

*Eastern State Hospital*

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Transforming  
Lives

**EASTERN STATE HOSPITAL**

**WORKPLACE SAFETY PLAN**

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Approved by: \_\_\_\_\_

Chief Executive Officer

5/31/19  
Date

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## **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 CBS 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 CBS 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 include review of Job Hazard Analysis (JHA) 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 CBS 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 and Safe Patient Handling Committee, Medical staff, Rehab Services, Nursing, Food Services, EVS 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.

| <b>Locations of<br/>Physical Safety Bulletin Boards</b> |   |
|---|---|
| <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</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>CBS 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/Close Call 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/Close Call 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, in addition to the Safety Incident/Close Call Report (DSHS 03-133), 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 CBS 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 marked 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 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 EOC and Life Safety 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 are prohibited 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. Smoking is permitted in designated locations only.
- 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 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 Support Services (CSS) 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, but not limited to, specific training materials and information, the implementation of expanded fire drills, daily/weekly documented inspections and compliance of CSS and 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 are implemented (as identified during planning phase). Refer to Interim Life Safety Policy for complete details and assessment form.

1. When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital evacuates the building or notifies the fire department (or other emergency response group) and initiates a fire watch when a fire alarm system is out of service more than 4 out of 24 hours or a sprinkler system is out of service more than 10 hours in a 24-hour period in an occupied building. Notification and fire watch times are documented.
2. When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital does the following: Posts signage identifying the location of alternative exits to everyone affected.
3. When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital does the following: Inspects exits in affected areas on a daily basis. The need for these inspections is based on criteria in the hospital's interim life safety measure (ILSM) policy.
4. When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital does the following: Provides temporary but equivalent fire alarm and detection systems for use when a fire system is impaired. The need for equivalent systems is based on criteria in the hospital's interim life safety measure (ILSM) policy.
5. When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital does the following: Provides additional firefighting equipment. The need for this equipment is based on criteria in the hospital's interim life safety measure (ILSM) policy.
6. When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital does the following: Uses temporary construction partitions that are smoke-tight, or made of noncombustible or limited-combustible material that will not contribute to the development or spread of fire. The need for these partitions is based on criteria in the hospital's interim life safety measure (ILSM) policy.
7. When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital does the following: Increases surveillance of buildings, grounds, and equipment, giving special attention to construction areas and storage, excavation, and field offices. The need for increased

surveillance is based on criteria in the hospital's interim life safety measure (ILSM) policy.

8. When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital does the following: Enforces storage, housekeeping, and debris-removal practices that reduce the building's flammable and combustible fire load to the lowest feasible level. The need for these practices is based on criteria in the hospital's interim life safety measure (ILSM) policy.
9. When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital does the following: Provides additional training to those who work in the hospital on the use of firefighting equipment. The need for additional training is based on criteria in the hospital's interim life safety measure (ILSM) policy.
10. When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital does the following: Conducts one additional fire drill per shift per quarter. The need for additional drills is based on criteria in the hospital's interim life safety measure (ILSM) policy. (See also EC.02.03.03, EP 1)
11. When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital does the following: 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.
12. The hospital conducts education to promote awareness of building deficiencies, construction hazards, and temporary measures implemented to maintain fire safety. The need for education is based on criteria in the hospital's interim life safety measure (ILSM) policy.
13. The hospital trains those who work in the hospital to compensate for impaired structural or compartmental fire safety features. The need for training is based on criteria in the hospital's interim life safety measure (ILSM) policy.  
Note: Compartmentalization is the concept of using various building components (for example, fire-rated walls and doors, smoke barriers, fire-rated floor slabs) to prevent the spread of fire and the products of combustion so as to provide a safe means of egress to an approved exit. The presence of these features varies, depending on the building occupancy classification.
14. Use of other ILSMs not addressed in 1–14.

### **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 Employee 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 new PPE is identified, a description is added to the corresponding JHA and employees who are affected are made aware and 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 added or if there is a serious injury while performing the task. JHA reviews and changes 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.

