Washington State Department of Social and Health Services

Western State Hospital
9601 Steilacoom Blvd. SE
Tacoma, WA. 98498
253-761-3398

Transforming Lives

WESTERN STATE HOSPITAL

WORKPLACE SAFETY PLAN

Washington State Department of Social & Health Services
Transforming lives

Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES	March 2017		
Effective Date:	**April 1, 2017**	Revised Date:	**March 2017**
Approved by:	Chief Executive Officer		4-12-17 Date

TABLE OF CONTENTS

1.0 PURPOSE

The purpose of the Workplace Safety Plan is to improve and maintain workplace safety at Western 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 Maintenance Office (CMO), Consolidated Institutional Business Services, (CIBS), staff, contract staff, interns, students and volunteers. CMO and CIBS employees work collaboratively with WSH personnel to create and maintain a safe work environment through the use of a Service Level Agreement (SLA) to identify hospital and CMO and CIBS responsibilities and service obligations.

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 Centers for Medicare & Medicaid Services (CMS) regulations.
- DSHS Administrative Policy No. 18.67 Workplace and Domestic Violence.

3.0 HOSPITAL LEADERSHIP COMMITMENT

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

The hospital CEO has delegated authority to the Safety Manager, Infection Control/Employee Health Manager, Security Manager and Industrial Hygienist to stop any action that places the lives of employees, patients, contractors and visitors in immediate danger.

4.0 SAFETY AND HEALTH RESPONSIBILITIES

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

4.1 Executive Leadership Responsibilities

Executive Leadership responsibilities to create and maintain workplace safety include:

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

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

4.2 Manager and Supervisor Responsibilities

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

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

4.3 Employee Responsibilities

Employee responsibilities to create and maintain workplace safety include:

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

5.0 SAFETY COMMITTEES AND SAFETY INFORMATION

5.1 Employee Safety Committee

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

address safety and health issues, in compliance with WAC 296-800-130. Western State Hospital maintains a Central Safety Committee and five (5) safety sub-committees. The committees are responsible for evaluating the effectiveness of the Workplace Safety Plan and for developing, implementing and overseeing action plans in order to create and maintain a safe workplace.

Each Safety Sub-Committee consists of employee-elected and management designated representatives, in an amount equal to or less than employee elected representatives. Guests (Ad-hoc members) are invited as required. The Central Safety Committee consists of two members (Management and Labor Co-Chairs) of each safety sub-committee and other resource members. Each safety sub-committee reports to the Central Safety committee. Management and Labor Co-Chairs of all safety committees are selected by majority vote of the committee. Each committee meets on a monthly basis and membership is re-appointed or replaced at least annually.

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.

5.2 Environment of Care Committee

The Environment of Care Committee (EOC) performs retroactive and proactive safety reviews, performs risk assessments of the Environment of Care, makes safety recommendations and develops action plans to improve workplace safety. The EOC has oversight responsibilities for life safety, environment of care, and emergency management regulations of the Centers for Medicare and Medicaid Services (CMS).

The EOC Committee is chaired by the Facilities Coordinator and membership consists of the Chief Operating Officer (COO), Facilities Coordination Office, Safety Office and representatives from Security, Infection Prevention, Quality Management, Consolidated Maintenance Operations, Medical Staff, Rehab Services, Nursing, Food Services, Environmental Services and Pharmacy.

5.3 Safety Bulletin Board

Western State Hospital has five physical bulletin boards and one electronic bulletin board that are specifically devoted to safety. The main bulletin board is located ***on the WSH intranet under Departments; Committees; Safety Committee*** where all employees have access. The locations of the 5 physical bulletin boards are:

PRTC East	***Building 28, 1st Floor Between East Campus Nursing Admin and East Campus Pharmacy***
CFS	***Building 29, 1st Floor Outside of CFS Nursing Admin***
PTRC Central	***Building 9, 3rd Floor Outside of Central Campus Nursing Admin.***
PTRC South & HMH	***Building 21, 2nd Floor, S-2 Outside of South Hall Nursing Admin.***
Safety Area	***Building 8, 1st Floor Next to Safety Office***

The bulletin boards contain the following OSHA required postings:

- Notice to Employees – If a job injury occurs (F242-191-000).
- Job Safety and Health Protection (F416-081-909).
- Your rights and a Non-Agricultural Worker (F700-074-000).
- OSHA 300A Summary of Work Related Injuries and Illnesses (required from February 1 through April 30 of each year).
- Safety Committee meeting minutes.

6.0 REPORTING AND RECORDKEEPING – INJURY, ILLNESS AND NEAR MISS

6.1 Employee Responsibilities

- Employees involved in an **on-the-job injury** must immediately report the incident to their supervisor and complete a current Injury/Illness Incident Report (DSHS 03-133A). Completed forms must be scanned and emailed or forwarded in the hospital mail to the Safety Office within three (3) working days of the injury or near miss.
- Employees involved in a **near-miss incident** must immediately report the incident to their supervisor and complete a WSH Form 1-100 "Administrative Report on Incident" (AROI).
- The Employee Report of Possible Client Assault (DSHS 03-391) form must be completed for all incidents resulting from a potential client assault as outlined in DSHS Administrative Policy 9.02 and attached to the Injury and Illness Incident Report.
- A Post Exposure Packet must be completed by employees in cases resulting in an exposure incident or blood borne pathogen exposure. This is defined as an eye, mouth, other mucous membrane, non-intact skin, or contacts with blood or other potentially infectious materials that results from the performance of an employee's duties.
- A Labor and Industry (L&I) Form 242-130-1111 is initiated at the healthcare provider's office, urgent care or emergency room when receiving medical or emergency treatment for a work-related incident/injury or exposure. The physician completes the form with the employee and mails a copy to Labor & Industries for processing.

6.2 Supervisor Responsibilities

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

Supervisor investigations must include:

- Gathering all necessary information.
- Recording the sequence of events.
- Listing all causative factors as they occur in the sequence of events.
- Interviewing and collecting statements from witnesses as indicated.
- Closely reviewing the employee's statement and description of the incident and identifying any discrepancies between employee's statement and actual findings.
- A determination based on the findings:
  (1) Unsafe Act
  (2) Unsafe Conditions
  (3) Unsafe Acts/Conditions

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

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

6.3 Safety Manager Responsibilities

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

The Safety Manager is responsible for posting a completed copy of the OSHA Summary for the previous year on the designated safety bulletin boards each February 1 until April 30. The Summary is kept on file for at least five years. Any employee can view an OSHA log upon request at any time during the year.

