Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES	FINAL August 2016		
Chapter:	**Western State Hospital Safety & Health**		
Policy:	**Workplace Safety Plan/Accident Prevention Program**		
Authorizing Sources:	**WAC 296-800-140**		
Effective Date:	**May 1, 2014**	Revised Date:	**August 22, 2016**
Approved by:	Chief Executive Officer		Date: 8/22/16

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1.0 PURPOSE:

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

2.0 AUTHORITY:

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

The 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.

3.0 SCOPE:

- Workplace Safety Plan: Applicable to all WSH staff, including contract and support services employees, (i.e. Consolidated Maintenance Operations, Central Institutional Business Services, etc.), interns, students and volunteers and includes prevention of risk related to the environment and provision of patient care.
- Accident Prevention Program (APP): Applicable to all WSH staff including support services employees, (i.e. Consolidated Maintenance Operations, Central Institutional Business Services, etc.) and encompasses any accidents, threats or acts of violence that may result in emotional or physical injury or otherwise places one's safety and productivity at risk. This includes supporting employees who are victims of domestic violence when requested, and assisting employees to access the Employee Assistance Program for counseling and referral.
- Western State Hospital incorporates the Accident Prevention Program (APP) of the Consolidated Maintenance Operations (CMO) and Centralized Institutional Business Services (CIBS) organizations into its business plan and strategic goals. CMO and CIBS employees utilize their own APP which aligns with WSH guidelines for employee safe work practices. CMO and CIBS employees will work in concert with WSH staff to create a safe and healthful work environment by adhering to both CMO & CIBS guidelines and WSH policies and programs. The ongoing interaction between agencies involves much more than just accident prevention. It involves employee, client and resident interaction. In order to clarify this relationship, CMO and CIBS employees and WSH staff cooperate utilizing the written Service Level Agreement (SLA) between CMO/CIBS and ADSA (WSH's parent Administration). The intent of the SLA is to describe the mutually agreed upon responsibilities, standards, and services obligation between agencies. WSH will retain a copy of the

CMO and CIBS APP to ensure it meets WSH criteria. WSH Safety staff will collaborate with CMO and CIBS safety personnel to create an ongoing and effective safe and healthful working environment

4.0 MANAGEMENT COMMITMENT:

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

All hospital staff is responsible for preserving a safe environment regardless of duty of assignment, level supervision or command. The Western State Hospital Safety Manager, Safety Committee Co-Chairs and members of the safety committee are responsible for this plan. The CEO is responsible for ensuring the existence and the effectiveness of a comprehensive Workplace Safety Plan/Accident Prevention Plan.

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

All Co-Located Support Operations area required to follow WSH's Accident Prevention Program. In addition, these areas are required to have their own Accident Prevention Program tailored specifically to their area.

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

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

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

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

We Believe

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

- Accident prevention is a partnership between staff, management and the Collective Bargaining Units.

5.0 SAFETY AND HEALTH RESPONSIBILITIES:

5.1 Executive Leadership Responsibilities:

- Ensure that the hospital maintains a safety committee that has both employee elected and employer-selected members in accordance WAC 296-800-13020.
- Ensure that the hospital safety committee(s) meet monthly and provide all required documentation.
- Ensure that the safety committees carry out their responsibilities as described in this program.
- Ensure that sufficient employee time, supervisor support, and funds are budgeted for Personal Protective Equipment (PPE) equipment and training to implement the safety program.
- Ensure that incidents are fully investigated and appropriate corrective action implemented to mitigate risk and prevent reoccurrence.
- Ensure a record of injuries and illnesses is maintained and posted as described in this program.
- Ensure an annual review of the Workplace Safety Plan/Accident Prevention Program, including Workplace Violence Prevention, is conducted to ensure compliance with State/Federal law and hospital needs, Centers for Medicare and Medicaid (CMS) certification and The Joint Commission accreditation of standards of performance and develop Performance Improvement Activities, as indicated.
- Provide guidance and oversight to hospital personnel to ensure compliance with this program. This includes facility management, approval and purchase of equipment, authorization and payment for training, participation in workplace inspections, and evaluation of facility program needs.
- Recruit and retain qualified staff to assure effective treatment and maintenance of a therapeutic milieu.
- Collect and review data and implement quality improvement measures.
- Maintain a communication plan to promote a Culture of Safety.

5.2 Management/Supervisor Responsibilities:

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

- Managers and supervisors must maintain appropriate safety management procedural knowledge regarding practices, policies, procedures and emergency management plans and set good example for employees by following safety rules and attending required training.
- Ensure each employee receives an initial, documented, site-specific Safety orientation/training that includes inherent hazards and safe practices ***before*** beginning work.
- Ensure each employee is competent to perform their duties safely and receives adequate/required training including prevention and intervention techniques, safe operation of equipment or tasks ***before*** starting work.

- Ensure that a hazard assessment is conducted on each job class and that each employee receives proper training in the use of the required personal protective equipment (PPE) *before* starting work.

- Ensure staff accounts for the safety and location of patients and monitor environmental factors that affect patient and staff safety ensuring that clinical, environmental and security needs are met. Ensure staff completed ward checks while respecting patient privacy and dignity (i.e. knocking on door before opening). This process may reflect clinical, environmental, and security differences among units. Staff assigned to ward check continuously circulate through the ward and intervene with patients as needed. They are not assigned any other duties during that time.

- Ensure that supervision is sufficient to identify unsafe work practices and that employees are provided additional training or disciplinary action is conducted as needed. Formal corrective action is documented according to Human Resources Policy.
- Ensure all employee injuries are investigated and all required documentation is properly completed and submitted to the WSH Safety Office.
- Work with the hospital Safety Manager/Officer and DSHS Enterprise Risk Management Office (ERMO) to identify and evaluate changes to work practices or equipment that improves employee safety.

5.3 Employee Responsibilities:

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

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

6.0 EMPLOYEE PARTICIPATION

6.1 Safety Committees

Western State Hospital maintains 6 safety committees to help employees and management work together to identify safety problems, develop solutions, review incident reports and evaluate the effectiveness of the Workplace Safety Plan/Accident Prevention Program. These committees consist of management-designated representatives and employee-elected representatives in an amount equal or less than employee-elected representatives, from the facility. Resource members include the Safety Manager, Facilities Coordinator, Security Director, SAFE Team Director, Infection Control Nurse or Employee Health representative, and a member from Quality Management. Guests are invited as needed. The safety committee structure at Western State Hospital includes four patient-care area sub-committees and one support area sub-committee that report to the Central Safety Committee.

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

A committee member will be designated to keep minutes for each Safety Committee. Copies will be posted on the WSH intranet under ***Departments Tab; Committees; Safety Committees*** and on the designated bulletin board for each safety sub-committee. (See below for locations). After being posted for one month, a copy of the minutes will be filed for one year. The minutes form contains the basic monthly meeting agenda items.

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

All committees meet on a monthly basis. ***See table below for date, time and location for each safety committee meeting.***

Safety Committee	Date & Time	Time	Location
PTRC East Sub-Committee	*3rd Tuesday of the Month*	*1:00 p.m.*	*East Nursing Adm. Conference Room*
CFS Sub-Committee	*3rd Thursday of the Month*	*1:00 p.m.*	*Hamilton Conference Room*

PTRC Central Sub-Committee	*3rd Wednesday of the Month*	*9:30 a.m.*	*Webster Conference Room*
PTRC South & HMH Sub-Committee	*3rd Tuesday of the Month*	*9:30 a.m.*	*S-2 Nursing Conference Room*
Support Services Sub-Committee	*4th Monday of the Month*	*1:00 p.m.*	*Building 8 Webster Conference*
Central Safety	*4th Thursday of the Month*	*10:30 a.m.*	*Fitzsimmons Conference Room*

- Membership of the safety sub-committee includes a minimum of 2 management representatives and a minimum of 6 labor representatives from each patient care or support area. Each safety sub-committee elects one Management co-chair and one Labor co- chair. This safety sub-committee structure allows for increased representation and input at the ward/support level and allows specific safety issues from each area to be discussed and acted on. Membership is re-appointed or replaced annually.
- Responsibilities/duties of each safety sub-committee member includes:
  - Encouraging and supporting co-workers to use safe work practices on the job and encourage co-workers to report hazards.
  - Performing and/or reviewing monthly self-inspections of the area they represent. Results and actions taken as a result of the self-inspections will be discussed at the monthly sub-committee meetings.
  - Communicating with the employees they represent on safety issues including results from safety sub-committee meetings.
  - Encouraging safe work practices among co-workers.
  - Reviewing reports of personal injury, 03-133, for their areas and make recommendations for corrective action as required.
  - Reviewing safety data related to assigned area and provide input to the sub-committee.
  - Actively participate in all scheduled sub-committee meetings. Present safety concerns of co-workers to sub-committee for discussion and consideration.
  - Maintain the safety bulletin board for the area they represent.

