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	August 2019		
Effective Date:	**August 2019**	Revised Date:	**June 2019**
Approved by:	Chief Executive Officer		Date
	Chief of Safety & Security		Date

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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. 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 ward has its own safety committee, which report to their respective center-based safety committee, which then report to the hospital-wide safety committee. The hospital-wide committee reviews all concerns that have been rolled up from the ward and center levels and assigns responsible parties to ensure action plans to address these concerns are completed. Information is communicated back down to the center and ward levels, for a top-down and bottom-up communication chain. The hospital-wide Safety Committee consists of employee-elected representatives and management designated representatives, in an amount equal to or less than employee elected representatives. Guests (Ad-hoc members) are invited as required. 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 is documented in the Employee Safety committee minutes.

Meeting minutes for each committee are documented and posted on the WSH Safety Committee SharePoint site and posted on designated Safety bulletin boards. (See 5.3. below for locations)

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.***

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, or a near miss incident** must immediately report the incident to their supervisor and complete a current Safety Incident/Close Call 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 and they will fill out a current Supervisors Review of the Safety Incident/Close Call Report (DSHS -3133) 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 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 analyzed by the Critical Risk Management Team. Reports are provided to Patient Care Quality Council Committee 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 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

Western State Hospital has one Violence Reduction Team (VRT) and two (Civil/CFS) Psychiatric Emergency Response Teams (PERT) that report to the WSH Violence Reduction Manager. These two teams are additional resources to be used by the hospital when necessary to assist with reducing violence throughout the hospital. VRT is an interdisciplinary team extensively trained in crisis intervention skills, incident management, analysis of antecedents for violence and aggressions, and de-escalation techniques and provides the below resources to the hospital:

Reviews all assaultive incidents across the hospital daily and performs daily functional assessment using an ABC (Antecedent – Behavior – Consequence) chart to record changes in behavior and identify inconsistencies with baseline presentation. This team also identifies trends amongst the patients with consistently assaultive behaviors and engages with the top ten most assaultive patients in the hospital. They therapeutically engage with patients that have assaultive behaviors to identify triggers of aggression and support the development of effective coping skills to reduce the number of assaultive incidents. In addition, they provide recommendations to treatment teams and ward staff, offering evidence-based interventions for mitigating assaultive behaviors, and milieu support on wards with higher acuity and offers immediate feedback and strategies for mitigating incidents.

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 is 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 actively responding to incidents, team members provide direct, therapeutic engagement with patients, often modeling best practices for staff.

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

1.6.4 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 is trained at hire and annually 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 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. 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 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 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, 2019

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 19, 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.	**Access/Egress:** **Update/New:** **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. Since 7/31/2018, over 1,000 contractors have been processed and badged according to policy. • To ensure WSH Identification badge policy is adhered to and controlled; only designated staff is authorized to print badges, all badge printing devices have been removed from locations around the facility and are now in restricted offices of those designated staff. **Continued Revisions to the Badge Identification Process as outlined below have been implemented at WSH in FY19 in order to ensure a safe environment for all:** • As of June 1st, 2019, the contractor badging process has been revised to ensure all contractors working on ground be background checked, trained and badged accordingly. • Security staff at the Quad Gate entry is trained regarding how to properly identify & clear everyone coming into the Quad Gate. Badging staff are notified when a person is attempting to enter without a badge and each incident is reviewed on a case by case basis. • Each Security Substation has been equipped with a temp badge checkout binder; IDs are taken and exchanged for temp badges as

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
		needed if the individual is cleared to enter the facility.
	Emergency Access & Exits: Emergency Access/Exits must Always be accessible and clearly identified for safe emergency evacuation.	**Update/New:** **Emergency Access/Exits**: • New evacuation floor plans were created and posted on walls in all healthcare occupancies at WSH during the first half of FY2019. **Ongoing:** • To ensure emergency evacuation exits continue to be accessible, an Exit Key Audit process was established and continues to be followed. • Emergency Key Sets continue to be available 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 continues to be completed by the Key Control Department.
	Door Locks: Allow access to all portions of a given building with no more than five master key cores.	**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. **Update/New:** **Key/Locks Multiple Building Key Core Replacement Project:** A Master Key Access Plan was submitted to West Pierce Fire Multiple Building Key Core Replacement Project This project improves emergency access to all building(s) rooms for emergent response crews. WSH currently has over 700 different keys, many of which do not have master keys. This project re-cores doors throughout WSH so that each building has no more than 5 master keys for the entirety of each building to provide efficient ad timely access for emergency response and inspection crews. A plan for re-coring was developed FY2019