Environment of Care 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, allow for observation of current practice and evaluation of environmental conditions/hazards. The inspections are conducted by the Director of Facilities safety and security staff, the Infection Preventionist, NursingEVS 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 CBS Commissary environmental inspections are conducted in accordance with procedures outlined in their 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 and other subject matter experts as applicable. The team examines the proposed changed conditions and makes recommendations to eliminate, mitigate 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, CBS and EOC/Employee Safety Committee members, as applicable, conducts comprehensive risk assessments to proactively evaluate risks associated with buildings, grounds, equipment, occupants, and internal 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, implement hazard surveillance elements in the affected area, safety orientation and education programs or safety performance improvement processes.

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. Refer to the Fire Safety Management Plan for additional details.

### **9.2 Hazard Vulnerability Analysis**

A hazard vulnerability analysis (HVA) is completed to evaluate which hazards require special attention. The HVA provides a systematic approach to recognizing hazards that may affect demand for the hospitals services or its ability to provide those services. The risks associated with each hazard are analyzed to prioritize planning, mitigation, response and recovery activities. Refer to the Emergency Operations Plan for additional details.

### 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 or two-way radio on Channel 1:

**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 expect 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 is 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 Operations and Response 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 CBS 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/CBS Commissary**

CSS staff receives site-specific training prior to working at the facility e.g. TEAM. CBS 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.”<sup>1</sup> Washington State Department of Social and Health Services (DSHS) defines workplace as any location, permanent or temporary, where an employee performs work-related duties, including but not limited to buildings and surrounding perimeters, parking lots, field locations, home and community activities, alternate work locations, agency vehicles, and travel to, from and during work assignments (DSHS Administrative Policy No.18.67).

#### **11.2 Workplace Safety and Security Assessment**

The Workplace Safety and Security Assessment is reviewed annually as 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
- 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 and 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. Refer to the Security Management Plan for additional details.

## **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).

Subject matter experts (SMEs) are identified on all shifts and trained to assist injured workers in completing required paperwork and connecting with resources to assist them with navigating the Worker's Compensation process.

## **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 is 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 is 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 Director of Facilities, 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 – 2019 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<br>RCW 72.23.400  | Assessment  | Prevention Action(s)   |
|--|---|--|
| <p><b>a) The physical attributes of the state hospital including:</b></p> <p><b>a) 1. Access Control</b></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.</p> <p>Walk-through detectors are not available at any of the public entrances at Eastlake or Westlake, including the FSU Administration and APU visitor entrance, and all APU and GPU ward locations; hand-held detectors only. All FSU wards have walk-through metal detectors that have reached their equipment life expectancy and are no longer supported by the manufacturer.</p> <p>Physical Security Survey and Vulnerability Assessment completed 2018. Results identified ESH risk is within “Green Zone”. Recommend continuing with current physical security program being mindful of changes of the frequency of criminal activity in ESH vicinity and vigilance of possibility staff complacency with security measures.</p> <p>It is problematic to obtain keys when staff quit via telephone or employment separation is initiated by ESH via letter.</p> | <p>Educational Services conducts hand-held metal detector wand training during NEO skills training. Unit education coordinators arrange/provide refresher training to all current staff on an ongoing basis.</p> <p>All Security events involving campus or building access e.g. unsecured doors are reviewed by the EOC and Employee Safety committee for development of recommendations or action plans as required. Events requiring Leadership awareness are reviewed at daily Leadership huddles for development of actions 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, in addition to ward access control panels and cameras. Pharmacy access is alarmed after hours and reports to the Eastlake PBX 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> <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 a card access building entry system. This will require Legislative approval and funding.</p> |

| Security Consideration<br>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.  | Refer to prevention listed above.  |
| a) 1. Access Control                    | <p>Security reports and security related Unusual Occurrence Reports (UORs) have identified interior and exterior building doors found unlocked. These occurrences are potentially related to the doors 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> <p>Both the Eastlake and Westlake PBX locations contain critical alarm system, communication and camera equipment for alerting and notification of hospital staff in an emergency and provide limited staff security as identified in multiple emergency response drills. The post-drill evaluation and After Action Planning have identified that PBX staff are vulnerable to workplace violence including 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.).</p> | <p>Quarterly and annual door inspections are completed by CSS to ensure proper function. Quarterly reports of these inspections are forwarded to the Director of Facilities for monitoring.</p> <p>Doors at required public egress entrances/exits must have panic hardware in place by Fire Code and unlocked during normal business hours. 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. This data is reviewed by the Environment of Care (EOC) and Safety committee for trend analysis and recommendations for performance improvement.</p> <p>Preliminary design for relocating the Westlake PBX 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 Administration building, including the PBX and center core offices have also been identified. A 2019-2021 Capital Programs project request has been submitted to address identified security and safety risks at these locations. No funding approval at this time.</p> <p>Capital Programs project funded 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; 2019-2021 biennium.</p> |

