



Report to the Legislature

Workplace Safety in State Hospitals

Chapter 187, Laws of 2005, Section 1

September 1, 2005

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**REPORT TO THE LEGISLATURE
WORKPLACE SAFETY IN STATE HOSPITALS**

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BACKGROUND

Chapter 72.23 RCW requires each state hospital to develop a plan to reasonably prevent and protect their employees from violence at those hospitals and directs the Department of Social and Health Services (DSHS) to provide an annual report to the legislature on efforts to reduce violence in the hospitals.

Specific statutory language follows:

RCW 72.23.400(1)(4) – Workplace safety plan.

- (1) By November 1, 2000, each state hospital shall develop a plan, for implementation by January 1, 2001, to reasonably prevent and protect employees from violence at the state hospital. The plan shall be developed with input from the state hospital's safety committee, which includes representation from management, unions, nursing, psychiatry, and key function staff as appropriate. The plan shall address security considerations related to the following items:
- (a) The physical attributes of the state hospital;
 - (b) Staffing, including security staffing;
 - (c) Personnel policies;
 - (d) First aid and emergency procedures;
 - (e) Reporting violent acts, taking appropriate action 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.
- (4) The plan must be evaluated, reviewed, and amended as necessary, at least annually.

Chapter 187, Laws of 2005, Section 1 – Annual report to the legislature.

By September 1st each year, the department shall report to the House Committee on Commerce and Labor and the Senate Committee on Commerce and Trade, or successor committees, on the department's efforts to reduce violence in state hospitals.

Initial workplace safety plans were submitted to the legislature November 2000 and have been implemented in each of the three state hospitals:

Western State Hospital (WSH) is located in Lakewood and has a capacity of 882 beds, including the Program for Adaptive Living Skills (PALS);

Eastern State Hospital (ESH) is located in Medical Lake and has a capacity of 274 beds;

Child Study and Treatment Center (CSTC) is located on the grounds of Western State Hospital in Lakewood and has a capacity of 47 beds.

Those plans have been evaluated, reviewed, and amended and are submitted as appendices to this report. The plans detail the outcome of safety and security assessments and resulting plans of action. Each hospital's ongoing security and safety assessment reveals separate and distinct needs addressed in respective plans. Provided as an additional source of information is supporting data related to patient-to-staff assaults, industrial insurance claims submitted and time loss due to injury.

WORKPLACE SAFETY PLANS

Creating the safest possible work environment in Washington's state hospitals is a top priority for the Department of Social and Health Services (DSHS) leadership, the department's Mental Health Division (MHD), the Department of Labor and Industries (L&I), local unions, and state hospital managers. Collaborative efforts have resulted in state hospital workplace safety plans that focus on reducing the number and severity of assaults against staff by patients.

The original workplace safety plans were developed in 2000 under the auspices of the MHD Quality Steering Committee. The committee established goals that are used as the foundation to assess and to continue to implement the plans in each of the three state hospitals. Staff from each state hospital, including representatives from labor and management, work as a team to accomplish the established goals listed below:

- Reduction of staff assaults;
- Reduction of compensable claims;
- Reduction of time loss due to assault;
- Review and analysis of trend data to help direct and support organizational decisions;
- Establishment of training programs to address individual safety/security issues; and
- Establishment of mechanisms for ongoing safety and security assessment.

EFFORTS TO IMPROVE WORKPLACE SAFETY

The following information summarizes numerous efforts to continually improve workplace safety in the three state hospitals:

- Physical security and safety assessments are conducted on an ongoing basis at the three hospitals and recommendations from these assessments are included in each hospital's safety plan update. Safety Committees, which include line staff and Executive Management of each state hospital, monitor the progress of work place safety plans and the hospital Governing Body reviews quarterly reports on claims data.

- Staffing levels remain within national accreditation and certification standards. As budget allocations, treatment models, census and patient acuity levels change, staffing ratios will be adjusted accordingly.
- Behavioral management and violence prevention training for staff is mandated prior to a ward-based assignment in all three hospitals. Training includes the fourteen elements addressed in RCW 72.23.400(1). The goal of the training is to prevent incidents of violence and reduce injuries to employees.
- The state hospitals continually work toward the reduction of seclusion and restraint interventions. In 2004 Washington State received funding from a Substance Abuse and Mental Health Services Administration (SAMHSA) grant. Each state hospital developed an advisory board consisting of front line staff, medical staff, administrative leadership and consumers to implement nationally recognized strategies for the reduction and elimination of seclusion and restraint. Increasing safety and reducing violence for staff and patients is an important outcome. Focusing on recovery-oriented care and the prevention of aggression are changes that will lead to a reduction of seclusion/restraint.
 - The WSH Non-Violence Initiative official kick-off was held in June 2005. The goals of the initiative include: creating a safer, more nurturing environment for every WSH staff member and consumer; transforming WSH into a setting that values individuals, provides comfort, and promotes recovery; and will prevent, reduce and eventually eliminate seclusion and restraint. The initiative requires a major culture change and will be an ongoing process. The primary focus is on reducing violence in order to increase safety for all staff and patients. A multidisciplinary steering committee has been established to oversee activities of the Non-Violence Initiative and receive feedback from WSH staff and consumers.
 - In collaboration with the Substance SAMHSA Training Grant and the Washington Institute for Mental Illness: Research and Training (WIMIRT), ESH is developing a plan to change from a Bio-Psycho-Social Model to a Recovery Model to reduce the number of seclusion/restraint events. A team will develop training modules and interventions to assist staff in making needed changes in a safe and therapeutic manner.
 - CSTC has placed an emphasis on communication and its impact on violence. A number of clinical staff attended training on Non-violent Communication and have implemented initiatives to improve civil communication and communication in a Culture of Caring across campus. Additionally, a focus on pro-active treatment strategies and intensive debriefing following incidental behaviors will continue to support efforts toward the reduction of restraint and seclusion.

- In January 2005, leadership staff from all three state hospitals, WIMIRT and the MHD attended a three-day training conducted by the National Technical Assistance Center as part of the SAMHSA grant for the reduction of seclusion and restraint.
- The hospitals have placed a major focus on decreasing unstructured time for patients. Therapeutic and leisure activity programs have been increased to cover weekend and evening shifts. Ongoing review of milieu programming has led to a number of specific actions with a focus on quality improvement to increase recreation participation hours of patients. A focus on increased structure and supervision has greatly contributed to the decrease in use of seclusion interventions in the adult hospitals. Program structure and intervention techniques that address staff safety have been assessed.
 - ESH's Adult Psychiatric Unit is developing a Treatment Mall for therapeutic patient activities/education. This approach allows patients to leave the immediate ward environment to participate in a selection of treatment options housed in a series of rooms of the ward. The patient has input into the selection of treatment options built into the care plan.
 - CSTC adjusted work hours of the Certified Recreation Therapists to increase the number of hours structured recreation activities are available to patients. The team of five Certified Recreation Therapists, along with work-study students and interns, facilitate recreation therapy activities through the evening hours and on weekends.
 - WSH is working towards improved programming in the Learning Center that will include patient input as the focus shifts to the recovery model of care and a decrease in the use of restraint and seclusion.
- Injury/illness and claims data, including the number of injury/illness reports filed each month, the number of assaults filed, and compensable/non-compensable claims are reviewed in each of the three state hospitals. At WSH data is reviewed by the Safety Committee, Environment of Care Committee and the Executive Management Team. CSTC's data is reviewed by the Safety Committee and at the Quarterly Quality Improvement Meeting attended by Executive Management Team and clinical leadership. At ESH, data is reviewed by the Safety Committee and the Executive Management Team. The hospitals monitor the data for trends that are used to guide decision-making.
- All hospitals have obtained communication and/or violence prevention equipment such as personal alarm devices, radios, padded shields, and paging devices.
 - At ESH, patients are escorted to dining areas during meal times by staff who are equipped with portable radios for communication.

- At WSH, a personal alarm pilot program was completed in October 2001 at the Center for Forensic Services (CFS) and resulted in high staff satisfaction. Response time to incidents was cut by two-thirds. The personal alarm system is now in full use in CFS and is being installed in the Center for Adult Services (CAS). Ward staff received training and carry alarm pendants. CAS staff also carry radios when escorting patients on hospital grounds as a means to obtain emergency assistance more quickly if needed.
 - CSTC uses radios to communicate emergency incidents among program staff and a separate radio system to communicate with WSH security. Currently, all radios are being inventoried, and a request for additional radios will be developed as needed.
- In 2005 team members were recruited and trained at WSH for the Critical Incident Stress Management Team (CISM). The team helps staff when incidents of violence occur. Through debriefing and review, efforts can be made to develop strategies to prevent future incidents and to decrease the trauma experienced by staff.
- ESH has had a CISM team in place since January 2004. This team is used to assist staff to cope with on-the-job stresses of assault, injury and loss in a healthy manner. It is anticipated that this will reduce staff use of sick leave and improve morale as it conveys management's concern for staff well-being.
- In 2004 WSH established Ward Program Manager (WPM) positions. The managers coordinate all the activities of their assigned wards. This promotes stability for patients and staff. The recently implemented hospital performance reports provide the WPMs monthly measures to monitor patient and staff safety indicators.
- In October 2004, the WSH Smoking Policy was updated. WSH went from a non-smoking facility to a facility that allows smoking in specific areas. An in-depth risk analysis was conducted prior to changing the policy. Data continues to be collected which tracks the number of fires intentionally set on wards. Arson fires have decreased since the new policy went into effect, making WSH a safer environment for patients and staff.
- In January 2005, WSH implemented an improved Return to Work Program. Under this new program all permanent employees who are injured on the job will return to their regular work area whenever possible. This will improve staff safety due to the fact that the knowledge and skills of seasoned employees will be available to the ward during their recovery. Safety will also be improved as patients will continue to interact with the staff they are familiar with on a daily basis.

