Washington State Department of Social and Health Services

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Transforming Lives

EASTERN STATE HOSPITAL

WORKPLACE SAFETY PLAN

Washington State Department of Social & Health Services
Transforming lives

Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

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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 Consolidated Business Services (CBS) staff, DSHS Maintenance and Operations Division (MOD)/Consolidated Support Services (MOD/CSS) staff, contract staff, interns, students, and volunteers. MOD/CSS employees work collaboratively with ESH personnel to create and maintain a safe work environment using a Service Level Agreement (SLA) to identify hospital and MOD/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, WAC 357-26-050, WAC 357-26-055, and WAC 357-26-060.

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 the Critical Incident Stress Management (CISM) Team.

The hospital CEO has granted 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 injuries, exposures, and 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 the year-end workplace safety summary completed by the Safety Manager to ensure plan scope and objectives are met and that the plan is effective in practice.
- 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 and Workplace Violence Plan (WVP).
- 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 and high reliability.

4.2 Manager and Supervisor Responsibilities

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

- Setting the example for employees by following all safety requirements and attending training as required.
- Providing employees with a documented site-specific safety orientation and training at hire and at required intervals dependent on the training curriculum and staff's job class, competency evaluation (if applicable) and review of their position specific Job Hazard Analysis (JHA) to ensure employee awareness of hazards and mitigation to ensure they perform their duties safely.
- Identifying unsafe employee work practices and providing training or disciplinary action as identified.
- 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, management, and DSHS Enterprise Risk Management Office (ERMO) to identify changes to work practices or equipment that improves workplace safety and decreases employee injuries.
- Ensuring employees understand the expectations of a violence free workplace and providing support 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.
- In accordance with DSHS Administrative Policy No. 18.67 Workplace and Domestic Violence/Reasonable Safety Accommodation develops and documents individual safety plan to support an employee's safety at work, determining if further actions are necessary.

4.3 Employee Responsibilities

Employee responsibilities to create and maintain workplace safety include:

- Immediately report to supervisor, Safety Committee representative and/or management any unsafe conditions, injuries, near miss incidents and workplace 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. 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 always behaving respectfully to patients and co-workers, reinforcing a Culture of Safety.
- Understanding and following patient treatment and safety plans to improve patient care outcomes and decrease safety risks.
- Understanding and complying with safety policies, procedures and training and encouraging coworkers 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 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 or as required to fill vacancies. The committee meets the second Tuesday of each month from 1300-1430 in a scheduled conference room or via online Microsoft Teams meeting platform.

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, MOD/CSS and CBS Commissary safety bulletin boards (see 5.3 below for locations).

5.2 Environment of Care Committee

The Environment of Care Committee (EC) 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 EC has oversight responsibilities for the

Life Safety, and Environment of Care, standards of The Joint Commission and related regulations under the Centers for Medicare and Medicaid Services (CMS).

EC membership consists of the Deputy Chief Executive Officer (DCEO), Director of Facilities, Safety Manager and representatives from Security, Infection Prevention, Quality Management, Consolidated Support Services, Medical Equipment, Safe Patient Handling Committee, Medical staff, Rehab Services, Nursing, Food Services, Environmental Services (EVS) and Pharmacy.

5.3 Safety Bulletin Board

Eastern State Hospital has two core bulletin boards that are maintained by the ESH Safety Office with all OSHA required postings for posting Safety Committee meeting minutes and other safety related information and announcements. Safety bulletin boards in MOD/CSS building M and the CBS Commissary are maintained by MOD/CSS and CBS staff.

Staff can find additional safety resources and information by visiting the ESH SharePoint site under Safety, Worker's Compensation and Emergency Management. All ESH employees have access to the ESH SharePoint site.

Locations of Physical Safety Bulletin Boards	
Eastlake Core Bulletin Board	**Eastlake Administration Building Main Entrance Near Switchboard Office**
Westlake Core Bulletin Board	**Corridor Near Double Doors Leading to the Westlake Kitchen**
MOD/CSS	**Building M in Corridor Across from the Conference Room**
CBS Commissary	**Commissary Office Near Entrance**

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 include 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, with an assigned ID number, involved in an **on-the-job injury** or a **near miss incident** must immediately report the injury or incident to their supervisor and complete an electronic Safety Incident/Close Call Report (DSHS 03-133), located on the ESH SharePoint located under "Quick Links" on the main page or by using the link in the Safety folder under Safety Forms. Contracted workers, without an employee ID number assigned, must utilize the paper Safety Incident/Close Call Report (DSHS 03-133) forms located on the ESH SharePoint in the Safety folder as described above. Electronic reports are automatically sent to the employee's supervisor for completion of their portion and a final copy is automatically generated and sent to ERMO and the ESH Safety Office. Contract employees must submit the paper injury forms to their supervisor for completion. Completed paper 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.

- For all incidents resulting from a potential client assault, as outlined in DSHS Administrative Policy 9.02, employees must select "yes" for all three questions below:
    - "Do you consider this incident an assault?"
    - "Do you feel this incident was a result of unauthorized touching by a resident, client or patient?"
    - "Did the unauthorized touching by a resident, client, or patient result in physical injury?"

  Contracted workers are not eligible to receive assault benefits per the DSHS policy.

- The BBP Exposure Packet located on the ESH Infection Control SharePoint, 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. An exposure incident is a needlestick, a bite that breaks the skin, or contact with another person's blood, urine, or other potentially infectious material to the eyes, nose, mouth, or non-intact skin. Potentially infectious materials include blood, urine, or other body fluids, including vomit, especially when blood is visible. A blood borne pathogen exposure is an example of an exposure incident.

- 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 sends a copy to Labor & Industries for processing.

6.2 Supervisor Responsibilities

Supervisors are responsible for investigating all injury, illness, and near-miss occurrences and to complete the electronic Supervisors Review of Safety Incident/Near Miss Report or paper form for contracted workers. The electronic form is automatically sent to ERMO and the ESH Safety Office. The paper report form 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, Director of Security, ERMO staff and others.
- The investigator(s) take written statements from witnesses, photographs of 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 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 the DSHS 03-133 and 03-133A incident forms (electronic and paper) to ensure all required and pertinent information has been collected. Additional comments or investigation results by the Safety Manager or designee, if indicated, are included on the form by printing the electronic version and documenting or directly documenting on paper forms. All documentation is forwarded to Enterprise Risk Management Office (ERMO) claims department and inputted into the RiskMaster database. Documentation including recommended corrective actions are reported to the Safety Committee.

The Safety Manager is responsible for ensuring a completed copy of the ESH OSHA Summary for the previous year is posted 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

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 the incident.

ERMO provides data reports to the Employee Safety Committee on at least a monthly or as requested basis. The committee reviews incident reports and ERMO data and may decide to conduct separate incident investigations or "drill downs" 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's 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.
   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 people 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 and other departments as indicated. Monthly reports are provided to EC and Employee Safety Committee and quarterly to Quality Council and Governing Body 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) identified in the JHA for their position such as safety glasses, respiratory and hearing protection.

7.1 Statement of Conditions

The Chief Quality Officer is responsible for maintenance of the Statement of Conditions documentation required by TJC and a copy is made available as required. The Director of Facilities maintains the building Life Safety plans, coordinates the identification and resolution of facility deficiencies and in coordination with the Chief Quality Officer 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 EC 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 use of proper lifting techniques, using personal protective equipment (PPE) when required, following safety warning signs and reading and following product labels.

- The 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, including completion of a Competency Validation Tool (CVT) if applicable before an employee is considered competent to perform the duties of the job and/or operate specific equipment.

- Unsafe work conditions, practices and hazard conditions must be immediately reported to supervisors and may be reported to a safety committee representative if unable to resolve at the staff or supervisor level.
- Follow all procedures for reporting accidents and near misses (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.
- 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 and 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 (EC) plans

ESH has developed detailed Environment of Care (EC) plans required for TJC and CMS standards compliance. These plans are located on the ESH SharePoint under Environment of Care. All plans are updated annually. The EC 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 (MOD/CSS) is responsible for maintaining all non-medical 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 by a contracted vendor and in accordance with the Medical Equipment Management Plan. Equipment hazard notices and recalls are coordinated through Central Supply and the Safety Office and forwarded to appropriate departments for review and action as indicated.