6.4 DSHS Enterprise Risk Management Office (ERMO) Responsibilities

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

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

ERMO provides data reports to the Employee Safety Committee on at least a monthly basis and prior to each meeting. In addition, WSH maintains a data base to analyze trends and a variety of associated variables. The committee reviews incident reports and ERMO data and may decide to conduct separate incident investigations and/or develop action plans as indicated.

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

Chief Executive Officer (CEO) or Designee Responsibilities:

1) The CEO or designee must report to the Department of Occupational Safety and Health (DOSH) within eight hours of becoming aware of a work-related incident that results in a fatality or inpatient hospitalization of any employee (unless it involves only observation or diagnostic testing).
2) The CEO or designee must report to DOSH within twenty-four hours of becoming aware of a work-related incident that results in either an amputation or the loss of an eye that does not require inpatient hospitalization.
3) The CEO or designee must report the following information to DOSH:
   a. The employer name, location and time of the incident.
   b. The number of employees involved and the extent of injuries or illness.
   c. A brief description of what happened and.
   d. The name and phone number of a contact person.

Staff Responsibilities:

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

Staff must not:

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

Staff must:

- Block off and secure the area. If in a room, the room must be closed and locked, and a guard posted. If in a common area, the area must be mark off with tape or ribbon and a guard posted.
- Keep unnecessary persons out of the area before and after securing the area.
- Record the names of persons who have entered the area during and after the incident.
- Record the names of persons who have witnessed the incident.
- Keep records of any items leaving the area before investigators arrive (e.g. clothing, bloody items, equipment and weapons).

6.6 Patient and Visitor Injuries

All patient and visitor injuries are reported to the Quality Management Department through the Administrative Report of Incident (AROI) System and reported to the Patient Care Quality Council Committee on a monthly basis.

7.0 HAZARD PREVENTION AND CONTROL

Western State Hospital policies and practices conform to State and Federal safety standards and rules for hazards or potential hazards in the workplace. Facilities are designed and equipment

chosen to eliminate or at a minimum, limit employee exposure to hazards. Work rules are written to effectively prevent or mitigate employee exposure to the hazard and employees are required to use personal protective equipment (PPE) such as safety glasses and hearing protection.

7.1 Statement of Conditions

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

7.2 Basic Safety Rules for Employees

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

- Always use safe work practices in performing duties including understanding and using proper lifting techniques, using personal protective equipment (PPE) when required, following safety warning signs and reading and following product labels.
- Manufacturer's instructions must be followed when using or operating equipment. Unsafe equipment must not be operated and equipment shall only be operated when trained and authorized. Supervisors must document training before an employee is considered competent to perform duties of the job.
- Unsafe work conditions, practices and hazard conditions must be immediately reported to supervisors and may be reported to safety committee representatives.
- Understand and follow the procedures for reporting accidents (section 7.0).
- Staff must comply with applicable collective bargaining agreements and DSHS Administrative Policy 18.75 Drug and Alcohol-Free Workplace.
- Firearms or explosives may not be on hospital property.
- Smoking inside the building or within 25 feet from any entry or ventilation intake is prohibited in accordance with DSHS Administrative Policy No. 18.65 and RCW 70.160.
- Refrain from behavior that is distracting to other employees.
- Maintain good housekeeping and keep emergency exits, aisles, walkways and working areas clear of slipping or tripping hazards. Replace all tools and supplies after use, and do not allow debris to accumulate where it will become a hazard. Clean up spills immediately.
- Refrain from horseplay, fighting and distracting fellow employees
- Know the location and use of:
    - First aid supplies
    - Emergency procedures (chemical, fire medical, etc.)

- Emergency telephone numbers
- Emergency exit and evacuation routes
- Firefighting equipment

7.3 Discipline for Failure to Follow Basic Safety Rules

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

7.4 Environment of Care (EOC) plans

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

- Fire Safety Management Plan
- Safety Management Plan
- Security Management Plan
- Hazardous Materials Management and Communication Plans
- Emergency Operations/COOP Plan
- Fire Safety Management Plan
- Chemical Hazard Communication Program
- Medical Equipment Plan
- Utility Systems Management Plan & Documentation

7.5 Equipment Maintenance

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

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

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

Interim Life Safety Measures (ILSM)

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

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

1. Construction activities (in or adjacent to all construction areas)

2. Temporary Life Safety Code deficiencies including but not limited to the following:
   a. Fire, smoke or sprinkler systems temporarily out of service
   b. Exit(s) blocked
   c. Access for emergency response team is blocked
   d. Fire walls/doors are breached
   e. Fire doors/windows are missing

Interim Life Safety Measures (as identified during planning phase)

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

Infection Control Risk Assessment (ICRA)

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

Job Hazard Analysis and Personal Protective Equipment

A Job Hazard Analysis (JHA) form is utilized to evaluate each type of job task employees perform. The JHA is completed by a supervisor and/or safety committee member along with an employee familiar with the task. The JHA defines the steps of the task, what hazards may be present during the task and what can be done to eliminate or protect workers from those hazards. Employees are trained if there are changes to current procedures or PPE.

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

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

8.0 HAZARD RECOGNITION AND REPORTING PROCEDURES

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

Supervisors must ensure that corrective measures are taken which may include completion of a work order or immediate correction of the hazard. If the employee or supervisor is unable to resolve the hazard, the Safety Manager must be notified and/or a WSH Internal Hazard Reporting form must be completed. Reports may be anonymous; however, providing a name and telephone number will assist in obtaining additional information that may be necessary to rectify the hazard and reporting corrective action(s) taken.

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

8.1 Environmental Safety Inspections

Western State Hospital is committed to identifying hazardous conditions and practices. In addition to reviewing injury records and investigating accidents for their causes, members of the EOC and Employee Safety committees along with management and supervisors regularly check the workplace for hazards.

Monthly environmental safety inspections are conducted by nursing staff prior to safety committee meetings. Safety Sub-Committees review the inspections at their monthly meetings to ensure hazards are identified and corrected and to make any additional recommendations.

Copies of the monthly inspections are sent to the Safety Office for review and monitoring. Nursing staff also conduct hourly environmental checks in all patient care areas.

In addition, members of the Environment of Care Committee and management staff inspect all patient and non-patient areas of the hospital bi-annually to evaluate staff safety knowledge and skill, observe current safety related practices and evaluate environment of care conditions. A qualified fire inspector conducts an annual wall to wall fire inspection of WSH, to include all tenant buildings.

