

Washington State Department of Social and Health Services

Eastern State Hospital

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Transforming
Lives

EASTERN STATE HOSPITAL

WORKPLACE SAFETY PLAN





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1.0 PURPOSE

The purpose of the Workplace Safety Plan is to improve and maintain workplace safety at Eastern 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 CBS staff, DSHS Consolidated Support Services (CSS) staff, contract staff, interns, students and volunteers. CSS employees work collaboratively with ESH personnel to create and maintain a safe work environment through the use of a Service Level Agreement (SLA) to identify hospital and CSS responsibilities and service obligations. DSHS CBS Commissary staff work with ESH staff to provide needed resources based on hospital and patient care needs.

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 accreditation standards of The Joint Commission (TJC) and 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 and leadership 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, injuries, exposures and 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 a Culture of Safety and high reliability.

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 include review of Job Hazard Analysis (JHA) to ensure employee performs 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 ESH 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 and decreases employee injuries.
- 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 workplace 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. 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 coworkers to use safe work practices.

5.0 SAFETY COMMITTEES AND SAFETY INFORMATION

5.1 Employee Safety Committee

The purpose of the Employee Safety Committee is for employees and management to mutually address safety and health issues, in compliance with WAC 296-800-130. The committee is 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.

The Employee Safety Committee consists of employee-elected representatives and management designated representatives, in an amount equal to or less than employee-elected representatives, from the facility. Guests (Adhoc members) are invited as required. A chairperson is selected by majority vote of the committee. Membership is re-appointed or replaced at least annually. The committee meets the second Tuesday of each month from 1300-1430 in the West Conference room.

Recommendations or concerns brought to the committee by employees are reviewed and the status of action plans are documented in the Employee Safety committee minutes. Written feedback is provided to the initiator, if known, within 60 days of Safety Committee review.

Meeting minutes are documented and copies posted on the ESH SharePoint in the Safety folder under Committee Minutes and posted on the designated ESH, CSS and CBS Commissary 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 the Life Safety, Environment of Care, and Emergency Management standards of The Joint Commission and related regulations under the Centers for Medicare and Medicaid Services (CMS).

EOC membership consists of the Chief Operating Officer, Director of Facilities, Safety Manager and representatives from Security, Infection Prevention, Quality Management, Consolidated Support Services, Medical Equipment and Safe Patient Handling Committee, Medical staff, Rehab Services, Nursing, Food Services, Environmental Services (EVS) and Pharmacy.

5.3 Safety Bulletin Board

Eastern State Hospital has two core bulletin boards that are maintained with all OSHA required postings and three unit safety boards for posting Safety Committee meeting minutes and other safety related information and announcements.

Staff can find additional safety resources and information by visiting the ESH SharePoint site under Safety, Worker's Compensation and Emergency Management. All employees have access to the ESH SharePoint site.

Locations of Physical Safety Bulletin Boards	
Eastlake Core Bulletin Board	Eastlake Administration Building Main Entrance Near Switchboard Office
Westlake Core Bulletin Board	Westlake Main Entrance in Corridor
GPU	Corridor Outside of Copy Room
APU	0N3 Corridor Near Loading Dock Entrance
FSU	FSU Administration Entrance
CSS	Building M in Corridor Across from the Conference Room
CBS Commissary	Commissary Office Near Entrance

Required OSHA Postings Include:

- Notice to Employees – If a job injury occurs (F242-191-000).
- Job Safety and Health Protection (F416-081-909).
- Your rights and a Non-Agricultural Worker (F700-074-000).
- OSHA 300A Summary of Work Related Injuries and Illnesses (required from February 1 through April 30 of each year).
- Safety meeting minutes.
- Other safety items suitable for posting on these boards includes: Safety Committee membership, time/date/location of safety meetings, Safety Newsletters, Safety training schedules.

