Washington State Department of Social and Health Services

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Transforming Lives

WESTERN STATE HOSPITAL

WORKPLACE SAFETY PLAN

Washington State Department of Social & Health Services
Transforming lives

Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

June 2018

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APPENDIX A. SECURITY AND SAFETY ASSESSMENT

1.0 PURPOSE

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

2.0 SCOPE

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

The WSP incorporates:

- Applicable federal and state laws and rules including the Occupational Safety and Health Administration (OSHA), Washington State Department of Occupational Safety and Health (DOSH), WAC 296-800-140 Accident Prevention Program, WAC 296-800-130 Safety Committees and 72.23.400 RCW Workplace Safety Plan.
- Applicable Centers for Medicare & Medicaid Services (CMS) regulations.
- DSHS Administrative Policy No. 18.67 Workplace and Domestic Violence.

3.0 HOSPITAL LEADERSHIP COMMITMENT

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

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

4.0 SAFETY AND HEALTH RESPONSIBILITIES

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

4.1 Executive Leadership Responsibilities

Executive Leadership responsibilities to create and maintain workplace safety include:

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

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

4.2 Manager and Supervisor Responsibilities

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

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

4.3 Employee Responsibilities

Employee responsibilities to create and maintain workplace safety include:

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

5.0 SAFETY COMMITTEES AND SAFETY INFORMATION

5.1 Employee Safety Committee

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

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

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

Recommendations or concerns brought to the committee by employees are reviewed and the status of action plans are documented in the Employee Safety committee minutes.

5.2 Environment of Care Committee

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

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

5.3 Safety Bulletin Board

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

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

The bulletin boards contain the following OSHA required postings:

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

6.0 REPORTING AND RECORDKEEPING – INJURY, ILLNESS AND NEAR MISS

6.1 Employee Responsibilities

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

6.2 Supervisor Responsibilities

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

Supervisor investigations must include:

- Gathering all necessary information.
- Recording the sequence of events.
- Listing all causative factors as they occur in the sequence of events.
- Interviewing and collecting statements from witnesses as indicated.
- Closely reviewing the employee's statement and description of the incident and identifying any discrepancies between employee's statement and actual findings.

- A determination based on the findings:
  (1) Unsafe Act
  (2) Unsafe Conditions
  (3) Unsafe Acts/Conditions

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

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

6.3 Safety Manager Responsibilities

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

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

6.4 DSHS Enterprise Risk Management Office (ERMO) Responsibilities

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

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

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

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

Chief Executive Officer (CEO) or Designee Responsibilities:

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

Staff Responsibilities:

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

Staff must not:

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

Staff must:

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

6.6 Patient and Visitor Injuries

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

7.0 HAZARD PREVENTION AND CONTROL

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

7.1 Statement of Conditions

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

7.2 Basic Safety Rules for Employees

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

- Always use safe work practices in performing duties including understanding and using proper lifting techniques, using personal protective equipment (PPE) when required, following safety warning signs and reading and following product labels.
- Manufacturer's instructions must be followed when using or operating equipment. Unsafe equipment must not be operated and equipment shall only be operated when trained and authorized. Supervisors must document training before an employee is considered competent to perform duties of the job.
- Unsafe work conditions, practices and hazard conditions must be immediately reported to supervisors and may be reported to safety committee representatives.
- Understand and follow the procedures for reporting accidents (section 7.0).
- Staff must comply with applicable collective bargaining agreements and DSHS Administrative Policy 18.75 Drug and Alcohol-Free Workplace.
- Firearms or explosives may not be on hospital property.
- Smoking inside the building or within 25 feet from any entry or ventilation intake is prohibited in accordance with DSHS Administrative Policy No. 18.65 and RCW 70.160.
- Refrain from behavior that is distracting to other employees.

- Maintain good housekeeping and keep emergency exits, aisles, walkways and working areas clear of slipping or tripping hazards. Replace all tools and supplies after use, and do not allow debris to accumulate where it will become a hazard. Clean up spills immediately.
- Refrain from horseplay, fighting and distracting fellow employees
- Know the location and use of:
    - First aid supplies
    - Emergency procedures (chemical, fire medical, etc.)
    - Emergency telephone numbers
    - Emergency exit and evacuation routes
    - Firefighting equipment

7.3 Discipline for Failure to Follow Basic Safety Rules

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

7.4 Environment of Care (EOC) plans

WSH has developed detailed Environment of Care (EOC) plans required by rules and regulations set by DOSH and CMS. These plans are located in the Facilities Coordinator's Office and/or the Safety Office and are updated annually. The EOC plans 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 is responsible for maintaining all equipment and buildings within the facility. All records are kept in the WSH Maintenance Office and maintenance documentation is kept on file for the life of the equipment.