- The WSH Central Safety Committee is comprised of the co-chairs of each of the sub-committees, SEIU 1199 representatives and the SAFE Team Director. This committee is co-chaired by the Chief Operating Officer, and a WFSE Local 793 representative. Resource members include the Safety Manager, Infection Control/Employee Health representative, Facilities Coordinator, Quality and Enterprise Solutions representative and DSHS-Enterprise Risk Management Office Safety Consultant. Guests are invited as needed.

- The responsibilities/duties of the central safety committee members include:
  - Be available to all staff in their assigned area of representation to answer questions or discuss safety concerns.
  - Present concerns of the sub-committees they represent at the Central Safety Committee.

- Present an overview of the findings from the self-inspections as they related to the entire hospital
- Provide an overview of findings from review of injury reports.
- Participate in a review of hospital-wide safety data and make recommendations
- Report Safety hazards to the committee and make recommendations to avoid future occurrences.
- Actively participate in all activities of the central safety committee.

All safety committee members are required to attend their monthly safety meetings held on ***the above referenced date/time and location.*** This meeting is to help identify safety problems, develop solutions, review incident reports, provide training and evaluate the effectiveness of our safety program.

6.2 **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 referenced in the above table.

Required postings:

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

7.0 HAZARD RECOGNITION

7.1 Injury Record Keeping and Review

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

The supervisor:

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

The Safety Manager/Officer:

- Reviews the incident form to ensure all pertinent information has been collected;
- Provides additional comments or investigation results, if indicated, will be included on the form;

- Forwards all paperwork to Enterprise Risk Management Office (ERMO) claims department.

ERMO (Claims Unit):

- Inputs and tracks all reports of injury through the Risk Master system;
- Determines from the Employee Report, Injury Investigation Report, and any L&I claim form associated with the accident, whether it must be recorded on the OSHA Injury and Illness Log and Summary according to the instructions for that form;
- Enters a recordable injury or illness within six days after the hospital becomes aware of it;
- If the injury is not recorded on the OSHA log, it is tracked through the Risk Master System (non-OSHA recordable injuries and near misses);
- Provides each month before the scheduled safety committee meeting, any new injury/claim reports and investigations to the safety committee for review. The safety committee reviews the incident reports for trends and may decide to conduct a separate investigation of any incident.

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

7.2 Incident Reporting and Investigation Procedure

Near Miss

Whenever there is an incident that did not but could have resulted in serious injury to an employee (a *near-miss*), the near-miss is reviewed by the supervisor and additional investigator(s) depending on the seriousness of the injury that could have occurred. The ***"Injury and Illness Incident Report (DSHS 03-133),*** or ***WSH's Administrative Report of Incident form)*** is used to report and investigate the near-miss. The form is clearly marked to indicate that it was a near-miss and that no actual injury occurred. The report will be used to document the near miss and correct the hazards to reduce and/or eliminate the possibility of an injury.

Employee Injury

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

- Injury and Illness Incident Report (DSHS 03-133) with the employee to insure all required information is complete. The injury is investigated by the supervisor and additional investigator(s) depending on the seriousness of the injury that occurred. In conducting an investigation, it is important to:
  a) Gather all necessary information.
  b) Record the sequence of events.
  c) List all causative factors as they occur in the sequence of events.
  d) Interview and collect statements from witnesses as indicated.

e) Closely review the employee's statement and description of the incident and identify any discrepancies between employee's statement and actual findings.
f) Make determination based on the findings:
   (1) Unsafe Act
   (2) Unsafe Conditions
   (3) Unsafe Acts/Conditions

- The Employee Report of Possible Client Assault (DSHS 03-391) is completed for all incidents resulting from a potential client assault. Attach to the Injury and Illness Incident Report.
- WSH Form 1-100 "Administrative Report on Incident" (AROI). Administrative Reports are also completed when any incident of unusual nature occurs involving patients, visitors, employees, equipment, property, etc.
- A Post Exposure Packet is completed in all 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.
- Labor and Industry (L&I) Form 242-130-1111 is completed by the employee if receiving medical or emergency treatment for a work-related incident/injury or exposure. This form is to be initiated at the physician's office or emergency room. The physician completes the form with the employee and mails a copy to Labor & Industries for processing.

Hospitalization, Fatalities, Amputations, and Losses of an eye
If any employee is in-patient hospitalized as a result of a work-related incident, or, an employee dies while working, or is not expected to survive, or, there is a work-related incident that results in either an amputation or the loss of an eye that does not require in-patient hospitalization, the facility designee must contact DOSH at Labor & Industries (L&I) following the reporting requirements of WAC 296-800-320.

For work related incidents that result in an in-patient hospitalization or fatality, the hospital CEO, or designee must contact the Department of Labor and Industries within ***8 hours*** after becoming aware of the incident.

For work related incidents that result in either an amputation or the loss of an eye that does not require in-patient hospitalization, the CEO, or designee must contact the Department of Labor and Industries within ***24 hours*** after becoming aware of the incident.

The hospital CEO, or designee must talk with a representative of L&I and report:
- The employer name, date, location and time of the incident;
- The number of employees involved and the extent of injuries or illness;
- A brief description of what happened and;
- The name and phone number of a contact person.

In the event of employee work-related in-patient hospitalization, fatality, amputation or loss of an eye that does not require in-patient hospitalization:

➧ **DO NOT DISTURB the scene except to aid in rescue or make the scene safe.** Refer to WAC 296-800-320.

- Block off and secure area. If in a room, close and lock the room and post a guard, if in a common area, mark off with tape or ribbon and post a guard. Do not clean up bodily fluids or pick up other items.
- Keep unnecessary persons out of the area before and after securing it.
- Record the names of persons who have entered the area during and after the incident.
- Record the names of persons who have witnessed the incident.
- Keep records of any items leaving the area before investigators arrive, i.e. clothing, bloody items and weapons.
- Do not move equipment involved (i.e. personal protective equipment (PPE), tools, machinery or other equipment), unless it is necessary to remove the victim or prevent further injures, refer to WAC296-800-32010.

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

Whenever there is an employee accident that results in death or serious injuries that have immediate symptoms, a preliminary investigation is conducted by the immediate supervisor of the deceased or injured employee, a person designated by ERMO, and/or any other persons whose expertise can help with the investigation. The investigator(s) takes written statements from witnesses, photographs the incident scene and equipment involved. The investigator(s) must also document as soon as possible after the incident, the condition of equipment and any anything else in the work area that may be relevant. The investigator(s) makes a written report of their findings. The report includes a sequence of events leading up to the incident, conclusions about the incident and any recommendations to prevent a similar incident in the future.

7.3 Patient and Visitor Injuries

All patient injuries are reported to the Quality Management Department through Administrative Report of Incident System.