| Security Consideration<br>RCW 72.23.400 | Assessment  | Prevention Action(s)   |
|---|---|--|
| a) 1. Access Control                    | The parking areas, hospital-wide, are not under surveillance and some locations are bordered by wooded areas or vacant buildings.   | <p>A Capital Programs request has been initiated for installation of additional cameras in high-risk, campus-wide, locations based on usage and restricted access requirements e.g. Pharmacy. No funding approval at this time.</p> <p>Security personnel patrol the campus and report findings and/or contact local law enforcement as required e.g. criminal activity.</p> <p>Existing exterior lighting has been improved with installation of LED lighting campus-wide.</p>  |
| a) 2. Egress Control                    | There is currently no physical control over egress (visitor/staff) on campus and outside of secured buildings or unit fenced yards 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. | <p>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.</p> <p>The north patient yard fencing was modified to increase height, add additional fine mesh and cameras for security and monitoring; complete March, 2019.</p> <p>The escorting policy has been reviewed and revised to clarify staffing ratios when escorting patients to the yard and Eastlake ON and OS basement floor. Guidance provides direction to staff reinforcing the use of clear language when communicating UL via radio e.g. "UL North Patient Yard.</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; 2019-2021 biennium. This will require Legislative funding.</p> |



| Security Consideration<br>RCW 72.23.400 | Assessment  | Prevention Action(s)  |
|---|---|---|
| <b>a) 2. Egress Control</b>             | 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.   | Refer to 1.c)   |
| <b>b) 3. Door Locks</b>                 | <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>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 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. |

| Security Consideration<br>RCW 72.23.400 | Assessment   | Prevention Action(s)  |
|---|--|---|
| 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.</p> <p>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. The upper terrace of the Eastlake parking lot and the north side of the Westlake parking lot are dark despite the presence of several pole lights.</p>   | <p>Security monitors lighting during daily Security rounds and reports burned out exterior lighting to 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. 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 of remodel with the APU alarm system installed during Phase 3 building renovations over 20 years ago. The APU system is currently beyond its life expectancy, non-functional and assessed as non-repairable. The FSU alarm system was installed under Phase 4 building renovations but was updated during a recent Capital Programs project to install additional cameras; FSU must interface with the old APU system for reporting emergency to APU wards. Wiring, equipment inadequacies and failures, specific to the APU duress system, have been identified during the FSU 1N3/3N3 Ward Renovation Capital Programs project currently underway.</p> | <p>To ensure reliability, the existing staff duress alarms were being tested daily on all wards by ward staff (APU &amp; FSU) and weekly on GPU per Nursing policy. Alarm testing between APU and FSU wards is currently on-hold until APU alarm system is replaced. Alarm deficiencies identified during these tests are reported to CSS for immediate repair. Testing is monitored by the Safety Office.</p> <p>A request to install a new APU duress system that will interface with the new and existing FSU wards has been made as part of the 1N3/3N3 renovation project; target for completion May, 2020. Staff utilize two-way radio communications to report requests for staff assistance in escalating patient behavior events.</p> <p>A Capital Programs request has been made to replace the existing antiquated staff duress systems on the all wards and install a "personal duress alarm" system in all (on and off ward) locations that provides wider coverage, ease of activation and electronic location tracking for quicker emergency response. This will require Legislative approval and funding.</p> |