- ESH is currently participating in a program offered by the Spokane County Domestic Violence Consortium (SCDVC). This program is funded through the National Institutes of Occupational Safety and Health/Centers for Disease Control. Services offered include:
 - Supervisor/manager training
 - Crime prevention/environmental analysis
 - Management plan development
 - Employee training
 - Follow-up training and education
 - Critical incident response

Employee feedback and SCDVC analysis and recommendations have been reviewed and incorporated into this plan.

The attached workplace safety plans for each state hospital detail the outcome of safety and security assessments and the resulting plans of action. The workplace safety plans are working documents at each hospital and remain a top priority for hospital management.

RESULTS

Reduction of staff assaults

At the two adult hospitals, the number of reported patient-to-staff assaults rose each year from 2000-2002. The numbers remained steady between 2002-2004. Data for 2005 indicates the number of assaults are decreasing. More specific injury data is being analyzed to identify injury cause, injury type, body part injured, and when and where the injury occurred. The data is provided to management for their review and to assist them with making recommendations/improvements for a more pro-active, comprehensive safety prevention program.

CSTC has observed a decrease in reported assaults on staff since 2001. Consistent use of proactive treatment strategies, teaching skills to children and youth to assist them to manage emotional dysregulation and structuring the environment have all contributed to a safer treatment milieu. As with ESH and WSH, more specific injury data is analyzed and reviewed at Safety Committee and Executive Management Team meetings to assist with planning for further training and supervision of staff.

Reduction of compensable claims due to an assault

According to data, the number of non-compensable claims at the adult hospitals has risen each year since 2000 with the exception of 2004 when the number of compensable claims were fewer than the number of non-compensable claims. At WSH, reducing the number of patient-to-staff assaults combined with the improved return-to-work program will reduce the number of compensable claims for the organization. A reduction in compensable claims means that employees are working and WSH is able to retain the use of their valuable trained employees. This results in lower Workers' Compensation costs and improved safety for the organization as skilled staff are available to the wards.

The number of compensable and non-compensable claims at CSTC has decreased with the number of assaults on staff. CSTC provides opportunities for staff to return to work in alternative capacities when an injury disallows return to their assigned workstation. Similar to the other hospitals, this effort has decreased compensable L&I costs.

Reduction of time loss due to assault

Time loss days have steadily risen at WSH since 2000, while ESH and CSTC have seen a decrease. Reducing the number of patient-to-staff assaults along with having an effective return-to-work program results in a reduction in time loss days for an organization's workers' compensation claims and their associated costs. WSH projections for 2005 indicate that time loss days are decreasing, and it is attributable to their improved return-to-work program.

Review and analysis of trend data to help direct and support organizational decisions

The Safety and Claims Office, the Safety Committee and the Governing Body Sub-Committee review and analyze trend data at least quarterly to assist in directing and supporting organizational decisions.

Establishment of training program to address individual safety/security issues

The Staff Development Departments at WSH and ESH reviews the new employee orientation curriculum, as well as annual update procedures on an ongoing basis. CSTC is planning an organizational change which will place more focus on workforce development.

Establishment of mechanism for ongoing safety and security assessment

Each hospital's plan describes their respective method for ongoing safety and security assessment. Collaboration among hospitals, labor, and management has resulted in sharing of ideas and resources, which ultimately is reflected in the plans.

APPENDICES

Appendix A - Workplace Safety Plan (WSH)

Western State Hospital

ANNUAL UPDATE

June 2005

RCW 72.23.400 requires each state hospital (WSH, ESH, CSTC) to develop a plan to reasonably prevent and protect employees from violence. The law requires completion of a security and safety assessment to identify existing or potential hazards for violence in the workplace. Using the results of the assessment, each state hospital must develop a plan to prevent and protect employees from violence and provide an update to the legislature annually. The following table lists the elements of both the assessment and the updated plan as required by law. It then provides a summary of the results of the assessment as well as the plan derived from that assessment.

Elements of the plan per law. (Items a through h below are part of the security & safety assessment)	Assessment – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence.	Plan – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence.
<p>a. The physical attributes of the state hospital including:</p> <ol style="list-style-type: none"> 1. Access control 2. Egress control 3. Door locks 4. Lighting 5. Alarm systems 	<p>Physical security tour of Western State Hospital (WSH) campus revealed the following:</p> <ul style="list-style-type: none"> • Access, egress control and door locks were found to be generally in good order. • Annual Lakewood Fire Inspection to be conducted. • More strict enforcement of Identification Badge Policy is needed. • Lighting is adequate on all wards, offices, and shop areas. Outdoor lighting is adequate. 	<ul style="list-style-type: none"> • The Environment of Care Committee conducts a year-round assessment of access control, egress control, door locks, lighting, and alarm systems. Maintenance Department will monitor and prioritize work requests to maintain current condition. Target: Ongoing • Since 2001, the annual Lakewood Fire Inspection has been completed by the Lakewood Fire Marshall and team from WSH comprised of Safety Manager, Facilities Representative, and others as needed. This assessment is valuable for evaluation of locks, access, and egress control issues. Shortcomings are identified and corrected to preclude a fire emergency. • All supervisors are directed to strictly enforce the wearing of ID badges for all staff and visitors. Added to new employee hospital orientation curriculum. A new badge system is being implemented. Target: Ongoing • Maintenance Department is responsible to ensure lighting is maintained regularly. Selected trees and shrubs have been removed. Ongoing monitoring will be conducted by the WSH ground maintenance crew. Target: Ongoing

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	<ul style="list-style-type: none"> • Personal Alarm systems – Minimally, all high-risk wards require a personal alarm device system for immediate alert for assistance during assault/crisis. Response times for crisis assistance can be cut significantly as demonstrated by the Center for Forensic Services (CFS) Pilot Program. • Upgraded and additional communication equipment is a growing need (radios, walkie-talkies) on various units throughout the hospital. High-risk areas are adequately stocked and staff is fully trained to use communication equipment. 	<ul style="list-style-type: none"> • Improvement of Organizational Performance (IOP) group was chartered to conduct a nationwide comparative study on various personal alarm device systems. The study was completed and Headquarters accepted the group’s recommendation. Capital Programs approved funding for a pilot and a three-phase installation process. The pilot project was completed in October 2001 with high staff satisfaction, and response time cut by two-thirds. Full use is occurring in CFS. In addition, the personal alarm system is being installed in the Center for Adult Services (CAS). CAS staff have been trained in their use and carry personal alarm pendants. Planning for phased in installation of system hospital wide is Ongoing. Target: January 2006 • CAS has implemented a walkie-talkie radio communication between ward staff and staff escorting patients on the grounds to provide a better means of getting assistance during emergencies. Target: Ongoing
<p>b. Staffing, including security staffing</p>	<ul style="list-style-type: none"> • Center for Medicare Medicaid Services (CMS) and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) inspections regularly include staffing assessments in terms of meeting the needs of the patients. Exceptional staffing needs are considered when variances occur in census and /or acuity levels, at which time nursing management revises the demands. Nursing management constantly monitors staffing for safe staffing levels. • Reviewing options to overtime use when staffing is not adequate. It is recommended that a “float pool” be considered that may decrease expenditures while making more adequate staffing readily available. A float pool consists of employees assigned to a central location available and trained to work in any or all of the centers specific to their job classification and licensure. 	<ul style="list-style-type: none"> • Staffing practices will remain within CMS and JCAHO standards. As budget allocations, treatment models, census and acuity change, staffing levels will be adjusted accordingly and within the standards of those two agencies Target: Ongoing • Budget constrictions have not allowed development of a float pool as yet. The idea of a float pool continues to be considered and would be dependent on budget constraints Target: Budget dependent

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	<ul style="list-style-type: none"> • The WSH Security Department assessment of staffing concluded that increased security presence on campus would be beneficial. Increase in workload continues due to enhanced reporting protocols, data tracking, alarm monitoring and incident follow-up protocols. • Enhanced training (behavior intervention and management, crime scene preservation, police report writing, witness statements, evidence collection, etc.) and progressively increasing responsibilities warrant review of Security Officer classification to ensure equitable salary and decrease recruitment/retention difficulties. Position re-classification may enable retention of more experienced security staff. 	<ul style="list-style-type: none"> • The WSH Security Manager and Chief Operating Officer conduct regular reviews of security staff. Because of a new ward opening, a request was made for additional staffing. Additional positions were not funded. Target: Ongoing • Security Officer re-classification and increased compensation was accomplished in order to recruit and retain qualified individuals. Target: Completed (Fall 2004)
<p>c. Personnel policies</p>	<p>All policies identified in the 2002 assessment have been reviewed and updated. Sunset review dates will be monitored for completion by the WSH Policy Committee.</p>	<ul style="list-style-type: none"> • Updated and new policies will be made available to staff hospital-wide via Intranet with hard copy distribution and/or Staff Development Department training. The policies are presented in New Employee Orientation, during duty-site training or as stand-alone training. The Smoking Policy (previously a non-smoking campus) was changed to allow smoking in specific outdoor areas. An in-depth risk analysis was conducted to provide data that supports the number of intentional ward fires have decreased since the new policy went into effect, resulting in a safer surrounding for patient and staff. Target: Ongoing