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

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 by MOD/CSS and all contractors with ILSM during the construction and/or maintenance period. The Safety Manager coordinates the planning, implementation, and monitoring of interim life safety plans in coordination with the Director of Facilities and others 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.

Refer to the ESH ILSM Policy and Procedures for full details.7.7 **Infection Control Risk Assessment (ICRA)**

Potential hazards related to construction, renovation or maintenance activities are assessed through the Infection Control Risk Assessment (ICRA) process that identifies potentially new or altered risks related to infection control, utilities or building systems, fire safety or life safety, general safety issues, emergency preparedness or response, and security. The ICRA is reviewed and monitored by the DCEO, Safety Manager, Director of Facilities, Security, Chief Quality Officer, and Infection Preventionist and reported to the Employee Safety, Infection Control and Environment of Care Committee.

7.8 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 tasks, what hazards may be present during

the task and what can be done to eliminate or protect workers from those hazards to mitigate risk. Employees are trained if there are changes to current procedures or PPE.

Each JHA has a section in which Personal Protective Equipment (PPE) and/or training is identified related to a particular hazard. Employees are trained by their supervisor at hire and annually during their performance review on both the JHA for their job class and PPE as it applies to hazards. If new PPE equipment or training is identified, a description is added to the corresponding JHA and employees who are affected are made aware and trained.

Each JHA 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.

7.9 **Recall Alerts**

Eastern State Hospital utilizes a contracted vendor to manage all Food and Drug Administration (FDA) recalls potentially impacting patient and staff safety. The FDA classifies medical device recalls by severity. Class I recalls involve a defective product that could cause serious adverse health consequences or even death, Class II recalls address products that may cause temporary or medically reversable health consequences, and Class III recalls relate to products that are unlikely to cause adverse health consequences. Recall alert information is provided to designated ESH department staff e.g., Pharmacy, Lab, Central Supply, Food Service, etc. for review and action as required. The ESH Safety Manager oversees all recall alerts and any required recall actions are taken to ensure the risk is corrected or mitigated.

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 implementation of corrective actions and reported to the EC 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 EC and Employee Safety committees, along with management and supervisors, regularly check the workplace for hazards.

Monthly Environment of Care inspections are conducted 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 or designee, Nursing, EVS, Central Supply, MOD/CSS and other 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, EC, and Employee Safety Committee and the CEO/DCEO. MOD/CSS and CBS Commissary environmental inspections are conducted in accordance with procedures outlined in their Workplace Safety Plan/APP (refer to Attachments for guidance).

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 (MOD/CSS), Centralized Business Services (CBS) and EC/Employee Safety Committee members, as applicable, conducts comprehensive risk assessments to proactively evaluate risks associated with buildings, grounds, equipment, occupants, processes and internal systems that have the potential to impact the safety of patients, staff and visitors. Results of the risk assessment 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 EC and Employee Safety Committee meeting minutes and reported to the Quality Council and Governing Body.

8.4 Safety & Health Performance Assessment (SHPA)

Safety staff from DSHS ERMO/Safety conducts an annual assessment 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 assessment provides the hospital with information about hazards that may be missed during routine inspections. Action plans are developed for all assessment 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 drills are conducted at least quarterly in all patient care areas and annually in non-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 natural, human, technological and hazardous waste hazards that require emergency response procedures. 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 Pan 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 be provided CPR certification upon request and supervisor approval. 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 (509)-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 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.

Refer to the ESH Medical Emergency Response procedures for further information.

9.4 Infectious Disease Exposure Hazard

Infectious diseases are a risk with some job tasks at the facility. The Eastern State Hospital Infection Control Plan is designed to mitigate the exposure 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 regulations.

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 potential for exposure to extreme infectious diseases such as Viral Hemorrhagic Fever (Ebola), Coronavirus (COVID) or other emerging infectious diseases. There is the possibility of staff exposure to these more fervent contagions while performing routine work in addition to exposure through some form of secondhand or thirdhand contact with the 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 information available.

It is important all staff know what to do if potential exposure is suspected. Staff should notify their supervisor and the Infection Preventionist of 1) a patient, staff member, or anyone in a patient or staff member's immediate circle who has recently returned from visiting, working, or volunteering in an area of the world experiencing an outbreak; and/or, 2) the returning person is reporting or presenting with symptoms of an illness. The public health department is notified of all conditions that are required by law.

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 a comprehensive safety orientation during All Hospital New Employee Orientation (AHNEO). This orientation addresses all required Safety information including, but not limited to, Accident Reporting, Workplace Violence Prevention, emergency response, Lock Out Tag Out (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 for verifying that each employee, contractor, and affiliated agency partner has received an initial, site-specific orientation and any additional training required to perform their job safely. All training is documented ~~and maintained~~ in the Washington State Learning Center and or the learner's supervisory file. The Safety Manager in conjunction with Staff Education Services is responsible for developing and maintaining New Employee, Annual Safety/Accident Prevention/Workplace Violence Prevention, Emergency Operations and Response and Supervisor Safety training materials. Basic Life Support (BLS) training is provided to clinical staff and Security personnel in orientation with recertification every two years. If a clinical staff's BLS certification expires, they cannot work in a patient care area providing direct patient care until the certification is current.

10.2 Basic Orientation

Newly hired ESH employees and contracted direct-care staff are required to attend AHNEO. Training includes all Washington State Department of Occupational Safety and Health (DOSH)/ OSHA required Safety, Accident Prevention, Workplace Violence prevention, Infection Control, and other required training. Additional 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. MOD/CSS and CBS training requirements and curriculum are maintained according to their Workplace Safety Plan/APP.

10.3 Orientation for Clinical and Nursing Staff

Upon completion of AHNEO, clinical and nursing staff completes additional training, related to working with people with mental illness, violence prevention, crisis intervention, 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. All training is documented and maintained in the supervisory file and/or The Learning Center.

10.4 Mandatory Refresher Training

Employees receive mandatory training refreshers annually or as required by job class and training type.

10.4 Site-Specific Training for MOD/CSS/CBS Commissary

MOD/CSS staff receive site-specific training prior to working at the facility e.g., CPI. CBS Commissary staff are required to complete ESH Safety and Emergency Response training via an online course through the Learning Center.

11.0 WORKPLACE VIOLENCE PREVENTION

Eastern State Hospital mitigates the risk of workplace violence by providing effective, evidenced/informed based patient care including:

- The violence escalation cycle.
- Violence-predicting factors.

- Obtaining patient history for patients with violent behavior or a history of violent acts.
- Verbal and physical techniques to de-escalate and minimize violent behavior.
- Strategies to avoid physical harm.
- Restraining technique.
- Use of the intershift reporting process to communicate between shifts regarding patients who are agitated; and
- Use of the multidisciplinary treatment process or other methods for clinicians to communicate with staff regarding patient treatment plans and how they can collaborate to prevent violence.

This combined staff training and safety related policies and procedures are utilized to promote a safe physical environment and Culture of Safety.

Prevention of workplace violence is based on principles of:

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

11.1 Definition of Workplace Violence

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

The Joint Commission defines workplace violence as "an act or threat occurring at the workplace that can include any of the following: verbal, nonverbal, written, or physical aggression; threatening, intimidating, harassing, or humiliating words or actions; bullying; sabotage; sexual harassment; physical assaults; or other behaviors of concern involving staff, licensed practitioners, patients, or visitors".

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 assaultive behavior have treatment plans formulated to address the risk and include 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 debriefing interventions of 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 are 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 unsafe and violent behavior is a priority for patient care and leads to a safe work environment and milieu for staff and patients. 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 and escalating behavior.