8.2 Periodic Change Process

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

8.3 Proactive Risk Assessment

The Safety Manager, in coordination with hospital leadership, security, department managers, Consolidated Maintenance Office, and EOC/Employee Safety Committee members conducts comprehensive risk assessments to proactively evaluate risks associated with buildings, grounds, equipment, occupants, and internal physical systems that have the potential to impact the safety of patients, staff and visitors. Results of the risk assessment process are used to create new or revised safety policies and procedures, hazard surveillance elements, safety orientation and education programs or safety performance improvement standards.

Risks are prioritized to ensure appropriate controls are implemented to mitigate potential adverse impact on the safety and health of patients, staff and others. The prioritized risks are addressed immediately or integrated into planning objectives and performance improvement processes. Specific findings, recommendations, and opportunities for improvement are documented in EOC and Employee Safety Committee meeting minutes and reported to the Patient Care Quality Counsel (PCQC), Safety Committee and hospital Governing Body.

8.4 Annual Loss Control Evaluation (ALCE)

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

9.0 EMERGENCY PLANNING

9.1 Evacuation Maps

Evacuation maps for the facility are posted in all patient care and non-patient care buildings. Evacuation maps show the location of exits, fire alarm pull stations and fire extinguishers. Fire evacuation drills are conducted at least annually for all buildings and a quarterly drill is conducted in all patient care areas.

9.2 Hazard Vulnerability Analysis

A hazard vulnerability analysis (HVA) is completed to determine which hazards require special attention. The HVA provides a systematic approach to recognizing hazards that may affect demand for the hospitals services or its ability to provide those services. The risks associated with each hazard are analyzed to prioritize planning, mitigation, response and recovery activities. The hazard vulnerability analysis is evaluated annually, at a minimum, to assess the hospital's emergency management activities and to identify necessary changes, additional planning activities and specific exercise scenarios if required.

Contingency plans are developed as the result of a hazard vulnerability analysis and are designed to guide personnel in the initial stages of specific emergency situations that may seriously impact or threaten routine capabilities of the hospital. The HVA and emergency procedures are located in the Safety manual in the Emergency Operations Plan.

9.3 Response to Injuries

First aid supplies are maintained in all patient care locations. Injuries must be promptly reported to a supervisor. All direct care staff are required to have CPR training and other employees may also have CPR certification. In case of serious injury:

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

Procedures outlined in the Emergency Medical Response policy must be followed. To initiate an emergency medical response, employees call 2222, or 253-756-2692 or use a radio on channel 1 to report the location and nature of the emergency.

Code Blue is initiated for all cardiopulmonary arrests (no pulse and/or not breathing) involving a patient, staff person, or visitor.

Code Rapid Response Team is initiated when a patient, staff or visitor experiences a medical emergency other than cardiopulmonary arrest (i.e. person is responsive, breathing and moving) or a progressive deterioration in physical condition that requires immediate medical assessment. Examples include, but are not limited to, falling, fainting, seizures and symptoms associated with low blood pressure or hypoglycemia.

9.4 Infectious Disease Exposure Hazard

Infectious diseases are a risk with some job tasks at the facility. The Western State Hospital exposure control plan is designed to mitigate the risks of Bloodborne Pathogens and infectious diseases. All information regarding Bloodborne Pathogens and infectious diseases can be found on the WSH intranet under Departments; Infection Prevention & Control /Employee Health. Universal precautions, work policies, and PPE are covered under the plan as well as how to report any exposure to infectious diseases. All reports are kept confidential as required by HIPAA and other DOSH regulation.

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

The most frequent contagions employees can expected to be exposed to in the course of their daily official duties are common infectious agents that include the common cold and influenza. Depending on the specific strain, these annually occurring contagions can have the greatest impact on WSH 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 WSH have little potential for exposure to extreme infectious diseases such as Viral Hemorrhagic Fever (Ebola). Possible staff introduction to these more fervent contagions in the course of performing routine work is extremely remote. The most likely means of any sort of exposure would be through some form of second or third-hand contact with the general public (e.g., exposure to a patient or staff member who has a family member who may have been exposed to a contagion). Employees should review the Washington State Department of Health website for the most current and factual information available.

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

10.0 SAFETY AND HEALTH TRAINING AND EDUCATION

10.1 Safety Training

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

10.2 Basic Orientation

On the first day of hire, and annually or as required by job class and training type, employees are required to attend New Employee Orientation (NEO) that includes all OSHA required Safety, Accident Prevention, Workplace Violence prevention, Infection Control and other required training. Training includes procedural knowledge regarding practices, policies, procedures, use and maintenance of personal protective equipment, behavioral intervention techniques, safe operation of equipment and emergency management and response plans. All training curriculum is maintained by the WSH Staff Development Department.

10.3 Orientation for Clinical and Nursing Staff

Upon completion of the basic NEO, clinical and nursing staff completes additional training, utilizing a Competency Based Evaluation Tool, related to working with people with mental

illness, violence prevention, safety policies specific to patient care, and advanced skills in managing escalating situations with patients.

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

10.4 Site-Specific Training for CMO and CIBS

CMO and CIBS staff receives site-specific training prior to working at the facility e.g. TEAM.

11.0 WORKPLACE VIOLENCE PREVENTION

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

Prevention of workplace violence is based on principles of:

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

11.1 Definition of Workplace Violence

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

11.2 Workplace Safety and Security Assessment

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

a) Physical attributes including access control, egress control, door locks, lighting and alarm systems
b) Staffing including security staffing
c) Personnel policies
d) First aid and emergency procedures
e) Reporting violent acts, taking appropriate actions in response to violent acts and follow-up procedures after violent acts
f) Development of criteria for determining and reporting verbal threats,
g) Employee education and training; and

h) Clinical and patient policies and procedures including those related to smoking, activity, leisure and therapeutic programs; communication between shifts; and restraint and seclusion.

11.3 Risk Assessment and Treatment Planning

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

Effective patient care requires accurate analysis of behavior and consideration of the patient's predisposing and co-existing conditions, circumstances and vulnerabilities that increase the potential for maladaptive behavior. Vulnerabilities can be episodic (e.g. specific triggers or stressors), short-term (e.g. sleep patterns), long-term or permanent in nature such as developmental disorders, type of mental illness, substance abuse or side-effects of medication.

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

11.4 Special Population Considerations

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

- Geriatric
- Forensic
- Children and Adolescents
- Developmental Disabilities
- Civil commitments,
- Habilitative Mental Health
- Co-occurring diagnoses

11.5 Effective Patient Care

Preventing and constructively addressing with unsafe and violent behavior is a priority for patient care and leads to a safe work environment. 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.

Western State Hospital conducts team debriefings of incidents of seclusion, restraint and assaults and conducts post-incident and inter-shift meetings to support staff as well as identify effective interventions and opportunities for improved awareness or skill

development. Effective team process and communication is essential to managing an environment with inherent risks for disruption.