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d. First aid and emergency procedures	<ul style="list-style-type: none"> • Recommend enhanced membership and education for the Critical Incident Stress Management (CISM) team by adding peer support members from all areas and shifts. This function is now required by JCAHO in the Environment of Care Chapter of the Center for Addiction and Mental Health under the Emergency Management element. • The Behavioral Management and Intervention Team (BMIT) consisted of patient care staff from all areas and all shifts of the hospital that had the experience and training to provide therapeutic interventions for patients in crisis in order to prevent incidents of violence and injury. The team’s initial focus was on working towards a culture of a more hope and recovery approach to patient care and behavior management. 	<ul style="list-style-type: none"> • A CISM workshop was held March 30-31, 2005. New team members have been recruited and trained. Target: Ongoing • The original BMIT was assembled in August 2000 as the result of receiving a grant from the Department of Labor and Industries (L&I). A year later L&I funding was withdrawn and the BMIT disbanded. There is renewed interest and support for re-establishing the BMIT. At present funding is not available. Target: May be budget dependent
	<ul style="list-style-type: none"> • Dedicated phone line for emergencies is now on all WSH wards. All staff are trained. Should be added to the new employee’s “Orientation to Duty” checklist. 	<ul style="list-style-type: none"> • Nursing Department will ensure that this item is placed on the “Orientation to Duty” checklist and reviewed with all new staff. Target: In place/ Ongoing
e. Violent acts: 1. Reporting of violent acts 2. Taking appropriate action in response to violent acts 3. Follow-up procedures after violent acts	<ul style="list-style-type: none"> • All staff received training/procedures for reporting incidents, taking appropriate action in response to violent acts and follow-up procedures. New employees receive training during new employee orientation. 	<ul style="list-style-type: none"> • Reporting incidents, taking appropriate action in response to an incident, and follow-up procedures have become part of the new employee orientation curriculum in Staff Development. Target: Completed. Training is Ongoing • WSH Safety Committee reviews security-related information and injury/claims data on a monthly basis to determine patterns and trends for risk management purposes. Target: Ongoing

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	<ul style="list-style-type: none"> • Communication/coordination enhancement is recommended among local law enforcement, prosecutors and WSH in terms of reporting and responding to assault/crisis situations. • All occurrences of assaults and verbal threats are recorded in a log to provide more efficient tracking of violent incidents and follow-up action. • WSH established the Critical Incident Stress Management (CISM) team and members received nationally-accredited CISM training. The team provides stress management and post traumatic stress assistance to staff after becoming the victim of an assault or after witnessing a serious assault. The team recommended that all supervisors be trained to identify need for this service in their subordinates after a crisis situation. It is also recommended that all supervisors be trained to identify need for this service and to assist staff transitioning back into the workforce after a time-loss assault. 	<ul style="list-style-type: none"> • A “recording line” is in place in the Safety Office for anyone to report any unsafe practice, concern or issue. The Safety Manager will be responsible for immediate follow-up action. All staff have been informed of the availability of this line. New employees will be advised of the availability of the recording line during initial orientation. Target: Completed • Establish specific response protocols between WSH and the Lakewood Police Department (LPD). Target: Completed June 2005 • In addition to establishing response protocols, training will be provided. WSH will provide site-specific training to the LPD. The LPD and Pierce County will provide ward search procedures to WSH Security staff. Target: Completed June 2005/Ongoing • The WSH Security Department maintains a record (log) of assaults and threats. Additionally, a security database has been developed to track all security incidents. Workplace violence data is submitted to the Safety Committee monthly. Target: Completed (Ongoing) • All supervisors received mandatory training by the CISM team to: <ol style="list-style-type: none"> 1. Be aware of the service and how to access it. 2. Be sensitive to the needs of staff transitioning back into the workforce after a time-loss assault. Target: Ongoing

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f. Development of criteria for determining and reporting verbal threats.	<ul style="list-style-type: none"> Criteria has been identified by the MHD Quality Steering Committee for reporting verbal threats. 	<ul style="list-style-type: none"> Verbal threats are tracked when reported using the Security Incident report or the Administrative Report of Incident. <p>Target: Completed</p>
g. Employee education and training	<ul style="list-style-type: none"> A curriculum has been developed for identifying and reporting violence in the workplace. Professional Assault Crisis Training (ProACT) is mandatory for all new employees prior to reporting for a ward-based assignment. All current employees' records were reviewed for compliance. All incumbents of ward-based job classifications are required to receive annual update training in ProACT. Currently this training is in video format. The video should be reviewed periodically by Staff Development and updated/modified as needed. 	<ul style="list-style-type: none"> The WSH Security Manager is providing training to all new employees in identifying and reporting violence in the workplace. This training will remain a consistent part of the curriculum for all new employees. <p>Target: Completed/Ongoing</p> <ul style="list-style-type: none"> ProACT training is a mandatory requirement for all WSH employees who are hired into ward-based job classifications. ProACT training shall be accomplished prior to ward assignment. Staff Development has provided an enhanced training schedule to ensure all current employees in a ward-based job classification receive training in ProACT. Staff Development is working on changing ProACT training to TEAM – Training in Effective Aggression Management. The TEAM training will shift the emphasis of the training from “assault” to prevention of aggression and the creation of a safer, non-violent environment. <p>Target: Ongoing</p> <ul style="list-style-type: none"> The Nursing Department and Staff Development are developing an independent learning packet that shall be required of each ward-based employee to complete on an annual basis. A record of this training will be placed in the employee's individual education file. Update training is being revised. The focus is on a culture change – prevention of violence through improved connection and communication.
h. Clinical and patient policies and procedures including those related to: 1. Smoking 2. Activity, leisure and therapeutic programs	<ul style="list-style-type: none"> A review of intentionally set fires indicated they were on the rise. During the period January 2001 – August 2004, 56 fires were intentionally set. 	<ul style="list-style-type: none"> Effective October 2004, the WSH Smoking Policy was changed to again allow smoking in certain outdoor areas. Outdoor storage areas are provided for cigarettes, matches, etc. Prior to changing the policy, an in-depth risk analysis was completed. According to data, there has already been a decrease in the number of intentionally set ward fires resulting in a safer

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3. Communication between shifts 4. Restraint and seclusion	<ul style="list-style-type: none"> • Clinicians suggest that unstructured time leads to more violent incidents. Recommend enhanced programming for patients hospital-wide. • WSH Policy 2.4.1 Restraint/Seclusion is under review by the Quality Management and Patient Care Committee. • WSH is placing major focus on taking steps to significantly reduce the use of seclusion and restraint. Hospital management is promoting a culture change which will encourage a more humane approach to patient care. This approach promotes hope and recovery and earlier intervention in behavior management and de-escalation techniques. This will ultimately result in a significant decrease in violent behaviors, and reduce restraint/seclusion usage. 	environment. Target: Complete <ul style="list-style-type: none"> • Wards continue to improve unstructured time during evenings and weekends. Target: Ongoing • The policy has been revised to align with the Nonviolence Initiative and the reduction/elimination of restraint and seclusion. Target: Complete • Funding was received from a Substance Abuse and Mental Health Services Administration (SAMHSA) grant. The Nonviolence Steering Committee is overseeing activities connected to the grant. Ongoing efforts continue to promote an overall culture change towards a more humane approach to patient care and earlier intervention in behavior management and de-escalation techniques. Target: Ongoing
Analysis of data on violence and workers compensation claims during at least the preceding year	<ul style="list-style-type: none"> • WSH Safety & Claims office provides monthly data regarding staff injuries and L&I claims information. • Established a Return-To-Work program. 	<ul style="list-style-type: none"> • WSH Governing Body Sub-Committee and Safety Committee review injury data and L&I claims information on at least a quarterly basis to identify where the injuries are occurring and what can be done to reduce them. • A Return-To-Work program was implemented in December 2004. Due to budget constraints, the program was temporarily suspended (May 20, 2005) An effective Return-To-Work program can reduce L&I time loss payments, return employees to work more quickly, help in continuity of care to patients and reduce L&I premiums. The program was reactivated effective July 1, 2005. Improving staff safety is an expected outcome of the program. Knowledgeable staff will continue to be available to wards and patients will continue to interact with staff they are