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 (if applicable), 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, but are not limited to:

- DSHS Policy 18.67 Workplace and Domestic Violence.
- Prohibition of illicit drugs and actual or potential weapons on campus grounds.
- Evidence informed 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).
- Walkthrough and hand-held metal detectors.
- A system of visitor and contractor access control.
- Identification badges worn by all Eastern State Hospital employees, contractors, and visitors.
- Staff duress alarm systems on the units.
- Strategically placed convex mirrors for heightened visibility.
- Handheld radios with emergency alarms carried by direct care staff and base station radios for emergency response in other non-patient care areas e.g., Administration, HIM office, kitchen, etc.
- Closed-circuit television (CCTV) cameras
- 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, 1 Registered Nurse (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 facilitates seclusion and restraint as a last resort and works 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, applied therapeutic engagement of patients, often modeling best practices for staff. A secondary benefit of PERT is enhanced staffing for patient treatment units throughout the hospital. PERT is not included in the staffing count on the ward.

11.6.4 Security

ESH Security is the authorized liaison with local law enforcement 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. If an employee sustains a more serious injury, the supervisor assists the employee to obtain additional medical attention if indicated.

DSHS Administrative Policy No. 18.67 Workplace and Domestic Violence/Reasonable Safety Accommodation provides guidance regarding workplace violence and domestic violence affecting the workplace. The department director or supervisor works with the employee to develop and document a safety plan to support the employee's safety at work, determining if further actions are necessary including, but not limited to:

- Alternate or modified schedule/shift.
- Change in work telephone number.
- Change of work email address.
- Provided resource information, including:
  - Washington State Employee Assistance Program (EAP).
  - National Domestic Violence Hotline 1-800-799-SAFE 7233)/TTY 1-800-787-3224 CHATTHE HOTLINE.ORG

A Critical Incident Stress Management (CISM) team is in place and may be initiated to provide aid 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 7.08).

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 are also trained in approved procedures for physical intervention should a patient become assaultive or engage in self-harm and less restrictive interventions have been unsuccessful. This training includes evasion techniques, the hierarchy of physical intervention, physical containment procedures and application of mechanical restraints. All physical skills require return demonstration and documentation of competency.

11.10 Data and Surveys Addressing Workplace Violence Data

Review:

Workplace violence is tracked utilizing incident databases. An electronic Safety Incident/Close Call Report (DSHS O3-133A) incorporating the Employee Report of Possible Client Assault form (DSHS 03-391) is maintained by ERMO in the RiskMaster database and an Unusual Occurrence report (UOR) database is maintained by ESH. 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 EC and Employee Safety Committee meetings. A narrative summary with recommended action plans is presented to Quality Council and at quarterly Governing Body meetings. All UOR's are reviewed by leadership in daily morning meetings.

Workplace Safety Surveys and Culture of Safety:

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.

The Strategic direction and pillars of focus for Eastern State Hospital include defining a Culture of Safety as a just culture where employees are not fearful to report adverse events, close calls, unsafe practices or conditions. A just culture is non-punitive, addresses the adverse event, close call, unsafe practice or condition by looking at the system not the person. ESH Culture of Safety Goals Include:

- Implementing a consistent rounding program for Executive leaders and supporting employees exposed to secondary violence.
- Creating consistency between shifts and wards and consistent communication across the facility.
- Empowering employees by providing training and education opportunities.
- Using collected data to support more decisions and practices throughout the organization.
- Creating a practice where Culture of Safety behaviors are mirrored by supervisors.
- Involving front-line staff in solutions.
- Creating and implementing an organizational wide communication process/plan so the entire hospital, departments/wards and employees hear the same message.
- Post reports and goals throughout the hospital for transparency, awareness, and discussion.
- Updating specific measurements that support BHA/ESH strategic plans and Culture of Safety measurements and posting this information in all departments/wards.

12.0 WORKPLACE SAFETY GOALS AND PERFORANCE 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 EC Committee is responsible for EC PI initiatives that are based on priorities identified by the EC 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 EC 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 EC Committee and provided to Quality Council and Governing Body.

13.0 WORKPLACE SAFETY PLAN – ANNUAL EVALUATION

The Safety Manager, in coordination with the Director of Facilities, EC 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 EC Committee, Employee Safety Committee, Quality Council and Governing Body.

Appendix A: Workplace Safety and Violence Prevention Plan – 2023 Security and Safety Assessment
Eastern State Hospital

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

Security Consideration RCW 72.23.400	**Assessment**	**Prevention Action(s)**
The physical attributes of the state hospital including: **a) 1. Access Control**	Walk-through detectors are not available at many of the public entrances at Eastlake and Westlake, including the FSU Administration entrance and GPU ward locations, hand-held detectors only. The north visitor entrance is equipped with a walk-through detector as well as all FSU ward entrances. The FSU walk-through detectors have reached their equipment life expectancy and are no longer supported by the manufacturer. A Physical Security Survey and Vulnerability Assessment has been completed for 2022. Results identified ESH risk is within "Green Zone". Recommend continuing with the current physical security program, being mindful of changes to the frequency of criminal activity in ESH vicinity and vigilance of possibility staff complacency with security measures.	The Administrative Directors for FSU, APU, and GPU have evaluated individual unit visitor access and metal detector use policies and revised them to reflect increased consistency across the hospital units, wards, and shifts. A workgroup including the Safety Office, Security and Director of Facilities are evaluating existing walk-through metal detectors for age, life expectancy, maintenance capabilities and policy/procedures to develop recommendations for hospital-wide implementation. Target for completion August 2023. A Capital Programs project 2022-431 ESH-Westlake Lobby Security Enhancement provides a new security office and area for more a detailed security screening as necessary. Includes updating and hardening the office with bulletproof glass and walls. Start date April 2023.Anticipated completion September 2023.

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
a) 1. Access Control	Campus-wide key control is maintained by the Security Department. Access to FSU is controlled using proximity cards approved by FSU Administration and issued by security, 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. It is problematic to obtain keys and badges when staff quit via telephone or when employment separation is initiated by ESH via letter. FSU areas accessed via card readers can be disabled for employees no longer working in these areas, employees leaving employment or for terminated employees. As part of an After-Action Review (AAR) from an emergency response event, it was identified that there is no ESH policy/procedures for when staff are separated from employment to include escorting and/or trespassing them from campus.	Eastlake Main Entry security project, Capital Program CBS 40000789 is funded and with February 2023 start date and anticipated to be completed November 2023. ESH IT Department project in place to make door control systems on all FSU wards consistent by updating software and hardware. Equipment is onsite with target for project completion Fall 2023. The access control system has been expanded to Pine Lodge Building K, entry doors, as well as to Eastlake Health Information Management entry doors, Eastlake Information Technology Offices in Administration Building Floor 3, and Main Distribution Frame entry doors at Eastlake and Westlake. To address single point of failure mitigation for the FSU door control, new PLC units were installed in the FSU south IDF closets. Programming has been updated to reflect these changes. Additional hardware is on order, due July 2023. Estimated completion date August 2023. Phases 1 and 2 have been completed – system configuration and project planning, pilot doors are online and in use. Phase 3 estimated start date July/August 2023 – FSU card readers cut over from TAC/iNet to VAX – Estimated completion TBD.

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
a) 1. Access Control		Educational Services conduct hand-held metal detector wand training during All Hospital New Employee Orientation (AHNEO)or Nursing. Unit education coordinators arrange/provide refresher training to all current staff as needed. All Security events involving campus or building access e.g., unsecured doors are reviewed by the EC and Employee Safety committee for development of action plans as required. Events requiring Leadership awareness are reviewed at daily Leadership huddles for implementation of actions plans as required. As part of an AAR, language is being developed for addition to the existing ESH 2.14 Patient Visitors policy to define procedures for trespassing campus visitors, including employees separated from employment. Estimated completion date June 30, 2023.
a) 1. Access Control	Access to the hospital campus is controlled primarily using identification badges, provision of personal identification and advance notification of authorized visitors. A badge identification system is in place that allows Security and all staff to quickly determine appropriateness of visitor access based on badge color, decreasing the risk of workplace violence and other security concerns.	A Capital Program request has been made for funding to install an electronic key management system" issuance and tracking system for internal building keys and a card access building entry system. This will require Legislative approval and funding. Not funded to date.