7.4 Hazardous Materials and Waste Spills and Exposures

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

7.5 Fire/Safety Management Deficiencies and Failures

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

7.6 Product Safety Recalls

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

7.7 Utility System Failure or User Errors

Failures or user errors related to utility systems are reported Consolidated Maintenance Operations as described in the Utility Management Plan.

7.8 General Hazards

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

- Notify supervisor immediately.
- Supervisor must ensure that corrective measures are taken (i.e. Work order entered and follow-up on completion, immediate correction of the hazard, etc.)
- If no action is taken, notify the Safety Manager by telephone on WSH's Support Our Safety (SOS) toll free number ***(1-888-346-8824)*** and/or complete an Internal Hazard Reporting Form. Complete this form in as much detail as possible. Reports may be anonymous; however, providing a name and telephone number will assist in obtaining additional information that may be necessary to rectify the hazard.
- Hazard reports are evaluated by the Safety Manager to determine causative factors and implement corrective actions.
- All reports and action(s) taken are reviewed by Executive Leadership and the Safety Committee during regular monthly meetings. Actions are captured in Safety Committee Minutes and the Safety Action Items/Recommendations-Results posted on WSH's electronic Safety Committee Bulletin Board.

7.9 Interim Life Safety Measures (ILSM)

Potential hazards related to construction, renovation or maintenance activity are assessed through the Environment of Care Committee in conjunction with Consolidated Maintenance Operations, and the Facilities Coordinator Office to identify potential new or altered risks related to utilities or building systems, fire safety or interim life safety, general safety issues, emergency preparedness or response, and security. These hazards are reviewed and monitored by the COO, Safety Manager, Facilities Coordinator, and reported to the Environment of Care and Safety Committees.

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

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

1) Construction activities (in or adjacent to all construction areas)
2) Temporary Life Safety Code deficiencies including but not limited to the following:

a) Fire, smoke or sprinkler systems temporarily out of service
b) Exit(s) blocked
c) Access for emergency response team is blocked
d) Fire walls/doors are breached
e) Fire doors/windows are missing
f) Other

Interim Life Safety Measures (as identified during planning phase)

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

7.11 Statement of Conditions

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

7.11 Safety Inspection Procedures

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

Environmental Safety Inspections:
Each month, before the regularly scheduled safety committee meetings, nursing staff conduct environmental safety inspections to ensure that all patient care areas are inspected for hazards. The Safety Sub-Committees review these inspections at their monthly meetings to ensure hazards are being corrected and to make any additional recommendations necessary. Copies of all monthly inspections are sent to the Safety Office for review and monitoring.

The Environment of Care Committee sponsors an additional continuous self-inspection program. Members of the Environment of Care Committee and the Management Team at a minimum inspect all patient and non-patient areas of the hospital bi-annually to evaluate staff knowledge and skill, observe current practice, and evaluate environmental conditions. These inspections are in addition to the documented monthly environmental safety inspections and the hourly environmental checks completed by nursing staff in all patient care areas. The results of the area inspections and any action taken are reported to the Environment of Care and Safety Committees.

A qualified fire inspector conducts an annual wall to wall fire inspection of WSH, to include all tenant buildings

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

Proactive Risk Assessment
The Facilities Coordinator in coordination with hospital leadership, Safety & Security, Department Managers, Consolidated Maintenance Operations and Environment of Care Committee members conduct comprehensive risk assessments to proactively evaluate risks associated with buildings, grounds, equipment, occupants, and internal physical systems that have the potential to impact the safety of patients, staff and visitors coming to the hospital's facilities. Results of the risk assessment process are used to create new or revise existing safety policies and procedures, hazard surveillance elements in the affected area, safety orientation and education programs or safety performance improvement standards. Risks are prioritized to assure appropriate controls are implemented to achieve the lowest

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

Annual Loss Control Evaluation (ALCE)

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

Job Hazard Analysis

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

8.0 HAZARD PREVENTION AND CONTROL

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

8.1 Basic Safety Rules

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

1. Never do anything that is unsafe in order to get the job done. If a job is unsafe, report it to your supervisor or safety committee representative. We will find a safer way to do that job;

2. Report hazardous conditions to your supervisor or safety committee immediately. Do not operate unsafe equipment;
3. Understand and follow the procedure for reporting accidents (section 4);
4. Never operate a piece of equipment unless you have been trained and are authorized. Supervisors must document training before an employee is considered competent to perform duties of the job ;
5. Use your personal protective equipment (PPE) whenever it is required;
6. Obey all safety warning signs;
7. All employees must comply with applicable collective bargaining agreements and DSHS Administrative Policy 18.75 entitled Drug and Alcohol-Free Workplace. Working under the influence of alcohol or illegal drugs or using them at work is prohibited. Use of prescription drugs that may impact judgment or work performance must be disclosed to your supervisor.
8. It is a felony to bring firearms or explosives onto Hospital property;
9. Smoking is only permitted outside the building, 25 feet away from any entry or ventilation intake in accordance with DSHS Administrative Policy No. 18.65 and RCW 70.160. ;
10. Follow appropriate work habits:
    - Read and follow product labels
    - Refrain from horseplay, fighting and distracting fellow employees
    - Understand and use proper lifting techniques
    - Maintain good housekeeping
    - Keep emergency exits, aisles, walkways and working areas clear of slipping/ tripping hazards
11. Know the location and use of:
    - First aid supplies
    - Emergency procedures (chemical, fire medical, etc.)
    - Emergency telephone numbers
    - Emergency exit and evacuation routes
    - Firefighting equipment
12. Clean up spills immediately. Replace all tools and supplies after use. Do not allow scraps to accumulate where they will become a hazard. Good housekeeping helps prevent injuries.

8.2 Job Related Safety Rules

Western State Hospital has established safety rules and personal protective equipment (PPE) requirements based upon the job hazard assessment for the common workplace hazardous tasks. All JHA's are kept in the Safety Office.

8.3 Discipline for Failure to Follow Basic Safety Rules:

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

8.4 Equipment Maintenance

Each facility is responsible for servicing and inspecting their equipment following manufacturers' recommendations. The Consolidated Maintenance & Operations

(CMO) is responsible for maintaining all equipment and buildings within the facility. All records are kept in the maintenance office. A checklist/record to document the maintenance items is maintained and kept on file for the life of the equipment and tracked through CMO Work Order System (AAMS).

Inspections will be conducted periodically by BioMed Tech to ensure safety requirements are met. A record of these inspections will be maintained per (WSH Policy 2.6.4, "Ward Medical Equipment Management Program").

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

9.0 EMERGENCY PLANNING

9.1 In case of emergency

Evacuation maps for the facility are posted in all WSH buildings; patient care and non-patient care areas. Evacuation maps show the location of exits, fire alarm pull stations and fire extinguishers. Fire evacuation drills are conducted at least annually in all non-patient areas and one drill per shift for each quarter of the year for all patient care areas. A hazard vulnerability study has been analysis (HVA) is completed to determine which hazards require special attention. The HVA provides a systematic approach to recognizing hazards that may affect demand for the hospitals services or its ability to provide those services. The risks associated with each hazard are analyzed to prioritize planning, mitigation, response and recovery activities The hazard vulnerability analysis is evaluated annually to assess the hospital's current emergency management activities and to identify necessary changes, additional planning activities and specific exercise scenarios. Contingency plans are developed as the result of a hazard vulnerability analysis and are designed to guide personnel in the initial stages of specific emergency situations that may seriously impact or threaten routine capabilities of the hospital. The HVA and emergency procedures are located in the Comprehensive Emergency Management Plan on the WSH intranet under the Red Icon that states, "Click Here In Case of Emergency". ERMO is available to help develop procedures to deal with each emergency situation that may develop at a facility.