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

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

Interim Life Safety Measures (ILSM)

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 all interim life safety plans in coordination with others (e.g. CMO, 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 is 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. Situation requires an additional fire drill for each shift in each quarter.
i. Activities require inspection and testing of temporary systems monthly.
j. Building deficiencies, construction hazards, and temporary measures implemented require additional education to promote awareness of fire and life safety activities.
k. 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 MATRIX GUIDE (Attachment B).** Appropriate ILSM's are determined and implemented as follows:

1. The hospital evacuates the building or notifies the fire department (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.

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

3. Inspects exits in affected areas on a daily basis, 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 when appropriate

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. The completion date of the tests is documented.

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 that identifies potential new or altered risks related to infection control, utilities or building systems, fire safety or interim life safety, general safety issues, emergency preparedness or response, and security. The ICRA is reviewed and monitored by the COO, Safety Manager, Security and Infection Control Coordinator and reported to the Safety, Infection Control and Environment of Care Committee.

Job Hazard Analysis and Personal Protective Equipment

A Job Hazard Analysis (JHA) form is utilized to evaluate each type of job task employees perform. The JHA is completed by a supervisor and/or safety committee member along with an employee familiar with the task. The JHA defines the steps of the task, what hazards may be

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

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

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

8.0 HAZARD RECOGNITION AND REPORTING PROCEDURES

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

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

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

8.1 Environmental Safety Inspections

Western State Hospital is committed to identifying hazardous conditions and practices. In addition to reviewing injury records and investigating accidents for their causes, Ward Administrators and the Facilities Coordination Office, regularly check 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 Ward Administrators monthly and the Facilities Coordination Office Quarterly. Inspections for Non-patient care area 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, EOC and Employee Safety Committee and the CEO. CMO and CIBs environmental inspections are conducted in accordance with procedures outlined in their Workplace Safety Plan/APP.

A qualified fire inspector conducts a wall to wall fire inspection of WSH, which includes all tenant buildings annually.

8.2 Periodic Change Process

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

8.3 Proactive Risk Assessment

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

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

8.4 Annual Loss Control Evaluation (ALCE)

Safety staff from DSHS ERMO/Safety conducts an annual inspection of the hospital to include all 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 that may be missed during routine inspections. Action plans are developed for all inspection findings with identified target dates to ensure each hazard is corrected in a timely manner.

9.0 EMERGENCY PLANNING

9.1 Evacuation Maps

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

9.2 Hazard Vulnerability Analysis

A hazard vulnerability analysis (HVA) is completed to determine which hazards require special attention. The HVA provides a systematic approach to recognizing hazards that may affect demand for the hospitals services or its ability to provide those services. The risks associated

with each hazard are analyzed to prioritize planning, mitigation, response and recovery activities. The hazard vulnerability analysis is evaluated annually, at a minimum, to assess the hospital's emergency management activities and to identify necessary changes, additional planning activities and specific exercise scenarios if required.

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

9.3 Response to Injuries

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

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

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

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

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

9.4 Infectious Disease Exposure Hazard

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

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

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

Employees should also expect to occasionally be conducting business with patients, other staff, contractors, or general members of the public who may be infected with more severe, though

less common, contagions, including: Human Immunodeficiency Virus (HIV), Hepatitis B virus (HBV).

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

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

10.0 SAFETY AND HEALTH TRAINING AND EDUCATION

10.1 Safety Training

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

10.2 Basic Orientation

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

CMO and CIBS staff receives site-specific training prior to working at the facility. CIBS and CMO staff are required to complete WSH annual Safety and Emergency Response training via LMS.

11.0 WORKPLACE VIOLENCE PREVENTION

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

Prevention of workplace violence is based on principles of:

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

11.1 Definition of Workplace Violence

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

11.2 Workplace Safety and Security Assessment

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

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

11.3 Risk Assessment and Treatment Planning

Patients with an increased risk for assault have treatment plans formulated to address the risk and includes safety plans to identify triggers and prevention and de-escalation. Violent

acts are tracked to identify frequency and severity of assaults. Weekly inter-shift meetings include the interdisciplinary team and psychiatric consultation to develop treatment strategies, tailor responses, develop staff safety strategies and examine and debriefing interventions or critical events.

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

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

11.4 Special Population Considerations

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

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

11.5 Effective Patient Care

Preventing and constructively addressing with unsafe and violent behavior is a priority for patient care and leads to a safe work environment for staff. The multidisciplinary treatment team works proactively with patients to reduce incidents of unsafe behavior, including assault. All direct care staff are trained in the principles of effective treatment and behavioral management strategies.

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

11.6 Administrative and Engineering Controls, Work Practices, Security

Western State Hospital complies with Labor and Industry and OSHA regulations that apply to workplace violence hazards and accident prevention including mandatory employment

practices such as background checks, primary source verification of qualifications, reporting of employee work-related hospitalization and/or fatality and provision of safety orientation and training tailored to our specific hospital environment and population.

11.6.1 Administrative Controls

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

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

11.6.2 Environmental Controls

Environmental controls include:

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

11.6.3 Work practices

The Psychiatric Emergency Response Team (PERT) is designed as a first-responder system to promote a culture of safety for patients and staff. This highly skilled team, comprised of Psychiatric Security Attendants (PSA), Registered Nurses (RN), Psychiatric Social Workers (PSW), Psychology Associates (PA) and a Supervisor are trained in crisis intervention skills, incident management skills, analysis of the antecedents for violence and aggression, and de-escalation techniques.