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
a) 1. Access Control	There are occurrences of stolen, misplaced, lost, or not turned in employee identification badges and/or keys assigned to individual employees. ESH Security Department maintains oversight of the key and FSU badging process for improved control and accountability.	Refer to prevention listed above. Security is currently implementing a process to place all individual sets of hospital keys on a tamper proof key ring. Each ring has its own unique numerical identifier that will be tracked in a Security database. Target for completion June 30, 2023. Security has worked with HR and staffing to receive timely updates when staff are leaving state service, ensuring improved accountability and collection of keys upon employee departure.
a) 1. Access Control	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.	Quarterly and annual door inspections are completed by MOD/CSS to ensure proper function. Quarterly reports of these inspections are forwarded to the Director of Facilities for monitoring. Door security checks are completed by Security staff after hours and unsecure locations documented and reported to designated area supervisor for follow-up. This data is reviewed by the Environment of Care (EC) and Safety committee for trend analysis and recommendations for performance improvement. Capital Program funding for Smoke and Fire Retro-Commissioning project design includes additional fire door replacements, including exterior and interior entrance replacements, as indicated by assessment, to ensure proper function and compliance with Life Safety code requirements and TJC/CMS standards compliance. Anticipated design completion in December 2023.

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
a) 1. Access Control	The Westlake Switchboard (PBX) desk area is enclosed, and cameras installed at the entrances to increase visibility of the parking lot and in-coming visitors. The Eastlake PBX location contains critical alarm systems, communication and camera equipment for alerting and notification of hospital staff in an emergency but provides limited PBX staff security as identified in multiple emergency response drills and a Spokane County Sheriff office assessment of ESH buildings. The post-drill evaluation, and Sheriff's office assessment have identified that PBX and Administration and Eastlake center core office 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 (limited barriers between visitor and operator and/or barrier easily broken to access location, etc.), no metal detection prior to entering building. The Administration building and Campus Café must remain unlocked during normal business hours and/or provide a means of free egress by either monitoring access/egress by physically manning the doors,	Capital Programs project 2022-431 ESH-Westlake Lobby Security Enhancement provides a new security office and area for more a detailed security screening as necessary. Project includes updating and hardening the office with bulletproof glass and walls. Start date April 2023. Anticipated completion September 2023. Capital Programs project #2021-423ESH Admin Building Security Improvements was funded with start date of March 2023 and anticipated completion November 2023. This includes replacement of entrance doors and access controls, PBX office security improvements, installation of additional cameras and intercom systems to improve overall safety and security for PBX, Administration building, Campus Cafe and Eastlake center core office staff and visitors. Due to ongoing, nationwide active shooter events, an interim plan was implemented to secure the Administration building and PBX, Eastlake center core office and Campus Café gate access ahead of the Capital Programs project. Fire Code is maintained through physical manning of the Administration main entrance and new hardware at the Campus Café gated entrance and patio added that ensures free egress. Alternative Administration building accesses were re-keyed for controlled access by office staff. May 2023.

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
a) 1. Access Control	or through controlled access via card readers or keys with panic hardware or magnetic locks that release during a fire alarm activation. The Westlake entrance doors are tied to the alarm system and release when the fire alarm is activated.	
a) 1. Access Control	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. A metal detector is in place at the Eastlake north entrance for screening visitors and patients as needed. In addition, visitor lockers are provided to secure visitor belongings prior to entering patient care areas to decrease the risk of contraband on the wards. Hand-held metal detector wands are in place in addition to the walkthrough detectors.	Refer to Security staffing for long-range visitation planning. ESH 4.112 Handling Controlled Substances is in place to provide guidance for the safe handling of patient property potentially contaminated with controlled/illicit substance(s) which may be present in powder, tablet, or liquid forms and pose a risk to staff is exposure occurs. A workgroup has been created to update the existing Visitor policy and guidelines which will include what items are authorized on campus/wards when visiting and what's allowed to be brought by visitors for patient personal use during their stay. Visitors have the option to leave these belongings in their vehicles or they can lock them up in the lockers provided. Refer to metal detector workgroup information above.

Security Consideration 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.	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. Security personnel patrol the campus and report findings and/or contact local law enforcement as required e.g., criminal activity. Existing exterior lighting has been improved at the west and north Eastlake parking lots including installation of LED lighting. Additional LED lighting installation has been completed in the North recreational yard adjacent to the north parking lot increasing overall visibility.
a) 2. Egress Control	There is currently no physical control over egress (visitor/staff) on campus and outside of secured buildings or outside 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.	Unauthorized patient leave data is reported via Unusual Occurrence reporting. Drill downs or Root Cause Analyses are conducted by Quality Management to identify action plans as indicated. Results are reported to Quality Council and Governing Body. The escorting policy is being revised to clarify required staffing ratios and location specific procedures for all units. Target for completion June 2023. A Capital Programs request CBS 40000615, 2023-25 Biennium has been submitted for installation of fencing around the baseball field to provide additional secured space for patient group activities. This will require Legislative funding. Not funded to date.

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
a) 2. Egress Control	Security reports and security related Unusual Occurrence reporting have identified interior and exterior building doors found unlocked. These occurrences are potentially related to the door not closing properly (HVAC air pressure related), door lock malfunction or the door being left unsecured by staff. Some doors require manual locking, and some locks are self-locking.	Refer to access control listed above.
a) 3. Door Locks	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 in the Security database in a timely manner or not entered at all (human error).	A Capital Program request has been made for funding to install an electronic key management system" 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.
a) 3. Door Locks	All FSU wards have ward-specific keys checked out by staff when they arrive on the ward using a "chit" system. Missing keys are reported through the hospital UOR process and reviewed by the Security department for investigation and plan of	

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
a) 3. Door Locks	correction if indicated. There have been reported incidents of staff leaving at the end of their shift and forgetting to turn in their ward keys.	
a) 4. Lighting	The potential for burned-out or malfunctioning outside lighting decreases staff ability to monitor outdoor patient activities in the evening, Security's ability to conduct campus surveillance and staff's ability to monitor parking lots or other campus areas for hazardous conditions when arriving or leaving. Monthly Security reports have revealed areas where the lighting has not been corrected for extended periods of time. The Linden Hall parking lot is poorly lit. The upper terrace of the Westlake parking lot, the north side of the Eastlake parking lot and some parking areas near the AT building are dark despite the presence of several pole lights.	Security monitors lighting during daily Security rounds and reports burned out exterior lighting to MOD/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. The Director of Facilities meets with MOD/CSS monthly to review work order status and adjusts priority as needed.
a) 5. Alarms	The existing staff duress alarms on Eastlake South (FSU) and Eastlake North (APU/FSU) were installed in four 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, partially non- functional and assessed as non-repairable. The north FSU wards, 1N3,	To ensure reliability, the existing staff duress alarms are tested daily on all wards by ward staff (APU & FSU) and Pharmacy, and weekly on GPU per Nursing policy. Alarm deficiencies identified during these tests are reported to the Director of Facilities and MOD/CSS for immediate repair. Testing is monitored by the Safety office and action plans and/or staff awareness of deficiencies reported to all staff via News Flash and

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
a) 5. Alarms	2N3 and 3N3 were installed during recent renovation projects and are unable to be tied into the existing, adjacent APU wards.	communicated to affected area supervisors.
a) 5. Alarms	The FSU duress system must interface with the old APU system to enable reporting emergencies to the south FSU and north APU wards. Wiring, equipment inadequacies and failures, specific to the APU duress system, preventing interfacing, were identified during the FSU 1N3/3N3 Ward Renovation Capital Programs project. The FSU alarm system requires the use of proximity cards with readers located throughout the corridor. The APU wards have a keyed system with key boxes located throughout the corridor which is cumbersome to activate potentially delaying response. 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. The existing staff duress alarm notification only indicates the ward location; it does not identify specific/exact location of staff activating the alarm.	A Capital Programs request (ESH Integrated Safety and Security Controls) for the 2025-27 Biennium has been made to replace the existing, antiquated staff duress systems on 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. Staff utilize two-way radio communications to report requests for staff assistance in escalating patient behavior events. Radio policy and procedures were revised to combine the FSU Competency Restoration wards, 1N3 and 3N3, and north NGRI ward, 2N3, with the existing APU channel for daily coordination and expedited emergency response from adjacent north wards. Project for replacement of the Turboview radio dispatch targeted for completion in the 2024-2025 Biennium. Eastlake north radio repeater replacement target for completion 2023.