9.2 If an injury occurs

- First aid supplies are maintained in all patient care locations. If you are injured, promptly report it to any supervisor.
- All direct care staff are required to have first aid/CPR training. Other employees may also have certification in First aid/CPR.
- In case of serious injury, do not move injured person unless absolutely necessary. Only provide assistance to the level of your training. Call for help. If there is no response, call 2222 for assistance.
- Infectious diseases are a risk with some job tasks at the facility. Western State Hospital has developed an exposure control plan to mitigate the risks of Blood borne Pathogens and infectious diseases. All information regarding Blood borne Pathogens and infectious diseases can be found on the WSH intranet under Departments; Infection Prevention & Control /Employee Health. The Exposure control plan covers HIV/AIDS and Hepatitis B; the primary infectious diseases of

concern in blood. Universal precautions, work policies, and PPE are covered under the plan as well as how to report any exposure to infectious diseases. All reports are kept confidential as required by HIPAA and other DOSH regulation.

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

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

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

     Nevertheless, employees should always conduct official business with others always keeping Universal Precautions in mind. Universal Precautions refer to the generally accepted preventative practice to treat blood and all other potentially infectious bodily fluids as if they contain blood-borne pathogens, whether the blood or fluid has been identified as having blood-borne pathogens or not. Employees are encouraged to:
     - Actively participate in initial and annual refresher Blood-Borne Pathogen training appropriate to position, duties and responsibilities;
     - Maintain a respectable, professional distance from others in the workplace to help prevent easy passage of any contagion;

- Wash hands frequently, and between washings use alcohol-based sanitizers or waterless hand cleaner;
- Wear gloves appropriate to the task whenever there is any possibility of coming into contact with potentially infectious fluids (e.g. performing first aid, handling SHARPS containers, cleaning up bodily discharges, removing trash, etc.);
- If there is a possibility of fluids being splashed onto an employee performing clean-up or a rescue, they should wear gloves, full body gowns, face masks and eye protection;
- At locations with an increased possibility for exposure to blood or other potentially infectious bodily fluids (e.g., hospitals, 24-hour facilities), employees should be certain to review and become very familiar with their site's specific Infectious Disease Exposure Control Plan.

C. Despite sensationalized reports in the media, employees should know that employees in DSHS have little potential for exposure to extreme infectious diseases such as Viral Hemorrhagic Fever (Ebola). Possible DSHS staff introduction to these more fervent contagions in the course of performing state business is extremely remote. The most likely means of any sort of exposure would be through some form of second or third-hand contact with the general public (e.g., exposure to a client or staff member who has a family member who may have been exposed to a contagion). To dispel all the misinformation regarding these extreme contagions, DSHS employees should review the Washington State Department of Health website for the most current and factual information available.

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

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

10 SAFETY AND HEALTH TRAINING AND EDUCATION

10.1 Safety Training

Training is an essential part of our plan to provide a safe work place at Western State Hospital. The Safety Manager and Supervisors will conduct a basic orientation to ensure that all employees are trained *before* they start a task that requires training. The

Supervisor is responsible to verify that each employee has received an initial, site-specific orientation and any training required to do the job safely. All training is documented and maintained in the employee file. The Safety Manager is responsible for developing and maintaining New Employee Safety, Annual Safety/Accident Prevention, Emergency Management and Supervisor Safety training materials.

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

Orientation for Nursing Staff:
Upon completion of the basic NEO nursing staff completes an additional 5 day training for orientation to duties that includes additional safety related training that includes information on working with people with mental illness, violence prevention, safety policies specific to nursing, and advanced skills in managing escalating situations with patients using a Competency Based Evaluation Tool.

- **Other Required Training**

Training related to safety will be conducted as needed prior to an employee performing a specific task. CMO staff receives site-specific training prior to working at the facility. Other required training topics are conducted by the CMO Safety Office.

Competency Training:
Nursing staff (direct care and licensed staff) is required to attend competency based refresher training. A competency fair is held every month for two days. Staff attend the competency trainings during their anniversary month. All direct care staff attend on day 1. Day 2 is for licensed staff only. Each staff is required to demonstrate competency in a wide variety of safety related nursing functions. Upon successful completion, staff receive certification of competency.

10.2 Other Hazard Control Programs

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

Fire Safety Management Plan	Facilities Office
Security Management Plan	Facilities Office
Utility Systems Management Plan & Documentation	Facilities Office
Medical Equipment Management Plan	Facilities Office
Hazardous Waste Management Plan	Facilities Office
Emergency Management/COOP Plan	Facilities Office/Safety Office

Safe Patient Handling Program	Safety Office
Chemical Hazard Communication Program	Industrial Hygienist Office
Personal Protective Equipment (PPE)/JHA	Safety Office
Facility Inspections	Facilities Office

11 WORKPLACE VIOLENCE PREVENTION PLAN

11.1 Purpose

The Western State Hospital Workplace Violence Prevention Plan demonstrates the hospitals commitment to reduce and eliminate workplace violence. WSH recognizes that as a psychiatric hospital our patients create an additional risk of violence in the workplace. The hospital mitigates this additional risk through a continuous commitment to providing effective treatment to our patients combined with staff training and support, to ensure a safe physical environment and promote a Culture of Safety per WSH Policies 3.4.13, (Culture of Safety) and 3.4.10 (Workplace Violence). At the foundation of the Workplace Violence Prevention Plan is the recognition that Management is committed to:

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

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

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

11.2 Scope

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

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

11.3 Definition

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

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

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

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

11.4 Background:

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

- Develop and implement a plan to reasonably prevent and protect employees from violence at the setting.
- Conduct a security and safety assessment to identify existing or potential hazards for violence and determine the appropriate preventive action to be taken.
- Consider for incorporation guidelines on violence in the workplace or health care settings issued by the department of health, the department of social and health services, the department of labor and industries, the federal occupational safety and health administration, Medicare and health care setting accrediting organizations.

72.23.400 RCW relating to Public and Private Facilities for the Mentally Ill further delineates this law for state hospitals, requiring input to the plan from management,

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

unions, nursing, psychiatry and key function staff as appropriate and requiring that the plan be evaluated, reviewed and amended as necessary at least annually.

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

a) Physical attributes including access control, egress control, door locks, lighting and alarm systems
b) Staffing including security staffing
c) Personnel policies
d) First aid and emergency procedures
e) Reporting violent acts, taking appropriate actions in response to violent acts and follow-up procedures after violent acts
f) Development of criteria for determining and reporting verbal threats,
g) Employee education and training; and
h) Clinical and patient policies and procedures including those related to smoking, activity, leisure, and therapeutic programs; communication between shifts; and restraint and seclusion

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

Finally, the Workplace Violence Prevention Plan reflects Western State Hospital's Safety Policy(ies) #3.4.10, "Workplace Violence" and #3.4.13 "Culture of Safety" and is additionally grounded in accreditation requirements of The Joint Commission.

11.5 Executive Leadership Responsibilities:

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

11.6 Management/Supervisor Responsibilities:

- Ensure employees understand the expectations of a violence free workplace.
- Conduct employee competency evaluation annually
- Hold staff accountable for participation and competency in key skills and abilities related to workplace violence prevention
- Identify employee needs for knowledge and skills refresher in non-violent crisis intervention techniques
- Fully investigate all occurrences of workplace violence and implement corrective action(s) to eliminate or mitigate issue.

- Support employees that are victims of workplace violence facilitating debriefing, Critical Incident Stress Management (CISM) or referral to Employee Assistance Program (EAP), as indicated.
- Ensure accurate reporting of incidents (e.g. AROI) and Employee injuries (DSHS Form 31-133)

11.7 Employee Responsibilities:

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

11.8 Risk Assessment

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

11.9 Treatment Plans and Milieu:

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

Western State Hospital conducts team debriefings of incidents of seclusion, restraint and assaults utilizing post incident as well as structured inter-shift meetings to support staff as

well as identify effective interventions employed and opportunities for improved awareness or skill development. Effective team process and communication is essential to managing an environment with inherent risks for disruption.