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
		and key cores ordered to address HD series lock. Key cores for the HD series have been ordered and are in process of being coded. Cores are anticipated to arrive in late FY2019. Installation to occur early late FY2019 thru FY2020.
(a) The physical attributes of the state hospital including: 4. Nurse Station Enclosure Project	**<u>Nurses Station Enclosure Project:</u>** Due to several recent incidents of patients climbing over nurse's stations and injuring staff, a decision was made to enclose all nurses' station throughout campus.	**Nurse Station Enclosure Project** • 3 nurse stations will be completed by mid FY2019; wards C3, C7 and S7. Design phase for the remainder of units without enclosed nurse station begins after July 1st with construction activities anticipated to begin early FY2020.
(a) The physical attributes of the state hospital including: 5. New Fire System(s)	**<u>New Fire System(s):</u>** The fire system in building 21 was identified as needing replacement Sprinkler heads that are not tamper resistant need to be replaced with vandal resistant models. Fire Doors throughout campus that did not meet current code were identified for either needing replacement or repaired	**New Fire System(s)** • Bldg. 21 (South Hall) received a new Fire Alarm System throughout the building. Construction completed and the new system went live early FY2019. • Sprinkler Head replacement project is started design phase mid FY2019. This project replaces sprinkler heads that are not tamper resistant, with vandal resistant models on the following patient rest units: ▪ Bld. 19:Wards C1, C3 ▪ Bld. 20: Wards C4, C5, C6 ▪ Bld. 29: Wards E1, E2, E5. • 25 fire door replacement project completed in early FY2019. This project replaced or repaired fire rated doors not meeting existing code.
(a) The physical attributes of the state hospital including: 6. Patient Safety Projects	**<u>Patient Safety Projects:</u>** Ligature risks in bathrooms/shower and tub rooms need to be mitigated	**Patient Safety Projects** **On-going:** • Building 21 (South Hall) still requires a Capital Project to remove the ligature risks in shower and tub rooms. This project is currently in design phase and is anticipated to start construction towards the end of FY2019. • Anti-ligature bathroom partition renovations were completed early FY2019. • WSH developed a new ligature risk assessment process and procedure mid

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
		FY2019. In-field assessments and the development of risk reducing strategies have begun and will continue through to the end of 2019 for completion. This process to occur on an annual basis thereafter.
(a) The physical attributes of the state hospital including: 7. Ward Remodels & Renovations	**Ward Remodels and Renovations:** Various wards throughout campus were identified to be renovated or remodeled. Building 28 was identified as needing a new roof.	**Ward Remodels & Renovations** • South Hall wards S4 and S5 received capital renovations that were completed by mid FY2019. • East Campus wards E5 and E7 received capital renovations that were completed by mid FY2019. • East Campus ward E6 is currently under construction for ward hardening and improvements. Construction is anticipated to be completed by July 2019. • East Campus wards E3 and E4 are currently in design phase for renovations, hardening and repurposing of a forensic population. Construction is anticipated to begin on these units August 2019. Construction completion is anticipated for early FY2020. • Building 28 new roof replacement project is currently underway; construction is anticipated to be completed during the month of July 2019.
(a) The physical attributes of the state hospital including: 8. Elevator Modernization	**Elevator Modernization:** Two Elevators in Building 29 were identified as needing modernization	**Elevator Modernization** Elevators 29-5 and 29-6 started construction to modernize both elevators. These elevators are anticipated to be fully modernized and put back into service mid-late FY2019.
(a) The physical attributes of the state hospital including: 9. New Cleaning Process and Equipment Improvements	**New Cleaning process and Equipment Improvements:** It was determined that a more efficient cleaning and sanitizing products was needed throughout the hospital In order to keep laundry clean, it was determined that new carts needed to be purchased throughout the hospital	**New Cleaning Process and Equipment Improvements:** • Microfiber cleaning program started in FY2019 which included finalizing a contract for material and training. The hospital moved away from using tradition cloth rags and string mops to using microfiber products, a more efficient cleaning and sanitizing material. • New mobile, covered laundry carts were ordered and received for use on patient wards in clean utility rooms to store and transport clean linen and clothing.
(a) The physical attributes of the	**Floor Replacement Projects:** Several critical areas throughout	**Floor Replacement Projects** Over 60K dollars was allocated to replacing floors in