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		familiar with. Target: Ongoing
Input from staff and patients such as surveys and information relevant to the lettered elements above.	<ul style="list-style-type: none"> A DSHS employee survey is conducted on an semi-annual basis. 	<ul style="list-style-type: none"> The survey was recently completed and suggested improved communication take place between management and ward staff. Target: Completed
Review of guidelines on violence in the workplace or state hospital issued by Department of Health (DOH), DSHS, L&I, Occupational Safety and Health Administration (OSHA), Medicare, others	<ul style="list-style-type: none"> The Safety and Claims Office reviews and implements these guidelines and has frequent consultation with the DSHS Office of Risk Management (ORM). 	<ul style="list-style-type: none"> Safety and Claims Office will continue to be updated on DOH, DSHS, L&I, JCAHO and CMS guidelines and utilize them in planning workplace violence prevention at WSH. Target: Ongoing
Violence prevention training with consideration to 14 topics in the law	<ul style="list-style-type: none"> Prior to an assignment to hands-on patient care, all employees must complete ProACT. This training covers all 14 topics in the law. Staff Development has developed a briefing on domestic violence in the workplace. Training objectives are to raise awareness, improve identification of domestic violence in the workplace and suggest resources for victims and supervisors. 	<ul style="list-style-type: none"> WSH Staff Development provides mandatory orientation training for all new employees that covers all areas listed in the assessment. Staff assigned to clinical positions receive a two-week orientation, while support staff receive the one-week version. All ward-based staff must attend this training prior to being assigned to duty. Other non-ward-based staff must receive the training within 60 days of hire. Further, a training brochure will be prepared and distributed by Staff Development which covers the 14 training topics for existing staff who received orientation prior to the implementation of the workplace safety for hospitals legislation passed in 2000. Target: Process is currently in place Domestic violence training is provided by Staff Development on a scheduled basis throughout the year. Target: Ongoing
Record of violent acts including physical assault or “attempted”	<ul style="list-style-type: none"> A procedure for centralized recording of all violent acts has been developed. The log is available upon 	<ul style="list-style-type: none"> The Threat and Assault Log, a collection of Security Incident Reports (SIRs), is the responsibility of the WSH Security

Appendix A

<p>Elements of the plan per law. (Items a through h below are part of the security & safety assessment)</p>	<p>Assessment – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence.</p>	<p>Plan – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence.</p>
<p>physical assault</p>	<p>request for inspection by WISHA (L&I) Compliance Officers. Data on assaults has been gathered for over 10 years. Quarterly trends have been presented to Governing Body Sub-Committee.</p> <ul style="list-style-type: none"> • Recorded information will include all of the following: <ol style="list-style-type: none"> 1. A full description of the violent act 2. When the violent act occurred 3. Where the violent act occurred 4. To whom the violent act occurred 5. Who perpetrated the violent act 6. The nature and severity of the injury 7. Weapons used 8. Number of witnesses (and names) 9. Action taken 	<p>Manager and is a working document ready for inspection. Target: Completed /Ongoing</p> <ul style="list-style-type: none"> • The WSH Governing Body Sub-Committee receives quarterly assault trends from Safety and Claims to utilize as a risk management tool and use as an indicator to measure success of the Workplace Safety Plan. Target: Completed - process in place • In addition to the SIRs, incidences of violence are recorded on the DSHS Form 133 – Report of Employee Personal Incident, when an employee injury is involved. Target: Completed - process in place • All information required by law is collected and will be retained no fewer than five years to utilize in analysis of assault and injury due to assault. Target: Completed – process in place

Appendix B – Workplace Safety Plan (ESH)

Eastern State Hospital

UPDATE
June 2005

RCW 72.23.400 requires each state hospital (WSH, ESH, CSTC) to develop a plan to reasonably prevent and protect employees from violence at the state hospital. The law requires completion of a security and safety assessment to identify existing or potential hazards for violence in the workplace. Using the results of the assessment, each state hospital must develop a plan to reasonably prevent and protect employees from violence. The following table lists the elements of both the assessment and the plan as required by law. It then provides a summary of the results of the assessment as well as the plan derived from that assessment.

Elements of the plan per law. (Items a through h below are part of the security & safety assessment)	Assessment – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence.	Plan – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence.
<p>a. The physical attributes of the state hospital including:</p> <ol style="list-style-type: none"> 1. access control 2. egress control 3. door locks 4. lighting 5. alarm systems 	<p>Access Control</p> <ul style="list-style-type: none"> • Open campus/ location (rural), multiple buildings and locations (multiple areas isolated after dark). Problem identified with security staffing (one per shift, hospital-wide). • There are occurrences of stolen, misplaced, lost or not turned in employee cards and/or keys assigned to individual employees. 	<p>Access Control</p> <ul style="list-style-type: none"> • Increase security staffing to two per shift to provide back up. Additional security guard position established for 7am-3pm shift. • Identify what keys are required for specific work areas/job classes. <ul style="list-style-type: none"> • Re-issue keys to all staff based on this information. • Stamp serial numbers on each key to assist in identification and tracking. • Develop a database tracking system for the return and issuance of keys/cards to/from employees transferring to other areas/departments or leaving Eastern State Hospital (ESH) employment.

Appendix B

<p>Elements of the plan per law. (Items a through h below are part of the security & safety assessment)</p>	<p>Assessment – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence.</p>	<p>Plan – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence.</p>
	<ul style="list-style-type: none"> • Westlake Building exterior doors do not always remain locked (not all are self-locking). The hospital’s geropsychiatric program is located in Westlake Building. • Increased potential hazards at Westlake Switchboard due to limited visibility of in-coming visitors, patients and staff. • The parking areas on the north side of Eastlake Administration building are not under surveillance of the main building and are bordered by woods and an unsecured road/access trail. • Some doors into private offices, common areas and hallways lack security windows. • The walkway between the main kitchen and the boiler room is obscured. • The area between the Therapy Pool and the unused Interlake building has no surveillance and is not well lit. 	<ul style="list-style-type: none"> • Identify exterior doors that do not close properly and place work orders to repair or replace. Ongoing - weekly environmental surveys (work site inspections). Westlake patio doors are particularly problematic and latest information from Capital Programs indicates these are high on the priority list for replacement. Funded, but waiting to go out for bid. • Identify high-risk exterior doors that do not have self-locking mechanisms and place work order for lock replacement. High-risk doors have been identified and prioritized for replacement. • Turn switchboard/reception desk 180 degrees to increase visibility of parking lot and in-coming visitors, patient and staff. Safety Officer will request a cost estimate from Consolidated Support Services. • Identify high-risk areas and install surveillance cameras. There is no funding currently available for installation of surveillance cameras. Funding will be requested through Capitol Programs. • For existing doors where surveillance is a consideration, a 180 degree viewer should be added, both interior and exterior doors. Safety Officer will request a cost estimate from Consolidated Support Services. • Install security mirrors to increase visibility. Safety Officer will request a cost estimate from Consolidated Support Services. • Install eight foot high chain link fence to block access to this area. Safety Officer will request a cost estimate from Consolidated Support Services.

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	<p>Egress Control</p> <ul style="list-style-type: none"> No physical control over egress (visitor/staff) on campus. Remedy would essentially require a security fence around entire perimeter of hospital and this is not consistent with hospital mission, vision, or values. Potential for violence when apprehending patients that have gone on unauthorized leave. <p>Door Locks</p> <ul style="list-style-type: none"> Current employee key control and tracking system with regard to change of employee need/status is inadequate. <p>Outside Lighting</p> <ul style="list-style-type: none"> Burned out/malfunctioning outside lighting and amount of time for replacement. <ul style="list-style-type: none"> The parking lot to the north of the Therapy Pool is dimly lit and cannot be seen from any building that is typically occupied at night. The Linden Hall parking lot is poorly lit. 	<p>Egress Control</p> <ul style="list-style-type: none"> Security personnel log daily activity and report trends monthly and quarterly to the Safety Committee. Increase Security staffing. Refer to Element “a”, Page 1 <p>Door Locks</p> <ul style="list-style-type: none"> Refer to Access Control, Element “b” <p>Outside Lighting</p> <ul style="list-style-type: none"> Request monthly report from Consolidated Support Services regarding the submission of campus lighting work orders and completion dates. There is currently a procedure in place. The Electric Shop gives all lighting work orders a priority based on overall lighting requests/needs. FSU perimeter lighting has been increased and is immediately replaced when not working. Post signs in lot indicating “no parking after dark”. Safety Officer will place a work order for installation of sign. Attach flood lights to building. Safety Officer will request a cost estimate from Consolidated Support Services for installation of additional lighting. Install sidewalk lighting along the south side of the parking lot. Safety Officer will request a cost estimate from Consolidated Support Services for installation of

Appendix B

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	<ul style="list-style-type: none"> • Upper terrace and the north side of the Westlake parking lot are dark despite the presence of several pole lights. 	<p>additional lighting.</p> <ul style="list-style-type: none"> • Install additional low-level lighting in these areas (solar lights). <p>Safety Officer will request a cost estimate from Consolidated Support Services for installation of additional lighting.</p>
	<p>Alarm System</p> <ul style="list-style-type: none"> • No duress alarms in south end Eastlake Building basement. • No duress alarms in patient dining rooms (Westlake Building, Eastlake Building, Campus Cafe). • No duress alarm in FSU administration office. 	<p>Alarm System</p> <ul style="list-style-type: none"> • Access to the basement has been limited to staff only by locking all exterior access doors eliminating the need for installation of alarm. The duress alarm is currently tested daily on all wards by ward staff (APU and FSU) per ESH manual. When off wards escorting patients, staff carry two-way radios. Annual competency of staff in the use and maintenance of radio equipment is evaluated by supervisors utilizing a Criteria Based Performance Evaluation Tool (CBPET). • Patients are escorted by staff to dining areas during meal times and staff are equipped with portable radios for communication. Duress alarm system not indicated at this time. • Access to this area is limited and communication capabilities increased via portable radios. Duress alarm system is not indicated at this time.
<p>b. Staffing, including security staffing</p>	<ul style="list-style-type: none"> • With only one security staff member on duty most of the time, there is strong potential for an act of violence to overwhelm the Security staff's ability to contain or control it. This could subject the Security staff to injury and jeopardize others before local law enforcement could respond to provide assistance. • Systems for identifying variances in staffing and responding to these in a timely manner are in 	<ul style="list-style-type: none"> • Consider an increase in Security department staffing to provide coverage as follows. <ul style="list-style-type: none"> a. 7:00am - 3:00pm – 7 days per week. b. 3:00pm - 11:00pm – 7 days per week. c. 11:00pm - 7:00am – 7 days per week. d. 12:00pm - 8:00pm – 7 days per week. e. 8:00pm - 4:00pm – 7 days per week. <p>See Access Control 1 a.</p> • No additional actions required