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

11.6.4 Security

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

11.7 Support to Employees

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

Supervisors provide employees who are victims of workplace or domestic violence information regarding resources including access to the Employee Assistance Program for counseling and referral on an individual and confidential basis. A Critical Incident Stress Management (CISM) team is in place and may be initiated to provide assistance to staff on a voluntary basis to individuals, 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 Departments' efforts to reduce violence in state hospitals (RCW 72.23.451). This report, "Workplace Safety in State Hospitals" encompasses all three state hospitals, Eastern State, Western State and Child Study and Treatment Center and is submitted to the Legislature by September 1 of each year.

11.9 Training to Reduce Workplace Violence

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

Western State Hospital utilizes a crisis intervention program that is evidenced based, and provides staff with the tools to keep themselves and patients safe while maintaining a commitment to positive approaches in serving patients whose behavior(s) may pose a danger to themselves or others. The program identifies how to provide services and support in a manner that does not promote patient need to resort to aggression or violence in order to participate in treatment, to be heard or to get his/her needs met. Staff are also training in approved procedures for physical intervention should a patient become assaultive or engage in self-harm and less restrictive interventions have been unsuccessful. This training includes; evasion techniques, the hierarchy of physical intervention, physical containment procedures and application of mechanical restraints. All physical skills require return demonstration and documentation of competency.

11.10 Data and Surveys Addressing Workplace Violence

Data Review:

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

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

Data is analyzed at the Employee Safety Sub-Committee meetings and reported quarterly to the Patient Care Quality Council committee and Governing Body meetings.

Workplace Safety Surveys:

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

12.0 WORKPLACE SAFETY GOALS AND PERFORANCE IMPROVEMENT (PI)

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

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

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

13.0 WORKPLACE SAFETY PLAN – ANNUAL EVALUATION

The Safety Manager, Employee Safety Committee and EOC Committee evaluate the Workplace Safety Plan annually for its scope, objectives, performance, and effectiveness, as required under RCW 72.23.400. A year-end workplace safety summary is presented to the Employee Safety Committee, EOC Committee and PCQC.

Western State Hospital

Appendix A: Workplace Safety Plan - Security and Safety Assessment

May, 2018

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

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
(a) The physical attributes of the state hospital including: 1. Access control 2. Egress control 3. Door locks	In FY 18, an annual Security Assessment was completed which outlined several areas for improvement which addressed access, egress and door locks. **Access/Egress:** Difficult to identify who has authorized access/egress to the different areas of the hospital. **Emergency Access/Exits:** Emergency Access/Exits must always be accessible for emergency evacuation.	Policy 13.01 was updated on 7/31/2018, to improve access authorization (badging) and access control within the facility. In addition, processes were put in place to ensure emergency evacuation exits are accessible to appropriate personnel and Key audits are completed annually. **Access/Egress** **Badge Identification:** • The Identification Badge policy was updated on 7/31/2017 to identify the different types of people authorized to be in the facility. Specific colors were assigned to different classification of ID badges, (i.e. staff, vendors, patients, vendors/contractors, visitors etc.) The color badge system created a higher level of security for entry/exit control and identification of persons. • To ensure WSH Identification badge policy is adhered to and controlled; only designated staff are authorized to print badges. **Emergency Access/Exits**: • To ensure emergency evacuation exits are accessible, an Exit Key Audit process was established. • Emergency Key Sets were added at each Center within Key Watcher boxes for authorized staff to access during emergencies. **Key Control:** To identify missing Key sets an annual Key audit was completed by the Key Control Department.

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
		Door Locks: To secure vital areas within the hospital with restricted key cores, the Key Control Department is working with vendors to re-core and update the process.
(a) The physical attributes of the state hospital including: 4. Lighting & Pedestrian safety	**FY 2017** The Lighting and Pedestrian safety capital project began. Items encompassed in this project included: Additional lighting to the central quadrangle to enhance line of site visibility; Additional paving to parking areas east of the quadrangle; and some sidewalk additions to campus to permit safe traveling of staff while on campus. **FY 2018** To reduce the likelihood of undetected violence and to improve pedestrian safety, a campus wide lighting survey was performed in April of 2018. The lighting survey covered more than 400 locations ranging from inside the quadrangle and perimeters to the building exteriors and parking lots. The results of the lighting survey highlighted the areas in the most need of lighting enhancements and/or additional lighting	Update: Capital Projects completed in **FY 17** include: • An upgrade project to the West of Campus that included additional lighting. • Paving of the Building 24 parking lot. • Additional lighting from the DOC parking lot to the Quadrangle fence area to promote employees to park at the west end of campus. The portion of the project that was intended to improve lighting and pave parking lots to the East was not funded in this project. This is an area that continues to need to be completed and has been submitted to Capital for funding. In **FY 18,** a prioritized request based upon the lighting survey to improve paving, sidewalks and site lighting was completed.
(a) The physical attributes of the state hospital including: 5. Alarm systems	**FY 17,** **Fire Alarm Systems:** The Fire Alarm Systems in Building 9, 20 & 21 were identified needing replacement **Personal Alarm/Duress Systems:** Buildings 10, 15, 16, 24, 25 and priority exterior parking lots were identified as needing Personal	**FY17** **Fire Alarm Systems:** • New Fire Alarm systems were installed in January 2018 in Buildings 9 and 20. • The new Fire Alarm system in Building 21 is currently being installed and scheduled to be completed by December 2018. **Personal Alarm/Duress Systems:** • Personal Alarm/Duress Systems were installed in Buildings 10, 15, 16, 24, and 25 • The project did not have the funding to