11.6 Administrative and Engineering Controls, Work Practices, Security

Western 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

Western State Hospital establishes clear lines of authority and responsibilities, requires annual competency assessment, review of policies and procedure and annual safety training. Direct access to Leadership is available to express concerns or advise of safety risks. Controls include:

- DSHS Policy 18.67 Workplace and Domestic Violence.
- Prohibition of actual or potential weapons on campus grounds.
- State-of-the-art patient behavior intervention program and non-violent crisis response that include verbal and physical de-escalation techniques and training in team communication.

11.6.2 Environmental Controls

Environmental controls include:

- Entrance security (locks)
- A system of visitor or contractor access control
- Identification badges worn by all Eastern State Hospital employees, contractors and visitors
- Alarm systems on the units
- Strategically placed convex mirrors for heightened visibility
- Hand held radios carried by direct care staff
- Closed circuit vide
- 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 Psychiatric Security Attendants (PSA), Registered Nurses (RN), Psychiatric Social Workers (PSW), Psychology Associates (PA) and a Supervisor are trained in crisis intervention skills, incident management skills, analysis of the antecedents for violence and aggression, and de-escalation techniques.

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

volatile patient treatment units throughout the hospital. PERT is not included in the staffing count.

11.6.4 Security

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

11.7 Support to Employees

Victims of workplace violence may suffer a variety of consequences that may include physical injury, psychological trauma, reduced confidence, and concerns about returning to work. All employees injured at work have access to first aid measures and emergency medical response. In the event that an employee sustains a more serious injury, the supervisor assists the employee to obtain additional medical attention if indicated.

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

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

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

11.9 Training to Reduce Workplace Violence

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

Western State Hospital utilizes TEAM, an evidence based training, that provides staff with the tools to keep themselves and patients safe while maintaining their commitment to positive approaches in serving patients whose behavior(s) may pose a danger to themselves or others. The program identifies how to provide services and support in a manner that does not promote patient need to resort to aggression or violence in order to participate in treatment, to be heard or to get his/her needs met.

11.10 Data and Surveys Addressing Workplace Violence

Data Review:

Workplace violence is tracked utilizing incident data bases. Administrative forms (DSHS 03-133 Injury and Illness Incident Report and WSH Administrative Report of Incidents (AROI) are used to document assaults and are reviewed by leadership in daily morning meetings.

Western State Hospital tracks workplace injuries due to assault in the RiskMaster data base maintained by ERMO. 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 Employee Safety Sub-Committee meetings and reported quarterly to the Patient Care Quality Council committee and Governing Body meetings.

Workplace Safety Surveys:

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

12.0 WORKPLACE SAFETY GOALS AND PERFORANCE IMPROVEMENT (PI)

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 Safety Committee minutes.

The EOC Committee is responsible for EOC PI initiatives that are based are priorities identified by the EOC committee through evaluation of risks associated with safety security, utility systems, medical equipment, fire safety and hazardous materials. PI initiatives and activities are documented in the EOC Committee Minutes.

The PCQC is responsible for approving the workplace safety goals and PI initiatives brought forward from these committees, including performance measurements. Activities and progress related to safety goals and PI initiatives are reported monthly to the Employee Safety Committee and or EOC Committee and provided to the PCQC quarterly.

13.0 WORKPLACE SAFETY PLAN – ANNUAL EVALUATION

The Safety Manager, Safety Committee and EOC Committee evaluate 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 Employee Safety Committee, EOC Committee and PCQC.

Western State Hospital

Appendix A: Workplace Safety Plan - Security and Safety Assessment

March, 2017

RCW 72.23.400 requires each state hospital to develop a Workplace Safety Plan (Plan) to reasonably prevent and protect employees from violence at the state hospitals. The Plan must address security and safety considerations specified 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(1)	Assessment	Preventative Action(s)
(a) The physical attributes of the state hospital including: 1. Access control 2. Egress control 3. Door locks	In FY 17, a Security Assessment what was done by Department Of Corrections and newly hired Chief of Safety & Security to assess current WSH security policies procedures/protocols and identify areas of improvement with regard to the physical attributes of the hospital to include access and egress control, and door locks. The following results were found: **Access/Egress:** Difficult to identify all authorized personnel within the facility since not everyone is wearing a badge. There are occurrences of stolen, misplaced, lost or not turned in employee identification badges and/or keys assigned to individual employees. Keys belonging to staff outside of CFS can be taken off of key rings adding to the potential of lost keys.	New policies have been established and are under development to address access authorization (badging), access control, who can enter the secured area with credentials, and locking mechanisms. Currently, two policies have been completed: 13.03 Key Control, and 13.01 Identification Badges (See policy section c below for more details). **Access/Egress:** • Badging processes were added that require badges to be worn by all persons entering the facility. This includes Staff Volunteer's and contractors.) • A project to add facility access controlled doors (13) to outside entry doors into the facility were initiated and are underway. Staff would swipe their badge for entry into the facility. This project is currently in design phase, construction is anticipated to start late May of 2017. • Continued upgrade and expansion of the Key Watcher system in non-CFS areas to ensure staff keys are secured at the facility. Phase 2 and 3 are anticipated to be completed by the end of 2017, this will expand the system for use in over 50% of all hospital occupied areas. • Key rings throughout the hospital with locking key hubs continue to be replaced and have increased from approximately 50% last year, to 85% this year. This locking device ensures that keys cannot be taken off of the rings and lost. The hospital will continue to replace locking devices