Special Population Considerations

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

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

Patient Treatment Planning

Patients with an increased risk for assault have treatment plans which address their risk and safety plans which clearly identify triggers and effective prevention / de-escalation. Violent acts are tracked over time to identify frequency and severity of assaults. The WSH weekly inter-shift meetings engage the interdisciplinary team and psychiatric consultation to develop treatment strategies, tailor responses and examine / debrief interventions or critical events.

11.10 Training to Reduce Workplace Violence

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

Direct care (milieu) staff is trained in prevention practices that range from constant awareness of the environment and milieu dynamics, ongoing risk assessment, effective documentation, individual patient and group psycho-education to a formal non-violent crisis intervention training program.

The development of a Psychiatric Emergency Response Team (PERT) for the WSH 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 milieu with appropriate evidence-based debriefing.

When not active, team members will fold into the staffing model and provide direct, hands on therapeutic engagement of patients, often modeling a best practice for staff. A secondary benefit to establish the service is enhanced staffing on the more volatile patient treatment units throughout the hospital. PERT is not included in the staffing count.

11.11 Quality Management

Data Review

Workplace violence of any kind is reported through administrative channels and tracked in incident data bases. Administrative Report of Incidents document assaults and are reviewed by a Multidisciplinary Team in conjunction with the Incident Management Office (IMO). Incidents needing follow-up are tracked through the IMO office.

Western State Hospital tracks all workplace injuries due to assault in the RiskMaster Data base. In addition, the hospital has the capacity to compile data for analysis of frequency, severity and circumstances contributing to a deeper understanding of workplace violence among our patient population and staff and the potential for a systemic solution:

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

Data is analyzed monthly at all six sub-Committees as well as Quality Council and the Quarterly Governing Body Meeting. Patterns and trends are identified and corrective action plans are proposed to Leadership. The Safety Committee participates in monthly review of indicators and identification of the need to explore data at a deeper level.

Workplace Safety Surveys

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

Support to employees

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

All employees injured at work have access to first aid measures as indicated. Most injuries that result from hands-on containment or workplace violence are easily remedied by cleansing, applying comfort item such as ice to reduce swelling, bandage, etc. In the

event that an employee sustains a more serious injury the supervisor assists the employee to obtain additional medical attention if indicated.

All levels of leadership at Western State Hospital communicate personal interest in employees who have been injured by an episode of Workplace Violence. The CEO follows up with employees regularly. Direct supervisors provide support as indicated. Staff are made aware of the services of the Employee Assistance Program and on an individual and confidential basis may request help from the Human Resource Department in accessing personal support. Critical Incident Stress Management (CISM) is also available as indicated on a voluntary basis for groups or individual team members who have been impacted.

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

11.12 Administrative, Engineering Controls and Work Practices

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.

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

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

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

Precautions against workplace violence at Western State Hospital include Policy 3.4.10, Workplace Violence which clearly states a zero tolerance stance, prohibition of actual or potential weapons on campus grounds, and a state-of-the-art patient behavior intervention program and non-violent crisis response that includes verbal and physical de-escalation techniques and training in team communication. WSH establishes clear lines of authority and responsibilities, requires annual competency assessment, review of policies and procedure and annual safety training. Direct access to Leadership is available to express concerns or advise of safety risks.

Security

The extension to WSH Security Dispatch is visible on every unit (Ext. 2222). Security Officers who are well-informed about the nature of the population served and the treatment teams and programs are available 24/7 if additional help is needed. 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.

12 Workplace Safety/Accident Prevention Planning Objectives

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

13 Workplace Safety/Accident Prevention Performance Improvement

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

14 Workplace Safety/Accident Prevention Annual Evaluation

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

Appendix A: Workplace Safety Plan Annual Report

Workplace Safety Plan

Western State Hospital

ANNUAL UPDATE

July 1, 2015 through June 30, 2016

RCW 72.23.400 requires each state hospital (WSH, ESH, CSTC) to develop a plan to reasonably prevent and protect employees from violence at the state hospitals. . The law requires completion of a security and safety assessment to identify existing or potential hazards for violence in the workplace and determine the appropriate preventative action to be taken.

Elements of the plan per law. (Items a through h are part of the security & safety assessment)	**Assessment** – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence.	**Plan** – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence.
a. The physical attributes of the state hospital including: 1. Access control 2. Egress control 3. Door locks 4. Lighting 5. Alarm systems	A comprehensive Environmental Proactive Risk Assessment is completed annually in addition to individual assessments to identify all known physical plant deficiencies and problems determined to present a threat of physical injury to persons; damage to property, or a threat to general safety and associated risk. Through these various assessments in FY 15, it was determined the following was needed to provide a safer environment for all. • Continued anti-ligature improvements on wards • Continued expansion of the key watcher system, Personal Alarm/Duress System, Emergency Broadcast System, and Viacom Camera System • Installation of a new Fire Alarm System in Building 29 • Installation of new Secure outdoor fence "Quadrangle" in central Campus.	**Ongoing:** **WSH constantly monitors the physical environment hospital-wide. The below describes how the hospital examines the environment on a continuous and on-going basis to ensure the safety and security for all:** The Environment of Care (EOC) Committee conducts a hospital-wide annual assessment of the environment to include access control, egress control, door locks and lighting. The EOC Committee also conducts an annual Physical Risk Assessment of every patient care area to look for other safety/security risks. In addition, every ward conducts monthly EOC inspections of their ward to find deficiencies that need correcting in their work area. The ward produces work orders to repair the physical deficiencies identified and works with appropriate individual(s) to correct any process breakdown that led to the deficiency. The ward also monitors the work order(s) generated by the EOC to ensure closure of the deficiency. In addition, each Safety Sub-committee reviews the EOC's at their monthly meeting to ensure closure of deficiencies found and if needed works with appropriate individuals to ensure the loop is closed on any unresolved issues. The Safety and Security Committees meet on a monthly basis to help resolve any other safety and security issues that may come up throughout the hospital. Security Staff also provides daily campus-wide security checks on evening and night shifts and all 3 shifts 7 days a week to ensure all buildings are locked and secured. Alarm systems continue to be tested and monitored by the Consolidated Maintenance Operations, (CMO) Department. All alarm systems are on a Preventative Maintenance Schedule and CMO monitors and prioritizes work requests to maintain current condition. Since 2001, the annual West Pierce Fire Inspection has been conducted by the assigned West Pierce Fire Marshall and a team from WSH comprised of the Safety Manager, a Facilities Representative, and others as needed. This inspection evaluates fire safety issues. Shortcomings are identified and corrected to preclude a fire emergency. All areas are within the hospital are inspected on an

annual basis.

Update:
Below is a status update of all WSH Environmental Safety and Security projects that have been identified through the Annual Comprehensive Environmental Proactive Risk Assessment and Capital Funding Requests:

The following is the status of these projects:

Anti-ligature improvements:

- Plumbing fixtures replaced with anti-ligature type to include faucets, bathtubs, showers, and valves in all patient care areas as well as shrouding of exposed pipes and plumbing (75% Complete)
- Patient Locker Door replacement/reconfiguration (100% Complete)
- Design phase of the anti-ligature bathroom partitions. (Design Phase Complete)
- Door Top Alarms – In design phase

Safety/security Improvements:

- Continued upgrade and expansion of the Key Watcher system:
  7 Full Key Watcher Systems were purchased in 2015. To date, 1 full system has been installed in Bldg. 9. The other 6 systems will be installed in the following locations once the access control system on access doors is completed.
  - Building 29 (Three Locations)
  - Building 17 (One Location)
  - Building 18 (Two Locations)
- Key rings throughout the hospital with locking key hubs continue to be replaced and have increased from approximately 25% last year, to 50% 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 for keys over the next year.
- Installation of emergency broadcast speakers to every WSH building on campus including exterior speakers in the Central Campus quadrangle location is complete. This allows for emergency information to be disseminated quickly throughout campus. (100% complete)
- Expansion of the Personal Alarm System to Buildings 10, 15, 16 and 5 is under development. The required upgrade of the software for the Personal Alarm System to allow for the expansion to these building is complete.
- Installation of a new Fire Alarm System in Building 29 is complete.
- Installation of a Secure Outdoor "Quadrangle" fence in Central Campus was installed for patients to enjoy grounds privilege's in a secured setting once levels to do so have been earned.
- Expansion and installation of the Viacom Camera System in CFS is in progress and the vendor selection process is currently underway.
- All windows facing the outside of the hospital have been secured shut with tamper resistant fasteners to ensure a more secure environment
- Remodel of Ward E-4 to house high acuity patients, upgraded security of doors, windows and the Nurses Station.