| Security Consideration<br>RCW 72.23.400 | Assessment  | Prevention Action(s)  |
|---|---|---|
| a) 5. Alarms                            | <p>The FSU alarm system requires use of a proximity card with readers located throughout the corridor.</p> <p>The existing systems do not provide a method of activation for off-ward and/or outdoor escort/activities i.e. yard group, etc. The Activity Therapy Building (Eastlake Treatment Mall) does not have existing staff duress devices.</p> <p>The alarm notification only indicates the ward; it does not identify specific/exact location of staff activating the alarm. The Eastlake PBX is currently unable to visually see the APU/FSU alarms at their local panel due to removal of the non-functioning APU system. This requires staff reporting by radio or emergency phone number which is not always feasible dependent on emergency.</p> <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 of 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 PBX 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, PBX and Security for response.</p> |



| Security Consideration<br>RCW 72.23.400                                   | Assessment   | Prevention Action(s)  |
|---|--|---|
| <b>The Physical Attributes of the State Hospital: Environment of Care</b> | <p>Furniture in patient care areas (chairs, tables, desks, beds) pose a risk for use as a weapon or ligature point.</p> <p>There is the potential for coat hangers (plastic hangers are currently in use on 2N3 ONLY) to be used for self-harm or as a weapon if broken.</p> | <p>updated at least annually or as indicated as the result of hazard reporting, or a Sentinel Event root cause analysis.</p> <p>Patient rooms on all APU and FSU wards have been systematically renovated for patient and staff safety and include purchase and installation of additional molded 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 or sand-ballasted to prevent being thrown or broken apart and used as a weapon. The civil commitment wards and FSU patient bedrooms equipped with vinyl molded beds and cubicles for patient storage; target for completion August, 2019.</p> <p>All electric beds 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. The length of electric bed cords has been added to the EOC Audit Tool and monitored during the EOC rounds and reflected in the Environmental Proactive Risk Assessment.</p> <p>A checklist is utilized to document security and location of equipment located in the woodshop that present a staff and patient safety risk. This checklist is completed pre and post group. Completion compliance of the Woodshop security checklist is audited during EOC rounds to ensure the log is completed in real time.</p> <p>Hangers on 2N3 remain in place based on risk assessment. 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.</p> |

| Security Consideration<br>RCW 72.23.400                                   | Assessment  | Prevention Action(s)   |
|---|---|--|
| <b>The Physical Attributes of the State Hospital: Environment of Care</b> | <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 e.g. treatment rooms. 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.</p> <p>There is insufficient camera coverage on the Forensic admission ward for patient monitoring and investigation of incidents in all locations.</p> <p>Existing carpet is worn and dirty creating an infection control concern and slip/trip hazards.</p> | <p>All sharps are required to be in locked drawers/cabinets in treatment rooms and 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 Nursing for follow-up.</p> <p>All visitors are notified of what items constitute contraband (signage posted at PBX 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 (Eastlake) and at Westlake PBX.</p> <p>An alternative toothbrush manufactured for use in Behavioral Health and Corrections facilities is in place for use by all patients on APU and FSU wards. 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.</p> <p>Environmental checks are conducted and documented hourly on all wards and incorporates risks identified on the hospital-wide Environmental Proactive Risk assessment.</p> <p>Weekly EOC rounds conducted by Director of Facilities and Safety Manager and findings reported to department/area supervisor and Leadership for action as identified.</p> <p>Approximately \$800,000 dollars of operational funding was allocated to replacing flooring on Eastlake wards and center core office spaces. Anticipated completion July, 2019. A Capital Programs request is funded for replacement of Westlake carpeting in all off-ward locations. Ward carpet replaced under previous Capital Programs funding. Anticipated start August, 2019.</p> |

