Washington State Department of Social and Health Services

Transforming Lives

WESTERN STATE HOSPITAL

WORKPLACE SAFETY PLAN

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Transforming lives

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1.0 PURPOSE

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

2.0 SCOPE

The Workplace Safety Plan is applicable to all hospital staff, Department of Social and Health Services (DSHS) Maintenance and Operations Division (MOD), Consolidated Institutional Business Services, (CBS), staff, contract staff, interns, students, and volunteers. CBS employees work collaboratively with WSH personnel to create and maintain a safe work environment using a Service Level Agreement (SLA) to identify hospital, MOD and CBS responsibilities and service obligations. The Workplace Safety Plan incorporates applicable federal and state laws and rules including:

- Occupational Safety and Health Administration (OSHA)
- Washington State Labor and Industries
- Division of Occupational Safety and Health (DOSH)
- WAC 296-800-140 Accident Prevention Program
- WAC 296-800-130 Safety Committees
- 72.23.400 RCW Workplace Safety Plan
- Centers for Medicare & Medicaid Services (CMS) DSHS Administrative Policy No. 18.67 Workplace and Domestic Violence
- The Joint Commission regulations (TJC)

3.0 HOSPITAL LEADERSHIP COMMITMENT

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

The hospital center CEOs per WSH 03.130 Workplace Safety v.1 (navexone.com) have delegated authority to the Safety Manager, Director of Infection Prevention Control & Employee Health, Director of Security, and the Industrial Hygienist to stop any action that places the lives of employees, patients, contractors, and visitors in immediate danger.

4.0 SAFETY AND HEALTH RESPONSIBILITIES

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

4.1 Executive Leadership Responsibilities

Executive Leadership responsibilities to create and maintain workplace safety

include:

- Maintain a safety committee in accordance WAC 296-800-13020 and provide employees sufficient time to participate on the committee.

- Ensure injuries and illnesses are recorded and reported and an OSHA 300A Summary is signed by the highest-ranking official at the facility and posted per WAC 296-800.

- Review workplace safety data and implement prevention and mitigation measures to improve workplace safety.

- Provide guidance and supervision to hospital personnel to ensure compliance with the Workplace Safety Plan.

- Recruitment and retention of qualified staff to ensure effective patient care and maintenance of a safe workplace.

- Create, maintain, and promote a Culture of Safety WSH 01.02 Culture of Safety.

4.2 Manager and Supervisor Responsibilities

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

- Employees receive a new employee safety orientation and training to ensure employees know how to perform their duties safely.

- Provide supervision to identify unsafe employee work practices and to provide training or disciplinary action when needed.

- Ensure employee injuries are reported, investigated, and all required documentation is properly completed and submitted to the correct Center Safety Office and DSHS Enterprise Risk Management Office (ERMO).

- Work collaboratively with the center Safety Offices and DSHS Enterprise Risk Management Office to identify changes to work practices or equipment that improves workplace safety.

- Employees know the expectations of a violence free workplace and support is provided to employees who are victims of workplace violence by facilitating debriefings and making referrals to the Critical Incident Stress Management (CISM) team and/or Employee Assistance Program (EAP), as indicated.

4.3 Employee Responsibilities

Employee responsibilities to create and maintain workplace safety include:

- Immediately report any unsafe conditions, injuries, near-miss incidents, threats or acts of violence to supervisors.
- Use personal protective equipment (PPE) as required and immediately report equipment malfunctions, need for service or replacement to supervisors. In addition, removing or interfering with any PPE or equipment safety device or safeguard is prohibited.
- Utilize situational awareness to maintain a safe and respectful work environment, to include acting respectful to patients and co-workers, as well as demonstrating a culture of safety.
- Understand and follow patient treatment plans to improve patient care outcomes and decrease safety risks.
- Understand and comply with safety policies, procedures and training and remind co-workers to use safe work practices.

5.0 SAFETY COMMITTEES AND SAFETY INFORMATION

5.1 Hospital Safety Committees

WSH has three safety committees: two center level committees and one hospital wide safety committee. The purpose of the employee safety committees is for employees and management to mutually address safety and health issues, in compliance with WAC 296-800-130. The committees are responsible for evaluating the effectiveness of the Workplace Safety Plan, reviewing injury data, and overseeing action plans to create, maintain, and improve for a safer workplace.

There are several ways WSH employees can report safety issues:

- Speak with their supervisor
- Contact their respective Center level safety committee
- Send an email to the WSH Safety Concerns mailto:SAFETYCONCERNS@dshs.wa.gov
- Leave a voicemail at 253.756.2500
- Report their concern to the center safety office
- Contact any safety committee member
- Submit an online Report of Work-Related Incident/Close Call (03-133)

Any safety issues brought up that cannot be resolved at the center level safety committee are reported to the hospital wide safety committee. The hospital wide safety committee reviews safety concerns that have been rolled up from the center levels and assigns responsible parties to ensure action plans to address these concerns are completed. Information is communicated back down to the center

level committees, for a top-down and bottom-up communication chain. The hospital wide safety committee should consist of employee-elected representatives and management designated representatives. The management designated representatives are in an amount equal to or less than the amount of employee elected representatives. Guests (Ad-hoc members) are invited as required. Each of the three committees meet monthly and membership is re-appointed or replaced at least annually.

Recommendations or concerns brought to the safety committee by employees are reviewed and the status of action plans is documented in the safety committee meeting minutes. Safety committee meeting minutes for each committee are documented and posted on the center level Safety SharePoint site (See 5.3. below for safety bulletin board locations).

5.2 Environment of Care Committees

WSH has two Environment of Care Committees, one for each Center of Excellence, Civil and Gage.

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

The EOC Committee is chaired by the Planning and Operational Logistics Manager and membership consists of the Chief Operating Officer, Facilities Coordination Office, Safety Office and representatives from Security, Infection Prevention, Quality Management, Consolidated Maintenance Operations (MOD), Medical Staff, Rehabilitation Services, Nursing, Nutrition & Food Services, Environmental Services, Information Technology Infrastructure and Operations (ITIO), and Pharmacy. (Refer to section 7.4)

5.3 Safety Bulletin Board

Western State Hospital has designated safety bulletin boards and their locations are:

East	Building 28, First Floor Between East Campus Nursing Admin and East Campus Pharmacy
Gage Center of Excellence	Building 29, First Floor Outside of Gage Nursing Admin
Central	Building 9, Third Floor Outside of Central Campus Nursing Admin
South & HMH	Building 21, Second Floor, S-2 Outside of South Hall Nursing Admin

The safety bulletin boards contain the following required Workplace Posters (wa.gov) and Federal and State Posters (wa.lcl) :

- **Notice to Employees – If a Job Injury Occurs** (F242-191-000) December 2012.
- **Notice to Employees – If a Job Injury Occurs** (F416-081-909) July 2022.
- **Your Rights as a Worker** (F700-074-000) October 1, 2021.
- OSHA 300A Summary of Work-Related Injuries and Illnesses – required to be posted from February 1 through April 30 of each year.
- Any Department of Labor and Industries citation or complaint documents for the required time frame per OSHA/WISHA regulations.
- **Know your Rights: Workplace Discrimination is Illegal** (June 2023)
- **Employee Rights under the Fair Labor Standards Act (FLSA): State and Local Government Employees** (July 2016)
- **Employee Rights and Responsibilities Under the Family and Medical Leave Act (FMLA)** (April 2016)
- **Your Rights Under USERRA** (May 2022)
- **Employee Rights for Workers with Disabilities/Special Minimum Wage** (January 2018)
- **Domestic Violence** (July 2019)
- **Paid Family and Medical Leave** (December 2022)
- **Nondiscrimination Notice** (edition date not applicable)

6.0 REPORTING AND RECORDKEEPING - INJURY, ILLNESS, AND NEAR MISS

6.1 Employee Responsibilities

- WSH employees involved in an on-the-job injury or a near miss incident must immediately report the incident to their supervisor and complete the online DSHS Report of Work Related Incident/Close Call (03-133) Enter your DSHS credentials used to log into your computer. The submitted online report is automatically sent to the employee's supervisor. The employee's supervisor will fill out the supervisor's review portion of the Safety Incident/Close Call Report (DSHS 3-133A). Completed reports are reviewed by the center level Safety Offices, DSHS ERMO Claims department, and the BHA Incident Review team.