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
	Alarm/Duress Systems installed to ensure all patient care areas are covered and staff can be located easily in emergencies	complete all a requested exterior parking lots. The DOC parking lot was not completed and has been added to WSH's Capital Request.
(a) The physical attributes of the state hospital including: 6. Anti-ligature improvements	**Environmental:** A comprehensive Environmental Proactive Risk Assessment is completed annually by Environment of Care Committee to identify all physical plant deficiencies and problems determined to present a threat of physical injury to persons; damage to property, or threat to general safety and associated risk. **FY17** In FY 17, it was determined plumbing fixtures, valves, shrouding of exposed pipes, bathroom partitions, vanity mirrors, shower seating and door top alarms were high risks for patients. Most of the identified ligature risks have been mitigated. The hospital does have a few of the capital projects in various stages of completion. (See Adjacent Column for status). **FY18** In FY18, consultants from Russel Phillips were hired to conduct a wall to wall of all patient care areas to assist the hospital with identifying all ligature Risks. Findings from the wall to wall will be mapped, prioritized and funding	**<u>Status of FY17 Anti-ligature improvements not completed:</u>** • Plumbing fixtures replaced with anti-ligature type to include faucets, bathtubs, showers, and valves in all patient care areas as well as shrouding of exposed pipes and plumbing (95% Complete) ***South Hall west still requires a Capital Project to remove the ligature risks in the shower and tub rooms. Contractor required due to these fixtures being cemented in concrete. Project has been funded for $250,000, waiting on Project Manager to hire contractor to complete work.*** • Anti-ligature bathroom partition renovations will begin early March of 2017, starting with a pilot model in building 20 and to be followed by all other multi-toilet partition patient bathroom hospital wide. Full campus wide completion is estimated to occur by the end of 2017. ***This project was 60% complete when funding was cut for Capital Projects. The Project has restarted, 2018. Priorities had to be created and the project changed due to lack of funding. Only patient care wards will be completed. No funding for Treatment Malls or common areas at this time. Will request re-appropriation of funds to complete Project.*** • Door Top Alarms – In design phase: ***This project continues to be in design phase. No appropriate solution has been found yet.***

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
	requests created in order to mitigate all ligature risks throughout the patient care areas of the hospital	
(a) The physical attributes of the state hospital including: 7. Additional Security Improvements	**FY17** See adjacent column for status of the Security Projects that are still in progress from FY17. In FY18, a Security Assessment revealed improvements were needed in the following area to ensure a more secure environment. • There is a risk of a UL or escape from the Pierce County Court located on WSH grounds as the exit doors automatically open directly to the outside.	• Installation of the Viacom Camera System in the central secure Quadrangle is presently in Design Phase. ***This project was completed in January of 2018. Basic installation was completed. More funding needed to expand the camera system throughout the campus.*** • Expansion of the CFS (Center for Forensic Services) Viacom Camera System in 8 locations is presently in Design Phase. ***This project was funded and not completed.*** • Building 18 wall installation project in the communications center lobby to prevent possible patient escape attempts is anticipated to begin in August of 2017. ***This project was not funded and not completed*** • A six second delay was added to the push bar at the Pierce county court to slow down an attempted UL/Escape from the courts. This 6 second delay provides staff the opportunity to catch up to the patient
(b) Staffing, including security staffing	**<u>Nursing:</u>** (2) additional Clinical Nurse Specialist were hired to train on evidenced based practice (12) additional centered based ward educators were hired to provided immediate clinical or medical educational deficits	**<u>Nursing:</u>** To facilitate nursing education and training, two Clinical Nurse Specialists were hired to provide training on evidence based practice, seclusion and restraint, treatment planning, patient outcomes, medical assessment, and nursing practice standards. In addition as an adjunct to further facilitate training and education, the hospital hired centered based ward educators who work collaboration with the Clinical Nurse Specialist to provide on the spot training to address immediate clinical or medical educational deficits. The Clinical Nurse Specialists provided the following additional training to all appropriate staff in FY 18:

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
		• Maintenance of a safe and clean environment by identifying, mitigating, and correcting unsafe or hazardous conditions, including ligature risk areas or points. • Our admission process and standards were revised with stronger language on ensuring the patient's rights to Privacy and providing an accurate and sound assessment of the patient's needs and functional deficits. We also added a hyper link with instructions on the hospital policy (7.02) on what the RN needs to do if the RN suspects that there signs of physical abuse, neglect, or sexual assault. • In addition, instruction and training was provided on dealing with the suicidal patient with a hyperlink to the hospital policy was added. Nursing Standards Committee was form to ensure that our current treatment of both medical and psychiatric concerns reflect current best practice
	Security Staff: Security Staff where allowed to Bid into the posts that they wanted to work. This was a change from a previous practice of staff rotating each day into different assignments. A relief factor was also built into the staffing model which allows staff to take required time off without the use of overtime.	**Security Staff:** Security Staff working in a dedicated post provides stability to the area that the staff are assigned in. This allows patients to get to know the same staff working in the same area daily. This should ease the tension between patients and security staff.
	Violence Reduction Staff: The program's personnel include (1) Violence Reduction Program Administrator, (1) Violence Reduction Supervisor, and (8) Institutional Counselor 3 (IC3) positions. (6) IC3s are scheduled for day shift and (2) IC3s are scheduled for swing shift. The function of the IC3 is to:	**Violence Reduction Staff:** The function of the IC3's is to: • Identify and review all assaults throughout the hospital on all shifts and offer nursing staff preventative strategies, when necessary, to mitigate future assaults. • Provide scheduled and coordinated on-ward services in the form of preventative behavioral interventions, training/mentoring of ward staff, and intensive patient monitoring coaching for staff serving patients who demonstrate or have a history of high-risk/violent behaviors.
	Active Treatment Staff: In FY 18, 4 substance abuse screening staff were hired.	**Active Treatment Staff** These staff receive referrals, completes the screens and interface with social work when patients are

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
		discharged.
	In FY 18, 1 OT manager was hired.	OT Manager provides clinical supervision and complete competency evaluations of OT staff.
	In FY18, 1 Speech Therapist was hired.	Speech Therapist was hired to develop and begin providing in patient speech services.
	Facilities Coordination Office: In FY 18, (1) Facilities Planner 2 and (1) Facilities Planner 1 were added to the Facilities Coordination Office due to contractors leaving penetrations in our fire and smoke barrier walls after completing their projects.	**Facilities Coordination Office:** The Facilities Coordination Office will be providing the hospital with an "Above the Ceiling Team". This team processes permit requests; approve/disapprove above ceiling work requests; verifies in the field that work was completed correctly and no penetrations found in area where vendor performed the work.
	Central Campus Control Center: (10) PBX Switchboard Operator positions and one communications chief position were delineated then re-established as 10 Security Guard 1 positions and one Security Guard 3 position.	**Central Campus Control Center:** The main location that receives customers from the public, outside telephone calls and where emergencies are reported has historically been referred to the PBX Switchboard. Assessment of the work performed in this area is similar to that of a 911 Emergency Dispatch Center. In November 2017, the hospital experienced 6 vacancies, (more than half the work force), due to lack of attraction and retention of staff due to low pay. As a result, positions were delineated and then re-established as 10 Security Guard 1 positions and one Security Guard 3 position. In addition, the workplace area was re-named the Central Campus Control Center. The new rate of pay for the veteran staff, and SG1's began on April 16, 2018. During April 2018, candidates were interviewed and the first two hired starting April 30 and another hired for May 21, 2018. The new Control Center supervisor was hired to start on May 25th after approval of a bid for that position.
(c) Personnel policies	WSH Policy Committee continues to simplify the hospital policies to ensure they are easy to find and easily understood	WSH has developed a policy manual that is user friendly and includes easy to find and easy to read policies. All WSH policies are in the process of being "plain talked" and updated in the Sunset Review Process. The WSH Intranet homepage was redesigned, with easy to identify Policy Manual and Forms links. The policy chapters include 14 Chapters: 1. Administrative Services

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
		2. Admission and Discharge 3. Employees 4. Environment of Care and Facilities 5. Financial 6. Health Services 7. Incident Management 8. Patient Care 9. Patient Records 10. Patient rights 11. Campus Services 12. Safety 13. Security 14. Forensic Services (Added Aug 2018) These chapters are designed to facilitate WSH employees being able to look for a policy intuitively. WSH estimates all policies will be plain talked by August 2018.
c) Personnel policies:	Three new policies were created and three were updated to enhance safety and security throughout campus	Policies focusing on improving safety: **<u>New:</u>** WSH Policy 1.17 Ward Quality Performance Improvement: Uses performance indicators to deliver data directly to ward staff on patient to patient assaults, patient to staff assaults, as well as patient falls to increase safety awareness and inform patient care decisions. WSH Policy 8.35 Patient Identification Bands is a new, patient ID bands are now used to assist staff in identifying patients during treatment and in an emergency. New WSH Policy 12.13 Emergency Preparedness was created to describe the Emergency Preparedness Program (EPP) at WSH. The EPP maintains a high degree of emergency preparedness and response capabilities to ensure the health, safety and security needs of patients and staff. **<u>Updated</u>**: WSH Policy 4.17 Personal Electrical Equipment: updated with the process for inspecting electrical equipment and to specifically prohibit personal space heaters and electrical cords. WSH Policy 7.01Administrative Report of Incident (AROI) was updated with refined processes to review, analyze and trend incidents, including serious patient to staff assaults, to support WSH's