| Security Consideration<br>RCW 72.23.400                                   | Assessment  | Prevention Action(s)   |
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| <b>The Physical Attributes of the State Hospital: Environment of Care</b> | The Eastlake boiler plant building is original stone build with significant structural deficiencies.  | A Capital Programs project has been funded to replace the Eastlake boiler plant. The steam plant provides heating to the Eastlake building and is critical for Continuity of Operations. This project is targeted to start December, 2019 and anticipated completion is December, 2021.  |
| <b>b) Staffing, Including Security Staffing</b>                           | <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 average for FY18 was 5.9%.</p> | <p>Additional tools/systems used in nursing include:</p> <ul style="list-style-type: none"> <li>• Policy/procedure on how to acquire staff</li> <li>• Acuity based staffing plan</li> <li>• Guidelines for safe staffing levels</li> <li>• Use of contracted Nursing services.</li> </ul> <p>In FY18 ESH recruited and hired over 153 additional staff to fill direct-care vacancies and newly established positions in order to improve the provision of patient care, active treatment and workplace safety and security. New positions hired in FY18 include 109 clinical and non-clinical nursing employees, medical providers, psychologists and other support care staff.</p> <p>During the past legislative session, the state budget for hospital staffing was specifically tied to a requirement that a staffing tool be designed and implemented to identify, on a daily basis, the clinical acuity on each patient ward and determine the minimum level of direct care staff by profession to be deployed to meet the needs of the patients on each ward.” All future funding for staffing will be tied to this acuity tool and the data it generates over time. The Hospital Acuity Resource Tool (HART) evolved from the Johnson Behavioral Model by using a description of supervision and nursing interventions needed to safely and effectively provide quality care for patients. A team of ESH and WSH clinical, education and IT staff have further refined it to reflect activities that drive staffing levels. Currently, both hospitals are completing a pilot of the HART to insure that the tool supports an RN to complete a consistent acuity assessment and achieve inter-rater reliability. The next step will be to develop training and operationalize the procedures needed to meet the legislative requirements.</p> |

| Security Consideration<br>RCW 72.23.400 | Assessment | Prevention Action(s)   |
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|   |            | <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<br/>Eastern State Hospital has a pool of on-call employees for utilization when required.</p> <p>Pre-Arranged Overtime<br/>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> <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 HMM training needs requirement to work on HMM, 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<br/>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<br/>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> |



| Security Consideration<br>RCW 72.23.400         | Assessment  | Prevention Action(s)  |
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| <b>b) Staffing, Including Security Staffing</b> |   | <p>Agency Nurses</p> <p>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>  |
| <b>c) Personnel Policies</b>                    | <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.</p> | <p>The following list is not all inclusive, refer to individual policy manuals for additional information:</p> <ul style="list-style-type: none"> <li>• Behavior Undermining the Culture of Safety</li> <li>• Seclusion/Restraint</li> <li>• Safety Huddles</li> <li>• Workplace Safety Plan, including Accident Prevention, and Workplace Violence Prevention</li> <li>• Crisis Prevention and Intervention training (TEAM)</li> <li>• Psychiatric Emergency Response Team (PERT):<br/>A plan of response for patients during a psychiatric crisis or anticipated crisis</li> <li>• Code Grey Response (Escalating Patient Behavior Response)</li> <li>• Critical Incident Stress Management (CISM)</li> <li>• Disruptive And Intimidating Behavior By Staff</li> <li>• Incident Reporting</li> <li>• Key Control</li> <li>• Visitor Access</li> <li>• Background Checks</li> <li>• Law Enforcement Notification</li> <li>• Benefits for Employees Assaulted by Residents/Clients</li> <li>• Workplace Personnel Security Program</li> <li>• Emergency Operations and Specific Emergency Response Procedures <ul style="list-style-type: none"> <li>○ Active Threat</li> <li>○ All Hospital Lockdown</li> <li>○ Bomb Threat</li> <li>○ Evacuation</li> </ul> </li> </ul> |

| Security Consideration<br>RCW 72.23.400      | Assessment   | Prevention Action(s)  |
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| <b>c) Personnel Policies</b>                 | The 2018 annual evaluation of the Workplace Safety Plan validates the plan is adequate and effective in practice.  |   |
| <b>d) First Aid and Emergency Procedures</b> | <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.</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>  |
| <b>d) First Aid and Emergency Procedures</b> | Emergency medical response procedures for Code Blue and Code Rapid Respond are in place and activated by contacting PBX by radio or the emergency phone number (4333). PBX staff relays requests for nursing and medical provider response via two-way radio, overhead annunciation and radio paging alerts.   | The Medical Emergency Response Committee (MERC) reviews all emergency response events and develops and implements a Medical Emergency Response action plan, as indicated.   |
| <b>d) First Aid and Emergency Procedures</b> | Emergency medical supplies, including AEDs, 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>The MERC has developed and implemented "Mock Codes", to improve medical emergency response preparedness. Mock emergency medical codes continue to be conducted; one on each unit, day and evening shift, and one at the Treatment Mall.</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 March, 2019.</p> |