- WSH employees involved in a near-miss or close call incident must immediately report the incident to their supervisor and complete a WSH Form 1-100 Administrative Report of Incident (AROI).

- The Employee Report of Possible Client Assault (DSHS 03-391) form must be completed for all incidents resulting from a potential client assault as outlined in DSHS Administrative Policy 9.02 and attached to the Injury and Illness Incident Report.

- A Post Exposure Packet (provided by the employee health nurse during exposure management) must be completed by employees in cases resulting in an exposure incident or blood borne pathogen exposure.

This is defined as an eye, mouth, other mucous membrane, non-intact skin, or piercing the skin contacts with blood or other potentially infectious materials that results from the performance of an employee's duties. Employees shall immediately report exposure incidents to their supervisor and Employee Health to enable timely medical evaluation and follow up. Supervisors shall refer exposed employees to Employee Health during office hours, or the Medical Nurse Consultant after Employee Health office hours. This is covered in the Infection Prevention Manual located on the Infection Prevention SharePoint site.

- A Labor and Industry (L&I) Form 242-130-000 is initiated at the healthcare provider's office, urgent care or emergency room when receiving medical or emergency treatment for a work-related incident/injury or exposure. The physician completes the form with the employee and mails a copy to Labor & Industries for processing.

6.2 Supervisor Responsibilities

Supervisors are responsible to investigate all injury, illness, and near-miss occurrences and complete the supervisor's portion of the online "Report of Work-Related Incident/Close Call" form DSHS 03-133A. The DSHS ERMO office forwards the report to the WSH Safety Offices.

Investigations must include:

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

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

- This may include participation by first responders, regulatory authorities, union representation, safety manager, safety officer, DSHS ERMO, Clinical Risk Management, Behavioral Health Administration (BHA), and WSH leadership.

- The investigator(s) takes written statements from witnesses, photographs of the incident scene and equipment involved, as applicable.

- As soon as possible post-incident, the investigator(s) must document the condition of equipment, if applicable, and anything else in the work area that may be relevant.

- The investigator(s) makes a written report of their findings and forwards the report to the Safety Office. The report includes a sequence of events leading up to the

incident, conclusions about the incident and any recommendations to prevent a similar incident.

6.3 Safety Manager Responsibilities

The Safety Manager or designee reviews DSHS 03-133 incident forms to ensure all required and pertinent information has been collected. Additional comments or investigation results, if indicated, are included on the form by the Safety Manager or designee. All documentation is forwarded to DSHS ERMO claims department and entered and/or attached to the Risk Master database, as appropriate. Documentation including recommended corrective actions are reviewed by the center level Safety Committees.

The Safety Manager or designee is responsible for posting the OSHA 300A Summary for the previous year on the designated safety bulletin boards from February 1 through April 30 of each year. The OSHA 300A Summary is kept on file for at least five years. Any employee can view an OSHA log upon request at any time during the year.

6.4 DSHS Enterprise Risk Management Office (ERMO) & Behavioral Health Administration (BHA) Responsibilities

The Enterprise Risk Management Office provides workplace safety information, safety consultation, safety training, industrial insurance claims management, safety summits, and monitoring of DSHS' strategic objectives and action plans for reducing violence at WSH.

The ERMO claims unit inputs and tracks injury and illness reports through the Risk Master Database and determines whether the incident must be recorded on the OSHA Form 300 Log of Work-Related Injuries and Illnesses and prepares the OSHA Form 300A Summary of Work-Related Injuries and Illnesses. All recordable injuries and illnesses must be entered on the OSHA log within six days after the hospital becomes aware of the incident. ERMO Claims also produces the OSHA log when requested by regulatory agencies.

The ERMO claims unit provides data reports to the Safety Office and Research, Evaluation, and Data Analysis (REDA) per agreed upon intervals. WSH REDA manages data-related resources to analyze trends. The center level safety committees review incident reports and the associated ERMO data and may conduct incident investigations and/or develop action plans as necessary.

The Behavioral Health Administration post-assault incident review team completes a review of employee assault incidents. The post-assault review is provided to the BHA Risk Management Director and hospital leadership.

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

Chief Executive Officer (CEO) or Designee Responsibilities:

1) The CEO or designee must report to the WA State Department of Labor & Industries (L&I), 1-800-423-7233, option 1, within eight hours of becoming aware of a work-related incident that results in a fatality or inpatient hospitalization of any employee (unless it involves only observation or diagnostic testing).

2) The CEO or designee must report to L&I within twenty-four hours of becoming aware of a work-related incident that results in either a non-hospitalized amputation or the loss of an eye of any employee.

3) The CEO or designee must report the following information to L&I:
   a. The employer's name, location/address where the incident happened, date, and time of the incident.
   b. The names and number of employees harmed and the extent of injuries or illness.
   c. A brief description of what happened and
   d. The name and phone number of the employer contact person for any follow-up required by L&I.

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

Staff must not:
- Disturb the scene except to aid in rescue or make the scene safe.
- Clean up bodily fluids or pick up other items.
- Move equipment involved (e.g., personal protective equipment, tools, machinery, or other equipment) unless it is necessary to remove the victim or prevent further injuries (WAC 296-800-32010).

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

6.6 Patient and Visitor Injuries

All patient and visitor injuries are reported through the Administrative Report of Incident (AROI) System

Western State Hospital has a two (2) center level clinical risk management programs that identify, assesses, and mitigates clinical risks, and promotes patient and staff safety.

Clinical Risk Management provides three types of reviews that assist with violence reductions (1) Clinical Risk Management Team Reviews (2) Root Cause Analysis (using The Joint Commission RCA Framework) (3) Intensive Assessments.

CRM Review includes reviews of assaults (patient to patient, patient to staff assault) that result in an injury requiring care beyond first aid, reviews also include patient behavior if they display a pattern of assaults. This review takes a clinical look at the patient as well as a review of all applicable policies, the findings are reported to executive leaders and the direct supervisor of the area where the incident took place. Recommendations for improvement are included, this review requests a response from supervisors.

A root cause analyses (RCA) is completed on any assault related injury that meets the definition of an adverse event or sentinel event. The RCA provides a multidisciplinary comprehensive systematic analysis that helps to identify system vulnerabilities so that they can be eliminated or mitigated.

Intensive Assessment- looks for casual factors of patient safety events that may not meet the criteria of root cause analysis but are deemed significant.

Reports are provided to the Quality Council on at least a quarterly basis and action plans developed as required.

7.0 HAZARD PREVENTION AND CONTROL

Western State Hospital policies and practices conform to State and Federal safety standards and rules for hazards or potential hazards in the workplace. Facilities are designed and equipment selected to eliminate, when possible, or otherwise limit employee exposure to hazards. Work rules are written to effectively prevent or mitigate employee exposure to the hazard and employees are required to use personal protective equipment (PPE) when required.

7.1 Statement of Conditions

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

7.2 Basic Safety Rules for Employees

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

- Always use safe work practices in performing duties including understanding and using proper lifting techniques, using personal protective equipment (PPE) when required, following safety warning signs, and reading/following product and equipment labels.

- Participate in the Respiratory Protection Plan to eliminate exposures where feasible, use engineering and administrative controls to minimize exposures, and use respiratory protection and other PPE when required.

- The manufacturer's instructions must be followed when using or operating equipment. Unsafe equipment must not be operated, and equipment shall only be operated when trained and authorized. Supervisors must document training before an employee is considered competent to perform the duties of the job.

- Unsafe work conditions, practices and hazard conditions must be immediately reported to supervisors and/or the safety office and may be reported to safety committee representatives.

- Understand and follow the procedures for reporting accidents (refer to section 6.0 Reporting and Recordkeeping – Injury, Illness and Near Miss).

- Staff must comply with applicable collective bargaining agreements and DSHS Administrative Policy 18.75 Drug and Alcohol-Free Workplace.

- Firearms, knives, explosives, or any other weapons are not permitted on hospital property.

- Smoking inside the building or within 25 feet from any entry or ventilation intake is prohibited in accordance with DSHS Administrative Policy 18.65 Smoking in Department of Social and Health Services Facilities and RCW 70.160 Smoking in Public Places.

- Refrain from behavior that is distracting to other employees.

- Maintain good housekeeping and keep emergency exits, aisles, walkways, and working areas clear of slipping or tripping hazards.

- Replace all tools and supplies after use, and do not allow debris to accumulate where it will become a hazard.

- Clean up spills immediately, if trained to do so or block off access to the spill area.

