for patient and staff injury.</p> <p>The process of moving a patient off the floor and to the restraint bed during a restraint event increases risks for staff injury e.g. lifting, etc.</p>	<p>A Psychiatric Emergency Response Team (PERT) is in place and is designed as a first-responder system to promote a culture of safety for patients and staff. This highly skilled team, comprised of Institution Counselor 3s, and Registered Nurses (RN), and a Supervisor, are trained in crisis intervention skills, incident management skills, analysis of the antecedents for violence and aggression, and de-escalation techniques. When containment is necessary, this team will facilitate seclusion and restraint if necessary, and work with floor staff to re-integrate the patient back to the milieu with appropriate evidence-based debriefing. PERT responded to 2,445 in 2017.</p> <p>Physical Therapy Staff (as part of the Safe Patient Handling Committee) assisted Nursing and Educational Services in problem- solving the process of moving a patient off the floor and to the restraint bed utilizing a med sled after a patient containment. Use of the sled improves lifting biomechanics for staff and the bed redesigned to improve staff and patient safety. Staff is trained on how to use the med sled during restraint events as part of the existing Application of Restraint training.</p> <p>A new restraint bed was developed and piloted on the APU Admissions Ward (1N1). These beds are now in use hospital-wide; May of 2017. The new bed design is more robust, features anti-tip stabilizers, handles for bed movement, and large locking canister wheels.</p>

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
		<p>The PERT team provides situational awareness utilizing on-the-spot staff coaching, when applicable, to reduce overall patient-to-staff assaults and events resulting in patient seclusion or restraint. The PERT team provides situational awareness utilizing on-the-spot staff coaching, when applicable, to reduce overall patient-to-staff assaults and events resulting in patient seclusion or restraint. Seclusion and restraint hours have both decreased when comparing April 2016-May, 2017 to April, 2017-May, 2018; 41% and 46% respectively. Both seclusion and restraint require employees to initiate physical contact with a patient and increases the potential for patient-to-staff assault. 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" and PERT responses.</p>
h) 4. Restraint and Seclusion		<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 Code Grey policy requires implementation whenever a patient's behavior is escalating and may require seclusion or restraint or whenever seclusion or restraint is initiated. A "Code Grey" is in response to a critical incident and immediate response is required. Debriefing with staff and an analysis of the event is completed for action planning to prevent re-occurrence.</p> <p>For related policies and procedures and education refer to section "g", "Employee education and training" and section "h", "Clinical and patient policies and procedures".</p>