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| <p><b>d) 2. Medical<br/>Emergency Response</b></p> | <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 &amp; 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>The following actual events, emergency response drills and Emergency Operations and Response participation with community partners occurred in 2018:</p> <ul style="list-style-type: none"> <li>• ESH participated in the REDi Healthcare Coalition (HCC) Evacuation Situational Awareness Exercise, May 23, 2018. The R9 HCC Evacuation Situational Awareness Exercise is designed to support REDi HCC partners in meeting their CMS emergency preparedness exercise requirements. Additionally, this community-based exercise is used as an effort to strengthen local and regional partnerships.</li> <li>• Based on wildfire events occurring near the local community, summer 2018, and in response to a report of additional wildfire events potentially threatening the local community including ESH, CSS, and Lakeland Village facilities, the ESH Incident Command was activated, August 8, 2018. Designated staff was assigned to assess and/or verify patient census, acuity and medical status, CSS transportation capabilities, existing Memorandum of Understanding (MOU) status for Alternate Care Facilities, transportation and verification of contacts.</li> <li>• A functional exercise was conducted on November 28, 2018. This drill was completed to evaluate established hospital response and continuity plans for coordinating a complete and full Westlake facility evacuation based on an HVAC failure. The drill focused on assessment of patient acuity and coordination of movement to the Eastlake campus and/or identified alternate care location (Lakeland Village gym), coordination of patient and staff transportation, assessment of environmental risks, plans to mitigate risks at the alternate care facility, and resource requirements for maintaining Continuity of Operations and ensuring patient and staff safety.</li> </ul> |
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| Security Consideration<br>RCW 72.23.400     | Assessment  | Prevention Action(s)  |
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| <b>d) 2. Medical<br/>Emergency Response</b> | A Communications Plan is in place and 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 COOP and is administered by the hospital Incident Command. The plan is consistent with REDi Healthcare Coalition partners. | The ESH Continuity of Operations Plan (COOP) annual review completed June, 2019.  |
| <b>d) 2. Medical<br/>Emergency Response</b> |   | An IT Decision package submitted for 2019-2021 biennium for funding of additional repeaters to improve radio communication reliability in identified “dead spots” and in outside locations.   |
| <b>d) 2. Medical<br/>Emergency Response</b> | There is the potential for radio communications to be compromised due to: <ul style="list-style-type: none"> <li>• Low/dead batteries</li> <li>• Dead spots (lack of repeater coverage)</li> <li>• Incompatibility with community emergency response agencies</li> <li>• Lack of assigned radio/pager for all staff</li> </ul>  | 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 are fielded on an as needed basis for inoperable radios.   |
| <b>e) 1. Reporting of<br/>Violent Acts</b>  | All elements pertaining to reporting of violent acts are documented utilizing Safety Incident/Close Call Report, Unusual Occurrence Report, Uniform Law Enforcement Notification and Internal Hazard reporting forms.   | 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: <ul style="list-style-type: none"> <li>• Staff involved</li> <li>• Assailant identifier (patient, employee, visitor, other)</li> <li>• Incident date, time, shift</li> <li>• Use of restraint</li> <li>• Use of seclusion</li> <li>• Cause of injury</li> <li>• Patient assault involved</li> <li>• Object used in assault</li> <li>• Staff-initiated contact ; containment</li> <li>• Injury severity rating</li> <li>• Type of injury</li> <li>• Body part affected</li> <li>• Description of precipitating events</li> </ul> |

| Security Consideration<br>RCW 72.23.400  | Assessment   | Prevention Action(s)  |
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|  |  | Unusual Occurrence reporting has been transformed from paper copies to electronic completion and filing via the ESH SharePoint increasing timeliness of reporting.  |
| <b>e) 2. Taking<br/>Appropriate Action in<br/>Response to Violent<br/>Acts</b> | Policies, procedures, and training are in place to ensure appropriate actions and response to violent acts occurs. | <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>  |
| <b>e) 2. Taking<br/>Appropriate Action in<br/>Response to Violent<br/>Acts</b> |  | <p>The Psychiatric Emergency Response Team (PERT) responded to 2,331 staff calls for assistance June, 2018-June, 2019. The PERT provides a safe, effective and immediate plan of response for patients during a psychiatric crisis or anticipated crisis. This is accomplished through a least to most intervention technique utilizing verbal de-escalation tactics while promoting and maintaining patient and staff safety.</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> <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> |