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
	The Eastlake PBX is currently unable to hear the FSU south alarms at their local panel due to the non-functioning APU system interface capability, visual alarm to PBX only. Alternative reporting requires staff to use a two-way radio or a phone, which is not always feasible dependent on emergency. Daily tracking of staff assigned to radios is in place but there is no ability to electronically track the exact location of staff. The existing Westlake staff duress alarm consists of one location on wards for activation; a "push to activate" button at each nurse's 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.	Refer to prevention listed above.
a) **6. The Physical Attributes of the State Hospital: Environment of Care**	There are potential risks associated with the Environment of Care and high-risk processes that present a threat of physical injury to persons, damage to property, or a threat to general safety.	The comprehensive Environmental Proactive Risk assessment was reviewed and updated April 2023. This is in addition to any individual assessments initiated as a result of Sentinel Events or drill downs, data from hazard reports, environmental safety surveys, unusual occurrence and injury reporting, and individual building evaluations. Acton plans are developed based on assessment and monitored by EC and Safety Committee and Quality Council.

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a) **6. The Physical Attributes of the State Hospital: Environment of Care**	Some APU and FSU south wards have blind spots, without camera coverage, to monitor for patient-to-patient and patient-to-staff violence or patient self-harm and investigation of incidents in all locations.	Cameras in on-ward patient video visitation rooms were installed Spring 2023. Camera installation on both civil and forensic ward locations in ongoing with dayroom and dining room locations being a priority. Additional Security camera installations are targeted for building entrance locations not currently being monitored. Exterior recreational yard camera replacements, Eastlake south and north, complete November 2022. Phase 6 IT camera project covers zero level corridor areas, APU stairwells, court rooms, Patient Technology Center and Telehealth locations. Quote received and pending funding approval.
a) **6. The Physical Attributes of the State Hospital: Environment of Care**	There is the potential for patient property to be used for self-harm or as weapon e.g., belts, large pieces of jewelry, CD's, drawstrings, etc.	An Authorized Patient Property policy is in place and identifies patient belongings, personal care items, etc. and whether the item is not allowed or allowed. If the property is allowed, the policy/list identifies within what context (category based, staff supervision required, treatment team approval required, and other restrictions). The Authorized Patient Belongings list is updated at least annually or as indicated as the result of hazard reporting, or a Sentinel Event root cause analysis. The list is currently under review and revision to ensure safety precautions are taken based on assessment. Target for completion June 30, 2023.
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a) 6. The Physical Attributes of the State Hospital: Environment of Care	Furniture in patient care areas (chairs, tables, desks, etc.) pose a risk for use as a weapon, barricading in the room or as a ligature point.	Patient bedrooms on all GPU, 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 (APU/FSU) for patient storage which are specifically manufactured for Behavioral Healthcare and Correctional facilities.
a) 6. The Physical Attributes of the State Hospital: Environment of Care		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. Installation on civil commitment wards and FSU wards completed March 2023. Metal beds on 2N3 and 2S1 were replaced with molded vinyl, ligature resistant beds bolted to the floor March 2023. The 2N3 visitor room was also remodeled in May 2023. In response to a TJC citation, additional Behavioral Health furniture, ligature resistant TV enclosures and door hardware have been ordered. Target for installation October 2023. All electric beds cords are shortened to three feet and/or secured to the bed frame on all purchased and rental medical beds to mitigate risk of use for self-harm or as a weapon. The length of electric bed cords has been added to the EC Audit Tool and monitored during the Nursing EC rounds and mitigation reflected in the Environmental Proactive Risk Assessment.
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a) 6. The Physical Attributes of the State Hospital: Environment of Care	Potential for patients to access Woodshop equipment during patient groups and use for self-harm or as a weapon.	A checklist is utilized to document the 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 activity. Completion compliance of the Woodshop security checklist is audited during EC rounds to ensure the log is completed in real time.
a) 6. The Physical Attributes of the State Hospital: Environment of Care	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.	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 and Treatment Malls to ensure they are secure, present, and accounted for. Compliance is monitored during environmental surveys and by Core Team members at Treatment Mall and non-compliance reported to unit Administrative Directors, the unit Director of Nursing or Treatment Mall Manager for follow-up.
a) 6. The Physical Attributes of the State Hospital: Environment of Care	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. Plastic toothbrushes, combs, and hairbrushes can be broken and used for self-harm or as a weapon.	Metal clothing closets and plastic hangers were removed from NGRI ward 2N3 in March 2023 and replaced with molded and ligature resistant wall-mounted cubbies for storage of clothing. 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.
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a) 6. The Physical Attributes of the State Hospital: Environment of Care	A risk assessment was completed related to non-flexible pens for patient use on NGRI and GPU wards due to concern of potential for use as a weapon or for self-harm. All other wards prohibit use of non-flexible pens and utilize flexible pens consistent with DOC.	Risk assessment recommendation is to implement use of flexible pens hospital wide. This recommendation was approved by the Employee Safety Committee in May 2023. Requires final approval by Patient Care and Leadership prior to implementation. Target for approval and implementation TBD. Environmental checks are conducted and documented on all wards and incorporates risks identified on the hospital-wide Environmental Proactive Risk assessment. Monthly EC rounds conducted by Director of Facilities and Safety Manager and findings reported to department/area supervisor and Leadership for action as identified. Ward/room search policy in place for addressing concerns/reports of potential contraband that could be used for self-harm or as weapons as indicated.
a) 6. The Physical Attributes of the State Hospital: Environment of Care	The existing GPU nurses' stations were not enclosed. There were locking doors and half-height plexiglass surrounding the stations. This left the potential for patients to throw items/liquids over the plexiglass wall.	A Capital Programs project was funded and completed April 2023 to enclose all GPU nurse stations.
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a) 6. The Physical Attributes of the State Hospital: Environment of Care	Existing drinking fountains were shut down during the COVID response restricting access to drinking water for staff in non-patient care areas.	Operational funding utilized to initiate project for installation of water bottle fillers in non-patient care areas to improve access to drinking water for staff. Estimated completion date June 2023.
a) 6. The Physical Attributes of the State Hospital: Environment of Care	The Eastlake boiler plant building is an original stone build with significant structural deficiencies. The steam plant provides heating to the Eastlake building and is critical for Continuity of Operations.	A Capital Programs project has been funded to replace the Eastlake boiler plant. Project start February 2021 and online November 2022. Demolition of old boiler plant and projected project completion July 2023.
c) b) Staffing, Including Security Staffing	Security personnel are not assigned to patient care wards.	Security responds to requests for staff assistance on the wards via radio communication initiated by ward staff or Nursing Management in an emergency event requiring their assistance.
b) Staffing, Including Security Staffing	Transporting and escorting patients is currently provided by Nursing positions and Mental Health Technicians. Security Guard 2s are trained to cover these responsibilities and allow the direct care positions to focus on patient care.	Eastern State Hospital is seeking to bring the Security Department duties into alignment with other BHA facilities, which includes the coverage of responsibilities currently covered by direct care staff. This expansion of duties would also include the scheduled coverage as escorts for contractors and vendors on-site, transporting patients to medical appointments in the community and escorting/supervising patients for family/professional visits, including establishing a Visitation Center with Security Department oversight. A decision package has been submitted in support of this transition. Not funded to date.
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b) Staffing, Including Security Staffing	Consistency and reliability of acuity scores and staffing needed to provide adequate patient care and staff safety	HART application in place and consists of both a job aid that functions as a decision support tool, and a technical solution known as the HART application where patients' acuity scores are entered. HART replaced the existing acuity systems at Eastern State and Western State Hospitals, with the intent to increase both the consistency and reliability of acuity scores and staffing needed to provide adequate patient care and staff safety. HART meets legislative requirements to develop a single acuity-based staffing tool that was implemented at both hospitals and provides patient acuity data required prior to approval of funding for hospital staffing. All future funding for direct care staffing is tied to this acuity tool and the data it generates over time. This is expected to be a multi-year process to allow extensive analysis of staffing trends and follow-up on budget requests from the state legislature. HART will generate total overall care hours needed based on the acuity scores and reflect activities that drive staffing.
d) b) Staffing, Including Security Staffing	Use of on-call, voluntary and involuntary overtime. Eastern State Hospital's overtime average for FY22 was 7.8%. As of April 2023, ESH's overtime average is 6.1% due to ongoing staffing shortages.	Every attempt will be made to accommodate preferences. Due to various factors, this may not always be possible. <u>Involuntary Overtime</u> 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.
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b) Staffing, Including Security Staffing	Difficulty hiring clinical and non-clinical staff to fill vacant positions.	Eastern State Hospital's Staffing and Performance Operations team partnered with DSHS Human Resources Talent Acquisitions and collaborated with ESH Organizational Development and Communications to develop marketing strategies and materials, for an ad in the Journal of Business, position handouts, and posting available positions on the DSHS Facebook and Twitter pages in addition to community job fairs
c) Personnel Policies	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. All three (3) state hospitals (ESH, WSH, and CSTC) have collaborated to align their comprehensive Workplace Safety Plans to encompass Workplace Violence Prevention. ESH has improved the process for creating, reviewing, revising, communicating, distributing, and posting policies, protocols, and procedures through development and implementation of an intranet/SharePoint site, "News Flashes" and "Daily News", and posting of communications on safety and communication boards throughout the hospital.	The following list is not all inclusive; refer to individual policies for additional information: • Behavior Undermining the Culture of Safety • Seclusion/Restraint • Workplace Safety Plan, including Accident Prevention, and Workplace Violence Prevention • Crisis Prevention and Intervention training (CPI) • Psychiatric Emergency Response Team (PERT): A plan of response for patients during a psychiatric crisis or anticipated crisis • Code Gray Response (Escalating Patient Behavior Response) • Critical Incident Stress Management (CISM) • Disruptive And Intimidating Behavior By Staff • Incident Reporting • Key Control • Visitor Access • Background Checks • Law Enforcement Notification • Benefits for Employees Assaulted by Residents/Clients