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	<p>place and appear to be adequate in general.</p> <ul style="list-style-type: none"> • Additional tools/systems used in nursing include <ul style="list-style-type: none"> - policy/procedure on how to acquire staff - acuity based staffing plan - guidelines for safe staffing levels 	
<p>c. Personnel policies</p>	<ul style="list-style-type: none"> • Though the ESH Policy 1.41 – <i>Workplace Violence</i> - is part of the new employee training, it could be expanded to include intimate partner violence in the workplace. 	<ul style="list-style-type: none"> • ESH is currently participating in a program offered by the Spokane County Domestic Violence Consortium (SCDVC). This program is funded through the National Institutes of Occupational Safety and Health/Centers for Disease Control. Services offered include: <ul style="list-style-type: none"> • Supervisor/manager training • Crime prevention/environmental analysis • Management Plan development • Employee training • Follow-up training and education • Critical incident response <p>Employee feedback and SCDVC analysis & recommendations will be reviewed and incorporated into this plan.</p> <p>New Employee Orientation and current staff training will be expanded to include the SCDVC content.</p>
	<ul style="list-style-type: none"> • DSHS Administrative Policy 18.67 – <i>Domestic Violence and the Workplace</i> - should also be part of the new employee, annual refresher and supervisor safety training. 	<ul style="list-style-type: none"> • The ESH Workplace Violence Policy incorporates the DSHS Administrative Policy 18.67 and has been implemented.
<p>d. First aid and emergency procedures</p>	<ul style="list-style-type: none"> • There are hospital staff that are sometimes off campus and may need to administer first aid in the event of a violent act or accident. Because the employees that conduct these activities are not medical or nursing staff, they may need to be trained in first aid. • Not all Rehabilitation Services’ facilities/areas have been included in the Emergency Medical 	<ul style="list-style-type: none"> • ESH employees that are not medical staff or licensed nursing staff but are still involved in one-to-one or group patient activities (i.e. Rehab Services) should have first aid training. Rehabilitation Services’ staff trained – COMPLETE. • The Emergency Response Committee, with rehabilitation staff, have identified and incorporated all rehabilitation

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	<p>Response Plan.</p>	<p>facilities/areas into their response planning i.e. Therapy Pool, baseball field, etc.</p>
<p>e. Violent acts:</p> <ul style="list-style-type: none"> • Reporting of violent acts • Taking appropriate action in response to violent acts • Follow-up procedures after violent acts 	<ul style="list-style-type: none"> • All elements pertaining to reporting of violent acts appear to be covered and systems are working well. • All elements under this area appear to be currently covered and systems are working well. One exception is the ESH Workplace Violence Policy, which is a new policy/procedure and implementation thus far has been inconsistent. This is an area targeted by the Safety Committee for improvement. • All elements pertaining to follow-up procedures appear to be covered and systems are working well. 	<ul style="list-style-type: none"> • Maintain follow-up procedures. • Policies/procedures are implemented as directed. • Maintain follow-up procedures.
<p>f. Development of criteria for determining and reporting verbal threats</p>	<ul style="list-style-type: none"> • ESH has been using criteria as identified in the Mental Health Division Quality Steering Committee definition for assault in the Unusual Occurrence Reporting System (UORS) for the past 10 years. 	<ul style="list-style-type: none"> • Verbal threats are tracked when reported. Staff determine risk potential.
<p>g. Employee education and training</p>	<ul style="list-style-type: none"> • Not all new employees receive new employee orientation including the Safe and Therapeutic Aggression/Assault Reduction (STAART) training class in a timely manner. Some are employed at ESH for months before receiving this training. • Need an update class for current staff that incorporates the Violence in the Workplace Policy #1.41 and other aspects of this plan. This should be a mandatory class with updates annually that incorporate changes in the overall security plan. 	<ul style="list-style-type: none"> • All new employees receive new employee orientation within the first month of employment. • All current employees are required to take the initial eight hour STAART and four hour updates every two years. Current tracking system is in place to monitor compliance. • A mandatory update class for current staff that incorporates the Violence in the Workplace Policy #1.41 and other aspects of this Workplace Safety Plan are required annually. Current tracking system is in place to monitor compliance.

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	<ul style="list-style-type: none"> • Need more education in conflict management and classes in anger management, stress management and dealing with change in a positive manner. 	<ul style="list-style-type: none"> • Offer training in conflict management, stress management, anger management and dealing with change in a positive manner to ESH employees. Education to include various methods of instruction including classes, workbooks and videos. In collaboration with the SAMSHA Training Grant and the Washington Institute for Mental Illness Research and Training (WIMIRT), ESH is developing a plan to change from a Bio-Psycho-Social Model to a Recovery Model to reduce the number of seclusion/restraint events. A team will develop training modules and interventions to assist staff in making needed changes in a safe and therapeutic manner.

Appendix B

<p>Elements of the plan per law. (Items a through h below are part of the security & safety assessment)</p>	<p>Assessment – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence.</p>	<p>Plan – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence.</p>
<p>h. Clinical and patient policies and procedures including those related to:</p> <ul style="list-style-type: none"> • Smoking • Activity, leisure, and therapeutic programs • Communication between shifts • Restraint and seclusion 	<ul style="list-style-type: none"> • Limited rehabilitation services provided to patients may result in increased patient agitation due to limited activity, leisure and therapeutic programming. • Lack of communication between recreation therapy and recreation specialist disciplines. • There is an increased risk for patient agitation due to hearing deficits. 	<ul style="list-style-type: none"> • Review data related to patient behavioral problem times, areas, etc., to identify increased needs for structured treatment programming. Evening and weekend programming in Therapeutic Recreation has been supplemented to decrease agitation and use of seclusion/ restraint during specific hours identified through review of data. COMPLETED • Revise program scheduling to increase use of therapy pool/aquatic therapy. Implemented and ongoing • Standardize communication forms to increase communication between disciplines. A draft form was developed and piloted and is currently utilized. COMPLETED • Increase communication with attending physicians and other referral resources to increase referrals for audiology services especially on the Gero-Psychiatric Unit. Meetings are scheduled with physicians and/or program directors regularly to increase communication and education regarding audiology services. COMPLETED
	<ul style="list-style-type: none"> • There is an increased risk for patient unauthorized leave and/or negative patient behavior during community outings. • Increased patient agitation upon admission has been evaluated. 	<ul style="list-style-type: none"> • A community outing planning sheet has been developed and is utilized for all outings to identify potential risks and methods of managing/reducing these risks i.e. cell phones, personal protective equipment, patient-to-staff ratios. • Recommend that attending physicians address patient’s agitation as a high priority in prescribing admission medications and other interventions. In collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA) Training Grant and WIMIRT, ESH is developing a plan to change from a Bio-Psycho-Social Model to a Recovery Model to reduce the number of seclusion/restraint events. A team will develop

Appendix B

<p>Elements of the plan per law. (Items a through h below are part of the security & safety assessment)</p>	<p>Assessment – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence.</p>	<p>Plan – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence.</p>
	<ul style="list-style-type: none"> Limited adaptive equipment to increase patient mobility and decrease use of restraints. 	<p>training modules and interventions to assist staff in making needed changes in a safe and therapeutic manner.</p> <ul style="list-style-type: none"> Provide additional adaptive equipment to increase patient mobility and decrease use of restraints. <ul style="list-style-type: none"> Hi-Low Beds Mattresses (floor mats) Ultimate Walkers Broda Chairs <p>Improving Organizational Performance Team has reviewed the ESH fall protocol to include identifying need for additional adaptive equipment. Some of the equipment needs identified by this team include:</p> <ul style="list-style-type: none"> 12 Broda Chairs (\$3,000 ea) 100 Hi-Low Beds (\$2,000 ea)
<p>i. Clinical and patient policies and procedures including those related to:</p> <ul style="list-style-type: none"> Smoking Activity, leisure, and therapeutic programs Communication between shifts Restraint and seclusion 	<ul style="list-style-type: none"> Limited adaptive equipment to increase patient mobility and decrease use of restraints. (cont) 	<ul style="list-style-type: none"> Total costs for equipment needs are estimated at approximately \$75,000. There are approximately 13 Broda Chairs, seven ultimate walkers and 60 hi-low beds already purchased and in place. Funding is not available at this time for further purchases.
	<ul style="list-style-type: none"> Placing patients in seclusion/restraint increases potential for employee injury. Non-therapeutic interactions with patients increases the potential for employee injury. 	<ul style="list-style-type: none"> Increase staff training in use of less-restrictive alternatives. In collaboration with the SAMHSA Training Grant and WIMIRT, ESH is developing a plan to change from a Bio-Psycho-Social Model to a Recovery Model to reduce the number of seclusion/restraint events. A team will develop training modules and interventions to assist staff in making needed changes in a safe and therapeutic manner. Consistent supervision & corrective action to ensure therapeutic interactions. Refer to #7 above