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
		Culture of Safety. WSH Policy 12.02 Workplace Safety was updated from the 2010 version, including current links and process for supporting a safe environment. Crisis Prevention Institute Training is one of several inclusions in this update.
(c) Personnel policies: including Standard Operating Procedures	Several Security Operating Procedures needed updating to meet the changes of various policies.	The Patient Visitation Policy was updated which required changes to how visitors were processed by the Security Department and assigned to the Center Substations. Changes to the process for handling and processing evidence were updated. Changes to off-site Hospital Watch process. • SOP # 3 Patient Admissions to CFS and off Ward Evaluations • SOP # 25 Evidence/Discovery/Handling/Disposition • SOP # 29 Chain of Custody • SOP # 36 Hospital Watch • SOP # 50 Central Campus Security Substation • SOP # 51 South Hall Substation • SOP # 52 East Campus Substation New or updated
(d) First aid and emergency	Through self-evaluation and a cursory review by CSM consultants, it was determined that overall the hospital meets the minimum requirements set forth by CMS with regard to emergency preparedness.	WSH continues to participate and plan with our community partners in patient surge and mass casualty incidents with the Northwest Healthcare Response Network. (NWHRN) The local WSH Emergency Management Committee reviewed and accepted the Hazardous Vulnerability Assessment from the City of Lakewood, Tacoma/Pierce County Health Department, Pierce County Department of Emergency Management, State of Washington Emergency Management Division and DSHS Behavioral Health Administration in 2017. Emergency planning is based on an all-hazards approach as a result of the risks identified. The Comprehensive Emergency Management Plan (CEMP), Continuity of Operations (COOP) and the Administrator on Duty (AOD) manuals were reviewed and updated, especially the emergency checklists. Last year there were 30 activations of the Hospital Command Center. 15 emergency incidents occurred, 12 significant events met the criteria for an Incident

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
		Command System structure and three exercises were planned and conducted. **<u>The emergency incidents consisted of:</u>** • An attempted suicide, missing door handle (weapon and security breech), Fire evacuation, printer outage, clinical staff shortage, structural compromise, two fires, fire system failure, fire alarm outage, hazardous material dumpster event and the Amtrak Train Derailment. **<u>Pre-planned everts were:</u>** • Patient escorts, hyper-chlorination disinfection process, CMS survey (2), dignitary visit, PBX and power outage (6), BHA ICS Orientation, Patient surge (3), Eclipse event, ward evacuation, and a CMS monitoring visit. **<u>Emergency exercises consisted of:</u>** • Two patient surge exercises and the Amtrak Train Derailment with our community partners.
(e) Reporting violent acts, taking appropriate action in response to violent acts, and follow-up procedures after violent acts:	The Hospital established Hospital Safety Concerns Manager to assist with providing employees and others a confidential way to report concerns about hospital safety.	A Hospital Safety Concerns Program Manager has been hired at the hospital and a Hospital Safety Concerns Program has been established to provide a means, independent of an employee's chain of command, to report, review, and resolve safety concerns for reporting and resolving safety issues. The program is designed as a confidential way for employees and others to raise their concerns about issues related to hospital, industrial, and environmental safety. In FY18, the Hospital Safety Concerns Program received over 100 safety concerns which have been researched, assessed and resolved.
(e) Reporting violent acts, Analysis of data on violence and workers compensation claims during at least the preceding year	**Critical Risk Management Team, (CRMT)** continues to review violent acts on a daily basis and follows up on any safety concerns. **WSH's Safety Committees** (monthly) continue to review injury data and L&I claims information on a monthly basis to identify where the injuries are occurring and help formulate prevention recommendations on an on-going basis. Data is also captured and presented to WSH Safety Committee on a monthly basis. **Violence Reduction Team:** To reduce Violence on the wards,	**<u>Ongoing:</u>** CRMT and WSH's Safety Committees continue to review violent acts, injury data and LNI claim information to follow up on safety concerns and staff injury prevention recommendations in order to create a safer environment for all. **<u>Update/New:</u>** **Violence Reduction Team:**