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
	One common key allows access in and out of facility.	for keys over the next year. **Door Locks:** • A systematic change out occurred with the locking systems of all doors to add a two-step delay for exiting and entering buildings and fenced areas throughout campus. All previously used locking systems were changed in a manner that requires the use of two different keys to exit any building/fence area (Completed September 30, 2016).
(a) The physical attributes of the state hospital including: 4. Lighting & Pedestrian safety	In FY 17, a Security Assessment revealed improvement with lighting in the quadrangle area was needed to reduce the likelihood of undetected violence in patient areas. Additional lighting is needed in the central quadrangle area to enhance line of sight visibility. Additional paving is needed in some parking lots, as well as additional sidewalks and lighting improvements needed to improve pedestrian safety.	• Lighting was installed on the Steam Tunnel Access port building in the quadrangle area to assist with visibility within the area. (Completed January 2017). • Pedestrian safety for parking lot, sidewalk and lighting enhancements are anticipated to begin between April – May of 2017. This project includes the additional lighting to central quadrangle to enhance line of site visibility, adds paving to parking areas east of the quadrangle and some sidewalk addition to campus to permit safe traveling of staff while on campus.
(a) The physical attributes of the state hospital including: 5. Alarm systems	An assessment conducted by the Facilities Department has determined that the Fire Alarm Systems in Buildings 9, 20 & 21 exceeded their useful life and need replacing. The Personal Alarm/Duress System is not installed in all patient care areas and other priority outside locations to ensure staff can be located easily in emergencies.	• Installation of new Fire Alarm Systems for Buildings 09 and 20 is presently in construction phase. Completion time is anticipated to be June of 2017. Construction Phase of Building 21 is anticipated to begin Fall of 2017 and completion in early 2018. • Expansion of the Personal Alarm System to Buildings 10, 15, 16, 24, 25 and priority exterior parking lots is currently in construction phase and the installation is anticipated to be completed May of 2017.
(a) The physical attributes of the state hospital including: 6. Anti-ligature improvements	**Environmental:** A comprehensive Environmental Proactive Risk Assessment is completed annually by the Environment of Care Committee to identify all known physical plant deficiencies and problems determined to present a threat of	**Environmental Proactive Risk Assessment Anti-ligature Improvements:** The following is the status of anti-ligature improvement projects: **Anti-ligature improvements:** • Plumbing fixtures replaced with anti-ligature type to include faucets, bathtubs, showers, and valves

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
	physical injury to persons; damage to property, or a threat to general safety and associated risk. Through these assessments it was determined plumbing fixtures, valves, shrouding of exposed pipe, bathroom partitions, vanity mirrors, shower seating and door top alarms were high risks for patients. The hospital has capital projects in various stages of completion to mitigate these risks.	in all patient care areas as well as shrouding of exposed pipes and plumbing (95% Complete) • Anti-ligature bathroom partition renovations will begin early March of 2017, starting with a pilot model in building 20 and to be followed by all other multi-toilet partition patient bathroom hospital wide. Full campus wide completion is estimated to occur by the end of 2017. • Patient safety vanity mirror replacement is currently 90% complete. • Shower seating in patient shower rooms that present ligature points need to be removed campus-wide. Removal or patient shower seating is anticipated to occur in late March 2017. • Door Top Alarms – In design phase
(a) The physical attributes of the state hospital including: 7. Additional Security Improvements	In FY 16, a Security Assessment revealed improvements were needed in the following areas to ensure a more secure environment: • The hospital is unable to monitor central secured Quadrangle area for safety & security of patents and staff. • Unable to monitor all areas of CFS on Viacom Camera System. • Bldg. 17 elevator could possibly be assessed by unauthorized visitors into Bldg. 17. • The Communication center lobby could possibly be accessed by patients while being transported by staff from their home ward to treatment mall which could lead to a potential escape.	• Installation of the Viacom Camera System in the central secure Quadrangle is presently in Design Phase. • Expansion of the CFS (Center for Forensic Services) Viacom Camera System in 8 locations is presently in Design Phase. • Elevator in building 17 will be modified to require a key to access certain floors to enhance patient and staff safety during evening and weekend hours. This project mitigates the potential for unauthorized visitors to enter building 17. • Building 18 wall installation project in the communications center lobby to prevent possible patient escape attempts is anticipated to begin in August of 2017.
(a) The physical attributes of the state hospital including: 7. Safety	**Other Ward Safety Improvements Identified:** Medication Room Temperatures are at times outside of the allowable limits.	**<u>WSH Safety Improvements:</u>** **<u>Ward Safety Improvements:</u>** • Medication room temperature control HVAC units are in the process of being replaced throughout campus in buildings 17,19,20,21 and 29. This project assures medication room temperature

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
Improvements		stays with-in allowable limits to preserve patient pharmaceuticals. Construction is underway and anticipated to be completed by May of 2017.
	Refrigerators Temperatures for patient use are not always consistently checked/monitored for required temperature range.	• Refrigeration temperature monitoring project through-out campus on all refrigerators which store patient consumed food, medication or other related use. This project is currently in design phase and is anticipated to begin late April 2017.
	More hand washing/sanitizer stations are needed in patient care areas to help reduce the risk of infectious diseases.	• Vandal resistant hand sanitizers will be added through-out campus in common patient areas to reduce the risk of infectious disease, equipment and material has been selected and approved for use. The pilot model is on order; campus wide construction installation is anticipated to begin in March of 2017. • Hand washing sinks will be added to the day rooms in CFS wards F1 – F8 to permit staff the ability to wash their hands prior to engaging in patient treatment with-out re-contaminated their hands by touching a bathroom door handle. Currently in design phase, anticipated construction to start late March of 2017.
	Tub room on Ward F5 is not adequate to meet the needs of the high risk patient population in its' existing condition.	• Tub replacement and tub room renovations to occur on Ward F5, construction is anticipated to begin March of 2017. Ward F5 has multiple patients requiring staff assisted bathing, the room and tub in their existing condition is not adequate to meet the needs of the population.
	E7 &E8 Shower Room needs renovation.	• Shower room renovations for one shower room on Ward E7 and E8. Currently in CD phase and is anticipated to begin construction late March of 2017. • Ward F1 and F2 patient door vision panel replacement with the anti-ligature, vandal resistant duralux panel. This allowed the vision panels to be lowered to allow shorter staff to safely conduct census and 1:1 monitoring. This project has been completed. • Other Vision panel replacement in doors and multiple door replacement projects are anticipated to continue throughout the remaining campus. Some ward based and patient doors are planned for replacement while others will have the vision panels replaced to assure patient privacy while

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
		promoting staff safety to conduct census and 1:1 monitoring. This project is currently in design phase; construction is anticipated to begin late April of 2017. • Civil Patient Group Room and Forensic Patient TV Room ceiling enhancements project is currently in design phase and will replace suspended, dropped ceilings in two rooms per ward throughout campus in order to ensure patients do not have easy access to area due to high risk patient population housed on these wards. This project is anticipated to begin construction for the pilot model in March of 2017 on ward C1. The next construction phase is anticipated to begin late April of 2017 and continue on through-out mid to late 2017. **Off Ward Patient Area Improvements:** • New building construction for the patient supporting services center (Kitchen, Commissary, Pharmacy, Central Supply) is anticipated to break ground during the spring of 2017, this project is currently in CD (construction documents) phase. Contractor selection to occur upon completion of the CD with approval from the local authorities with jurisdiction. • Quadrangle fence pedestrian door enhancements and fencing addition to building 16 is currently in design phase. These enhancements further support and promote a safer environment for both patients and staff. • Beauty & Barber shop relocation project will permit patients to use this facility from within the secure quadrangle while segregating access to the Art Center and Infinity Center. Walls are planned to be constructed to enhance safe patient access to existing and future space within this building. This project is currently in design phase and is anticipated to begin construction early March of 2017. **Hospital Building Improvements:** • Elevator Modernizations: One elevator in building 18 and [a pair of two elevators are planned for modernization; design phase has been completed, anticipated completion by the end of 2017. • Building 06 asbestos abatement and shrouding project removes asbestos pipe wrapping and asbestos laden ceiling material in the Art Center.