Appendix B

<p>Elements of the plan per law. (Items a through h below are part of the security & safety assessment)</p>	<p>Assessment – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence.</p>	<p>Plan – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence.</p>
<p>j. Analysis of data on violence and workers compensation claims during at least the preceding year</p>	<ul style="list-style-type: none"> • Records are on a database. • ESH has been using criteria as identified in the MHD Quality Steering Committee definition for assault in the Unusual Occurrence Reporting System (UORS) for the past 10 years. 	<ul style="list-style-type: none"> • Data is analyzed and trended at least quarterly. • Continue current reporting, trending and analysis.
<p>k. Input from staff and patients such as surveys and info relevant to the lettered elements above.</p>	<ul style="list-style-type: none"> • The Complaint Review Team has identified that trending of the nature of the complaints is an area that requires improvement. • A survey of staff that specifically addresses the elements of this Workplace Safety Plan is needed. • The UORS is currently part of the new employee orientation and nursing services training. 	<ul style="list-style-type: none"> • The Complaint Review Team is meeting bi-monthly to identify how to capture trends that would inform and be of benefit to ESH. The Complaint Review Team meets bi-monthly to review trends. Aggregate data is distributed for ward/unit management groups to make appropriate program changes. • Survey has been developed and issued to all employees. Results have been reviewed and recommendations incorporated into the plan. • Implemented and ongoing.
<p>l. Review of guidelines on violence in the workplace or state hospital issued by DOH, DSHS, L&I, OSHA, Medicare, others. (Not required)</p>	<ul style="list-style-type: none"> • Utilize as resource 	<ul style="list-style-type: none"> • Reports to the Safety Committee routinely include updates on all pertinent guidelines and these are utilized in planning workplace violence prevention at ESH.
<p>m. Violence prevention training with consideration to 14 topics in the law</p>	<ul style="list-style-type: none"> • Must be addressed in the plan. 	<ul style="list-style-type: none"> • In-services encompassing interpersonal communication skills in a hospital setting, sexual harassment and workplace violence are incorporated into mandatory annual training.
<p>n. Record of violent acts including physical assault or</p>	<ul style="list-style-type: none"> • These records are on a database. 	<ul style="list-style-type: none"> • Data is analyzed and trended at least quarterly.

Appendix B

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“attempted” physical assault	<ul style="list-style-type: none"> • ESH has been using criteria as identified in the MHD Quality Steering Committee definition for assault in the UORS for the past 10 years. 	<ul style="list-style-type: none"> • Continue current reporting/trending/analysis improvement implementation process.

Appendix C – Workplace Safety Plan (CSTC)

Child Study and Treatment Center

ANNUAL UPDATE

June 2005

RCW 72.23.400 requires each state hospital (WSH, ESH, CSTC) to develop a plan to reasonably prevent and protect employees from violence at the state hospital. The law requires completion of a security and safety assessment to identify existing or potential hazards for violence in the workplace. Using the results of the assessment, each state hospital must develop a plan to reasonable prevent and protect employees from violence. The following table lists the elements of both the assessment and the plan as required by law. It then provides a summary of the results of the assessment as well as the plan from that assessment.

Elements of the plan per law. (Items a through h below are part of the security & safety assessment)	Assessment – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence.	Plan – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence.
<p>a. The physical attributes of the state hospital including:</p> <ol style="list-style-type: none"> 1. Access Control 2. Egress Control 3. Door Locks 4. Lighting 5. Alarm Systems 	<p>Access Control</p> <ul style="list-style-type: none"> • CSTC Administrative Building remains unlocked during normal business hours. The reception desk is located in the middle of the building, not easily located. Access to sensitive areas within the Administration Building and patient residence is effectively controlled. • All visitors are asked to “check-in” at the Administration Building. It is unclear if this occurs and does not account for visitors that proceed directly to a cottage. • More strict enforcement of Identification Badge Policy is needed. 	<ul style="list-style-type: none"> • CSTC has a Campus Green Project that will relocate the receptionist and improve access monitoring to the hospital. Target: Phase I of the Campus Green Project to begin July 2005. • Safety Committee will review the Security Management Plan that addresses access monitoring of the campus and signage/procedures. The Safety Committee will forward any recommendations to Executive Team. Target: Policy to be reviewed at July 2005 Safety Committee Meeting. • CSTC provided all staff with break-away lanyards to encourage staff to consistently wear identification (ID) badges. All supervisors have been directed to strictly enforce the ID Badge Policy that is first introduced to all employees at orientation. Target: Campus-wide audits of ID Badges will begin June 2005 and target 100 percent compliance by September 2005.

Appendix C

<p>Elements of the plan per law. (Items a through h below are part of the security & safety assessment)</p>	<p>Assessment – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence.</p>	<p>Plan – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence.</p>
	<p>Egress Control</p> <ul style="list-style-type: none"> Egress control is an area of ongoing assessment and formally reviewed during the DSHS Safety and Claims Inspection. No concerns have been identified. <p>Door Locks</p> <ul style="list-style-type: none"> Door locks are inspected during the quarterly Safety Inspection. Concerns are addressed immediately through the work-order process. During the annual DSHS Safety and Claims Inspection, the state vehicles were found to be unlocked. Inspection of state vehicles has been added to the quarterly safety check list and the chair of the Safety Committee communicated with all employees regarding the need to check vehicles after use. <p>Lighting</p> <ul style="list-style-type: none"> Following the move of Orcas Cottage to the temporary location on E-8, assessment of lighting indicated the need for improvement. Additional outdoor lighting fixtures were added for the safety of staff and patients entering E-8 via the stairs across from Firwood. In addition, lighting was enhanced in the Firwood parking lot as it is now utilized regularly by Orcas staff. <p>Alarm Systems</p> <ul style="list-style-type: none"> Fire Alarms – Within the past quarter, CSTC replaced a number of sprinkler heads that had been recalled. All have been checked and are functioning correctly. Fire Alarms are checked regularly with drills. Heating System Alarm – The low water and high water alarms on the boiler are checked monthly. Burglar alarms are located in the two school buildings. The alarms are checked regularly. 	<ul style="list-style-type: none"> No action at this time. CSTC Safety Committee will monitor compliance of locking state vehicles. Target: 100 percent compliance will be achieved immediately and be continually maintained as evidenced by the quarterly Safety Inspection. No action at this time. Personnel changes have prompted the need to reassign responsibility for conducting fire drills. Target: CSTC will review process for conducting and documenting fire drills and redesign process completed with new personnel by August 30, 2005. No action at this time. No action at this time.

Appendix C

Elements of the plan per law. (Items a through h below are part of the security & safety assessment)	Assessment – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence.	Plan – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence.
b. Staff, including security staffing	<p>Assessment –</p> <ul style="list-style-type: none"> • Maintaining staffing levels has been challenging recently due to the limited number of intermittent staff available and a number of open positions. • The hospital has questioned how significant the ratio of experienced to non-experienced staff is to incidental patient behavior and staff injury on particular shifts. There has not been a formal effort to assess this issue. • Recruitment of counseling staff continues to be a major problem. Salaries in the PCCC series fall far below similar positions in other divisions of DSHS and community facilities. • CSTC is supported by the WSH Security Department. During the month of May 2005, CSTC requested support from WSH Security on five occasions. WSH Security was able to respond in all five instances. WSH Security responded two other times for alarms that were activated unintentionally. WSH Security staffing is sufficient to meet the needs of CSTC. 	<ul style="list-style-type: none"> • Recruitment for counseling staff has focused on using a newspaper advertisement in addition to the state employment website. Target: CSTC will increase the number of intermittent staff trained and available to fill open shifts by September 15, 2005. • CSTC will develop a method of assessing the impact of experience and leadership on specific shifts to incidental patient behavior on the particular shift. Target: A method of identifying staff and assessing leadership and experienced will be developed by September 1, 2005. • CSTC Executive Management has advocated that the personnel system review the salary range for the PCCC series. Target: Ongoing. • No action at this time.
c. Personnel Policies	<ul style="list-style-type: none"> • In October 2001, CSTC developed Policy 223: <u>Workplace Violence by Employees or Visitors</u>. Policy 223 was developed in response to the Workplace Safety Legislation passed in 2000. The policy does not fully address the issues outlined in the legislation. 	<ul style="list-style-type: none"> • The Policy Committee will review the policy and legislation to determine what additional information, if any, needs to be added to the CSTC Policy. Target: Policy Committee review and recommendations to the Executive Team will be completed by September 1, 2005.

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<p>d. First aid and emergency procedures</p>	<ul style="list-style-type: none"> • CSTC provides nursing coverage on campus at all times. Policy 435: <u>Responding to Medical Emergencies</u> states that, “the individuals first on the scene, with the most medical training and experience, will assume the role of the first responder. Psychiatric Child Care Counselors (PCCC) and Recreational Therapists are trained in First Aid and CPR. In the absence of a licensed health care professional, the PCCC or Recreation Therapist will assume the role of first responder. <p>A recent medical emergency demonstrated that the policy is being followed. The registered nurse on duty and the psychiatrist responded first to the scene. 2222 was called and local Emergency Medical Services were called to the scene.</p> <ul style="list-style-type: none"> • The Disaster Plan was found to be “out of date” due to a number of recent personnel changes. • CSTC is expected to have a Disaster Drill that will include community emergency services. 	<ul style="list-style-type: none"> • No action at this time. • The Disaster Plan will be updated to reflect current personnel. Target: Updated plan will be completed and inserted into all manuals on campus by 07/01/05. • Following completion of the drill, CSTC / WSH / Community Services responses will be analyzed and needed actions identified. Target: Disaster Drill will be completed by December 2005, Action Items identified by January 30, 2006.
	<ul style="list-style-type: none"> • CSTC sent a group of eight employees to Critical Incident Stress Management (CISM) training at WSH in April 2005. A debriefing session occurred following the training with discussion of applicability to CSTC. 	<ul style="list-style-type: none"> • Recommendations from the debriefing were developed. Target: These recommendations will be taken to the Executive Team Meeting for review and prioritization by September 15, 2005.