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c) Personnel Policies	The Learning Center is utilized for ensuring employee compliance with mandatory training and changes to policies/procedures for employee awareness. 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 EC and Employee Safety committee to identify trends and develop a plan for improvement, if indicated, to correct deficiencies and mitigate risk.	• Workplace Personnel Security Program Emergency Operations and Specific Emergency Response Procedures • Active Threat • All Hospital Lockdown • Bomb Threat • Evacuation • Emerging Infectious Diseases (e.g., Ebola, COVID-19, etc.)
c) Personnel Policies	The 2022 annual evaluation of the Workplace Safety Plan validates the plan is adequate and effective in practice.	
d) First Aid and Emergency Procedures	There is a potential for exposure to communicable diseases, Bloodborne Pathogens (BBP), Hepatitis A/B/C, HIV, COVID and TB during provision of patient care.	Infection prevention measures are implemented on wards as required based on daily shift reports. Vaccination for Hepatitis B is assessed for each hired employee. Employees lacking presumptive evidence for Hepatitis B immunization are offered vaccination. All hired employees are required to be screened for TB. Plans and procedures are in place for emerging infection diseases and were implemented for emergency response and Continuity of Operations (COOP) related to COVID-19 and were ongoing in 2022 in accordance with the Governor's directive, CDC and DOH guidelines.

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d) First Aid and Emergency Procedures	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. Updated April 2023.	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. Flu vaccinations are available to staff at no cost.
d) First Aid and Emergency Procedures	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 (x4333). 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.
d) First Aid and Emergency Procedures	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 are trained as first responders.	The MERC committee implemented "Mock Codes", to improve medical emergency response preparedness. Medical providers are required to complete ACLS classes with bi-annual recertification. ECG rhythm and emergency response training is provided to shift Nurses.

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d) First Aid and Emergency Procedures	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 and includes evaluation of community and regional events conducted Spokane County Emergency Management and the Region 9 Healthcare Coalition.	The HVA was last revised October 2021 and includes, but not limited to, Emerging Infectious Diseases e.g., COVID 19, Cyber Security events, Active Threat, wildfire, and windstorms. It is currently being reviewed and revised with anticipated completion June 30, 2023.
d) First Aid and Emergency Procedures	A minimum of two (2) emergency response drills are conducted annually. A Plan for Improvement is developed for all identified deficiencies related to emergency response activities (staged and actual) related to internal/external communication, availability of and access to materials, safety & security of patients and staff, staff roles and responsibilities (assignment and performance), managements of critical utilities, management of clinical and support activities, transportation, and personal protective equipment.	The following actual events, emergency response drills and Emergency Operations and Response participation with community partners occurred in 2022/2023 YTD: • Campus-Wide Planned Power/IT Outage with ICC Activation • Potential Active Threat Event • FSU Mech Smoke Event • Earthquake Shakeout • EL Fire Suppression Flooding Refer to After-Action Reports for full details.
d) First Aid and Emergency Procedures	Continuity of Operations activities related to COVID 19.	Continuity of Operations activities were conducted throughout 2022 in accordance with the Governor's directives and CDC and BHA guidance.

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d) First Aid and Emergency Procedures	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 Communications Plan is currently being reviewed and revised to ensure inclusion of all required The Joint Commission (TJC) and Centers for Medicare and Medicaid Services (CMS) standards and BHA Major Incident Reporting guidelines. Target for completion June 30, 2023.
d) First Aid and Emergency Procedures	There is the potential for radio communications to be compromised due to: • Low/dead batteries • Dead spots and outside locations (lack of repeater coverage) • Incompatibility with community emergency response agencies • Lack of assigned radio/pager for all staff	A daily digital radio assignment log is used 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. ESH radio fleet replacement 95% complete as of May 2023. Replacement of base stations remains. This project upgrades the equipment to be Wi-Fi compliant for future expansion and replaces equipment that is no longer under warranty. This includes batteries, as needed.
e) 1. Reporting of Violent Acts	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: • Staff involved • Assailant identifier (patient, employee, visitor, other) • Incident date, time, shift • Use of restraint • Use of seclusion • Cause of injury

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e) 1. Reporting of Violent Acts		• Patient assault involved • Object used in assault • Staff-initiated contact; containment • Injury severity rating • Type of injury • Body part affected • Description of precipitating events
e) 1. Reporting of Violent Acts		Unusual Occurrence reporting via SMART forms for electronic completion and filing is in place increasing timeliness of reporting.
e) 2. Taking Appropriate Action in Response to Violent Acts	Policies, procedures, and training are in place to ensure appropriate actions and response to violent acts occurs.	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 Leadership for action as required. Workplace violence data is monitored by the EC, Employee Safety and Quality Council Committee. All seclusion/restraint, PERT, Code Gray, patient, and staff injury incidents are reviewed by Leadership in daily morning rounds and actions implemented as required. The Patient Care Committee evaluates data for trends in aggressive behavior (including assaults and seclusions) and compares those trends to activities and programming that take place on the wards. The comparison allows for targeting considerations for additional staffing to allow groups to take place or where additional resources are needed to support the therapeutic needs of the patients. This information is looked at on a regular basis with oversite by executive leadership when there are policy/procedure or resources needs.