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
		Shrouding of existing overhead steam pipes will occur to remove ligature points in supervised locations. • Bld. 10 Boiler Project; underground steam lines failed which resulted in the failure of the buildings heating system. A stand along boiler system was installed and is building heat was restored. This project was completed in 2016.
(a) The physical attributes of the state hospital including: 8. Refresh & Remodel Improvements	Through the annual physical comprehensive Environmental Proactive Risk Assessment and other individual assessments many Ward Remodel and Refresh projects were identified and Capital Funds Procured to ensure a safety environment for patients and staff. (See list of items to the right) These capital projects are currently in various stages of completion.	• CMO Ward Refresh project is currently underway and will be ongoing throughout the month of April of 2017. Ward C3 and S8 are the next two wards which will receive painting, wall and ceiling surface refreshes. 4 wards have been completed since the project began in October of 2017. • East Campus and South Hall Renovation Project is currently in contractor selection phase. This project is anticipated to begin in late April of 2017. Large scale renovations are included in this project with include but are not limited to; Fire Alarm System replacement in building 21, wall and ceiling surface replacement on 10 wards (5 wards in Bld. 29 & 5 wards in Bld. 21), HVAC roof top unit replacement, duct replacements, etc. This project is anticipated to last throughout 2017 and be completed early 2018. •
(b) Staffing, including security staffing	**Nursing:** Additional nursing staff is needed to across all 3 shifts hospital-wide to cover for staff leave time (annual leave, sick leave, L&I, FMLA) and staff training. Civil PERT requires additional staff to ensure adequate coverage throughout PTRC. Centralized ward management is needed to coordinate ward operations, administration and patient care. **PICU:**	**Nursing**: To improve staffing coverage, the following was accomplished: • Recruited 51 permanent additional nurses to provide at least 2 RNs scheduled on every ward every shift. • Every center assigned a Float RN and LPN on days and swings. • On-Call positions were converted to Ward Relief Positions as non-perm positions to ensure coverage. **PERT**: Three additional PERT Team staff members were added to provide additional coverage to respond to psychiatric emergencies throughout PTRC. Twenty nine Ward Administrators were hired to provide centralized leadership to ensure all disciplines coordinate and collaborate for effective treatment planning and a safe working environment. **PICU:**

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
	Staff for WSH PICU (11) are needed. **Other Direct Care Staff:** Additional staff in environmental services staff (31), food services (34) and Environment of Care (2) are also needed to contribute to a safe work environment. **Consolidated Maintenance Operations (CMO) staff:** Additional CMO staff is needed to remove ligature risks (10) and (5) to accompany contractors on the wards while they are performing their construction activities. **Emergency Management Staff:** Emergency Management staff (2), are needed to ensure the hospital is in compliance with CMS Emergency Management requirements. **Security Staff:** A security assessment was conducted by Chief of Safety & Security in July of 2016. The results of the security assessment resulted in the request for additional security staffing to reduce the amount of violence, improve overall operational security and improve security response times hospital wide. **Violence Reduction Staff:** Violence Reduction staff are needed to provide assist the hospital in the reduction of violence.	10 IC3 positions and 1 director to staff the WSH PICU for highly aggressive patients. **Other Direct Care Staff:** Facility Planner 2 (2), were hired to conduct environment of care rounds looking for safety issues and ensuring work orders get completed. 31 additional Environment of Care staff were hired to cover swing and night shift. 34 additional Food aides were hired to ensure that all wards have assigned food aides for every meal contributing to a safe work environment. **Consolidated Maintenance Operations (CMO) staff:** Additional CMO staff is required to mitigate the current list of ligature risks hospital wide. 10 additional CMO staff were hired to remove ligature risks, and 5security/maintenance staff were hired to accompany contractors on the wards doing construction work to manage tools and provide site security while trades staff complete work orders in patient areas. **Emergency Management Staff:** A Director of Emergency Management position was added July 5, 2016. Hired a second Emergency Management Specialist November 1, 2016 Hire of an Executive level Chief of Safety and Security was approved. The position was hired permanently on January 1, 2017 Hiring of 27 SG2's has been approved and recruitment is underway Hiring of 3 additional SG3' has been approved and recruitment is underway. **Violence Reduction Staff:** Hire of a Violence Reduction Administrator is approved and in process to assist staff with technical expertise and coaching on best practices as well as conducting initial investigations after serious assaults

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
	Active Treatment Staff: 30 additional IC3's to provide Active Treatment and Recreational and Leisure activities to the ward across day and swing shift 7 days a week.	and analyzing data on violent episodes. Hire an employee safety concerns program manager to provide support to those believing that they have a safety concern that needs addressed. **Active Treatment Staff:** 30 additional IC3 to provide active treatment and leisure activities on ward 7 days a week contributing to the overall safety of the ward.
(c) Personnel policies	WSH policies are difficult to find and not always easily understood.	WSH is working to establish a policy manual that is user friendly that will include easy to find and easy to read policies. All WSH policies are in the process of being "plain talked" . In addition, a new policy manual has been developed that will assist staff in easily locating policies. The new policy chapters include: 1. Administrative Services 2. Admission and Discharge 3. Employees 4. Environment of Care and Facilities 5. Financial 6. Health Services 7. Incident Management 8. Patient Care 9. Patient Records 10. Patient rights 11. Campus Services 12. Safety 13. Security These chapters are designed to facilitate WSH employees being able to look for a policy intuitively. The new manual goes live on 2.14.17. WSH estimates all policies will be plain talked by the end of 2017.
(c) Personnel policies	One existing safety policy needed to be plain talked, and 3 new safety & security policies were established to enhance the safety and security throughout campus. These new policies added guidelines for immediate identification of staff, maintaining security around hospital keys and providing more frequent security inspections of the environment for safety and security purposes.	1.9.2 Fire Safety and Evacuation combined the 1.9.2 Fire and Evacuation Drills and 1.9.3 Fire Marshall policies. The policy was plain talked but the process was not changed. 13.03 Key Control is a new policy the Chief of Safety and Security has implemented to ensure a process to maintain security arounds hospital keys. 13.01 Identification Badges is a new policy the Chief of Safety and Security has implemented to provide guidelines for immediate identification of staff ensuring safety.