- Refrain from horseplay, fighting and distracting fellow employees.

- Know the location and use of:
    - Emergency telephone numbers

        - Dial extension 2222 in the event of an emergency
        - On grounds from cell phone call 253-756-2692
    - First aid supplies
    - Emergency procedures (chemical, fire medical, etc.)
    - Fire Alarm pull station.
    - Emergency exit and evacuation routes
    - Fire Extinguishers
        - Every member of staff must know the locations of fire extinguishers and how to access them with their key.

7.3 Discipline for Failure to Follow Basic Safety Rules

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

7.4 Environment of Care (EOC) plans

WSH has developed detailed Environment of Care (EOC) plans required by rules and regulations set by DOSH, Centers for Medicare and Medicaid Services (CMS), and The Joint Commission (TJC). These plans are in the Facilities Coordinator's Office and/or the Safety Office and are updated annually. The EOC plans address:

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

7.5 Equipment Maintenance

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

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

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

Interim Life Safety Measures (ILSM)

To assure the safety of all WSH building occupants, Interim Life Safety Measures (ILSM) will be implemented as appropriate when construction activities, maintenance activities, or other conditions that compromise the level of life safety protection provided by the building occur. These conditions include significant deficiencies/impairments to the fire detection, suppression, and notification/alarm system or, when a route of egress is obstructed.

Implementation of appropriate ILSM may be required in or adjacent to all construction areas. Required ILSM's apply to all personnel, including construction workers and must be implemented if required upon project development, and continuously enforced throughout the project as appropriate. The Safety Manager coordinates the planning, implementation, and monitoring of interim life safety plans in coordination with MOD, Facilities, Security, etc. as indicated.

Conditions which may lead to the implementation of Interim Life Safety Measures may include but are not limited to the following evaluation criteria.

a. Emergency exits are obstructed.
b. Fire detection, suppression or alarm systems are inoperable or impaired.
c. Current fire-fighting equipment is insufficient.
d. Temporary construction partitions are not smoke tight or made of non--combustible or limited combustible materials.
e. Increased risks of fire are present in buildings, on grounds, and with equipment, giving special attention to construction and storage areas, excavation activities, and field offices requiring increased surveillance.
f. Increase in the building's flammability and combustible fire load.
g. Situation requires additional fire safety training for individuals on the use of fire-fighting equipment.
h. Activities require inspection and testing of temporary systems monthly.
i. Building deficiencies, construction hazards, and temporary measures implemented require additional education to promote awareness of fire and life safety activities.
j. Impaired structural or compartmental fire features require additional measures and/or training of hospital staff.

When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected, or during periods of construction, the Life Safety Standards will be evaluated and ILSM's put in place using the guidelines outlined in the **INTERIM LIFE SAFETY MEASURES** GUIDE (WSH policy 04.09 Interim Life Safety Measures, while utilizing the WSH form 07-03B, Interim Life Safety Measures Matrix July 2021). Appropriate ILSM's are determined and implemented as follows:

1. The hospital evacuates the building or notifies West Pierce Fire and Rescue (or other emergency response group) and initiates a fire watch when a fire detection/notification system is out of service more than 4 out of 24 hours or a sprinkler system is out of service more than 10 hours in a 24-hour period in an occupied building. Notification and fire watch times are documented via the Fire Watch Monitor Report, and records are kept digitally by the safety office.

2. Posts signage identifying the location of alternate exits to everyone affected.

3. Inspects exits in affected areas daily, when appropriate.

4. Provides temporary but equivalent fire alarm and detection systems for use while a fire system is impaired, when appropriate.

5. Provides additional fire-fighting equipment, when appropriate.

6. Uses temporary construction partitions that are smoke-tight, or made of Non-combustible material, or made of limited combustible material that will not contribute to the development or spread of fire.

7. Increases surveillance of buildings, grounds, and equipment, giving special attention to construction areas and storage, excavation, and field offices, when appropriate.

8. Enforces storage, housekeeping, and debris removal practices that reduce the building's flammable and combustible fire load to the lowest feasible level, when appropriate.

9. Provides additional training to those who work in the hospital on the use of fire-fighting equipment, when appropriate.

10. Conducts one additional fire drill per shift per quarter, when appropriate.

11. Inspects and tests temporary systems monthly, when appropriate.

12. The hospital conducts education to promote awareness of building deficiencies, construction hazards, and temporary measures implemented to maintain fire safety, when appropriate.

13. The hospital trains those who work in the hospital to compensate for impaired structural or compartmental fire safety features, when necessary. Note: Compartmentalization is the concept of using various building components (fire rated walls and doors, smoke barriers, fire rated floor slabs, etc.) to prevent the spread of fire and the products of combustions such as to provide a safe means of egress to an approved exit. The presence of these features varies depending on the building occupancy classification.

Infection Control Risk Assessment (ICRA)

Potential hazards related to construction, renovation or maintenance activity are assessed through the Infection Control Risk Assessment (ICRA) process performed by the infection prevention department/Employee Health manager that identifies potential new or altered risks related to infection control, utilities or building systems, fire safety or interim life safety, general safety issues, emergency preparedness or response, and security. The ICRA is reviewed and monitored by the Center Director, Safety Manager, Security, and Infection Control Coordinator and reported to the Safety, Infection Control and Environment of Care Committee. ICRAs are posted at the job site entrance.

Job Hazard Analysis and Personal Protective Equipment

A Job Hazard Analysis (JHA) form is utilized to evaluate essential job tasks that an employee performs. The original JHA form is completed and sponsored by the safety office and is reviewed annually by a supervisor and an employee familiar with the tasks. 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. WSH Form 07-04C Job Hazard Analysis-Simplified v.1 (navexone.com)

Each JHA has a control method where Personal Protective Equipment (PPE) is identified related to a particular hazard. Employees are trained during their onsite new employee orientation on-boarding with their supervisor on both the JHA for their job class and PPE as it applies to hazards. If a new PPE is identified, a description is added to the corresponding JHA and employees who are affected are trained. A copy of the employee's JHA is provided during new employee orientation.

DSHS Policy 9.07 Safety and Occupational Health Program requires the JHA to be reviewed with the employee at onboarding and annually thereafter for the following types of jobs:

- Job classes with a high potential for injury or illness.
- Job classes with the potential to cause severe or disabling injuries or illness, even if there is no history of previous accidents.
- Job classes in which one simple human error could lead to a severe accident or injury.
- Job classes with a high risk of assault.

For all other job classes, the JHA will be reviewed with the employee at onboarding and then every three years thereafter or sooner if the job class undergoes changes in processes and procedures.

8.0 HAZARD RECOGNITION AND REPORTING PROCEDURES

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

Supervisors must ensure that corrective measures are taken which may include completion of a work order or immediate correction of the hazard. If the employee or supervisor is unable to resolve the hazard, the Safety Manager must be notified. All hazard reports are evaluated by the Safety Manager to determine causative factors and implement corrective actions and reported to the EOC and center level safety committee during regularly scheduled meetings. Actions, as required, are documented in the center level safety committee minutes.

8.1 Environmental Safety Inspections

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

their causes, the Facilities Coordination Office regularly checks the workplace for hazards.

Environmental safety inspections are conducted to ensure that all patient care areas are inspected for hazards at least quarterly and all non-patient care areas are inspected at least annually. The inspections evaluate staff knowledge and skill, observe current practice, and evaluate environmental conditions/hazards. Inspections are conducted in patient care areas by the Facilities Coordination Office quarterly. Inspections for non-patient care areas are at least annually. These inspections are in addition to documented fifteen-minute to hourly environmental checks completed by nursing staff in all patient care areas. The results of the inspections and any action(s) taken are reported to the area supervisor(s), department manager, Environment of Care committee, center level safety committee, and the CEO. Maintenance and Operations Division (MOD) and Consolidated Institutional Business Services (CBS) environmental inspections are conducted in accordance with procedures outlined in their Workplace Safety Plan/Accident Prevention Plan.

A qualified fire inspector conducts a wall-to-wall fire inspection of WSH, which includes all tenant buildings annually. Currently, the qualitied fire inspector is West Pierce Fire and Rescue (WPFR). Scheduling is determined by WPFR.