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e) 2. Taking Appropriate Action in Response to Violent Acts		Debriefing of incidents is crucial to help identify antecedents to behavior and identify strategies to prevent events from re-occurring, they also help to support staff and patients emotionally following high adrenaline situations. For those patients whose behavioral presentation requires additional resources, a Behavior Management Team has been identified as a support mechanism to provide consultation to ward treatment teams. This team is in the recruitment phase.
e) 2. Taking Appropriate Action in Response to Violent Acts	The Psychiatric Emergency Response Team (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.	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 1 Registered Nurse (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 as a last resort, and work with floor staff to re-integrate the patient back to the milieu with appropriate evidence-based debriefing. PERT responded to 2,492 calls: April 2022 through April 2023. 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.

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e) 2. Taking Appropriate Action in Response to Violent Acts		A "Code Gray" is implemented whenever a patient's behavior is escalating and may require seclusion or restraint or whenever seclusion or restraint is initiated. A "Code Gray" is in response to an actual or anticipated critical incident and immediate response is required. Debriefing with staff and an analysis of the event is completed to develop action plans as required.
e) 2. Taking Appropriate Action in Response to Violent Acts	Some patients have multiple patient-to-staff assault episodes due to acuity.	To reduce violence on the wards, positions for a Behavior Management Team (BMT) were established. This team, meets with the treatment team to obtain background information on the patient and then conducts a comprehensive patient assessment, offers detailed treatment recommendations, and provides on-site ward staff training for the purpose of improving clinical outcomes, including a reduction in highly disruptive or assaultive behavior. The team will report to the Chief of Clinical Services. This team requires an on-going annual funding request of $454,000. The team consists of one psychiatrist, one psychologist, three Institution Counselor 3 positions and one Therapies Supervisor.
e) 2. Taking Appropriate Action in Response to Violent Acts	Employees may require assistance when completing injury paperwork or seeking medical attention.	All employees injured at work have access to first aid measures as indicated. If an employee sustains a more serious injury, an emergency medical emergency response is initiated, or the supervisor assists the employee to obtain additional outside medical attention if indicated.

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e) 2. Taking Appropriate Action in Response to Violent Acts	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 *peer-driven*, designed to help employees deal with their trauma by allowing them to talk about the incident when it happens without judgement or criticism.	A CISM referral request mechanism is located on the ESH SharePoint. All requests are initiated through the PBX Operator and then communicated to the CISM Coordinator/designee to initiate a response. In addition, affected staff is made aware of the Employee Assistance Program (EAP) and, on an individual and confidential basis, are encouraged to seek help from the Human Resource Department in accessing personal support. A communication site with worker compensation information and resources is located on the ESH SharePoint to include link to Labor and Industries (L&I) and DSHS Enterprise Risk Management (ERMO) safety and claims webpage. Process communication posters and name badge cards for improved employee awareness are in place. TLC training outlining this information is included as part of mandatory annual Safety training for all employees.
e) 3. Follow-up Procedures after Violent Acts	Potential for safety concerns to not be passed on to other shifts or Leadership and other departments responsible for developing action plans as required.	Safety Huddles are conducted prior to the morning report on each ward to share potential safety concerns/issues. A review of incidents is conducted by the Patient Safety Coordinator to ensure the severity of an injury or other incident is appropriately coded, reported to appropriate individuals for follow-up and actions taken.

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e) 3. Follow-up Procedures after Violent Acts		The Employee Safety Committee meets monthly and conducts in-depth reviews of patient-to-staff assault data and develops prevention strategies to mitigate future occurrences as identified. A narrative summary with recommended action plans, if indicated, is provided to the EC Committee, Quality Council and Governing Body for review and monitoring.
e) 3. Follow-up Procedures after Violent Acts		The 2023 Employee Safety Committee goal aligns with the BHA Strategic Goal of reducing patient-to-staff assault by 10% by 2023 through evaluation of assault occurrences including, but not limited to, timeframes for occurrences, and identification of precursors or other contributing factors. Refer to other performance improvement within this document for additional measures related to reducing violence and patient aggression.
e) 3. Follow-up Procedures after Violent Acts	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.	Employees who self-report to their employer as victims of domestic abuse are immediately referred to the Human Resource Business Partner (HRBP). HRBP will provide information regarding community resources for safety and assistance for the employee and their family as well as other resources. Additionally, they have access to the employee assistance program for referral to additional specialized resources. DSHS Administrative Policy No. 18.67 Workplace and Domestic Violence/Reasonable Safety Accommodation provides guidance regarding workplace violence and domestic violence affecting the workplace. The department director or supervisor works with the employee to

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
e) 3. Follow-up Procedures after Violent Acts		develop and document a safety plan to support the employee's safety at work, determining if further actions are necessary.
e) 3. Follow-up Procedures after Violent Acts	Investigation of assault on a DSHS employee which results in an employee's hospitalization or medical treatment beyond first aid	The ESH Safety Office is working with the BHA Safety Team to coordinate investigation, in addition to facility investigation, of any assault on a DSHS employee which results in an employee's hospitalization or medical treatment beyond first aid. A drill down of the event would be conducted to determine whether existing processes are effective or require modification. Data derived from the drill down would be used by ESH, as appropriate, to develop an action plan for process improvement and reported to Employee Safety Committee and Leadership. Target for implementation TBD.
e) 3. Follow-up Procedures after Violent Acts	ESH utilizes Unusual Occurrence (UOR) forms for reporting verbal threats, per RCW 72.01.045 and 74.04.790. Reporting staff determines risk potential. 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 member to another staff member.	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 EC and Employee Safety Committee and quarterly to Quality Council. Action plans are developed as required.

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g) Employee Education and Training		All direct care (milieu) staff are trained at hire and identified intervals in violence 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.
g) Employee Education and Training	A training plan is in place to ensure all staff are trained at-hire and on an ongoing basis as required. ESH utilizes the Washington State Learning Center as the platform for creating and distributing online learning experiences and as the official system of record and reporting for employees training via the training transcript. Educational Services has developed a matrix of mandatory training, at orientation and ongoing and is utilized to compile training compliance data. New Employee Orientation is conducted at regular intervals, at least monthly.	ESH has implemented CPI training which is evidence-based and incorporates philosophy, de-escalation, safe physical holds, and self-protection training. 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.
g) Employee Education and Training		Following the classroom portion of NEO, Nursing staff, MHT's, PSA's, LPN's, PSN's and RNs are assigned to precept on the wards. This is designed to intermix classroom content with coached on the job training and skill practice for different levels of nursing practice.

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g) Employee Education and Training		Preceptor (peer) training is conducted 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.
g) Employee Education and Training	Restraint events are high-risk and intermittent.	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. In addition, staff are trained to monitor patients in restraints for signs of physical distress.
g) Employee Education and Training	CPR training is required for all clinical staff and Security staff.	The American Heart Association Basic Life Support (BLS) training is instructed for Healthcare Providers which results in certification of participants. This is required every two (2) years for all direct-care staff and Security. "Stop the Bleed" is a grassroots national awareness campaign that encourages bystanders to become trained, equipped and empowered to help in a bleeding emergency before professional help arrives. ESH has purchased supplies and an implementation plan is being developed.

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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		Milieu Management training is provided to all RNs at hire (New Employee Orientation) in support of the provision of active treatment. RN3's and designees are offered a full day of training focused on the role and responsibilities of the Charge Nurse.
g) Employee Education and Training	The Strategic direction and pillars of focus for Eastern State Hospital include defining a . just culture where employees are not fearful to report adverse events, close calls, unsafe practices or conditions. A just culture is non-punitive, addresses the adverse event, cclose call, unsafe practice or condition by looking at the system not the person.	ESH Goals Include: • Implementing a consistent rounding program for Executive leaders and supporting employees exposed to secondary violence. • Creating consistency between shifts and wards and consistent communication across the facility. • Empowering employees by providing training and education opportunities. • Using collected data to support more decisions and practices throughout the organization. • Creating a practice where Culture of Safety behaviors are mirrored by supervisors. • Involving front-line staff in solutions/committees. Creating and implementing an organizational wide communication process/plan so the entire hospital, departments/wards and employees hear the same message. • Post reports and goals throughout the hospital for transparency, awareness, and discussion.