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 injury or incident to their supervisor and complete a current Safety Incident/Close Call Report (DSHS 03-133), located on the ESH SharePoint in the Safety folder. Employees must then submit the form to their supervisor for completion of a current Supervisors Review of the Safety Incident/Close Call Report (DSHS 03-133A). Completed forms must be scanned and emailed or forwarded in the hospital mail to the ESH Safety Office within three (3) working days of the injury or near miss.
- 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 located on the ESH Infection Control SharePoint, in addition to the Safety Incident/Close Call Report (DSHS 03133), 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 03-133A 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, Director of Security, ERMO staff and others.
- The investigator(s) take written statements from witnesses, photographs the incident scene and equipment involved, if applicable.
- The investigator(s) must also document as soon as possible after the incident, the condition of equipment, if applicable, and any anything else in the work area that may be relevant.
- The investigator(s) make a written report of their findings and forwards the report to the Safety Office. The report includes a sequence of events leading up to the incident, conclusions about the incident and any recommendations to prevent a similar incident.

6.3 Safety Manager Responsibilities

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

The Safety Manager is responsible for posting a completed copy of the OSHA Summary for the previous year on the ESH and CBS Commissary 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 RiskMaster 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. 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 injuries (WAC 296-800-32010).

Staff must:

- Block off and secure the area. If in a room, the room must be closed and locked, and a guard posted. If in a common area, the area must be marked off with tape or ribbon and a guard posted.
- Keep unnecessary 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 Unusual Occurrence (UOR) reporting system. Reports are analyzed by Quality Management and the Safety Office and other departments as indicated. Monthly reports are provided to EOC and Employee Safety Committee and quarterly to Quality Council and action plans developed as required.

7.0 HAZARD PREVENTION AND CONTROL

Eastern 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 chosen 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, respiratory and hearing protection.

7.1 Statement of Conditions

The Chief Operating Officer (COO) is responsible for maintenance of the Statement of Conditions documentation required by TJC and a copy of the document is maintained in the Director of Facilities Office. The Director of Facilities 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 TJC and CMS EOC and Life Safety survey findings. The Director of Facilities is responsible for identifying any corrections that require special funding or scheduling and communicating this information to Leadership and others as required.

7.2 Basic Safety Rules for Employees

Basic safety rules have been established at ESH 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 in unable to resolve at the staff or supervisor level.
- 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 are prohibited 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.
- 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 and 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

ESH has developed detailed Environment of Care (EOC) plans required for TJC and CMS standards compliance. These plans are located on the ESH SharePoint under Environment of Care and in the Safety Manual. All plans are updated annually. The EOC plans address:

- Safety Management
- Security Management
- 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 Support Services (CSS) is responsible for maintaining all non-medical equipment and buildings within the facility. All records are kept in the ESH 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 by a contracted vendor and in accordance with the Medical Equipment Management Plan. Equipment hazard notices and recalls are coordinated through Central Supply and the Safety Office and forwarded to appropriate departments for review and action as indicated.

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

Projects that could significantly impact life and/or fire safety result in the development of an interim life safety plan, which includes, but not limited to, specific training materials and information, the implementation of expanded fire drills, daily/weekly documented inspections and compliance by CSS and all contractors with ILSM during the construction and/or maintenance period. The Safety Manager coordinates the planning, implementation and monitoring of interim life safety plans in coordination with the Director of Facilities and others as indicated.

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

1. Construction activities (in or adjacent to all construction areas)
2. Temporary Life Safety Code deficiencies including but not limited to the following:
 - a. Fire, smoke or sprinkler systems temporarily out of service
 - b. Exit(s) blocked
 - c. Access for emergency response team is blocked
 - d. Fire walls/doors are breached
 - e. Fire doors/windows are missing

Refer to ILSM Policy and Procedures for full details.