8.2 Periodic Change Process

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

8.3 Proactive Risk Assessment

Risk Assessments are prioritized to ensure appropriate controls are implemented to mitigate potential adverse impact on the safety and health of patients, staff, and others. The prioritized risks are addressed immediately or integrated into planning objectives and performance improvement processes. Specific findings, recommendations, and opportunities for improvement are documented in EOC and the hospital Safety Committee meeting minutes and reported to the Quarterly QAPI Review Committee (QAPI is Quality Assurance and Performance Improvement), Safety Committee and hospital Governing Body.

8.4 Annual Safety & Health Performance Assessment (SHPA)

Safety staff from the DSHS ERMO/Safety conducts an annual inspection of the hospital to include associated buildings on the WSH campus and the workplace safety program to ensure compliance with applicable regulations, DSHS policies and hospital policies. The inspection provides the hospital with

information about hazards and compliance issues that may be missed during routine inspections. Corrective Action Plans are developed for all inspection findings with identified target dates to ensure each hazard is corrected in a timely manner.

9.0 EMERGENCY PLANNING

9.1 Emergency Preparedness Program

The Comprehensive Emergency Management Plan (CEMP), Continuity of Operations Plan (COOP), and the Hazardous Vulnerability Assessment (HVA) are three living documents and will be updated throughout the year when necessary. Specific Actions to emergencies, evacuation plans, and emergency checklists will continue to be updated throughout the year adding new action items and ensuring the material remains pertinent. Staffing, patient level, construction and logistics all affect specific plans. Emergency Management (EM) will design, conduct, and evaluate exercises annually. Lessons learned from the annual exercises will be put into practice and/or captured in the Improvement Action Plan (IAP) and tracked for completion. Continual monitoring of items in the IAP will take place throughout the year. EM will report out at the Quarterly Quality Review Committee. Hot washes or incident debriefings will take place after all incidents, pre-planned events, or exercises. EM staff will follow WSH 01.03 Emergency Preparedness Program policy to encourage targeted staff take the National Incident Management System (NIMS) and Incident Command System (ICS) training on-line.

9.2 Evacuation Maps

Evacuation maps for the facility are posted in all patient care and non-patient care buildings. Evacuation maps show the location of exits, fire alarm pull stations and fire extinguishers. Fire evacuation drills are conducted at least annually for non-patient care buildings and a monthly drill is conducted in all patient care areas. Documentation of all WSH fire drills is maintained by the center level WSH Safety Offices.

9.3 Hazard Vulnerability Analysis

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

Contingency plans are developed as the result of a hazard vulnerability analysis and are designed to guide personnel in the initial stages of specific emergency situations that may seriously impact or threaten routine capabilities of the hospital. WSH emergency plans are in the Comprehensive Emergency Management Plan

(CEMP) and the Continuity of Operations Plan (COOP) which are developed for the risks identified in the HVA. In addition, plans have been developed for All Hazards that may disrupt food service, pharmacy, staffing, utilities, IT, and other mission essential functions.

9.4 Response to Injuries

First aid supplies are maintained in all patient care locations. First aid kits are also available in non-patient areas and should be appropriate to the occupational setting and work-related activities. First aid supplies are readily available and easily accessible to all employees. First aid supplies should be stored in containers that protect them from damage or contamination and must be clearly marked.

Injuries must be promptly reported to a supervisor. All direct care staff are required to have CPR training and other employees may also have CPR certification. In case of serious injury:

- Injured persons must not be moved unless necessary.
- Assistance must only be rendered to the level of training possessed by the staff member.

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

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

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

9.5 Infectious Disease Exposure Hazard

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

As a matter of routine, employees come in daily contact with a high volume and broad range of patients, other staff, contractors, and general members of the public. Accordingly, employees should anticipate being regularly exposed to any

number of infectious diseases. In all cases, taking standard precautions and being constantly vigilant is the best defense.

The most frequent contagions employees can expect to be exposed to in the course of their daily official duties are common infectious agents that include the common cold and influenza, and COVID-19. Depending on the specific strain, these annually occurring contagions can have the greatest impact on WSH staff and productivity.

Employees should also expect to occasionally be conducting business with patients, other staff, contractors, or general members of the public who may be infected with more severe, though less common, contagions, including but not limited to: Human Immunodeficiency Virus (HIV), or Hepatitis B virus (HBV).

Employees at WSH have little potential for exposure to extreme infectious diseases such as Viral Hemorrhagic Fever (Ebola) or other Pathogens of Epidemiologic Concern. Possible staff introduction to these more fervent contagions while performing routine work is extremely remote. The most likely means of any sort of exposure would be through some form of second or third hand contact with the general public (e.g., exposure to a patient or staff member who has a family member who may have been exposed to a contagion). Employees should review the Washington State Department of Health website for the most current information available.

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

10. SAFETY AND HEALTH TRAINING AND EDUCATION

10.1 Safety Training

Safety training is essential to provide a safe workplace at Western State Hospital. The Safety Manager or designee conducts a basic safety orientation to ensure that employees are trained before they start work. The supervisor is responsible for verifying that each employee has received an initial, site-specific orientation and any additional training required to perform their job safely. Training is documented and maintained in either the employee file or the Learning Center. The Safety Manager in conjunction with Organizational Development is responsible for developing and maintaining New Employee, Annual Safety/Accident Prevention, and Supervisor Safety training materials. Employees are responsible for completing required online or instructor led safety training. Supervisors can monitor required online safety training in the Learning Center, under "MY TEAM" and "Manager Dashboard" and in-person training by having the employee complete a training attendance form WSH 19-31. A copy of the completed WSH 19-31 is kept in the employee's file.

10.2 Basic Orientation

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

10.3 Orientation for Clinical and Nursing Staff

Upon completion of the basic NEO, clinical and nursing staff completes additional training, utilizing a Competency Based Evaluation Tool, related to working with people with mental illness, violence prevention, safety policies specific to patient care, and advanced skills in managing escalating situations with patients.

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

10.4 Site-Specific Training for MOD and CBS

MOD and CBS staff receive site-specific training prior to working at the facility. CBS and MOD staff are required to complete WSH annual Safety and Emergency Response training via the Learning Center.

11.0 WORKPLACE VIOLENCE PREVENTION

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

Prevention of workplace violence is based on principles of:

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

11.1 Definition of Workplace Violence

DSHS Administrative Policy 18.67 provides guidance to DSHS staff regarding workplace violence and domestic violence affecting the workplace. The policy

promotes a safe and secure workplace environment for all agency employees and clients. The policy addresses the employer's responsibility to make reasonable safety accommodations requested by employees who are victims of domestic violence, sexual assault, or stalking unless the employer can show the accommodation would cause an undue hardship.

DSHS Administrative Policy 18.67 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 18.67 defines workplace violence as verbal or physical assault or threatening behavior which occurs in or arises from the workplace and which is committed toward or by DSHS employees, volunteers, service providers, contractors, clients, or customers.

11.2 Workplace Security and Safety Assessment

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

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

11.3 Risk Assessment and Treatment Planning

Patients with an increased risk for assault have treatment plans formulated to address the risk. Violent acts are tracked to identify frequency and severity of assaults.

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

Risk assessment continues throughout a patient's hospital stay and has a dynamic relationship with the patient's individualized treatment plan. Different tools may be utilized to determine risk. A behavior chain analysis is one tool that examines the

links of a behavior chain, including triggers, emotional, cognitive, and behavioral responses, and outcomes that reinforce or support behavior. Communication of risks and new or current information about patients' vulnerabilities and effective treatment responses must be communicated during treatment plan reviews and daily shift changes and report for ongoing situational awareness and tools to mitigate the risk of patient and staff injury.

11.4 Special Population Considerations

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

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

11.5 Effective Patient Care

Preventing and constructively addressing unsafe and violent behavior is a priority for patient care and leads to a safe work environment for staff. The multidisciplinary treatment team works proactively with patients to reduce incidents of unsafe behavior, including assault.

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

11.6 Administrative and Engineering Controls, Work Practices, Security

Western State Hospital complies with WA State Labor and Industries, Division of Occupational Safety & Health (DOSH) and OSHA regulations that apply to workplace violence hazards and accident prevention including mandatory employment practices such as background checks, primary source verification of qualifications, reporting of employee work related hospitalization and/or fatality and provision of safety orientation and training tailored to our specific hospital environment and population.