b. Staffing, including security staffing	**Nursing Staff:** Hiring permanent nursing staff has been difficult in FY 2016. The hospital responded by hiring approximately 100 additional on-call staff for coverage. In 2015, it was determined that a Schedule Managers office needed to be established to track and deploy staff where needed. In addition, 51 additional RN FTE's are needed to provide adequate coverage for the wards. Improvements in recruitment and retention are still needed **Security Staff:** The WSH Security Department assessment shows that the demand for security presence is increasing due to recent events that have led to a more vigilant stance when it comes to patient escapes and additional duties and posts that must be manned. **The need for security officers to cover all these areas has necessitated the hiring of 14 new non-perm officers.** This brings the total security officers up to to 60. **ERMO Investigator Positions:** Per DSHS and LNI Sidebar agreement, it was determined that two additional FTE's were needed to provide additional 3rd party investigations of patient to staff assaults.	**Nursing Staff:** **Ongoing:** Staffing in patient care areas is constantly monitored to ensure the hospital has safe staffing levels. On-call staff, overtime, and mandatory overtime are all used to ensure there is safe staff coverage on all wards. **Update:** The Schedule Manager's Office was created in 2015 to provide greater oversight in the scheduling of staff. The Schedule Manager's Office reviews the staffing numbers in Scheduler for each shift in each center 24-72 hours in advance and determines any staffing shortages to meet the needs of the hospital. They utilize the available on-call RNs, LPNs, MHTs, and PSAs as identified on the on-call staffing schedule. If it is determined that additional staff are needed after the available on-calls are entered into Scheduler, the Scheduler Manager's Office will utilize the Voluntary OT wheel to fill any remaining shortages in Scheduler. If there are not enough volunteers, the Schedule Manager's Office will solicit additional volunteers by posting on the WSH intranet and/or may need to initiate mandatory overtime to cover the shortages identified. The hospital had success in hiring many On Call Staff, however, the selection process as well as the retention efforts need improvement. A new initiative is underway to address the quality of the recruitment, interviewing, hiring, and training of new employees. In additional, a Hospital Improvement Project was established to address the Employee Retention issues. **Hiring 51 Additional Registered Nurses Hospital-wide:** The Hospital is actively recruiting 51 additional non Permanent Registered Nurses to provide adequate coverage on the wards. These additional RN's will provide 3 RN's on every ward. **Security Staff:** **Update:** Security Staffing continues to be analyzed by the Director of Security as part of an overall effort to identify risk of violence and address security needs. This included a review of needed safety/security on the grounds, court security, security response for the civil wards and safety/security within CFS. The staffing needs for security have increased to include additional duties (Escorts & Hospital Watches) and posts that must be manned. These new posts include manning the quadrangle sally port, manning the court with 4 officers instead of two, manning a new 24 hour post on ward E 2 and also providing officers for all patient court details off of campus. Security is also tasked with fire watches when needed and hospital watches. **ERMO Investigator Positions:** **Update:** July 1, 2015, DSHS Enterprise Risk Management Office (ERMO) hired 2 FTE's to provide additional 3rd party investigations on patient to staff assaults that resulted in employee's hospitalization or medical treatment beyond first aid. These investigations will use Root Cause Analysis to determine whether existing processes are effective or require modification. Data derived from the Root Cause Analysis will

		be used, as appropriate, to develop an action plan for process improvement.
	Additional Active Treatment FTE's: It was determined that 30 additional FTE's were needed to provide additional active treatment hours and ward based activities to patients on every ward.	**Additional Active Treatment FTE's:** **Update:** In the Spring of 2016, the hospital recruited and hired 30 additional non-permanent FTE's (Institutional Counselors) to provide active treatment to the patients who are unable to go to the Treatment Mall and to provide more ward-based leisure activities in the evenings. These 30 additional FTE's will work 4 10's, and provide coverage 7 days a week across day and swing shifts
	Psychiatric Emergency Response Team (PERT) Civil Expansion: It was determined that the expansion of the Psychiatric Emergency Response Team (PERT) was needed on the Civil side of the hospital to respond to crises on wards	**PERT Civil Expansion:** **Update:** A Psychiatric Emergency Response Team (PERT) was expanded to the Civil wards of the Hospital to respond to wards in crises. In the Spring of 2016, interviews were conducted and PERT members selected (11 FTE's plus 1 Supervisor) for the expansion to the civil side. This full time unit begun on July 1, 2016.
c. Personnel policies	It was determined that a new policy was needed for staff to follow with regard to the newly built Quadrangle fence.	• New Quadrangle Fence Area Policy (1.10.4) defines access of the Area and the expectations of personnel, visitors, and patients entering and exiting the defined area. In addition, a Standard Operating Procedure (#43) was established to provide guidelines to all security personnel with regard to the Quadrangle.
	It was determined that a new hospital policy was needed to assist staff with ensuring patients do not have easy access to items that can be harmful in the environment.	• A new hospital wide policy was established (1.3.9/ Environment of Care Standards for Patient Care Areas) to ensure a safer environment for all. This policy included guidelines for staff to follow with regard to cord management, a controlled system for electrical devices and personal items that were not allowed for patient to have access to that could be used for self-harm or as a weapon.
	It was determined that Policy 2.6.6 needed to be revised to include reviews of employee and non-employee events and to establish a better methodology for defining the responding to all safety events.	**Revised Policies:** • Hospital Policy ***2.6.6/Review of Sentinel Events and Adverse Safety Events*** has been revised to establish a better methodology for defining and responding to patient, employee and nonemployee safety events to improve patient care, treatment, services and overall safety of everyone. Below is a synopsis of what changed: • Critical Risk Management Office added the review of ***employee and non-employee*** safety events in addition to patient safety events. • A new coding system was developed for coding all Safety Events. ✓ Close Call; ✓ No-harm event; ✓ Hazardous Condition; ✓ Adverse Safety Event and ✓ Sentinel Events • Any safety event that is defined as an Adverse Safety Event (ASE), is reviewed daily at Unit-based Safety Huddles to address immediate issues of safety. • The CRM Committee conducts daily reviews of all submitted events and supporting documentation and identifies the factors that contributed to the event. • Any ASE that meets the following definitions are routed to the Chief Medical Officer (CMO), Chief Executive Officer (CEO),