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
	the Violence Reduction Team reviews all assaults and offers nursing staff preventative strategies, behavioral interventions, training/mentoring and coaching, when necessary, to mitigate future assaults. **Additional Focus Groups:** In FY17 & FY 18, Patient to Staff Assaults increased at WSH. To help mitigate this recent increase, two additional focus groups began conducting further reviews of the assault data to assist with decreasing violence throughout the hospital: • Executive Leadership Team (ELT) utilizes Friday morning huddles to specifically review and analyze assault data • A Workplace Violence System Focused Improvement Project (SFIP) was developed to continue reducing violence	The Violence Reduction Administrator reports to the Patient Care Quality Committee (PCQC) on a monthly basis, information relating to all assaults that occurred during the previous month. During this report, the Violence Reduction Administrator offer trends the VRT has identified that contribute to assaults. In addition, strategies that can help reduce such assaults. **ELT Morning Huddle:** ELT utilizes their Friday morning huddles to specifically review & analyze assault data. They look at patient to patient and patient to staff assaults and compare the data to the previous weeks. Outlier data and patients are discussed. The team discusses actions already taken, actions currently in place and works together to develop additional immediate actions to take in an effort to reduce violence/assaults. They discuss the data and actions by center and share practices and interventions that have been effective. This helps ELT monitor and keep a pulse on assaults throughout the hospital. Staff injuries and follow-up with staff are discussed daily as they occur in morning huddle as well. **Violence Reduction SFIP:** WSH has determined four main areas to focus improvement efforts. They have termed them System Focused Improvement Project (SFIPs). Each SFIP has a charter and consists of a multidisciplinary team that has developed and implemented process improvement action items. Data is reviewed from each distinct area that contributes to the process and helps to form data-driven decision making. The teams meet regularly to monitor the projects improvement progress and reports regularly to Leadership. Violence Reduction was one of the SFIPs and has an executive sponsor. The team is in process of implementing action items and reviewing data for the effectiveness of actions taken. This team has also worked in conjunction with our CSM consultants throughout the entire process. As part of the Workplace Violence SFPI, the hospital has developed a three-tier committee structure. The committee tiers are focused on all wards throughout the hospital, however, the top 9 wards featuring assault incidents have been focused on initially. 1. The Project Executive Team (PET) will oversee the process of the subordinate groups and offer support and mentoring as

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		needed. 2. The Violence Reduction Design Group (VRDG) will develop strategies to offer the Hospital in an effort to reduce violence. The VRDG will report to the PET at least bi-weekly, strategies under development and others ready to implement 3. The Violence Reduction Implementation Team is responsible for implementing strategies created by the VRDG. The group will be led by the ward Psychologist, Rn3s and Ward Administrators. They implement the strategies in the context of their individual ward, Center, and patient population. The Violence Reduction Design Group (VRDG) has created three strategies to support the reduction of violence. The below strategies to reduce violence has been completed on the top 9 assaultive wards. • **Medication Initiative:** The PET has identified an opportunity to focus on medication optimization, medication practices, and medication administration algorithms, regarding specific patients who present dangerous/assaultive behaviors. • **Confinement Reduction Initiative:** This strategy addresses the assault activity that occurs during periods of unstructured time on the units. The strategy contemplates the areas in each center that require adjustment. This includes the creation of comfort carts and comfort rooms on East Campus wards, extra off-ward activities on Central and South Campus wards, and the Center for Forensic Services (CFS). CFS was also targeted for additional yard-out periods, extra off-ward activities, and budgetary increases in ward incentive programs. • **CPI Training**: This nationally known Crisis Prevention Training Program is currently being implemented for delivery to all staff, on all shifts. The goal is to have staff from all disciplines to speak the same language when engaging patients who experience high-risk and or assaultive behaviors. The above strategies are currently being expanded to

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		the rest of the hospital to assist with reducing violence.
(f) Development of criteria for determining and reporting verbal threats.	Criteria have been identified within the Administrative Incident Reporting policy for reporting verbal threats.	Verbal threats continue to be tracked using the Security Incident report and/or the Administrative Report of Incident and reviewed in the Critical Risk Management Office to ensure appropriate actions and follow-up procedures are taken in response to verbal threats.
(g) Employee Education and Training	**Organizational Development:** In FY18, education and training provided to employees needed continued improvement. A staff education team in Organizational Development was formed and a curriculum review board was established to review all training and revisions, as necessary.	A comprehensive Education and Training on all new nurses employed by Western State was developed by Organizational Development to ensure that nurses are fully trained to work on the wards. Since July 2017, the Center for Organizational Development (OD) has completed the following: • Completed the hiring of 12 new Ward-Based Nurse Educators with the role of providing education and training across shifts directly to the wards. • Trained 20 multi-disciplinary staff to be instructors in the Crisis Prevention Institute (CPI): Nonviolent Crisis Intervention model. • Completed CPI training for 10 wards identified by the Violence Reduction Design Group as having the highest rates of violence. • As of this date, OD has successfully completed CPI training for 667 staff and established the goal of training all direct-care ward staff by December 2018. • Hired a Safety and Intervention Administrator. • Provided Fire Box Training for all staff and added the curriculum to New Employee Orientation (NEO) for continuous training. • Provided Fire Watch Training for all staff. • Provided Emergency Preparation Training through the Learning Management System (LMS) for all staff, and added the curriculum to NEO for continuous training. • Completed Module 1 of the Enhanced Safety Training with a total of 869 trained. • Implemented an Application of Restraints refresher training in March 2018 and have trained 200 staff as of this date. • Developed and launched CPI Coaching tools (incident debriefing forms, posters, pocket cards, etc.) for use on wards. • Implemented a Situational Awareness course in NEO.