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g) Employee Education and Training		ESH has implemented Psychological Safety training to support the ESH Culture of Safety Strategic Goal. The goal is to have all employees complete the workshop with the intent to help supervisors create an action plan with their teams to hardwire behaviors toward becoming a psychologically safe organization.
g) Employee Education and Training		Specific measurements that support BHA/ESH strategic plans and Culture of Safety measurements are posted in all departments/wards.
h) Clinical and Patient Policies and Procedures Including Those Related to: 1. Smoking	Patient and Visitor smoking on ESH campus is not allowed. Staff smoking is allowed in designated areas only.	Visitor information and signage in place.
h) 2. Activity, Leisure, and Therapeutic Program	Limited Rehabilitation Services may result in increased patient agitation due to decreased activity, leisure, and therapeutic programming opportunities.	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 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.

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h) 2. Activity, Leisure, and Therapeutic Program	Risk assessments required prior to approval of conditional releases.	To demonstrate readiness for a conditional release to reside in the community, Not Guilty by Reason of Insanity (NGRI) patients must demonstrate the ability to manage stress and symptoms associated with increased access to the public. A Community Access Privilege (CAP) refers to a community activity that supports an NGRI patient to safely reintegrate into the community with various levels of community exposure. The following Community Access Privileges for NGRI patients at ESH requires approvals and risk assessments and include: • Escorted Grounds Privileges • Staff Escorted Community Outings (SECOs) • Unescorted Grounds Privileges (UGPs) • Unescorted Community Outings—Day Trips (UCODs) and Night Trips (UCONs). The overall goal for all these community access privileges is to prepare the NGRI patient to achieve a court order allowing discharge from the hospital to the community via Conditional Release. The NGRI patient must demonstrate to the court that they DO NOT present a substantial danger to the community or substantial likelihood of committing criminal acts jeopardizing public safety in accordance with the conditions of their release per RCW 10.77.150. This CAP is identified as Conditional Release to Reside in the Community (CRCOMM). The NGRI Community Transition Team partners with the Department of Corrections to supervise NGRI patients residing in the

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
h) 2. Activity, Leisure, and Therapeutic Program		community with a court order for CRCOMM. As of May 2023, ESH supervises approximately 22 NGRI patients residing in the community via CRCOMM.
h) 2. Activity, Leisure, and Therapeutic Program	Inconsistency between ward and shift routines, ward guidelines, group offerings, etc. increasing patient frustration when transferring from ward to ward.	Unit Administrative Directors have cross-referenced 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. NGRI Ward Guidelines have undergone an extensive review and update process during the past two years. The current draft is under review as of May 2023. An update of the Competency Restoration Ward Guidelines is scheduled to begin in August 2023 with a completion date TBD.
	Many patients are diagnosed with substance use disorders which often leads to recidivism and acuity upon admission	SUD staff 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 groups to prepare patients for SUD treatment and recovery. SUD counselors have expanded services to provide groups to competency restoration patients to decrease recidivism due to substance use.

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h) 2. Activity, Leisure, and Therapeutic program	Lack of group facilitation training.	An introduction to group facilitation training was added to the NEO and implemented in January 2022 utilizing a facilitation competency assessment tool. The consistent delivery of this NEO training was limited due to Covid restrictions and at this time is not occurring. 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.
h) 2. Activity, Leisure, and Therapeutic program	On-ward active treatment during the afternoon shift is limited or cancelled due to conflicts with ward routines e.g., medication distribution, snacks, etc. Rosters for afternoon shifts are not consistently being completed to document occurrences of active treatment or reasons for group cancellation. While activities are scheduled, they were not structured or formal, ort a structured and consistent way of tracking when or if staffing prevented groups from occurring.	The Rehab department provides programming Monday-Friday 7am-3pm. Development of a structured schedule for each ward with identified activities and leaders was developed May 2023. In addition to a consistent structure with the use of a calendar and programming language across all wards, the selected activities for evenings all have intervention descriptions available to the staff conducting the activity. Group rosters to document activities completed and by whom and cancelled (and why it's cancelled) have been re-implemented. Psychology and Social work currently conduct individual sessions with patients up to 5pm. Capturing those sessions in the active treatment data will be implemented.

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		Vacant positions in rehab are being reclassified to support enhancing programming beyond treatment mall hours and increase the diversity of disciplines providing groups in the evenings/weekends.
h) 2. Activity, Leisure, and Therapeutic program	There is an increased risk for patient unauthorized leave and/or negative patient behavior during unsecured or community outings.	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. A Community Outings policy and procedures are in place. This policy includes safety and security procedures and protocols to ensure community outings are implemented safely and securely while patient and staff safety during transport to/from patient activities, medical appointments, etc. A risk assessment is completed on patients who attend community outings.
h) 3. Communication Between Shifts.	There is the potential for patient information including changes in recovery levels, acuity and identified safety risks to not be relayed to oncoming shifts/staff.	Safety Huddles are conducted prior to the morning report on each ward to share safety concerns and provide information regarding potential safety issues. 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 potential safety risks.

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h) 3. Communication Between Shifts.	There is the potential for patient information including identified safety risks to not be relayed hospital wide.	Executive Leadership reviews ward report data from the previous evening during daily morning rounds and initiates actions or requests for additional investigation as indicated. Hospital-wide communication is conducted using hospital-wide "News Flashes", Daily Newsletter, use of an intranet/SharePoint site and postings on communications boards throughout the hospital.
h) 3. Communication Between Shifts.	Increased requirements specific to the forensic population requires additional staff knowledge and communication of FSU security requirements.	As of January 2023, the FSU Security Committee has been replaced with a new model of practice that provides forensic staff representation and participation at the Hospital Safety Committee meetings. Security issues identified on the wards are communicated through department meetings and rolled up to the ESH safety committee for larger issues that require policy or process changes. FSU Administration and staff have replaced the Security Break Memo and review process with the ESH Unusual Occurrence Reporting system to ensure a more global audience of safety concerns occurring on forensic wards.
h) 4. Restraint and Seclusion	Review of seclusion/restraint events completed as required.	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.

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h) 4. Restraint and Seclusion	Consultation may be required for some patients whose recovery becomes stagnate and may need additional clinical assistance related to medications or other interventions to move patient's progress forward.	Refer to Behavior Management Team information above.
h) 4. Restraint and Seclusion	Some patients present increased risk of inpatient aggression including new admissions.	A workgroup of frontline employees collaborated to choose a Violence Risk Assessment to utilize for routine assessment of all new admissions and patients who present increased risk of inpatient aggression. The (Dynamic Appraisal of Situational Aggression (DASA-IV) has been identified as the tool for use at ESH. This tool assesses seven indicators to provide a score of predictive aggressions that correspond to scaled interventions. As the score increases it triggers the creation of a safety plan and interventions which help the patient avoid aggression.
h) 4. Restraint and Seclusion	**Specialized evaluation team would provide enhanced assessment**	A Certified Sexual Offense Treatment Professional (CSOTP) position has been established and posted. The CSOTP is an essential clinician for robust continuity of care and discharges into the community without jeopardizing public safety. External contracts are in place for Clinical Neuropsychologist services and Psychology Evaluators with specialized training and experience in conducting psychodiagnostics and forensic risk assessments. These assessments would go above the typical assessments for suicide, depression, etc., providing more robust assessments to determine diagnosis and risk for violence, sexual offenses, etc.

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h) 4. Restraint and Seclusion		ESH serves over one-hundred forensic and civil patients with complex treatment challenges associated with TBI, dementia and intellectual disability. A Clinical Neuropsychologist would establish an evidenced-based foundation for treatment and discharge.
h) 4. Restraint and Seclusion	Policy and procedures in place for escalating patient behavior.	A "Code Gray" 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. For related restraint and seclusion policies and procedures and education refer to section "g", "Employee education and training" and section "h", "Clinical and patient policies and procedures".