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
		13.03 Security Inspections is a new policy the Chief of Safety and Security has implemented to provide more frequent security inspections of the environment for safety & security purposes.
(c) Personnel policies: including Standard Operating Procedures	In FY17 a Security Assessment was done and as a result, all Standard Operating Procedures (SOP's) for Security were reviewed and updated. Nineteen new SOP's (listed to the right) for Security were added for staff to follow to ensure Security responds to situations throughout campus in a safe and consistent manner. In addition, post orders were developed to provide information who to call during an emergency.	The following new SOP's were developed and/ or updated to ensure a more secure environment: • SOP 8- Response and Movement • SOP 9 Campus Patrol • SOP 17 Assistance Calls • SOP 32- Searches • SOP 38 Patrol Log sheet • SOP 40 E-1 and E2 Operations • SOP 42 CSTC Assistance • SOP 43 Quadrangle Duties • SOP 46 Safety Procedures for Ice and Snow Roads/Walkway Conditions on WSH Campus • SOP 47 MNC Keys • SOP 48 Security Officer Training • SOP 49 Emergency Response • SOP 50 Central Ward Security • SOP 51 South Ward Security • SOP 52 East Ward Security • SOP 53 Logbook Maintenance • SOP 55 Emergency Key Sets • SOP 56 Alleged Patient Abuse or Neglect- Hotline Follow-up dispatch • SOP 57 Mail Room Duty • Post orders provide information regarding who to call during an emergency, emergency procedures, how to open a post, how to close a post and how to operate in the post. This provides the person in the post a clear picture of how to respond, react, or operate during standard operations.
(d) First aid and emergency	**Emergency Operations and Response:** Through self-evaluation by emergency management team, it was determined that overall the hospitals meets the minimum requirements set by FEMA and the Centers for Medicare & Medicaid Services (CMS) with regard to emergency management.	WSH continues to participate and plan with our community partners for potential emergencies based upon the Hazard Vulnerability Assessments (HVA) of the hospital and our community partners. These partnerships include (DSHS/ Office of Emergency Management Office, King & Pierce County Northwest Healthcare Response Network Coalition, Pierce County Department of Emergency Management, Tacoma Pierce County Health Department, and the City of Lakewood Emergency Management Committee. The following was completed with regard to Emergency Management in FY 17: • Reviewed Comprehensive Emergency Management

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
		Plan. The 2016 version is currently posted on the intranet. Changes and updates will be made after CMS SIA survey, Spring of 2017. • Updated the hospital order of succession. • Updated the Administrator on Duty Manual, working draft issued January 2017. • Developed training curriculum and emergency checklists for Communications Center operators. Starts March 1, 2017. • Coordinating the Critical Incident Stress Management team, start-up, training and response. • Attend local Emergency Management Committee for the city of Lakewood • Facilitated emergency key sets are available for approved staff The hospital also participates in community-wide drills and/or has real events that occur which provide the hospital with learning opportunities for being prepared in the future when incidents/disasters occur A plan of improvement is developed for all identified deficiencies. A minimum of 2 drills and/or real events are required annually per FEMA the CMS. In FY 2017, WSH participated in the following tabletops exercises, Exercises, Workshops and/or real events: • Conducted an executive level tabletop exercise using ICS July 2016. • Conducted a tabletop workshop with the Military Department, DSHS HQ and community partners regarding the PBX (communication) failure mitigation and response November 30, 2016. • Conducted a full-scale, hospital wide active shooter exercise with Lakewood Police, December 7, 2016. • Facilitated Hospital Incident Command Center operations for Legionella precautions for approximately 2 weeks in January 2017. • Developed after action reports and lessons learned from the November 30, 2016 fire, January 2, 2017 suicide attempt and the Legionella event For the rest of 2017, the hospital is working on developing emergency exercises for: • Escape Response with local police • Patient surge exercise with Northwest Health Care Alliance
(e) Reporting violent acts, taking appropriate	The hospital has many avenues methods for staff to report violent acts and several Departments, teams/committees to ensure	In FY 16 the Near Miss Performance Improvement Project (NM PIP) was initiated to improve the current Administrative Report of incident process. Last years' annual update outlined what was completed with

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
action in response to violent acts, and follow-up procedures after violent acts:	appropriate actions and follow-up procedures are taken in response to violent acts. In FY17 Patient Care Quality Committee (PCQC) approved the Near Miss Performance Improvement Project (NM PIP) to improve the current Administrative Report Of Incident (AROI) process and related policies to ensure staff can effectively and efficiently report all critical information with regard to patient/staff safety events.	regard to this PIP in FY16. In FY 2017, the NM PIP completed the following: • Revision of the AROI form to better capture patient-level and environmental factors • Created and tested an electronic reporting system for the AROIs • Developed training for the new system • In the remainder of FY 2017, the NM PIP will: • Train staff on the new system • Implement the new system • Begin to analyze patient-level factors now being collected with the new system
(e) Reporting violent acts, Analysis of data on violence and workers compensation claims during at least the preceding year	Critical Risk Management Team continues to review violent acts on a daily basis and follows up on any safety concerns. WSH's Safety Committees (monthly) continue to review injury data and L&I claims information on a monthly basis to identify where the injuries are occurring and helps formulate prevention recommendations. Data is also captured and presented to Safety Committee (Monthly), and Patient Care Quality Counsel (PCQC) (Quarterly) on an on-going basis. In FY17, the Patient to Staff Performance Improvement Project (PS PIP), analyzed the assault data and found that a small percent of the patient population assaulted multiple times. The PS PIP recommended a PICU be established at WSH to help stabilize these patients. The Violence Reduction Administrator has been hired and a Violence Reduction Work Team has been formed.	In FY17, the Patient to Staff Performance Improvement Project (PS PIP) analyzed the hospital assault data and identified that nearly 30% of the violence at WSH was created by 7 patients. Based upon the results found, the PS PIP recommended that the hospital establish a Psychiatric Intensive Care Unit (PICU) at WSH. WSH Psychiatric Intensive Care Unit is anticipated to open in mid-2017 with the goal of serving high risk patients who are not thriving on the ward due to aggressive behaviors. The goal of the PICU is to stabilize the patient and return them to the ward of origin to begin normal activities, and to reduce acting out behaviors to self, others, or property. The PICU will implement the most effective treatment to reinforce recovery. The PICU will have no more than 15 patients and a length of stay of no more than 60 days. A violence reduction Administrator has been hired at the hospital and a Violence Reduction Team made up of multi disciplines throughout the hospital has been formed to review all assault data and make recommendations for prevention. Additionally, the hospital is currently in the process of adding assault data review annually by the Violence Reduction Workgroup to the WSH Safety Policy 12.01 and report finding to the Safety Committee.
(f) Development of criteria for determining	Criteria has been identified within the Administrative Incident Reporting policy for reporting verbal	Verbal threats continue to be tracked using the Security Incident report and/or the Administrative Report of Incident and reviewed in the Critical Risk