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
state hospital including: 10. Floor Replacement Projects	the hospital needed replacement.	critical areas used by both staff and patients. The hospital as even able to replace nurse station floors on units C6, F2 and F4 while they were fully occupied.
(a) The physical attributes of the state hospital including: 11. Ergonomic Equipment	**Ergonomic Equipment:** There is a need for ergonomic equipment throughout the hospital to assist staff with adjustable work stations to help prevent injuries.	**Ergonomics** 200 electric sit & stand desks were deployed throughout campus to staff.
(b) Staffing, including security staffing	**Nursing:** Over time the nursing staff schedule became unbalanced creating an unequal number of staff on each ward each shift 24/7 **Security Staff:** Security staff is not assigned to dedicated posts in order to provide stability to the area they are assigned. There are vacant Security positions. Filling these positions quickly will make the environment safer. **Violence Reduction Staff:** Western State Hospital has one Violence Reduction Team (VRT) and two Psychiatric Emergency Response Teams (PERT). As of December 2018 all three programs were allocated under one Administration. The two PERT teams (Union) have recently bargained with Western State Hospital to change their schedules to provide sufficient coverage throughout the centers of the hospital. The PERT and VRT programs will be offered new hours scheduled for day shift and swing shift	**Nursing:** Balancing of the nursing staff schedule is currently underway. This will level and equalize the number of staff on each ward each shift 7 days a week. **Security Staff:** Security Staff working in a dedicated post provides stability to the area that the staff is 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. All vacancies are filled as quickly as possible with a recruitment happening approximately every two months, sometimes shorter duration between recruitments. **Violence Reduction Team:** The VRT is an interdisciplinary team extensively trained in crisis intervention skills, incident management, analysis of antecedents for violence and aggression, and de-escalation techniques. • Reviews all assaultive incidents across the hospital daily and; • Performs daily functional behavior assessments using an ABC (Antecedent – Behavior – Consequence) chart to record changes in behavior and identify inconsistencies with baseline presentation. • Identifies trends amongst the patients with consistently assaultive behaviors and engages with the top ten most assaultive patients in the hospital. • Therapeutically engages patients with assaultive

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
	starting July 1, 2019. Day shift hours: 06:30-15:00 Swing shift hours: 14:30-23:00 CFS PERT will cover East and Center for Forensic Services Departments. Civil PERT will cover Central and South Departments. • Violence Reduction Administrator (1) • Therapy Supervisor (3) • Registered Nurse (1) • Violence Reduction Specialist (7) • Center for Forensic Services Psychiatric Emergency Response Team members (13) • Civil Psychiatric Emergency Response Team members (14) **Active Treatment Staff:** In FY 18, 2 licensed and 1 intern Chemical Dependency Professional (CDP) staffs were hired. In FY 19, there are 3 licensed Chemical Dependency	behaviors to identify triggers of aggression and support the development of effective coping skills to reduce the number of assaultive incidents. • Provides recommendations to treatment teams and ward staff, offering evidence-based interventions for mitigating assaultive behaviors. • Consults with treatment teams, as requested, to provide feedback and offer strategies for milieu as well as individual intervention. • Provides milieu support on wards with higher acuity and offers immediate feedback and strategies for mitigating incidents. Civil/CFS PERT Team: • Responds to all requests for PERT. • Identifies high acuity "hot-spots" and allocate resources accordingly. • Conduct rounds to assess ward milieu. • Check-in with Charge RN2 to discuss any potential problematic patients on the ward. • Provide therapeutic presence in "hot-spot" areas. • Support floor staff using VDSP method to de-escalate patients in crisis. • Engage patients to build rapport and trust. • Assist in turning IM back-up meds into a PO PRN. • Provide floor staff support for blood draws. • Respond to code Gray. • Assist floor staff with seclusion/restraints. • Respond to code Red, drills, and rapid response. • Assist staff clearing ward rooms and getting patients to safety during code Red. • Provide milieu support during rapid response. • Assist with ward search. **Active Treatment Staff** Under Department of Health licensure, the Chemical Dependency Professional staff receive referrals, complete screenings, conduct full substance use disorder assessments, provide psychoeducation to patients both on the wards and in treatment malls