11.6.1 Administrative Controls

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

Controls include:

- DSHS Policy 18.67 Workplace and Domestic Violence.
- Prohibition of actual or potential weapons on campus grounds.
- State-of-the-art patient behavior intervention program and non-violent crisis response that include verbal and physical de-escalation techniques and training in team communication.
- DSHS Administrative Policy 18.66 Discrimination, Harassment and other Inappropriate Behaviors

11.6.2 Environmental Controls

Environmental controls include:

- Entrance and exit security (locks)
- A system of visitor or contractor access control
- Identification badges worn by Western State Hospital employees, contractors, and visitors
- Alarm systems on the units
- Strategically placed convex mirrors for heightened visibility
- Handheld radios carried by direct care staff
- Closed circuit video
- Use of quiet/comfort rooms for de-escalation when patients are escalating or unsafe.
- Safe furniture appropriate for a psychiatric setting

11.6.3 Work practices

The Behavioral Management Team is a new service and is a united team whose purpose is to support improved patient care for referred patients and increase staff safety through providing multi-disciplinary expertise. The BMT responds to referrals from wards using the BMT referral process. The team includes a Director, Administrative Assistant 3, a parttime Psychiatrist, RN3s, Psychologist 4, Psychiatric Social Worker 3, four Psychology Associates, and three Therapies Supervisors, each working with small teams of IC3s.

As wards send patient referrals, the BMT will:

Triage the referrals to determine what services might be needed, and work with the patients and treatment teams to develop recommendations for incorporation into patient treatment plans.

Provide possible recommendations and support the treatment team with implementing the recommendations.

BMT staff focus on working with all ward staff and patients to identify therapeutic approaches, and will provide a range of services including:

Review of diagnoses, medication, recommendations the treatment team may incorporate into the treatment plan, and review of behavioral processes that lead to seclusion and restraint (including efforts to first use less restrictive measures, seclusion and restraint paperwork and process, debriefing with patient and team, etc.).

Review possible physical health concerns, and therapeutic services to referred patients by psychiatric social workers and psychology associates, and
behavioral analysis and interventions by the psychologist.

Work directly with the staff and patient to implement recommendations, which may involve deploying BMT, and support to treatment teams seven days a week during day and evening shifts.

Micro-training related to situational awareness, CPI/ACIT, de-escalation and patient engagement, and recommendations regarding the ward milieu to lower ward acuity.

WSH has a psychiatric emergency response team (PERT) who are trained in advanced crisis intervention and incident management skills, identification of antecedents for violence and aggression, and de-escalation techniques. The PERT teams respond to code greys including difficult patient situations and manages conflicts by focusing on staff and patient safety. The PERT was created to help ward staff engage with patients in crisis when other methods of engagement have been exhausted. The PERT assists ward staff with behavioral support, de-escalation, physical intervention, and therapeutic presence.

A secondary benefit PERT is enhanced staffing on the more acute patient treatment units throughout the hospital. PERT are not included in the staffing count.

A pendant personal alarm and duress system is operational at WSH. The pendant personal alarm is mandatory for all employees. Each employee is provided their own personal alarm pendant to use in a personal safety and/or security threat situation. Employees can activate their pendant whenever they think there is an immediate or potential violent or aggressive situation. When activated the pendant location is triangulated, a code grey is called, and security guards and additional staff respond. If the pendant moves, the control center provides the security on the ground with updates on location.

The Behavioral Health Administration is implementing Trauma Informed Care (TIC). The TIC model will be useful for achieving positive outcomes such as reducing assaults, reducing seclusion and restraint, improving staff retention, and creating an atmosphere of universal safety. WSH is now working towards being a trauma informed organization that realizes the widespread impact of trauma and understands the potential paths for

recovery; recognizes the signs and symptoms of trauma in people involved with the system of care; and responds by fully integrating knowledge about trauma into policies, procedures, and practices while actively seeking to prevent re-traumatization.

Research suggests trauma-informed care:

- Improves client and staff safety and wellbeing
- Improves outcomes for clients and enhances client care
- Improves employee satisfaction and engagement
- Reduces staff burnout and turnover

11.6.4 Security

WSH Security is the authorized liaison with local police authorities and readily responds to Western State Hospital needs for heightened security or containment of a violent incident. There is a dedicated campus patrol 24 hours per day, 7 days per week on the grounds to WSH. The responsibility of this campus patrol is to respond to all emergent situations.

11.7 Support to Employees

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

All employees injured at work have access to first aid measures and emergency medical response. If an employee sustains a more serious injury, the supervisor assists the employee to obtain additional medical attention if indicated. Supervisors provide employees who are victims of workplace or domestic violence information regarding resources including access to the Employee Assistance Program for counseling and referral on an individual and confidential basis. A Critical Incident Stress Management (CISM) team is in place and may be initiated to provide assistance to staff on a voluntary basis to individuals, team members or as a group who have been impacted by workplace violence.

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

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

11.9 Training to Reduce Workplace Violence

Patient care staff are trained at hire in prevention practices that include but are not limited to strategies for effective communication, situational awareness of the environment, ongoing risk assessment, understanding baseline behavior, safe

application of restraints, defensive tactics, preventing patient abuse and neglect and how to operate emergency equipment.

Western State Hospital utilizes a crisis intervention program that is evidence based and provides staff with the tools to keep themselves and patients safe while maintaining a commitment to positive approaches in serving patients whose behavior(s) may pose a danger to themselves or others. Staff are also trained in approved procedures for physical intervention should a patient become assaultive or engage in self-harm and less restrictive interventions have been unsuccessful. This training includes de-escalation strategies using verbal interventions, body proxemics that enhance safety, evasion techniques to mitigate assault/injury, the hierarchy of physical intervention, and physical containment procedures. All physical skills require demonstration and documentation of competency.

11.10 Data and Surveys Addressing Workplace Violence

Data Review:

Workplace violence is tracked utilizing incident reporting data bases. Administrative forms (DSHS 03-133) Report of Work-Related Incident/Close Call, WSH Administrative Report of Incidents (AROI), and Security Incident Reports are used to document assaults and are reviewed.

WSH uses Tableau as a data and visualization tool and has licenses available for leadership to track data for their areas of responsibility at the ward level or center level. The WSH Research, Evaluation, and Data Analysis (REDA) office focuses their efforts on increasing the availability and transparency of data to ensure data-driven decision making to improve patient and staff outcomes. Tableau is also used to monitor individual patient trends and patterns to determine if individual interventions were effective. The REDA and Safety offices work closely with DSHS ERMO claims regarding staff injury data generated by Risk Master.

Western State Hospital tracks workplace injuries due to assault in the Risk Master Data base maintained by ERMO. Risk Master provides the capacity to compile data for analysis of frequency, severity and other circumstances contributing to a better understanding of workplace violence increasing the potential for a systemic solution.

Data is analyzed at the safety committee meetings and reported quarterly to the Quality Council committee and Governing Body meetings.

Workplace Safety Surveys:

The WA state Department of Enterprise Services, Office of Risk Management, conducts a safety survey open to all state employees. The survey results are used to obtain feedback on communication, teamwork and leadership related to safety. The surveys identify or confirm the need for improved security measures, training, supervision, or management responsiveness. Action plans are developed, as required, to improve the overall Culture of Safety.

12.0 WORKPLACE SAFETY GOALS AND PERFORMANCE IMPROVEMENT (PI)

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

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

Activities and progress related to safety goals and Pl initiatives are reported to the hospital safety committee and/or EOC Committee and provided to the QAPI Review Committee.

13.0 WORKPLACE SAFETY PLAN - ANNUAL EVALUATION

The Safety Manager and Safety Committee members update the Workplace Safety Plan annually for its scope, objectives, performance, and effectiveness, as required under RCW 72.23. 400.

Western State Hospital

Appendix A: Workplace Safety Plan

June 2023

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

Security Consideration RCW 72.23.400(1)	**Assessment**	**Preventative Action(s)**
		Key Core Audits are a daily process that catalogs all core placements and proper door identification. During these audits K.A.C.D. staff examine, replace, or revise cores as necessary to be in compliance with W.P.F.R and the designated job discipline core for the occupant. All activity is updated in our Key Core Matrix.
	Medication Room Doors Some civil medication room configurations allow patients to “reach in” to the medication room.	**Medication Room Doors** Nine WSH Civil wards began receiving upgrades in their med rooms during the second half of 2022. These upgrades will make work locations safer for staff by: Replacing the current hallway med room Dutch doors with new single leaf, heavy gauge metal doors with heavy duty tray-ports and vision panels. Project has completed the design stage. Permit for this project has been received. Construction to start mid-July 2023. Building 28, Gage Center ward server doors have been replaced by new single leaf, heavy gauge metal doors with heavy duty tray-ports and vision panels.