Infection Control Risk Assessment (ICRA)

Potential hazards related to construction, renovation or maintenance activities are assessed through the Infection Control Risk Assessment (ICRA) process that identifies potentially new or altered risks related to infection control, utilities or building systems, fire safety or life safety, general safety issues, emergency preparedness or response, and security. The ICRA is reviewed and monitored by the COO, Safety Manager, Director of Facilities, Security and Infection Preventionist and reported to the Employee 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) and/or training is identified related to a particular hazard. Employees are trained by their supervisor at hire and annually during their performance review on both the JHA for their particular job class and PPE as it applies to hazards. If new PPE or training is identified, a description is added to the corresponding JHA and employees who are affected are made aware and 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 added or if there is a serious injury while performing the task. JHA reviews and changes 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 an ESH 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 implementation of 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

Eastern State Hospital is committed to identifying and eliminating hazardous conditions and practices. In addition to reviewing injury and illness records and investigating accidents for their causes, members of the EOC and Employee Safety committees, along with management and supervisors, regularly check the workplace for hazards.

Environment of Care inspections are conducted weekly to ensure that all patient care areas are inspected for hazards at least bi-annually and all non-patient care areas are inspected at least annually. The inspections evaluate staff knowledge and skill, allow for observation of current practice and evaluation of environmental conditions/hazards. The inspections are conducted by the Director of Facilities, Safety and Security staff, the Infection Preventionist, Nursing, EVS, Central Supply, CSS and other Leadership representatives as available. These inspections are in addition to documented 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. CSS and CBS Commissary environmental inspections are conducted in accordance with procedures outlined in their Workplace Safety Plan/APP (refer to Attachments for guidance).

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 and other subject matter experts as applicable. The team examines the proposed changed conditions and makes recommendations to eliminate, mitigate 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 Director of Facilities and hospital leadership, security, department managers, Consolidated Support Services (CSS), Centralized Business Services (CBS) and EOC/Employee Safety Committee members, as applicable, conducts comprehensive risk assessments to proactively evaluate risks associated with buildings, grounds, equipment, occupants, and internal 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 revise existing safety policies and procedures, implement hazard surveillance elements in the affected area, safety orientation and education programs or safety performance improvement processes.

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 Quality Council and 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 ESH 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

drills are conducted at least quarterly in all patient care areas. Refer to the Fire Safety Management Plan for additional details.

9.2 Hazard Vulnerability Analysis

A hazard vulnerability analysis (HVA) is completed to evaluate natural, human, technological and hazardous waste hazards that require emergency response procedures. 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. Refer to the Emergency Operations Plan for additional details.

9.3 Response to Injuries

First aid supplies are maintained in all patient care locations. The Emergency Medical Response policy outlines procedures for response to non-patient care areas including movement of medical supplies and equipment. 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 4333 on a hospital phone or 565-4333 by cell or two-way radio on Channel 1:

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

Code Rapid Response 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 Eastern State Hospital exposure control plan is designed to mitigate the risks of Bloodborne Pathogens and infectious diseases. All information regarding Bloodborne Pathogens and infectious diseases can be found in the ESH Infection Control Manual located on the ESH SharePoint. 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 be 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 ESH 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 ESH have potential for exposure to extreme infectious diseases such as Viral Hemorrhagic Fever (Ebola), Coronavirus (COVID) or other emerging infectious diseases. There is the possibility of staff exposure to these more fervent contagions in the course of performing routine work in addition to exposure 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 it is learned 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 and the Infection Preventionist should be notified. As required, the local county public health department is notified.

10.0 SAFETY AND HEALTH TRAINING AND EDUCATION

10.1 Safety Training

Safety training is essential to provide a safe workplace at Eastern State Hospital. The Safety Manager or designee conducts New Employee Orientation addressing all required Safety information including, but not limited to, Accident Reporting, Workplace Violence Prevention, Ladder Program, emergency response, Lock Out Tag Out (LOTO), Asbestos Awareness and voluntary respirator use (refer to Staff Education Services for mandatory training requirements and assignments for departments and/or job assignment) 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 Staff Education Services is responsible for developing and maintaining New Employee, Annual Safety/Accident Prevention, Emergency Operations and Response and Supervisor Safety training materials. Basic Life Support (BLS) training is provided to direct care staff and Security personnel in orientation and recertified every two years. If a direct care staff's BLS certification expires, they cannot work in a patient care area providing direct patient care until certification is current.