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<p>e. Violent Acts: Reporting of violent acts</p>	<ul style="list-style-type: none"> • CSTC has a firmly established policy for reporting of violent acts. Employees are trained to the procedure and the cottage supervisor, program director and psychiatrist review every report of a violent act. Incidents of violent acts in non-clinical departments are also reported using the same procedure and forms. Our system does not have a process to identify when a violent act is not reported. Orientation and Ongoing training of staff and supervisors is the method used to support the procedure. 	<ul style="list-style-type: none"> • Semi-annual in-service training will be developed to review emergency procedures and reporting of violent acts. Target: In-service training will be offered in September 2005.
<p>f. Development of criteria for determining and reporting verbal threats</p>	<ul style="list-style-type: none"> • CSTC continues to collect data on verbal threats via the incident reporting process. While there is concern that incidents of verbal threats are underreported, there is not currently a process identified to capture this information. 	<ul style="list-style-type: none"> • A review of the mechanisms in place to report verbal threats will be part of a larger initiative to review the incident reporting system at CSTC. Data that are collected under the current system are reviewed in the quarterly Quality Improvement Meeting and action is taken as needed.
<p>g. Employee education and training</p>	<ul style="list-style-type: none"> • Washington State was one of nine states to receive a Substance Abuse and Mental Health Services Administration (SAMHSA) Grant related to the reduction of seclusion and restraint. Training employees in pro-active treatment strategies, non-violent communications and de-escalation are all aspects of the initiative. • CSTC staff complete a web-based training on violence in the work place. In November 2004, 100 percent of staff had completed the training. 	<ul style="list-style-type: none"> • Executive Staff will review the status and focus of training efforts for the purposes of planning for Fiscal Year 2006. Target: Review to be completed by September 30, 2005. • No action at this time.

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<p>h. Clinical and patient policies and procedures including those related to:</p> <ol style="list-style-type: none"> 1. Smoking 2. Activity, leisure, and therapeutic programs 3. Communication between shifts 4. Restraint and seclusion 	<ul style="list-style-type: none"> • Patients at CSTC are all under the age of 18 and not allowed to smoke. Families, visitors and employees are required to smoke in designated smoking areas. No incidents of violence have been noted related to the smoking policy. • The clinical and patient policies support activity, leisure and therapeutic programming by allowing optimal patient activity levels and movement of patients, as allowed by law, on and off campus. CSTC Recreation Therapists are certified. They provide individual assessments of patients, and develop and facilitate recreation therapy activities. • Communication between shifts is critical to the safety of the patients and staff on the cottages. CSTC has a structured shift report where each patient is noted daily. Staff communicates the occurrence of escalated behaviors during the shift and identifies any patients that remain in escalated states for support by the oncoming shift staff. Additionally, each program has a Communication Log Book where additional patient information may be communicated among staff. • Seclusion and Restraint Policies clearly define these procedures as safety measures to prevent harm to a patient or staff. Debriefing of seclusion and restraint episodes is common practice. Proactive Treatment Strategies are critical for the reduction of seclusion and restraint. 	<ul style="list-style-type: none"> • No action at this time. • No action at this time. • No action at this time. • No action at this time.

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<p>i. Analysis of data on violence and workers compensation claims during at least the preceding year</p>	<ul style="list-style-type: none"> • The following performance indicators, trended over time, are reviewed monthly at Safety Committee. <ul style="list-style-type: none"> ○ Total Staff Injuries ○ L&I Compensable Claims ○ L&I Non Compensable Claims ○ No L&I Claim Files ○ Incidents of Staff Injury – by Assault ○ Incidents of Staff Injury – by Accident ○ Incidents of Staff Injury – by Hands On Involvement • During the June 2005 Safety Committee, it was noted that the number of staff injuries due to <i>accident</i> has trended upward since January 2002. The committee identified this as concerning and requested further analysis of the data to determine if improvement opportunities exist on campus. 	<ul style="list-style-type: none"> • Performance Indicators are reviewed monthly at the safety committee and by the clinical leadership in each program. Data points that fall outside of the control limits and/or data that trends in a direction that is contraindicated are analyzed further for identification of improvement opportunities. Target: Ongoing. • Further analysis of the data is needed to better understand the incidents of staff injury by accident and target improvement efforts. Target: The Director of QI will present data by cause of accident to the Committee during the September 2005 Safety Committee Meeting.
<p>j. Input from staff and patients such as surveys and info relevant to the lettered elements above.</p>	<ul style="list-style-type: none"> • CSTC employees are surveyed annually. Survey questions target issues related to staff morale. In 2004, staff did not specifically identify workplace safety as having a negative impact on morale. • Exit interviews are conducted with parents / legal guardians of the children and youth at the time of discharge. Interview feedback has led to two specific initiatives, unrelated to workplace safety. No specific concerns regarding the workplace safety have been identified through the interviews. 	<ul style="list-style-type: none"> • Annual CSTC employee survey is due. Target: Survey to be distributed by September 30, 2005. • No action at this time.
<p>k. Review of guidelines on violence in the workplace or state hospital issues by DOH, DSHS, L&I, OSHA, Medicare, others. (Not required)</p>	<ul style="list-style-type: none"> • CSTC leadership team has frequent consultation with the DSHS Office of Risk Management. 	<ul style="list-style-type: none"> • CSTC’s contact person from DSHS Office of Risk Management is now a member of our Safety Committee. Target: Ongoing.

Appendix C

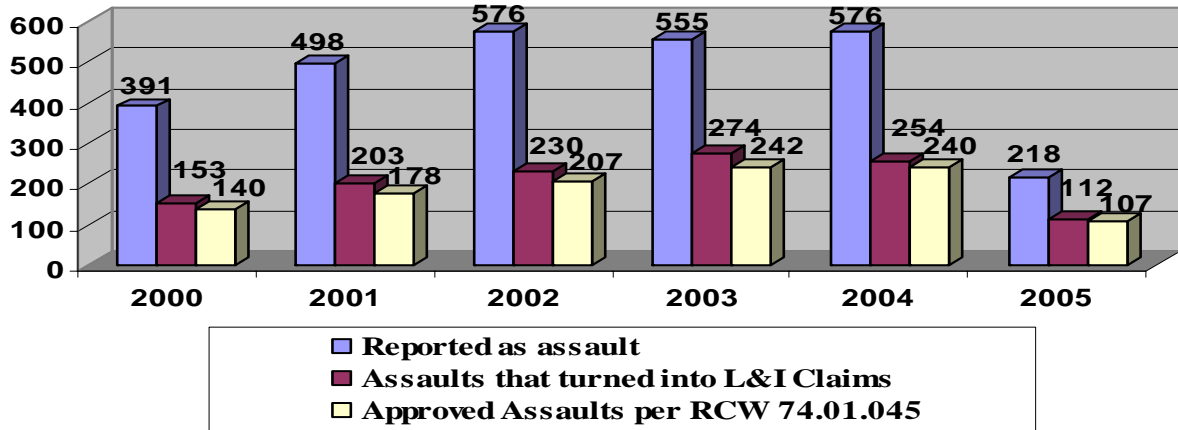
<p>Elements of the plan per law. (Items a through h below are part of the security & safety assessment)</p>	<p>Assessment – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence.</p>	<p>Plan – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence.</p>
<p>1. Violence prevention training with consideration to 14 topics in the law</p>	<ul style="list-style-type: none"> • All new employees in positions of direct patient care receive two-weeks of orientation and training prior to any patient contact. Included within this orientation/training is a course on responding to crisis behaviors. Throughout 2004, CSTC developed Child and Adolescent Assault Management training curriculum to replace Physical Aggression Response Training (PART). The new training curriculum allows for increased focus on the age and development of the population served at CSTC and allows for integration with the larger initiative to reduce restraint and seclusion. The curriculum includes, but is not limited to, the following: <ol style="list-style-type: none"> 1. General safety procedures 2. Personal safety procedures and equipment 3. The violence escalation cycle 4. Violence predicting factors 5. Obtaining patient history for patients with violent behavior or a history of violent acts 6. Verbal and physical techniques to de-escalate and minimize violent behavior 7. Strategies to avoid physical harm 8. Restraining techniques 9. Documenting and reporting incidents 10. Debriefing of violent acts 11. Resources available to employees for coping with violence 12. CSTC’s work place safety plan and policy 13. Use of intershift reporting process to identify high-risk patients. 14. Use of the multidisciplinary treatment process and/or ways to communicate treatment plans and violence prevention strategies to all staff on the cottage. 	<ul style="list-style-type: none"> • CSTC will develop a method of evaluating the effectiveness of this training curriculum to be used to update and improve the curriculum. Target: Method for evaluation will be developed by September 2005.