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
	Professionals (CDP) staff and 1 intern. In FY 19, 1 OT manager supervises 32.5 available OT positions with 6.5 open positions. Currently OT full time filled positions include: 1 Speech Therapist 2 Physical Disabilities Therapists 29.5 Mental Health Therapists with 22 filled positons	and interface with social work when patients are preparing to discharge from Western State Hospital OT Manager provides clinical supervision and complete competency evaluations of OT staff.
(c) Personnel policies	The adjacent policies that focus on improving safety were established or updated in FY 2019	The WSH Policy Committee continues to ensure hospital policies are easy to find and easily understood. In FY2019, the below policies that focus on improving safety are listed below: **<u>New and updated Policies:</u>** **Above Ceiling Permit Policy** • This policy is currently in design and will be sent to WSH policy committee mid FY2019. This new process implements safeguards to monitor and prevent fire deficiencies above the ceiling grid to insure a safe environment for all. **Ligature Assessment Policy & Process** • A functional work team completed creating a new process and policy for conducting ligature assessment on campus. Process of implementation has begun to survey patient rest locations. **Code Red Fire Drill Policy** • The Code Red Fire drill policy has been updated to reflect updated Fire drill process and will be sent to WSH policy committee mid FY2019 **Interim Life Safety Measures Policy** • The Interim Life Safety Measures Policy has been updated to reflect new process for determining what Interim Life Safety Measures need to be put into place when necessary. The updated policy will be sent to WSH policy committee mid FY2019

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
(d) First aid and emergency	The Emergency Preparedness Program was evaluated by a Performance Improvement Manager and again by a Management Analyst; 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) WSH participated in a patient tracking and bed status exercise with the WA Department of Health. The local WSH Emergency Management Committee (EMC) 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. The WSH EMC conducted an annual review so the plan is current as of March 2019. Emergency planning is based on an all-hazards approach as a result of the risks identified. The Continuity of Operations (COOP) plan was finalized with new names, titles and contact information. It is scheduled to be signed by the CEO in June. The Comprehensive Emergency Management Plan (CEMP), and the Administrator on Duty (AOD) manuals were reviewed and updated. Policy 12.13 Emergency Preparedness Program policy signed May 2018. Last year there were 23 activations of the Hospital Command Center during this period. 11 emergency incidents occurred, 10 activations were for planned events that met the criteria for an Incident Command System structure to be used to manage them and 5 exercises were planned and conducted. **<u>The emergency incidents consisted of:</u>** • Generator 1 outage, CMS Mock Survey, DOH Monitoring visit, CMS Re-certification Survey, Father's Day Staffing Shortage, Patient P.T. Unauthorized Leave, FUSE Caused Power Outage, Patient A.A. Off-grounds UL, UL Patient B.S., PBX UPS B18 Evacuation, Inclement Weather Event, and Power Failure Blown Fuse **<u>Pre-planned events were:</u>** • Planned outage for PBX repair*, South Hall Renovation Project-Multiple building utility shutdown, Planned power outage building 17, Planned power bump for 400kw generator hook-