| Security Consideration<br>RCW 72.23.400   | Assessment | Prevention Action(s)   |
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| <p><b>e) 2. Taking<br/>Appropriate Action in<br/>Response to Violent<br/>Acts</b></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>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 incident when it happens without judgment or criticism. 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 referral request mechanism is located on the ESH SharePoint. ESH is currently changing the CISM request process so that all requests are initiated through the PBX to ensure standardization and consistency.</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 communication site for with worker compensation information is located on the ESH SharePoint to include link to L&amp;I and DSHS Enterprise Risk Management (ERMO) safety and claims webpage; trained Subject</p> |

| Security Consideration<br>RCW 72.23.400             | Assessment | Prevention Action(s)  |
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| e) 3. Follow-up<br>Procedures after<br>Violent Acts |            | <p>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. Process communication posters and name badge cards for improved employee awareness are in place. LMS training outlining this information is included as part of mandatory annual Safety training for all employees.</p> <p>Safety Huddles are conducted prior to morning report on each ward to share potential safety concerns/issues.</p>   |
| e) 3. Follow-up<br>Procedures after<br>Violent Acts |            | <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> <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>                     |
| e) 3. Follow-up<br>Procedures after<br>Violent Acts |            | <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.</p> |

| Security Consideration<br>RCW 72.23.400  | Assessment  | Prevention Action(s)   |
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| <b>e) 3. Follow-up Procedures after Violent Acts</b>                           |   | 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.  |
| <b>f) Development of Criteria for Determining and Reporting Verbal Threats</b> | <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> | Workplace violence, including verbal threats, is monitored and analyzed daily by Quality Management, Safety, Security 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.                                      |
| <b>f) Development of Criteria for Determining and Reporting Verbal Threats</b> | 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.   |  |
| <b>g) Employee Education and Training</b>                                      | 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.  | 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 |



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|   | Educational Services has developed a matrix of mandatory training, at orientation and ongoing which is utilized to compile monthly compliance reports. New Employee Orientation is conducted monthly. | 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.  |
| g) Employee Education and Training      |   | <p>Application of Restraints is 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, and de-escalation.</p> <p>Staff are 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, 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> <p>A preceptor (peer) training class has been designed, 2019, to provide practical actions that a front-line preceptor (peer trainer) can do to optimize a new employee's learning and enable them to achieve early success in demonstrating core job competencies. This class helps peer trainers understand what is needed to optimize on the job learning for new employees to create a supportive, safe work environment. Participants learn the importance of using consistent techniques to develop rapport with patients. Tools and techniques are practiced in the classroom to effectively assess knowledge and skills transfer of the learner. Skill building</p> |

| Security Consideration<br>RCW 72.23.400 | Assessment | Prevention Action(s)   |
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|   |            | <p>exercises include how to apply adult learning principles, interactive feedback and coaching skills with a new employee. The current focus is to train core team members who directly impact patient care.</p> <p>On-ward, FSU training is being included in NEO content for all new nursing staff in addition to a day of preceptor led security training for all non-FSU assigned nursing staff.</p> <p>In September 2018, the Westlake Safety Committee initiated a discussion with Education Services on how to improve the therapeutic interactions between staff and patients AND improve the skillful, respectful communications between all team members in the patient care environment. The Committee is interested in supporting an effective path towards creating a safe environment to speak up, give feedback and keep a consistent focus on what is safe and best for patients. The overall purpose is to improve the skillful, respectful communications between all team members in the patient care environment by implementing a set of consistently demonstrated rules of engagement (CARE). The deliverables over the next six months are:</p> <ul style="list-style-type: none"> <li>• C.A.R.E. Agreements – behaviors that all staff who work at Westlake agree to do to support a therapeutic environment for the patient.</li> <li>• C.A.R.E. Coaches – identify, train and support peer leaders at Westlake who will be coaching and aligning staff behaviors to the C.A.R.E. Agreements.</li> <li>• Supervisor support, alignment and training – as determined from the focus groups</li> <li>• Front line staff training – as determined needed to support team dynamics and support</li> </ul> |