	All other safety-related policies have been reviewed and updated. Sunset review dates will be monitored for completion by the WSH Policy Committee.	and Quality Management Director (QMD) 1. An event, incident or condition that resulted in patient or employee injury requiring treatment, evaluation or admission to a community hospital or 2. Any event for which a recurrence carries a significant chance of meeting the definition of a Sentinel Event or, 3. Any event, incident or condition that resulted in a non-employee safety event. • The CRM Committee, in consultation with the CMO, CEO and QMD, may determine that an Intensive Assessment (IA) is warranted, and will be completed by the CRM unit and presented to quality Council. • Quality Council will review report and proposed action plans and provide direction as needed, ensuring that the action plan specifies the person responsible for each action and the timeframes for achievement.
d. First aid and emergency procedures	**Emergency Operations and Response:** It was determined that overall the hospitals meets the minimum requirements set by the Joint Commission Standards with regard to emergency management.	**Emergency Operations and Response:** **Ongoing:** d. **First aid and emergency procedures:** Improvement in Emergency Preparedness is the responsibility of the Safety Manager, the Emergency Management Specialist 1 and the Emergency Management Committee. WSH prepares for Emergencies in accordance with Joint Commission Standards. 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 hospital also participates in community-wide drills and/or has real events that occur which provide the hospital with learning opportunities for being more 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 The Joint Commission. In FY 2016, WSH participated in the following drills and/or real events: • **10 WA-TRAC Drills (Washington System for Tracking Resources, Alerting and Communications)** that tested the hospital ability to effectively utilize the Wa-Trac system to communicate with our community partners in a timely manner. (June 3, 2015, July 1, 2015, August 8, 2015, September 2, 2015, October 7, 2015, January 6, 2016, February 3, 2016, March 2, 2016, May 6, 2016) • **WSH's IT Disaster Recovery Plan** to check/ensure the accuracy of the Information Technology call back list as outlined in the WSH IT On Call Manual and the WSH IT DRP and to test the speed at which voice contact can be made between the caller and the IT specialist being called. Exercise Objectives: 1). Heighten awareness of the standard operating procedures documented in the On Call Manual and DRP. 2). Heighten awareness of roles and responsibilities of IT On Call Technicians and the IT Network Administration Team. 3).

	AOD Binder: It was determined that the development of an Administrator on Duty Binder was needed to Guide AOD through emergencies.	Heighten awareness of call back responsibilities. 4). Identify and correct contact list errors. **Power Outage and Fire:** August 28, 2015- Hospital Command Center activated; WSH campus lost power due to a power surge/outage in the community. Communications Center received a phone call from HMH stating there was smoke coming from the basement, a compressor had started smoking/fire due to the power surge and evacuation has begun. Communications Center called 911. West Pierce Fire & Rescue responded. Dietary Services had to change lunch services due to outage. Power was out from 1115hrs to 1551hrs. **Bomb Threat:** September 28, 2015- 0927hrs WSH Communications Center received a telephone call from an outside caller. Notifications were made, coordination with Lakewood Police Department. Determined the caller was an ex-patient with a history of calling bomb threats to WSH. Email sent to staff as a precautionary measure. Incident cleared at 1437hrs **Communication Center PBX Failure:** March 1, 2016, Hospital Command Center activated; A flash of lighting and a Thunder clap rendered the PBX system in-operative. An email was sent out hospital wide indicating telephone system and overhead paging systems are out in parts of the hospital. Systems put in place to address staff/patient safety, fire alarm notification and communication. Maintenance and shift coordinators notified. **AOD Binder:** **Update:** An Administrator On Duty (AOD) Binder was developed for AOD to use to help guide them through emergencies. Processes and Procedures are outlined for staff to follow for items such as unauthorized leaves, Fire, Bomb Threat, Natural Disaster, Evacuation or Patient Surge, etc.
e. Reporting violent acts, taking appropriate action in response to violent acts, and follow-up procedures after violent acts:	The hospital has many avenues for staff to report violent acts and several teams/committees that ensure appropriate action in response to violent acts, and follow-up procedures after violent acts are done. However, improvements were needed in the following areas: • Staff reported that they never knew what the outcome was for safety issues that were brought up on the Support Our Safety (SOS) • Administrative Report of Incident (AROI) needed improvement to effectively and efficiently report all	**Reporting Violent Acts:** **Ongoing:** WSH has 5 different avenues for staff to report violent acts. (Administrative Report of Incident, Security Incident Report, 3-133 Employee injury report, Lakewood Police report, and the 1-888 Support our Safety Line). WSH has 5 Safety Sub-Committees that are made up of both Management and Labor employees and meet on a monthly basis. The Management & Labor Co-Chairs from each Safety Sub-Committees Reports up to one Central Safety Committee. The Safety Sub-Committees are tasked with reviewing all 3-133 and other safety items and follow up on any unresolved issues. Issues that cannot be resolved at the Sub-Committee level are then brought to the Central Committee for Resolution. The WSH Safety Office also reviews all of

	critical information.	the 3-133's and SOS hotline issues and makes recommendations to the hospital for corrections needed. The Critical Risk Management Office (CRM), Lakewood Police Department, Various Safety Committees and Safety Manager, ensure appropriate actions and follow up procedures are taken in response to violent acts
	<u>SOS Hotline:</u>	**<u>SOS Hotline:</u>** **<u>Update:</u>** The Support Our Safety (SOS) Hotline procedures were revised to ensure staff can easily follow up on results of actions taken in response to their reported safety concerns. The Safety Manager is responsible for monitoring the SOS Hot line Monday through Friday 8:00 am to 4:30 pm. All safety concerns reported on this hotline, are logged in an excel spreadsheet and followed up on by the Safety Manager. Any actions taken are also logged to ensure loop is closed. The log is posted on the QAPI Share Point site for staff to review. All safety concerns reported on the hotline are reported out to Quality Council and Central Safety Committee.
	<u>Near Miss Performance Improvement Project established:</u> The current Administrative Report Of Incident (AROI) process and related policies are not conducive for staff to effectively and efficiently report all critical information with regard to patient/staff safety events. A Near Miss Performance Improvement Project (NM PIP) was initiated to improve the process.	**<u>Near Miss Performance Improvement Project (NM PIP):</u>** **<u>Update:</u>** Due to a narrow definition and focus on individual and not aggregate analysis with regard to patient/staff safety events including pre-assaultive events, a Near Miss Performance Improvement Project (NM PIP) has been started to improve the hospitals current data collection and analysis structure of these events. In FY 2016 the NM PIP completed the following: ✓ Revised policy 2.6.6. (Review of Sentinel Events and Adverse Safety Events) to reflect new business need. ✓ Revised AROI form (Draft) to better fit current needs (captures enough information without adding too much complexity; and is easy for staff to complete) In FY 2017, the NM PIP will revise the current AROI form to enable the hospital to capture critical information for all safety events. The next step will be moving the AROI process into an electronic format.
Analysis of data on violence and workers compensation claims during at least the preceding year	WSH Safety Office continues to provide data regarding staff injuries and L&I claims information on a monthly basis to Safety Committee and Quality Council.	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 what can be done to reduce them. Data is also captured and presented to Safety Committee month and to Quality Council Quarterly on an on-going basis.
f. Development of criteria for determining and reporting verbal threats.	Criteria has been identified within the Administrative Incident Reporting policy for reporting verbal threats.	Verbal threats continue to be tracked using the Security Incident report and/or the Administrative Report of Incident and reviewed in the Critical Risk Management Office to ensure appropriate actions and follow-up procedures are taken in response to verbal threats
g. Employee Education and Training	In FY 2016, it was determined that the following was needed to improve the safety of the hospital • Additional enhanced safety training for staff was needed • The current Training Structure and Programming needed to be evaluated and recommendations	**<u>NEO and Annual Mandatory Trainings:</u>** Curriculum has been developed for ***New Employee Orientation*** and ***Annual mandatory update training*** to include identifying and reporting violence in the workplace, as well as supporting an environment of safety. **<u>Ongoing:</u>** New employee orientation continues to provide new employees live instructor led training in Safety, Industrial Hygiene, Accident