	An on-going project to replace fire doors in multiple buildings that do not meet current code has expanded over time.	This fire door replacement project is still in design phase. This is ongoing.
(a) The physical attributes of the state hospital including: New Fire System(s)	**New Fire System{s}:** New Fire Systems were identified due to aging system **Fire Damper Access**	**New Fire System{s}:** In FY 2021, upgrades to the campus wide fire alarm notification and detection system began construction. The project spans out over numerous buildings throughout campus to replace outdated fire detection and notification systems, construction is anticipated to be completed towards the end of Q2 2023. Fire Damper access has been restricted due to building layout. This project addresses several compliance-related concerns and affords maintenance teams access to better control heating and control distribution to wards throughout campus. Construction is set to begin April 26, 2023.
	Building 29 Roof Replacement	Design began to replace the roof covering eight patient wards to address failing infrastructure in late FY 2021. Construction has begun.
(a) The physical attributes of the state hospital including: Patient Safety Projects	**Patient Safety Projects:** New kitchen facilities necessary for proper patient food preparation. Construction was completed on the Support Services building (Bldg. #22) that houses the main kitchen, commissary, central services, and pharmacy.	**Patient Safety Projects:** The kitchen moved into the new facility in March 2021, immediately followed by the Commissary and Central Services. Additional upgrades to the physical plant included adding new dock levelers for safer material transport and construction renovations to the Pharmacy continue. Construction efforts in the pharmacy are anticipated to reach substantial completion on 8/1/2022.Pharmacy is anticipated to move in by the end of 2022. Although, not directly related to violence reduction, improvements in services rendered

	Create a safe space for patients and support creating a safer environment for staff. Patient seclusion and restraint.	Five WSH civil wards will receive a padded patient room. The project is estimated to cost $365K. The Office of Capital Projects is working on the procurement process now. The five padded rooms are expected to be installed by November 2023. WSH recently purchased new safety restraint chairs for civil wards in January 2022. These chairs are slowly being included as relevant and clinically appropriate. Ongoing staff training to solidify safe use is continuing. Gage has also received safety restraint chairs. Ongoing staff training to solidify safe use is continuing there as well Seclusion and restraint policies and procedures are being reviewed for potential enhancements to enhance safety for staff and patients.
(**a) The physical attributes of the state hospital including:** Elevator Refurbishment	**Elevator Refurbishment:** Operational elevators provide reliable and a safer means of transportation for both patients and staff.	**Elevator Refurbishment:** The following Elevator Modernization projects were scheduled to begin June 2021, Building 21/Elevator 12-1. Elevators 9-1, 29-1 and 29- completed. Refurbishment completed Q1 of 2023.
(a)The physical attributes of the state hospital including: New patient wards	Ward Remodels and Renovations: Environment of Care: In FY 2022, Western State Hospital (WSH) completed or are in the process of completing several patient and staff safety initiatives to create a safer environment for both our patients and staff. Additional forensic wards to accommodate patient	**Ward Remodels and Renovations:** Construction began in September 2020 on two new forensic wards in **Environment of Care:** Building 28, (Wards F9 and F10). Construction is scheduled for substantial completion around late September 2022 timeframe. This was completed in April 2023. An east campus renovation to convert space into a therapeutic treatment and recovery center has been in design since FY 2021. The project is nearing

	capacity. There are multiple projects to promote pedestrian safety around campus. Gage Overhead PA System Replacement Parking Lot Upgrades Clinic Dental X-Ray	the end of design phase and construction is anticipated to begin in August 2022. Construction efforts will span several years, with an anticipated completion date in 2024. Building 29, E7 and E8 will be converted into a new Treatment Recovery Center. Construction efforts will span 20 months, with an anticipated completion date in 2025. Some of these safety initiatives include but are not limited to on-going projects to replace sprinkler heads that are not ligature resistant; fire door replacement in various areas across the campus; replacing security dome mirrors with a safer model; and several other physical plant renovations. Speed humps and flashing pedestrian signs were installed on or along several roadways in FY2022. Over 10 more locations will be receiving speed humps and additional signage to promote pedestrian safety. A new parking area creating 27 parking stalls is being restriped behind building 6 to include cross walks in several locations. A designated Golf Cart parking lot was created by the building 9 tunnel for safety of staff who utilize them not having to park within the normal parking lots. Construction began in FY2021 to replace the overhead PA system that is used to call codes for emergent response throughout campus; construction concluded in FY 2022. Staff parking has been an ongoing challenge on the Western State Hospital campus. Design for a new Gage Center North parking lot began in September 2022. Construction is expected to begin in May 2023 and anticipated completion is August 2023. The new parking lot will provide improved pedestrian circulation and access to and from the Gage Center. Approximately 165 new parking stalls, including 8 electric vehicle charging stations will

	Anti-Ligature/Vandal Resistant Upgrades	be included. Work to replace the East Campus Clinic Dental X-Ray machine began in FY 2022. This converts the equipment over to digital, removing the need to have hazardous chemicals on site to develop film, and affords the opportunity to electronically retain documentation. Construction efforts are anticipated to begin June 2023 and completed by October 2023. Design efforts began in FY 2021 to replace patient furnishings that were identified as being a higher risk for self-harm opportunities. In FY 2022, non-shatter proof clocks in patient common day rooms were replaced with models providing both anti-ligature and vandal resistant properties. This project includes door revisions to East Campus wards containing bathrooms with dual patient room entry points and the replacement of some bedroom furnishings. This work is anticipated to start construction in FY 2023. In FY 2022, non-shatter proof clocks in patient common day rooms were replaced with models providing both anti-ligature and vandal resistant properties.
(b) Staffing, including security staffing	**Nursing/Medical Staff:** **Nursing/Medical Positions are difficult to fill at WSH.** Due to national shortage of nursing/medical staff and competition with the private sector, many nursing positions have been difficult to fill. This	**Nursing/Medical Staff:** **Nursing/Medical Positions Difficult to Fill:** Nursing positions continue to be difficult to fill, the nursing shortage being experienced by WSH was exacerbated by the COVID-19, wage differentials, and a specialty service line; recruitment also continues to be a challenge. Despite this, the hospital has employed a variety of strategies to

	continues to be a challenge.	increase recruitment, such as, contracting agency nurses, billboard advertisement, contracting nursing.com to conduct mailing campaigns, and recruitment through social media such as LinkedIn and Twitter and other websites such as Indeed.com. Work is also being done to link career.wa.gov to the BHA public facing websites, this ensures that when the community "googles" Western State Hospital jobs opening will also be visible. The WSH workforce administration is also attending nursing career day at local nursing school. There is a nationwide shortage of RNs not just at WSH. All of WA and the nation is experiencing a shortage of RN as many RN and healthcare professionals are leaving healthcare as the pandemic is causing accelerated burn out. We are currently in the great resignation as reported by all media types. Additionally, there has been wage increases to reduce wage disparities with the private sector. Also, efforts have begun on identifying more favorable schedules for nursing. Evaluating if moment to 12 hours shifts over 8 hours shifts will enhance recruitment and retention efforts. Developed part-time positions to capture nursing staff that are interested in not working full-time with good success on the Civil side of the hospital.
	Acuity Staffing Model Hospital Acuity Resource Tool, (HART) has been developed and continues to be implemented for both Eastern and Western state hospitals. All future funding for direct care staffing will be tied to this acuity tool and the data the tool generates over time	**Acuity Staffing Model:** HART was implemented in December 2019. Data continues to be collected. BHA received funding for 80.1 FTEs of direct care staff at ESH and ESH in the 2023-25 Biennium totaling 14.8M. BHA is in the process of FTE allotments between ESH and WSH.
(c) Personnel policies	**The WSH Policy Committee** Policies are currently	**WSH Policies and Procedures:** PolicyTech software was purchased by DSHS-Behavioral Health