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
and reporting verbal threats.	threats.	Management Office to ensure appropriate actions and follow-up procedures are taken in response to verbal threats. The creation of a new electronic AROI reporting system and revision of the AROI form to better capture patient-level and environmental factors will assist with analysis of patient-level factors now being collected with the new system.
(g) Employee Education and Training	FY17education and training provided to employees needs continued improvement. A staff education team has been formed and a curriculum review board established to review all training and revise as necessary.	Since July 2016, Center for Organizational Development has completed the following: • Created the Center for Organizational Development with an evolving infrastructure to support over 2000 employees. • Hired a new Instructional Effectiveness Administrator to lead instructor development and adult learning curriculum. • Hired a new Instructional Effectiveness Administrator, who is a certified Master Instructor with the Washington State Criminal Justice Training Commission to lead safety and intervention training. • In the process of hiring 12 new Nurse Educators to provide ward based education and training across shifts. Currently, four new Educators have been hired and are engaged in training. • Nurse Educators, Instructors, and Mentors are receiving training to effectively engage employees, reduce resistance, and build upon strengths. • Creating and revising all subject courses for New Employee Orientation and refresher training; to include competency evaluation. • Created a Multi-Disciplinary Curriculum Review Board to assess and approve new and updated curriculum courses. • Completed surveys of employee training needs. • Reviewed multiple evidence based safety and intervention curriculums. • Recruiting and hiring a Safety and Intervention Manager • Trained 760 new employees in New Employee Orientation and 1,364 staff in Modules 1 & 2 of the Enhanced Safety Training. • Changes have been made to the Patient Interaction Training (Formerly TEAM) to include portions of the

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
		physical training.
(h) Clinical and patient policies and procedures including those related to: 1. Smoking	Due to a Fire that occurred on a ward on November 3, 2016, it was determined that patients would no longer be allowed to have lighters in their outside smoke boxes to light their cigarettes. Some patients were able to bring them back into the environment which caused this particular fire.	Due to this incident the hospital did the following to ensure this type of contraband no longer is introduced into the environment. • Lighters were confiscated by security and safety in all smoke boxes. • Outside lighting stations were fixed to ensure patients had the ability to light their cigarettes and additional handicap stations were installed. • Weekly searches by Security of smoke boxes occur looking for lighters and other contraband. • All staff were provided an in-service again regarding how to wand patients when they return from grounds privileges.
(h) Clinical and patient policies and procedures including those related to: 2. Activity, leisure and therapeutic programs	CMS cited WSH for not providing: • Evening and weekend active treatment for our patients • Weekday active treatment for patients refusing to attend or not appropriate for the Treatment Mall. To assist with reducing aggression on the wards, the Ad-hoc Workplace Safety Committee recommended PERT be expanded to the Civil wards.	WSH has improved active treatment and leisure programs on the wards to provide patients more meaningful and recovery-oriented activities by hiring additional recreational staff. In FY 16, 30 additional Institutional Counselors 3's were hired permanently to provide additional active Treatment and Leisure activities on the wards on the weekends and during evening. In FY17, an additional 30 Institutional Counselor 3's have been hired to ensure that all wards have staff available to provide active treatment to patients who are refusing or not appropriate to attend the treatment mall. All PTRC and CFS wards will receive one rehabilitation staff assigned to their ward 7 days a week to assist with engaging patients in active treatment, providing on ward group activities and joining other rehab staff to offer larger activities in the Recovery Centers. They will work 4 ten hours days (Approximately 9:30 am – 8:00 pm with their days off during the week. This will allow these Specialists to be available across shifts to provide a multitude of activities for the wards on Day and Evening shift. In FY 16 PERT was expanded to the Civil Wards to include PTRC East. PERT team members are: • Taking a proactive approach in reducing patient aggressive behaviors by making continued rounds on wards to engage patients before they reach their peak of aggression and acting out behaviors. The goal being to assist patients to self-regulate their behaviors.

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
		• Participating in treatment team conferences to discuss and review difficult cases. • Is providing training to all the 1:1 monitoring staff to ensure situational awareness and safety of staff and patients.
(h) Clinical and patient policies and procedures including those related to: 3. Communication between shifts	Communication between shifts was improved in FY15 and the process still being following and continues to be effective.	**Communication between shifts**: All staff who are not present and change of shift report must read report and sign that they have done so. In addition, new staff are required to be orientated to the ward by reading the report and signing that they understand the report.
(h) Clinical and patient policies and procedures including those related to: 4. Restraint and seclusion	**Seclusion and Restraint:** WSH continues to place a major focus to reduce the use of seclusion and restraint. The Seclusion and Restraint Hospital Performance Improvement Project that began in FY16 resulted in new procedures that continue to be implemented in FY17.	In FY 16, WSH began a Patient Seclusion & Restraint Hospital Performance Improvement Project to reduce the use of seclusion and restraint. Roll out of the new S/R process continues FY17 The Pilot wards for the new Seclusion/Restraint process was successful and is now complete. Training for the new seclusion and restraint procedure is in the process of expanding to the rest of the hospital. The following has been completed: • Nursing standards were revised to place a stronger emphasis on utilizing Least Restrictive Options and only using seclusion and restraints as a last resort. • Seclusion and Restraint documentation was revised to allow for ease of documentation to determine if the patient has met release criteria. • Policies/procedures were implemented to assess any patient who is in restraint or seclusion over 4 hours. • A stronger emphasis placed on conducting debriefing after a seclusion and restraint to allow for improvement and discuss safety concern. • Changed Restraint orders to be only written to specify a specific time of restraint. No longer can the physician write an order that reads "up to 4 hours" of restraint/seclusion. • A Seclusion Restraint Checklist was developed to ensure each episode of seclusion or restraint complies with requirement of hospital and nursing policies and procedures. • Communication has been sent to all clinical staff to

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
		re-advise them on the requirement for updating the treatment plan within 48 hours after an episode of S/R. • Training has begun on Trauma Informed Care to review what the meaning of Trauma Informed Care is and how secluding or restraining patients may re-traumatize the patient and impact their ability to self-regulate their behavior. • Staff reeducation on S/R policy and procedure began in January 2017.