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
		up, PBX repair, Strategies for B28/29 steam outage Operational Period 1, and Building 28/29 steam outage stand-by Operational Period 2, January PBX Planned Outage, February PBX Planned Outage (3 attempts), DSHS HQ DD Patient Movement Plan, and 2019 Annual Generator Run. * *The HCC was activated in stand-by mode when there were cascading incident within the incident. Having ICS on hand and in place shortened the amount of time it took to get back to normal operations.* **Emergency exercises consisted of:** • Patient surge exercise, Amateur Radio Emergency Services communication exercise, the Great Shake (earthquake) exercise, and a radio failure exercise (based on a real event). Due to the actual and potential infrastructure failures because of the age of construction and years of neglect at the hospital, the following plans were developed. 1. Catastrophic Generator Failure Plan - for a hospital wide power failure. If the hospital loses commercial power it is feared the generators will not work or will only work for a short period of time due to several probable points of failure. 2. South Hall Elevator Failure Plan – South Hall has three elevators, one is dead lined and may never run again. A second elevator works *most* of the time but is not reliable. The third elevator is going out of service more frequently. Special plans were developed if all three elevators are down at the same time. They are emergency evacuation plans, plans to evacuate non-ambulatory patients, plans to carry food trays, supplies and linen up 5 narrow flights of stairs. 3. Comprehensive Emergency Management Plans inclusive with the Fort Steilacoom Competency Restoration Program. 30 patient program moving in building 27 and will piggy back on WSH emergency services, alerts, notifications, command center and ICS response to emergencies or disasters. Inclement Weather Plan was developed after last February and March winter events. The plan is posted on the hospitals' intranet page with all the

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
		other emergency plans so staff can reference them at any time. Quarterly reporting to the Quality Council on the percentage of Improvement Action items that are completed or not completed as identified from After Action Reports. The After Action Reports are conducted after planned events, real incidents and emergency exercises.
(e) Reporting violent acts, taking appropriate action in response to violent acts, and follow-up procedures after violent acts:	**Reporting Violent Acts:** WSH continues to run Hospital Safety Concerns program, Critical 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	**Ongoing:** The Hospital continues to run the Hospital Safety Concerns program, which provides a means, independent of an employee's chain of command, to report, review, and resolve safety concerns for reporting and resolving safety issues. 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. If warranted, incidents are also reviewed by an Investigations team. The hospital continues to utilize the electronic Administrative Report of Incident system, which requires the supervisor to read the incident report and provide information on how the incident was addressed. If an employee reports an injury on the 03-133 form, the supervisor is also required to outline what steps have been taken to address the conditions that led to the injury.
(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.	**Ongoing:** CRMT 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 in order to create a safer environment for all. **Update/New:** **Safety Committees:** The safety committees at WSH have been restructured to ensure all safety concerns are appropriately addressed. Each ward has its own safety committee, which report to their respective center-based safety committee, which then report to the hospital-wide safety committee. The hospital-wide committee reviews all concerns that have been rolled up from the ward and center levels and assigns responsible parties to ensure action plans to address

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		these concerns are completed. Information is communicated back down to the center and the ward levels, for a top-down and bottom-up communication chain. Last year, the Violence Reduction System Focused Improvement Project (SFIP) was tasked with tracking and analyzing violence data and working on interventions to reduce violence on the most assaultive wards. The SFIP has since been disbanded and has morphed into the current safety committee structure. Additionally, based on a proposal from the prior SFIP, the hospital is working on developing a ward that will house the most assaultive patients, with a step-up ward for those patients that have improved. Staff on these wards will be trained in depth for their roles on this ward, in order to work effectively with the highly assaultive patients.
	Tableau 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:** All ward administrators and center directors have been granted licenses for Tableau, which is a data visualization tool that allows them to track data for their wards and centers, and drill down the data to identify patterns and trends. When these patterns and trends are identified, they can be addressed in order to prevent similar incidences from occurring in the future. Additional key staff has been granted licenses as well, ensuring that data is easily accessed and readily available for analysis. Data reports are also created on a monthly basis and posted to the Research, Evaluation, & Data Analysis (REDA) Office's SharePoint page, which is available to all WSH employees. The REDA Office has been 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. Hospital-wide data trends for assaults and injuries are presented monthly at the Safety Committee meeting, including a performance scorecard that was developed specifically for the committee to track whether or not we are meeting our targets across key outcome measures relating to violence.
	Violence Reduction Team: To reduce Violence on the wards, the Violence Reduction Team reviews all assaults and offers nursing staff preventative strategies, behavioral interventions, training/mentoring and coaching, when necessary, to	**Violence Reduction Team:** The VRT continue to work with nursing staff to provide training and mentorship. They also focus their efforts on working with the patients that are the most assaultive, developing rapport and providing therapeutic engagement for these patients. Assaults attributed to the most assaultive patients are presented each quarter to the Quality Council by the