	updated at WSH using manual type system.	Administration to assist all areas of BHA with updating their policies. The software purchased is designed to allow for efficient distribution of policies, procedures, manuals, and forms. Streamlining our policies and how we update them helps contribute to BHA/WSH overall quality assurance goals. The new system was launched at WSH in January 2021.
(d) First aid and emergency	**Emergency Preparedness:** The Emergency Preparedness Program was evaluated by CSM and the WSH Quality Team. It was determined that all but three CMS standards were met. The remaining three were partially met are currently being improved upon. The EPP continues to meet and in cases exceed the minimum requirements set forth by CMS with regard to emergency preparedness. There are three areas Emergency Management will improve in the next year to be compliant in all standards. E 0032, 007 More specific directions in ward evacuations and inclusion of access and functional needs. Plans need to be posted for access by employees. E 00320 A common way to account for staff after an emergency incident or natural disaster. E 0036 Update all curriculum that exist in NEO, Nursing Incident Management and	**Emergency Preparedness:** WSH continues to participate and plan with our community partners to include the Northwest Healthcare Response Network, Regional Emergency Management Coalition, and others monthly or when topics arise that need immediate attention. The WSH Emergency Preparedness Committee (EPC) reviewed and updated various documents for the Comprehensive Emergency Management Plan (CEMP). Planning is based on an all-hazards approach to identify and address hospital, Lakewood, county, and state risks. The CEMP was signed and adopted for the GAGE center on March 7, 2023. The update for the 2023 Hazardous Vulnerability Assessment (HVA) is in progress. WSH EM is collaborating with WSH SME's, MOD, facilities, EPC and Pierce County Emergency Management. The Continuity of Operations (COOP) plan is being updated in BOLD (the DSHS software program. In the Spring of 2023 EM will begin solicitating an update for succession, key personnel, delegation of authority and the mission essential functions from Center Executive staff. The Administrator on Duty (AOD) manual was reviewed and updated January 2023.

	Emergency Preparedness Plan, annual on-line course.	<u>Hospital Command Center (HCC) Activity</u> There were 7 activations of the Hospital Command Center between June 2022 and July 2023. 3 emergency incidents 2 planned events 2 exercises 7/29/2022 Flood/Heat Incident Gage Center 8/25/2022 Hash Brown Recall Gage Center HCC, Hospital wide involvement 10/20/2022 Great Shakeout Earthquake exercise, Hospital wide participation 10/20/2022 Great Shakeout Earthquake HCC tabletop exercise 12/23/3022 Ice Storm, Civil Center 4/18/2023 Building 29 Power Outage, planned event, aborted. 5/8/2023 Building 29 Power Outage, planned event, second try. Collaboration WSH identified SME's working with Maple Lane facility to receive patient surge of 70 residents if their facility required full external evacuation. As Maple Lane worked on their evacuation plan, WSH worked on accepting patient surge from any entity. Working tandem like this allows opportunity for WSH to develop their external evacuation plans. An exercise involving both facilities will occur in the fall of 2023, or early in 2024.

		Provided Quarterly reporting to the Quality Performance Review committee regarding the percentage of Improvement Action Plan (IAP) items completed or receiving action from After-Action Reports. The After-Action Reports (AAR) are conducted after planned events, real incidents, and emergency exercises. The target is 90% completions or active issues. The percentage varied from 92%-88%. The decline in percentage is attributed to the need to identify and make a Hospital Command Centers (Civil and Gage) operational, continued NIMS training, written evacuation plans, staff accountability plans and the addition of AAR items for incidents that occurred but were not added to the IAP.
(e) Reporting violent acts, taking appropriate action in response to violent acts, and follow-up procedures after violent acts:	**Reporting Violent Acts:** **Psychiatric Emergency Response Team (PERT):** WSH has A psychiatric emergency response team ("PERT") who are trained in advanced crisis intervention and incident management skills, identification of antecedents for violence and aggression and de-escalation techniques.	**PERT:** The PERT teams responds to all code greys including difficult patient situations and manages conflicts by focusing on staff and patent safety. The PERT was created to help ward staff engage with patients in crisis when other methods of engagement have been exhausted. The PERT assists ward staff with behavioral support, de-escalation, physical intervention, and therapeutic presence.
(e) Reporting violent acts, Analysis of data on violence and workers compensation claims during at least the preceding year	**Reporting Violent Acts:** WSH continues to manage the Clinical Risk Management Team, and Safety Committees to assist with ensuring appropriate action in response to violent acts and follow-up procedures after violent acts are completed	**<u>Ongoing:</u>** Clinical Risk Management Team continues to review incident reports for patient safety concerns and WSH's Safety Committees continue to review violent acts, injury & assault data and LNI claim information to follow up on safety concerns and staff injury prevention recommendations to create a safer environment for all.

	WSH Safety Committees: The committees continue to review injury data and L&I claims information monthly to identify where the injuries are occurring and help formulate prevention recommendations on an on-going basis. Data is also captured and presented to WSH Safety Committee monthly.	**WSH Safety Committees:** The safety committees ensure all safety concerns are appropriately addressed. WSH employees can bring safety issues up through their respective Center level safety committees by either e-mailing their safety issues to the WSH Safety Concerns e-mail or, by reporting them to the safety office and/or safety committee members. Any safety issues brought up that cannot be resolved at the center level are reported to Hospital safety committee. The hospital safety committee reviews all concerns that have been rolled up from the center levels and assigns responsible parties to ensure action plans to address these concerns are completed. Information is communicated back down to the center levels committees, for a top-down and bottom-up communication chain. Recommendations or concerns brought to the committee by employees are reviewed and the status of action plans is documented in the Hospital Safety committee minutes.
	Tableau and Data Reports: Tableau Dashboards have been created to assist the hospital with focusing its efforts on increasing the availability and transparency of data at the hospital to ensure it is making data-driven decisions to improve patient and staff outcomes.	**Tableau and Data Reports**: The hospital continues to use Tableau as a data and visualization tool, with over 50 available dashboards. Center directors, Cabinet members, and other staff on the leadership team have been granted licenses to access Tableau, which provides them the ability to track data for their wards and centers, for the purpose of identifying patterns and trends and taking mitigation measures. Data reports are created monthly and are posted on the Research, Evaluation, & Data Analysis (REDA) Office's SharePoint page, which is available to all WSH employees. The REDA Office focuses its efforts on increasing the availability and

		transparency of data at the hospital to ensure it is making data-driven decisions to improve patient and staff outcomes. Hospital-wide data trends for assaults and injuries are presented monthly at the Safety Committee meeting to inform discussion on safety mitigation at the hospital. Tableau is also used to monitor individual patient trends and patterns to determine if individual interventions have been effective for specific patients. The REDA department also works closely with ERMO to ensure the accuracy of staff injury data in Risk Master, and with BHA Investigations staff to ensure they have the information they need to investigate safety-related incidents.
(f) Development of criteria for determining and reporting verbal threats.	**Reporting Verbal Threats:** Verbal threats continue to be tracked and reviewed to ensure appropriate actions and follow-up procedures are taken.	**<u>Ongoing:</u>** 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. Verbal threats are also provided in Tableau in the incident report dashboard so they can be tracked, trended, and analyzed by key staff. REDA staff follow strict coding guidelines and procedures to ensure all incidents are coded the same way, based on established coding criteria and definitions.
(g) Employee Education and Training	**Organizational Development:** In FY22-23, education and training continued to provide to New Employee Orientation (NEO) CPI, Personal Safety courses, and Advanced Crisis Intervention Training (ACIT).	**Organizational Development Training Overview** In 2022 a new personal safety training technique - Choke Disengagement Training was offered to staff, and this training continues to be provided for direct care staff, as a safety measure. New wheeled restraint chairs were purchased in

		2022 for each ward Civil Center of Excellence and The Gage Center of Forensic Excellence. Staff training for these chairs was initially provided to ward direct care staff on each ward. This training was also implemented into the New Employee Orientation (NEO) as well as annual in-service training to ensure training compliance. In April 2022, current training content offered in new employee orientation was reviewed and sent out to other disciplines and departments within the hospital for up-dates, the goal of this was to standardize a multi-disciplinary team process to develop a hospital wide standard of evidence-based best practices. The nationally recognized Crisis Prevention Intervention (CPI) Part 1 - Non-violent Crisis Intervention (NCI) and now, as of March 2023, CPI Part II - Advanced Physical Skills (APS) Training, are both provided and required for direct care staff at the Civil Center of Excellence and The Gage Center of Forensic Excellence. CPI Training Parts I (NCI) and Part II (APS) must be renewed every 2 years. In addition, Advanced Crisis Intervention Training (ACIT) is still required of direct care staff and must renewed annually. Separation of organization development to address the complexity of different populations. With allocated resources to both Civil and Forensics to further specialize and refrain training to better meet the patient and staff safety needs**.**