10.2 Basic Orientation

On the first day of hire, employees are required to attend New Employee Orientation (NEO). Training includes all OSHA required Safety, Accident Prevention, Workplace Violence prevention, Infection Control and other required training. Additional 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 ESH training curriculum is maintained by the ESH Staff Development Department. CSS and CBS training requirements and curriculum is maintained according to their Workplace Safety Plan/APP.

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 and/or The Learning Center.

10.4 Mandatory Refresher Training

Employees receive mandatory training refreshers annually or as required by job class and training type.

10.4 Site-Specific Training for CSS/CBS Commissary

CSS staff receives site-specific training prior to working at the facility e.g. TEAM. CBS Commissary staff are required to complete ESH Safety and Emergency Response training via LMS.

11.0 WORKPLACE VIOLENCE PREVENTION

Eastern 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 Workplace Safety and Security Assessment is reviewed annually as 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 are communicated during treatment plan reviews and daily shift changes and report for ongoing situational awareness and tools to mitigate the risk of patient and staff injury.

11.4 Special Population Considerations

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

- Geriatric
- Forensic
- Developmental Disabilities

- Civil commitments,
- Habilitative Mental Health
- Co-occurring diagnoses

11.5 Effective Patient Care

Preventing and constructively addressing unsafe and violent behavior is a priority for patient care and leads to a safe work environment and milieu for staff and patients. 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.

Eastern 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 and escalating behavior.

11.6 Administrative and Engineering Controls, Work Practices, Security

Eastern 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

Eastern 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, but are not limited to:

- 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)
- Walkthrough and hand-held metal detectors
- A system of visitor and 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 video

- Use of quiet/comfort rooms for de-escalation when patients are escalating or unsafe.
- Safe furniture appropriate for a psychiatric setting

11.6.3 Work practices

The Psychiatric Emergency Response Team (PERT) is designed as a first-responder system to promote a Culture of Safety for patients and staff. This highly skilled team, comprised of Institution Counselor 3s, Registered Nurses (RN), and a Supervisor, are trained in crisis intervention skills, incident management skills, analysis of the antecedents for violence and aggression, and de-escalation techniques.

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

11.6.4 Security

ESH Security is the authorized liaison with local police authorities and readily responds to Eastern State Hospital needs for heightened security or containment of a violent incident. Refer to the Security Management Plan for additional details.

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 or team members, as a group, who have been impacted by workplace violence (refer to ESH Policy 2.15).

Subject matter experts (SMEs) are identified on all shifts and trained to assist injured workers in completing required paperwork and connecting with resources to assist them with navigating the Worker's Compensation process.

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 range from situational awareness of the environment, ongoing risk assessment, effective documentation, individual and group patient education to a formal, non-violent crisis intervention training program.

Eastern State Hospital utilizes a crisis intervention program that is evidence based, and provides staff with the tools to keep themselves and patients safe while maintaining a commitment to positive approaches in serving patients whose behavior(s) may pose a danger to themselves or others. The program identifies how to provide services and support in a manner that does not promote patient need to resort to aggression or violence in order to participate in treatment, to be heard or to get his/her needs met. Staff is 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: evasion techniques, the hierarchy of physical intervention, physical containment procedures and application of mechanical restraints. All physical skills require return demonstration and documentation of competency.

11.10 Data and Surveys Addressing Workplace Violence Data

Review:

Workplace violence is tracked utilizing incident databases. Safety Incident/Close Call Report (DSHS O3-133A), the Employee Report of Possible Client Assault (DSHS 03-391) and ESH's Unusual Occurrence report form) are utilized to document assaults and are reviewed by leadership in daily morning meetings.

Eastern State Hospital tracks workplace injuries due to assault in the RiskMaster database maintained by ERMO and in the hospital database (UOR). RiskMaster 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 monthly EOC and Employee Safety Committee meetings and reported quarterly to Quality Council. A narrative summary with recommended action plans is presented to Quality Council and at quarterly Governing Body meetings.

Workplace Safety Surveys and Culture of Safety:

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.