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	mitigate future assaults.	Violence Reduction Administrator. During this report, the Violence Reduction Administrator offers trends the VRT has identified that contribute to assaults as well as strategies that can help reduce such assaults. **Training:** The hospital continues to provide Crisis Prevention Training (CPI) to ward staff. Additionally, Advanced Crisis Intervention Training (ACIT) is also being provided to all wards, with a plan to complete training by the end of 2019. The ward administrators have also been given Root Cause Analysis training & education for a better understanding of the cause of specific incidents and assist the ward committees with developing actions to reduce violence.
(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.	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 FY19, education and training provided to employees needed expanded to close identified learning gaps. Expanded NEO, Leadership Training, and ACIT training for all employees were identified as priorities for WSH.	**Training Overview**: • The nationally known Crisis Prevention Intervention (CPI) Training Program was implemented in 2018 and has continued to be delivered to all new hires in New Employee Orientation (NEO). In addition to NEO, courses continue to be offered for current employees who haven't taken it. CPI requires annual recertification training, so a condensed refresher version of CPI will be offered to all direct-care staff and delivered through Annual In-service (AIS) training that is scheduled to start July 2019 and continue every year thereafter. • AIS will also include newly developed content on safeguarding personal welfare, small team tactics to incident response, incident debriefing, and personal safety. • In July 2019; general NEO will be expanded into a 2week program (currently 1week) to include Advanced Crisis Intervention Training (ACIT), which trains employees to intervene at the onset

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		of a crisis with the intent of preventing physical escalation. This program will also be included in AIS, which will provide an opportunity for current staff to receive it. **Since July 2018, the Center for Organizational Development (OD) has completed the following:** • Received additional resources to assist with the delivery of ACIT; including the Director of the Security Officer Academy (WMS2) and three double-filled, non-perm SG2 trainers. This helps to supplement the loss of 11 FTEs (1 WMS, 10 Nurse Educators) from OD that occurred after leadership changes. • Trained a total of 148 staff in ACIT after receipt of additional resources. • Conducted CPI training for all direct-care staff on day and swing shifts, and continues to offer courses that provide opportunities for staff that missed their scheduled training to attend and gain compliance with this mandatory training. • Trained a total of 1500 staff in CPI to-date. • Trained a total of 148 staff in ACIT after the addition of new resources. • Conducted 25 cohorts of NEO (averaging 25-30 students each) for a total of 746 new staff trained. • Completed train-the-trainers in Instructional Design and Instructional Delivery for OD employees to enhance their knowledge, skills, and abilities. • Completed train-the-trainer for Equity, Diversity, and Inclusion training; to be incorporated into expanded 2week NEO. • Conducted staff surveys of recent NEO grads to identify areas of improvement and learning gaps to close. Information received was used in the design process for the 2week expanded general NEO. • Incorporated Emergency Equipment (e.g. Firebox, wands) Training into the NEO for continuous training • Added Enhanced Defensive Tactics and Restraint Training to the Clinical week of NEO. • Hired a new Instructional Effectiveness Administrator with extensive experience in personal safety tactics, and Master Instructor certification. • Partnered with the Human Resources Division (HRD) to streamline NEO and enhance learner's experience. • Partnered with HRD to offer more frequent on-site