(h) Clinical and patient policies and procedures including those related to: Activity, leisure and therapeutic programs **Vocation** - 02.12	**Treatment Services/Rehab:** **<u>Vocational program:</u>** The Patient Vocational Training Center (PVTC) is an exciting new program at the Civil Center of Excellence. The purpose of the PVTC is to provide job-related tasks and activities that are productive and offer hands-on practice for vocational readiness. Patients who are not yet ready to engage in vocational activities can learn needed skills through the PVTC.	**Treatment Services/Rehab:** **<u>Vocational program:</u>** No changes to policy or procedure. Patient vocational opportunities are available only to the degree allowed under BHA/ Safe Start associated with on-going Covid-19 restrictions. New vocational training center operating procedures are in progress. Policies and Procedures that govern vocational programing include: 02.12. If changes are made to the CFS level system this policy will require revision. **Patient Vocational Training Center** Interventions used include cognitive remediation, skills training, and aerobic exercise. Several stations are included that patients rotate through as they practice cognitive skills, object assembly, social skills interactions, simulated instrumental activities of daily living, and aerobic exercise (which improves learning). The PVTC opened on June 3 and will serve patients from Central campus. Patients who are accepted into the program will receive six hours of treatment per week for 3-6 months. The following criteria must be considered when referring a patient to the PVTC: • Patient is level 3 or higher • Patient has been risk assessed to be safe to work with various tools and equipment under staff supervision • Patient receives a physician clearance to engage in moderate to vigorous intensity level aerobic exercise Patient would benefit from cognitive

		and function-based interventions to promote independence, build skills, and improve occupational performance.
Occupational Therapy- 8.12 (4.2.4) changed to 10.17	**Occupational Therapy (OT):** Mental Health OT programs remain unchanged this year and are governed by policy as it related to mental health treatment and treatment malls. Physical Function OT programs continue to provide services with no change to policy or procedure.	**Occupational Therapy (OT):** No changes to policy and procedure Launching of the physical OT clinic is estimated for August 2022 Hospital split has had no impact to staffing in OT
Substance Use Disorders Policy 15.04 changed to 02.130 Policy 15.05 changed to 02.131 Policy 15.06 changed to 02.133 Policy 15.07 changed to 02.132	**Substance Use Disorders:** No changes to program or policies in FY 21. The program meets CMS standards and DOH licensure. The program remains at 4 staff and utilizes other WSH rehab staff who are licensed for SUD to assist if available and able to complete assessment training through the SUD department. Continued challenges with meeting consultation requests (CRTS) remain the same as this is a function of staffing for the department.	**Substance Use Disorders:** No changes to policy, procedure, or services within the SUD program. Policies that govern the SUD program continue as: policy 15.04 changed to 02.130 policy 15.05 changed to 02.131 policy 15.06 changed to 02.133 policy 15.07 changed to 02.132
(h) Clinical and patient policies and procedures including those related to: **Communication between shifts**	**Communication between shifts:** Communication between shifts has been impacted by the COVID-19 pandemic.	**Communication between shifts:** Currently in initial parts of working towards the development of change of intershift reporting to a more

		modern format to enhance the end user experience. Western State Hospital communicates regularly to staff regarding efforts to reduce violence. Current efforts to communicate this information include monthly town halls where current assault rates, trends and action plans are discussed. The town hall provides a forum for staff to ask questions regarding current efforts. These meetings are recorded so staff from all shifts can review the information as they are able to. Staff are also able to read about violence reduction efforts through newsletters and emails from our CEOs.
(h) Clinical and patient policies and procedures including those related to: Restraint and seclusion	**Seclusion and Restraint:** Assessment of seclusion and restraint process is on-going to enhance the safety for the patient and staff	**Seclusion and Restraint:** WSH continues to assess the hospitals seclusion restraint process to enhance safety for patients and staff. The hospital did the following to assist staff in reducing the use of seclusion and restraint Instituted more leadership presence in monitoring the process by reporting all seclusion or restrain events that were over 24 hours to cabinet for their input Started two new seclusion and restraint improvement projects: one focused on rate reduction and the other on compliance to best practice/compliance. Implemented the use of a wheeled restraint chair in January 2022 Ongoing ad hoc training for staff on Seclusion and restraint. More training on de-escalation techniques has been ongoing.
h) Clinical and patient policies and procedures including those related to:		**Behavioral Management Team** The STAR Ward staffs' consulting roles expanded to include other patients. By August 2022, it became clear the STAR Ward could not be

Behavioral Management Team		reopened and the STAR Ward program was closed. The Star Ward staff became the Consult Liaison Service (CLS) and provided consultation for the hospital's most acute patients based on their multidisciplinary expertise. Although similarities exist between the former Violence Reduction Team (VRT) and CLS regarding input to treatment teams on behavioral interventions, considerable differences are also present. The CLS staff provided interventions for the treatment team in support of CLS treatment consultation recommendations, while VRT continued their work with patients to address ongoing violent episodes. CLS is a multidisciplinary team that includes a Psychiatrist, Pharmacist, Registered Nurses, Psychologist, Psychology Associates, Psychiatric Social Worker, and Institutional Counselors. The VRT was composed of a Therapies Supervisor and Institutional Counselors. Through efforts of several staff from the VRT, Star Ward program, and CLS teams, a solid foundation was laid for a new interdisciplinary group that provides improved integrated services for the Civil Center's most acute patients. The new service is called the Behavior Management Team (BMT), which retains its multidisciplinary resources and experienced staff. The focus of the BMT is to work as a referral service to treatment teams in both hospital centers. Ward treatment teams can request assistance with patients experiencing challenging behaviors that include aggressive/assaultive behavior, frequent episodes of seclusion and restraint, and other complex behavior patterns. The BMT may also be referred to assist treatment teams by clinical leadership. The goal is to provide all members of the treatment teams with interventions

		to decrease the patient's challenging behaviors so they can optimize the implementation of effective treatment recommendations. The level of BMT involvement may be brief, from two or three weeks to up to three months, depending on the patient's needs. The BMT is a united team whose purpose is to support improved patient care for referred patients and increase staff safety through providing multi-disciplinary expertise. The BMT responds to referrals from wards using the BMT referral process. The team includes a Director, Administrative Assistant 3, a parttime Psychiatrist, RN3s, Psychologist 4, Psychiatric Social Worker 3, four Psychology Associates, and three Therapies Supervisors, each working with small teams of IC3s. As wards send patient referrals, the BMT will: Triage the referrals to determine what services might be needed, and work with the patients and treatment teams to develop recommendations for incorporation into patient treatment plans. Provide possible recommendations and support the treatment team with implementing the recommendations. BMT staff focus on working with all ward staff and patients to identify therapeutic approaches, and will provide a range of services including: Review of diagnoses, medication, recommendations the treatment team may incorporate into the treatment plan, and review of behavioral processes that lead to seclusion and restraint (including efforts to first use less restrictive measures, seclusion and restraint paperwork and process, debriefing with patient and team, etc.).

		Review possible physical health concerns, and therapeutic services to referred patients by psychiatric social workers and psychology associates, and behavioral analysis and interventions by the psychologist. Work directly with the staff and patient to implement recommendations, which may involve deploying BMT, and support to treatment teams seven days a week during day and evening shifts. Micro-training related to situational awareness, CPI/ACIT, de-escalation and patient engagement, and recommendations regarding the ward milieu to lower ward acuity.
h) Clinical and patient policies and procedures including those related to: Response to COVID-19	**COVID-19 Response:** WSH developed an action plan in coordination with the State Department of Health and the Behavioral Health Administration in response to COVID-19.	**WSH's COVID -19 Action Plan:** Although the height of the pandemic is over. Covid-19 continues to require a significant amount of resource to maintain a safe environment for staff and patients. • Use Contact tracing to refine testing. • Update admission/transfer testing for patients. • Continue with targeted patient and staff testing for COVID-19. • Continue to require mandatory face masks for all staff while in patient care areas according to ward risk matrix. Required PPEs/ward risk is posted outside the entrance to every ward. • Started and continue the use of eye protection for staff in area(s) with COVID-19 activity. • Started and continue to

		administer COVID-19 vaccines to staff and patients. • Required all WSH staff be N-95 respirator fit tested and/or equivalent and/or PAPR trained. • Annual mandatory COVID education on LMS. (Annual IP updates). • Participate in BHA infection prevention work groups for COVID guideline updates.