The Strategic direction and pillars of focus for Eastern State Hospital include defining a Culture of Safety as a just culture where employees are not fearful to report adverse events, close calls, unsafe practices or conditions. A just culture is non-punitive, addresses the adverse event, close

call, unsafe practice or condition by looking at the system not the person. ESH Culture of Safety Goals Include:

- Implementing a consistent rounding program for Executive leaders and supporting employees exposed to secondary violence.
- Creating consistency between shifts and wards and consistent communication across the facility.
- Empowering employees by providing training and education opportunities.
- Using collected data to support more decisions and practices throughout the organization.
- Creating a practice where Culture of Safety behaviors are mirrored by supervisors.
- Involving front-line staff in solutions.
- Creating and implementing an organizational wide communication process/plan so the entire hospital, departments/wards and employees hear the same message.
- Post reports and goals throughout the hospital for transparency, awareness and discussion.
- Updating specific measurements that support BHA/ESH strategic plans and Culture of Safety measurements and post in all departments/wards.

12.0 WORKPLACE SAFETY GOALS AND PERFORMANCE IMPROVEMENT

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 Employee Safety Committee minutes.

The EOC Committee is responsible for EOC PI initiatives that are based on priorities identified by the EOC Committee through evaluation of risks associated with Safety, Security, Utility Systems, Medical Equipment, Fire Safety and Hazardous Materials Management. Performance improvement activities are documented in the EOC Committee minutes.

Quality Council is responsible for approving Workplace Safety goals and PI initiatives, including performance measurements. Activities and progress related to goals and PI initiatives are reported quarterly to the Employee Safety Committee and/or EOC Committee and provided to Quality Council and Governing Body.

13.0 WORKPLACE SAFETY PLAN – ANNUAL EVALUATION

The Director of Facilities, Safety Manager, EOC and Employee Safety Committee evaluates 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 EOC Committee, Employee Safety Committee, Quality Council and Governing Body.

**Appendix A: Workplace Safety Plan – 2020 Security and Safety Assessment
Eastern State Hospital**

RCW 72.23.400 requires each state hospital to develop a plan (Workplace Safety Plan) to reasonably prevent and protect employees from violence at the state hospitals. The Plan must address security and safety considerations related to specified items 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	Assessment	Prevention Action(s)
<p>a) The physical attributes of the state hospital including:</p> <p>a) 1. Access Control</p>	<p>Walk-through detectors are not available at many of the public entrances at Eastlake and Westlake, including the FSU Administration and GPU ward locations; hand-held detectors only. The APU visitor entrance is equipped with a walk-through detector as well as all FSU wards. The FSU walk-through detectors have reached their equipment life expectancy and are no longer supported by the manufacturer.</p> <p>A Physical Security Survey and Vulnerability Assessment has been completed for 2021. Results identified ESH risk is within “Green Zone”. Recommend continuing with current physical security program being mindful of changes of the frequency of criminal activity in ESH vicinity and vigilance of possibility staff complacency with security measures.</p> <p>Campus-wide key control is maintained by the Security Department. Access to FSU is</p>	<p>The Administrative Directors for FSU, APU, and GPU have evaluated individual unit visitor access and metal detector use policies and revised them to reflect consistency across the hospital units, wards and shifts.</p> <p>A Failure Mode Effect Analysis (FMEA) was conducted to review the FSU visitor and patient screening process. Recommendations included providing additional education related to existing hospital and FSU policies and movement of all visitor screening to the Eastlake and Westlake entrances with Security monitoring.</p> <p>A Capital Programs project, 2020-471 W32V5 ESH - Westlake Switchboard Security Relocation, is funded and anticipated to start May 2021. Addition of visitor screening equipment to the project is dependent on funding. Eastlake Main Entry security project, Capital Program CBS 40000789, is not funded to date, but is part of the 2021-23 biennium request. This will also require approval of additional Security FTEs’ to staff visitor screening locations 24/7.</p> <p>Educational Services conducts hand-held metal detector wand training during</p>