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| g) Employee Education and Training  |   | 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.  |
| g) Employee Education and Training  |   | Nursing skills training events are held two times a year for review of required nursing skill competencies. Education Services, In conjunction with nursing leadership determines content of the fair based on skill required; annually or every 2 or 3 years.  |
| g) Employee Education and Training  |   | <ul style="list-style-type: none"> <li>• 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</li> <li>• Verbally and physically aggressive client with/without delusions</li> <li>• Interactions with patients who have borderline personality disorder</li> <li>• Patients with dementia and agitation and/or anxiety</li> <li>• Patients experiencing mania</li> </ul> <p>Milieu Management training is provided to all RN's at hire (New Employee Orientation) in support of provision of active treatment.</p> <p>RN3's and designees are offered a full day of training focused on the role and responsibilities of the Charge Nurse duties.</p> |
| h) Clinical and Patient Policies and Procedures Including Those Related to:<br>1. Smoking | Patient and Visitor smoking on ESH campus is not allowed. Staff smoking is allowed in designated areas only.  |   |
| h) 2. Activity, Leisure, and Therapeutic Program  | <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</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.  |

| Security Consideration<br>RCW 72.23.400                        | Assessment   | Prevention Action(s)  |
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| <p><b>h) 2. Activity, Leisure, and Therapeutic Program</b></p> | <p>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 use disorders which often leads to recidivism and acuity upon admission</p> | <p>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>Unit Administrative Directors have to cross-walked ward guidelines and identified shift inconsistencies and implemented 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.</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 for patients to be placed in SUD treatment 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; 1<sup>st</sup> quarter, 2018.</p> |
| <p><b>h) 2. Activity, Leisure, and Therapeutic program</b></p> |  | <p>An introduction to group facilitation training has been added to the NEO utilizing a facilitation competency assessment tool. Programs, treatment and care are provided by rehabilitation clinical staff focusing on anxiety and stress management, recovery, 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 20 hours. The average number of hours for 2017 was 15.78 and 17.71 for 2018</p>   |

| Security Consideration<br>RCW 72.23.400                | Assessment   | Prevention Action(s)   |
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| h) 2. Activity, Leisure,<br>and Therapeutic<br>program |  | <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>  |
| h) 2. Activity, Leisure,<br>and Therapeutic<br>program | <p>There is an increased risk for patient unauthorized leave and/or negative patient behavior during unsecured or community outings.</p> | <p>SUD counselors have expanded services to provide groups to the competency restoration patients in an attempt to decrease recidivism due to substance use.</p> <p>A Wellness Center for the patients was developed promoting physical as well as mental health well-being through groups, such as cardiovascular strengthening, yoga, tai chi.</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> <p>Staff escorted community outings (SECO) outings are conducted on a regular basis for the NGRI wards. Community reintegration groups are now offered four (4) times per week for APU patients.</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.</p> |

| Security Consideration<br>RCW 72.23.400                 | Assessment   | Prevention Action(s)  |
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|   |  | <p>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> <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>  |
| <b>h) 2. Activity, Leisure, and Therapeutic program</b> |  | <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>  |
| <b>h) 3. Communication Between Shifts.</b>              | <p>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> | <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.</p> |

| Security Consideration<br>RCW 72.23.400        | Assessment   | Prevention Action(s)  |
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| <b>h) 3. Communication<br/>Between Shifts.</b> |  | <p>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 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>   |
|  | <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 2,331 in 2019.</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>The PERT team provides situational awareness utilizing on-the-spot staff coaching, when applicable, to reduce overall patient-to-staff assaults and events resulting</p> |

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| <h4>h) 4. Restraint and Seclusion</h4> |  | <p>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. Both seclusion and restraint require employees to initiate physical contact with a patient and increases the potential for patient-to-staff assault</p> <p>Executive staff reviews all seclusion/restraint incidents occurring over the past 24 hours during the following morning report. The 24 hour shift report is screened for patterns or trends with Code “Gray” and PERT responses.</p>   |
| <h4>h) 4. Restraint and Seclusion</h4> |  | <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> |