	made to ensure staff are being trained in the most effective manner. • In order to stabilize our wards and provide better continuity of care for our patients, an effective and efficient on-boarding process is needed to recruit staff into the hospital as quickly as possible to fill the many current vacant positions. **Enhanced Safety Training:** It was determined through the Ad-hoc Workplace Safety Committee that staff are in need of some additional enhanced patient safety training to improve patient and staff safety.	Reporting, Infection Control and Blood-borne Pathogens, Security Awareness, Workplace Civility, Culture of Safety, and TEAM Training. All existing employees receive annual mandatory training in Safety, Accident Reporting, Infection Control and Blood borne Pathogens, Security Awareness, Workplace Civility, and Culture of Safety. These trainings are available by attending live classes or online with testing to ensure comprehension. **Updates:** **Enhanced Safety Training (EST):** The Ad-hoc Workplace Safety Committee researched best practices for additional Enhanced Safety Training (EST) for staff to promote better outcomes and improve safety throughout the hospital. Additional 8 hours of funding for Overtime or fill behind positions were pursued in order to get staff off the wards to attend the EST. In December 2015, WSH began providing additional EST for staff to assist them in working with our patient population. This additional training is part of an L&I settlement that requires the hospital to provide additional hours of extra safety training per year. All patient care staff are required to attend these training and overtime was authorized for ward staff to complete them. All staff were encouraged to take the trainings and many non-patient care staff attended as well. Below is information on the additional training modules provided: ***Plan of Correction Training:*** This 3 hour training covers active engagement, seclusion and restraint policy, and infection control/hand hygiene. ***Situational Awareness/De-Escalation:*** This 2 hour training covers situational awareness, de-escalation, and pre-assaultive indicators. This training was initially accomplished on wards and then taught in the classroom. ***Suicide Awareness:*** This is an online training available through Learning Management System under DSHS BHA WSH 2016 Annual Suicide Prevention Update **EST Module #3 -Trauma and Resiliency:** This is a 2 hour classroom training. What you will learn? How to bounce back and take care yourself in the face of trauma. ***EST Module #4 Trauma Informed Care/Behavioral Assessment:*** This is a3 hour classroom training where you will learn how to take a Trauma Informed Care approach to our clients. Understand patient behavior and how to use problem solving skills to encourage patients to use safe behaviors to get their needs met.

	Evaluate Training Structure and Programming" It was determined by the Quality Council that and evaluation of the Current Training Structure and Programming as needed to make our training more effective.	**Western State Training Structure and Programming Hospital Improvement Project:** **Update:** In December 2015, WSH's Quality Council recommended that a Hospital Improvement Project be created to evaluate the current structure of training and staff development and resource deployment, obtain feedback from staff who deliver and coordinate training as well as those who receive training regarding ideas for change, and submit a recommendation for how we can make changes that will result in more effective training and staff development that will lead to a safer hospital and improved quality of care.
	Effective and Efficient NEO On-boarding Process: It was determined by the Quality Council that an effective and efficient on-boarding process was needed to quickly fill many vacancies the hospital has.	**NEO an Effective and Efficient On-boarding Process:** **Update:** In the Fall of 2015, the Quality Council recommended that a workgroup be created to make NEO a more effective and efficient on-boarding process in anticipation of the need to quickly fill the many vacancies the Hospital currently has by the end of 2016. This new process will take hires directly from the door to the ward floor. In April 2016, the following changes were made to accommodate the on-boarding of staff: • The Recruitment Team, Staff Development and Nurse educators will all be housed in the same building (Building 10) • A weekly start to NEO which allows a new hire to start on the ward quicker; • An expansion of health and safety curriculum; • An expansion of psychology and mental health curriculum; • A seamless transition between general and Nursing NEO; • Addition of mentors to transition staff competencies from the classroom to the floor; • A prioritization of pharmacy curriculum and evaluation for Nurses.
h. Clinical and patient policies and procedures including those related to: 1. Smoking 2. Activity, leisure and therapeutic programs 3. Communication between shifts 4. Restraint and seclusion	WSH continues to improve active treatment and leisure programs to provide patients more meaningful and recovery-oriented activities.	**Activity, Leisure and therapeutic programs:** **Update:** Additional Institutional Counselor 3's (30) have been hired to provide additional active Treatment and Leisure activities on the wards. All PTRC and CFS wards received one rehabilitation staff assigned to a ward 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 7 days a week.
	Communication Between Shifts: It was determined that Communication between shifts was adequate or done consistently for all staff assigned to the ward.	**Communication Between Shifts:** **Update:** In March 2016, Nursing Services Standards Manual – Assignment of Patient-Procedure 201 was revised to ensure **all** staff are knowledgeable of any pertinent or emergent treatment concerns prior to assuming patient care between shifts. This new procedure requires all staff to read the inter-shift report, check assignment form for current

		assignments and initial they have read and understand. This procedure also required staff not available for report to check with the Charge Nurse for any pertinent or emergent treatment concerns prior to assuming care of patients. (All staff includes staff participating in inter-shift safety rounds or other staff who are not able to attend inter-shift report such as overtime staff or pulled staff.)
	PERT Expansion: It was determined by the Ad-hoc Workplace Safety Committee that Expansion of Civil Psychiatric Emergency Response Team (PERT) was needed to respond to patient crisis situations	**PERT Expansion to Civil Wards:** **Update:** PERT has expansion to the Civil Wards (12 FTE's) is a dedicated, full-time unit that responds to patient crisis situations, heightened ward milieu conditions, anticipated troublesome patient movements, and to provide for PO vs. IM situations. PERT has training in de-escalation and can be utilized as a quicker, coordinated response system. They can be called to intervene during early crisis instead of codes. PERT is called in to temporarily assist with care for patients who are unable to exert internal control over their behaviors, are having a behavioral crisis, or are at risk for harming themselves or others, are in need of de-escalation services to regain control, or are in need of milieu reintegration services. PERT uses least-to-most restrictive measures as specified in our policies, in concert with the charge RN to deliver needed treatment to the patient and to keep all involved parties safe from harm. PERT members respond to all code grays.
	Seclusion and Restraint: WSH continues to place a major focus to reduce the use of seclusion and restraint and created a Seclusion/Restrain Performance Improvement Project to develop strategies to reduce it's use.	**Seclusion and Restraint:** WSH continues to work on strategies to reduce seclusion/restraints. There is currently a Patient Seclusion and Restraint Hospital Performance Improvement Project (S/R PIP) underway. The S/R PIP was established to change our culture with regard to seclusion/restraint usage. The committee used the "Six Core Strategies for Reducing Seclusion/Restraint" as a guideline because it is a nationally recognized model that has been tested and works. The three goals set by the S/R PIP include: 1) Reducing seclusion/restraint episodes, duration; 2) Reducing patient and staff injuries and 3) Improving accuracy and completeness of documentation. The model requires every episode of seclusion/restraint be thoroughly documented, examined and analyzed. It also requires Executive support. The changes in the process include: • Documentation, • Process, • Education and • Accountability Several forms were modified to assist. Forms will be labeled with their current form designation plus (S/R PIP) through the pilot process so changes needed can be made and documented. 1. Physician 24 hour assessment 2. Current Seclusion/Restraint Continuation Order and Assessment form 3. Seclusion/Restraint RN Assessment 4. Seclusion/ Restraint Monitoring flow sheet 5. The debriefing form a. patient debriefing form b. staff debriefing form 6. An Administrative Review based on the Six Core Strategies. This tird level review is done by the Center

		Director and the Center Management Team as a deliberate process improvement activity. **In early FY 2017**a pilot will begin on F2. The S/R PIP team will meet weekly to evaluate the episodes of S/R on F2 based on the goals and make any indicated adjustments. If positive changes a CFS ward will be added one at a time after ward staff receive training on the changes prior to their go-live date. Eventually, implementing on other CFS wards and then across the hospital. The S/R team will require ongoing visible, vigorous, consistent and persistent support in order for this project to succeed facility wide.

WAC 296-800-140

Accident prevention program.

Summary.

Your responsibility: To establish, supervise and enforce an accident prevention program (APP) that is effective in practice. (You may call this your total safety and health plan.)

You must:

Develop a formal, written accident prevention program (APP).

*WAC **296-800-14005**.*

Develop, supervise, implement, and enforce safety and health training programs that are effective in practice.

*WAC **296-800-14020**.*

Make sure your accident prevention program (APP) is effective in practice.

*WAC **296-800-14025**.*

[Statutory Authority: RCW **49.17.010**, [49.17].040, and [49.17].050. WSR 01-11-038, § 296-800-140, filed 5/9/01, effective 9/1/01.]