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
a) 1. Access Control	<p>controlled through the use of proximity cards approved by FSU Administration and issued by security, in addition to ward access control panels and cameras. Pharmacy access is alarmed after hours and reports to the Eastlake PBX for Security response. Security controls key issuance, retrieval from employees when transferred to other areas/departments and key returns from employees when leaving ESH employment.</p> <p>It is problematic to obtain keys and badges when staff quit via telephone or employment separation is initiated by ESH via letter.</p>	<p>NEO skills training. Unit education coordinators arrange/provide refresher training to all current staff on an ongoing basis.</p> <p>All Security events involving campus or building access e.g. unsecured doors are reviewed by the EOC and Employee Safety committee for development of action plans as required. Events requiring Leadership awareness are reviewed at daily Leadership huddles for development of actions plans as required.</p> <p>A Capital Program request has been made for funding to install an electronic “Key Watcher” issuance and tracking system for internal building keys and a card access building entry system. This will require Legislative approval and funding. Not funded to date.</p>
a) 1. Access Control	<p>Access to the hospital campus is controlled primarily through the use of identification badges, personal identification and advance notification of authorized visitors. Difficult for staff to quickly identify (at a glance) what areas of the hospital patients, visitors, contractors, DRW, court staff, attorneys, interpreters, etc. are authorized to access hospital-wide. This can lead to unauthorized access to areas and increased security risks.</p>	<p>ESH implemented a new badge identification system that allows Security and all staff to quickly determine appropriateness of visitor access based on badge color, decreasing the risk of workplace violence and other security concerns.</p>

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
a) 1. Access Control	There are occurrences of stolen, misplaced, lost or not turned in employee identification badges and/or keys assigned to individual employees.	Refer to prevention listed above. ESH Security Department took oversight of the FSU badging process for improved control and accountability.
a) 1. Access Control	Security reports and security related Unusual Occurrence Reports (UORs) have identified interior and exterior building doors found unlocked. These occurrences are potentially related to the doors not closing properly (HVAC air pressure related), door lock malfunction or the door being left unsecured by staff. Some doors require manual locking and some locks are self-locking.	Quarterly and annual door inspections are completed by CSS to ensure proper function. Quarterly reports of these inspections are forwarded to the Director of Facilities for monitoring. Doors at required public egress entrances/exits and some ward entrance locations must have panic hardware in place by Fire Code and, for public entrances, must remain unlocked during normal business hours. This requirement prevents use of self-locking mechanisms at these locations unless monitored and controlled to ensure egress and/or tied to fire alarm system via magnetic locks. The Westlake entrance doors are tied to the alarm system and release of the when the fire alarm is activated. Part Capital Programs Eastlake security project request includes installation of magnetic locks at visitor entrance locations. This project is not funded to date. Door security checks are completed by Security staff after hours and unsecure locations documented and reported to responsible area supervisor for follow-up. This data is reviewed by the Environment of Care (EOC) and Safety committee for trend analysis and recommendations for performance improvement.

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
a) 1. Access Control		<p>An assessment has been completed for all fire doors hospital-wide. Capital Programs project funded for replacement in some locations. This includes re-certification and installation of fire rating tags applied to FSU sally port door locations and was completed September, 2020. Additional Capital Program funding for Smoke and Fire Retro-Commissioning project design includes additional fire door replacements, including exterior and interior entrance replacement, as indicated by assessment, to ensure proper function and compliance with Life Safety code requirements and TJC/CMS standards compliance. Anticipated design completion June, 2021.</p>
a) 1. Access Control	<p>Both the Eastlake and Westlake PBX locations contain critical alarm system, communication and camera equipment for alerting and notification of hospital staff in an emergency and provide limited PBX staff security as identified in multiple emergency response drills and a Spokane County Sheriff office assessment of ESH buildings. The post-drill evaluation, and Sheriff's office assessment have identified that PBX staff are vulnerable to workplace violence including armed assailant, agitated visitor, etc. Vulnerabilities include, but are not limited to; limited visibility of in-coming visitors and staff, physical location is either unsecured or non-hardened (zero barriers between visitor and operator and/or barrier easily broken to access location, etc.), no metal detection prior to entering building.</p>	<p>Preliminary design for relocating the Westlake PBX reception desk, installing cameras at entrance doors and enclosing the desk area to increase visibility of the parking lot and in-coming visitors has been completed and funded. Project 2020-471 Westlake Switchboard (PBX) Security Relocation is tentatively scheduled to start May 2021 and completed September, 2021. The Westlake Camera project for installation of cameras throughout all of Westlake is anticipated to be complete June, 2021.</p> <p>Recommendations for added security at the Eastlake Administration building, including the PBX and center core offices, have also been identified and a Capital Programs request made. No funding approval to date.</p>