Appendix C

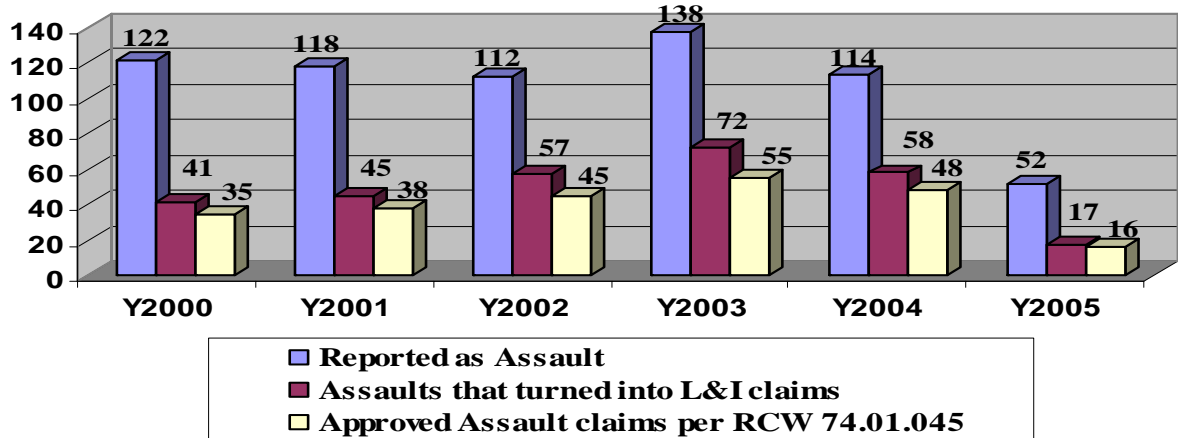
<p>m. Record of violent acts including physical assault or “attempted” physical assault.</p>	<ul style="list-style-type: none">• Incidents of physical assault or “attempted” physical assault are identified through the Incident Reporting System. Incidents are defined using the same criteria in all three hospitals.	<ul style="list-style-type: none">• Data is gathered, trended and reported quarterly. Target: Ongoing.
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Appendix D – Patient to Staff Assaults

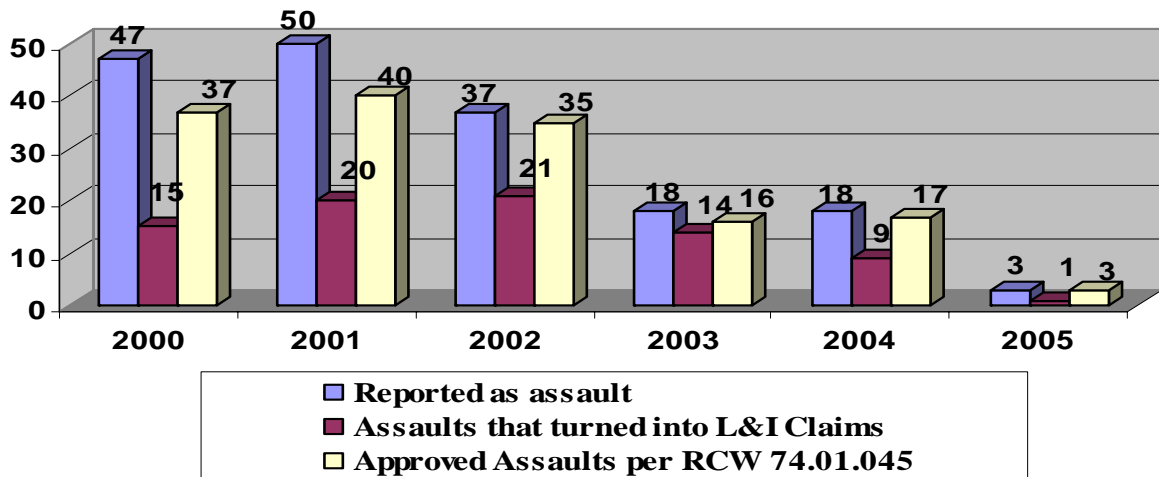
WSH Assault Information



ESH Assault Information

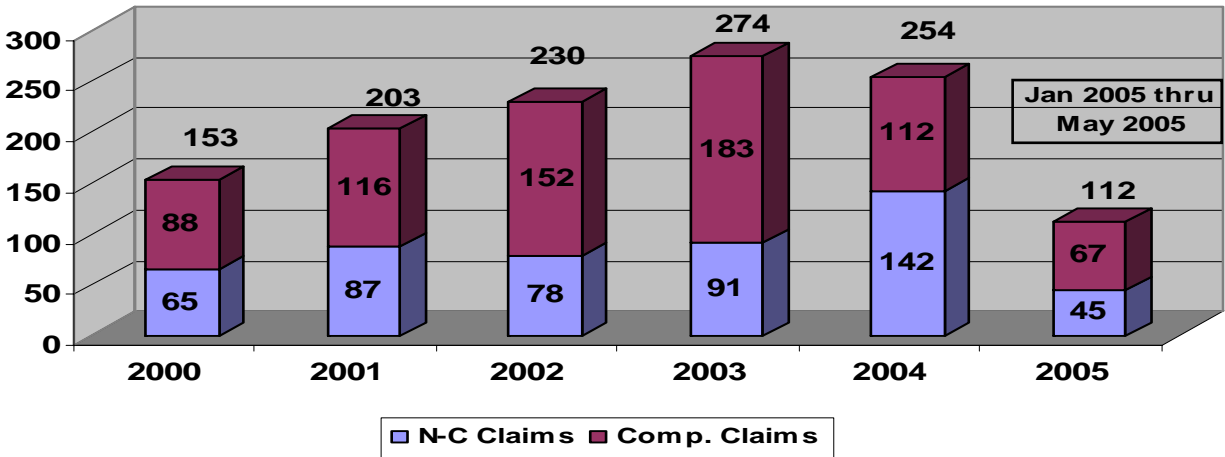


CSTC Assault Information

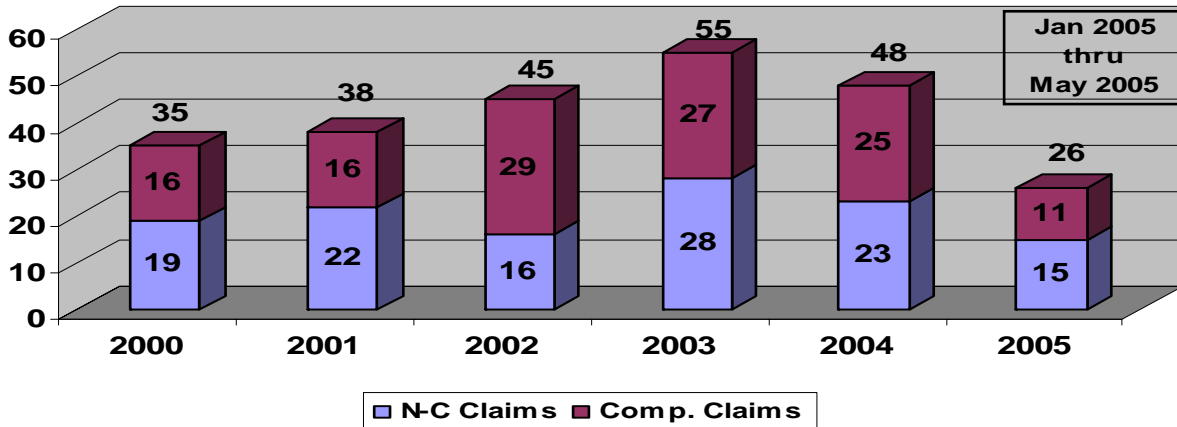


Appendix E – Industrial Insurance Claims Data

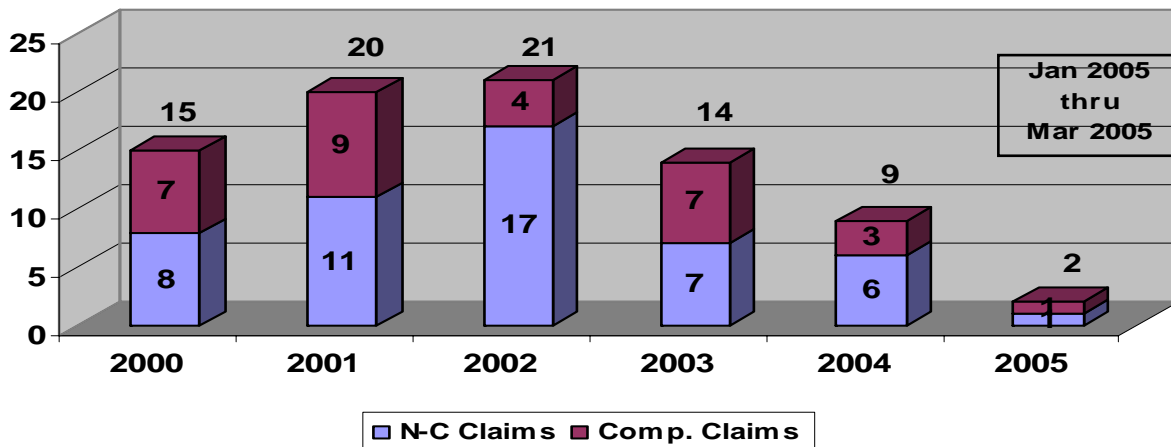
WSH Assault Claims Broken Down by Compensable vs. Non-Compensable



ESH Assault Claims Broken Down by Compensable vs. Non-Compensable



CSTC Assault Claims Broken Down by Compensable vs. Non-Compensable



Appendix F – Time Loss Data