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		• Implemented a Baseline Behavior course in NEO.
	Emergency Preparedness Training: In accordance with the new Center for Medicare and Medicaid Services (CMS) standards Emergency Preparedness Training was developed and delivered to all staff.	**Emergency Preparedness Training:** In December 2017, an hour long session for the Emergency Preparedness Program was developed for and is being delivered in New Employee Orientation, Security Officer Academy and Nursing Leadership. An on-line Learning System Management (LMS) class was launched for all staff to be knowledgeable in the Hospital's Emergency Preparedness Program in accordance to new (CMS) standards.
	Security Officer Academy: In an effort to reduce violence Hospital wide, a comprehensive "boot camp" style Security Officer Academy was developed.	**Security Officer Academy:** The three week long Academy focuses on crisis intervention and de-escalation while maintaining a safe and secure environment in a psychiatric hospital setting. The Academy covers a broad range of topics such as; security inspections, environment of care items, fire and life safety, incident mitigation and response strategies, client engagement, professional conduct, workplace violence, emergency management and crime scene management/evidence collection. The Academy utilizes both classroom and practical application to fully immerse trainees into the fundamentals of therapeutic security as well as the principles for safe response to emergent situations. Created an immersion based Academy specifically designed for the Western State Hospital Communications center (Control Center.)
	Central Campus Control Center: Due to the complexities of the work in Central Campus Control Center, the Safe Operations Team was assigned to help train new staff.	**Central Campus Control Center:** The new plan includes training at least two staff in approximately five to six weeks. The older training model took up to three months, (1 person at a time). The WSH Control Center serves as the central communication hub and emergency dispatch for the hospital. They work frequently with surrounding Law Enforcement as well as responding emergency personnel/first responders to dispatch them where they are needed on or off hospital grounds. The Control Center Situation Based Immersion Training and Testing (SBITT) academy was designed to accelerate the cognitive development of the trainee, so the trainee can quickly learn all the

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		processes to competently complete all critical tasks required of them. During the SBITT, the trainee is subjected to a high volume/repetition of realistic scenarios consisting of complete tasks profiles specific to the WSH Control Center.
(h) Clinical and patient policies and procedures including those related to: 1. Smoking	Policy 4.05 Tobacco use was updated to include the step by step Wanding process to ensure lighters are not brought into the facility.	This is a preventative measure to ensure flammable items are not introduced into patient care areas.
(h) Clinical and patient policies and procedures including those related to: 2. Activity, leisure and therapeutic programs	WSH has implemented a Substance Abuse screening program to improve the treatment provided to patients and communicate this information at discharge for continuity of care. • Policy 11.20 Substance Use Disorders Program Screening Assessment, Documentation and Transfer of Service • Policy 11.22 Substance Use Disorder Program Training In addition, Substance Abuse groups are provided in the Treatment Malls. Active Treatment services continue to offer evening and weekend programming as well as on ward and treatment mall services. CMS cited WSH for lack of supervisor for Occupational Therapy Services. Occupational services have been expanded to include individual OT services to assist with patient's functioning levels. The physician may refer for a specific Occupational need and services are provided. WSH had hired an Occupational Therapy Services manager and Speech Therapist. The speech	WSH had improved active treatment services by broadening the services provided for Substance Abuse and Speech Therapy. In FY18, 4 substance abuse screening staff was hired. These staff receive referrals, completes the screens and interface with social work when patients are discharged. The Active treatment staff provides the annual Carnival, special events, gardening, bike riding and other outdoor activities in the spring and summer. In FY 17, 1 OT manager was hired, to provide clinical supervision and complete competency evaluations of OT staff. These evaluations ensure OT staff are providing high quality, safe OT services.

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	therapist now provides individual speech therapy sessions as well as swallowing evaluations when referred by a physician.	1 Speech Therapist was hired to develop and begin providing in patient speech services. This can include swallowing evaluations that assist with reducing risk of choking.
(h) Clinical and patient policies and procedures including those related to: 3. Communication between shifts	Nursing recognized a need to further improve communication between shifts	A revision of our inter-shift report was conducted to ensure the complete ward team is informed of the status of every patient.
(h) Clinical and patient policies and procedures including those related to: 4. Restraint and seclusion	**Seclusion and Restraint:** WSH continues to place a major focus to reduce the use of seclusion and restraint.	Policies and procedures on Seclusion and Restraint of patients were revised and updated to reflect current best practice with repeated oversite by ward supervisors and nurse managers. We provided staff specialized training on Nonviolent Crisis Intervention, communication, and how to safely manage and prevent difficult behavior. We placed much more emphases on staff utilizing least restrictive alternative to address patient's behaviors and using restraint/seclusion as a last resort.