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		Foundations of Leadership training. • Partnered with the Psychology Department to redesign the "Understanding Mental Illness" course, which intends to develop empathy in staff to prevent crisis. • Director of OD is conducting ongoing walk-arounds with Violence Reduction Program Administrator to identify and address training needs. • To identify and address training needs: OD staff is attending the ward-level Safety Committee meetings, OD managers are attending center-level Ward Safety Committee meetings, and the Director of OD is attending the hospital-wide Safety Committee meetings. • Submitted request for funding of additional safety trainers; five were approved for hire after 7/1/19. These trainers will provide OD an opportunity to offer training on all three shifts, which will increase access for all direct-care staff. • Training noncompliance reporting will begin in July 2019 to identify staff that has not completed mandatory training. Reports to be shared with leadership for follow up and addressing noncompliance. **Nursing:** Educators and Clinical Specialists will collaborate and provide a competency fair for all nursing staff. *Assessment was accomplished by nurse educators on documentation and performance of ADL's. ---- *Education followed on SOAP format for documentation, skin assessment classes were provided. *Medication administration refresher for all RN's is on-going.
	Nursing: Nursing staff competency training is being developed to ensure all nursing staff is competent in the skills that necessary to perform their jobs safely.	
(h) Clinical and patient policies and procedures including those related to: 1. Smoking	Policy 4.05 Tobacco use was updated to include: WSH patient care areas are tobacco and smoke free. Patients are not permitted to use tobacco or electronic smoking devices on WSH grounds.	This is a preventative measure to ensure that Western State Hospital meets Washington Administrative Codes regarding smoking restrictions and to lower the opportunities for patients to engage in assaultive behavior regarding the desire to gain access to tobacco products. Patients were giving the opportunity to participate in eight (8) cessation programs to slowly bring them down from nicotine. In addition, patients and staff were provided the education on how to cope

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		with nicotine withdrawals. Recreational/vocational staffing was provided to increase activities in patient areas where smoking had previously been permitted. These activities were provided 2 weeks prior to and 2 weeks after the May 1st smoke free start date. To date, since May 1st, WSH has not had an assault directly related to a patient not being able to use tobacco products.
(h) Clinical and patient policies and procedures including those related to: 2. Activity, leisure and therapeutic programs	WSH continues to implement 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 therapist now provides individual speech therapy sessions as well as swallowing evaluations when	WSH had improved active treatment services by broadening the services provided for Substance Abuse and Speech Therapy. In FY18, 2 licensed Chemical Dependency Professionals and 2 Trainee staff was hired. In FY19, 3 licensed Chemical Dependency Professionals and 1 intern for a continued total of 4 staff with an improved number of licensed staff. These staff receives referrals, complete screenings, full evaluations 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. Additional year round activities include those offered as part of the Infinity Art Center, such as movies, music, pool table, karaoke and arts and crafts activities. 1 Speech Therapist was hired in FY17 to develop and begin providing in patient speech services. This can include swallowing evaluations that assist with reducing risk of choking. This staff continues to provide these services currently. Some additional services related to swallowing evaluations that were previously provided in the community are now offered at WSH which reduces the need to transporting patients outside of the hospital. In FY 17, 1 OT manager was hired, to provide clinical supervision and complete competency evaluations of OT staff. These evaluations ensure OT staffs are providing high quality, safe OT services. 1 Speech Therapist was hired to develop and begin providing in patient speech services. This can

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	referred by a physician.	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	**Communication between shifts:** WSH continues focus on ways to improve the Communications between shifts in order to improve safety	**Communication between shifts:** In FY2019, more focus was placed on enhancing the documentation of events within the patient charts which in turn provides better information for staff in the inter-shift report regarding what occurred in the previous shifts.
(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.	In 2018, WSH completed the below items to assist with the reduction of seclusion and restraint: • WSH Policies were updated to include enhanced supervision during the seclusion and restraint process • WSH enhanced the practice to be more evidence-based. More emphasis was placed on lesser restrictive interventions and enhanced safety with the monitoring and addressing physical medical concerns that could complicate or place patients at risk during an S/R event. • WSH increased training to staff on nonviolent crisis interventions, communication, and how to safely manage/prevent difficult behavior In 2019, WSH continues to work toward the reduction of seclusion/restraint. • WSH continues to enhance the delivery of education for lesser restrictive interventions, verbal de-escalation, and safe release from seclusion restraint. • WSH will update the S/R forms and process to support the identification of criteria for earlier release from restraints • WSH will continue to evaluate whether or not different restraint devices would be potentially safer for the staff and the patients for possible organizational adoption.