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
<p>a) 1. Access Control</p>	<p>A Failure Mode Effect Analysis (FMEA) was conducted for FSU wards evaluating processes in place for patient and visitor contraband screening.</p> <p>There is a potential for metal and non-metal contraband (unauthorized items) to be brought onto the ward by visitors that creates increased risk to patients and staff; illegal drugs, items that can be used for self-harm or as weapons, etc.</p>	<p>Analysis results indicated need to provide additional staff education regarding current policies with a long term recommendation for moving the screenings to the Eastlake building entrance per existing Security proposal. A Capital Programs project is funded to renovate the Westlake PBX for increased security. A request has been made to include installation of screening equipment during this project dependent on Capital Programs or operational funding.</p> <p>All visitors are notified of what items constitute contraband (signage posted at PBX locations). Visitors have the option to leave these belongings in their vehicles or they can lock them up in the lockers provided at the APU visitors entrance, outside of all FSU wards and at the Westlake PBX.</p> <p>A Capital Programs request has been made for security improvements at the Eastlake Administration building to include the PBX and screening equipment manned by Security personnel. Not funded to date. This would also require funding for additional Security FTE's.</p> <p>A FMEA was conducted for the APU visitor and patient screening processes. As a result of this assessment, a metal detector was installed in a location that can be shared by all APU and north FSU wards for screening visitors and patients. In addition, visitor lockers were installed outside the building to secure visitor belongings prior to entering the building to decrease risk of contraband on the wards. Hand-held metal detector wands are in place in addition to the walkthrough detectors.</p>

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
a) 1. Access Control	The parking areas, hospital-wide, are not under surveillance and some locations are bordered by wooded areas or vacant buildings.	<p>A Capital Programs request has been initiated for installation of additional cameras in high-risk, campus-wide, locations based on usage and restricted access requirements e.g. Pharmacy. In house funding was approved to install multiple cameras on the Patient wards. Additionally, Capital Programs project 2020-444 W32V3 ESH- 2019-21 Patient Safety Improvements - Westlake Cameras, is currently in progress with an anticipated end date of June 2021.</p> <p>Security personnel patrol the campus and report findings and/or contact local law enforcement as required e.g. criminal activity.</p> <p>Existing exterior lighting has been improved with installation of LED lighting campus-wide and additional lighting in some new parking lot locations.</p>
a) 2. Egress Control	There is currently no physical control over egress (visitor/staff) on campus and outside of secured buildings or outside unit fenced yards for staff escorted activities or unescorted patient walks (patient levels and risk evaluated prior to unescorted campus access). Restricting egress would require a security fence around the entire perimeter of the hospital. This would be logistically difficult due to the physical location of the hospital and surrounding landscape.	<p>Unauthorized patient leave data is reported via Unusual Occurrence reporting. Drill downs or Root Cause Analyses are conducted by Quality Management to identify action plans as indicated. Results are reported to Quality Council and Governing Body.</p> <p>The escorting policy has been reviewed and revised to clarify staffing ratios when escorting patients to the yard and Eastlake 0N and 0S basement floor. Guidance provides direction to staff reinforcing the use of clear language when communicating UL via radio e.g. "UL" North Patient Yard.</p> <p>A Capital Programs request CBS 40000615, 2023-25 Biennium has been submitted for installation of fencing around the baseball field to provide additional secured space for patient group activities. This will require Legislative funding. Not funded to date.</p>

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
a) 2. Egress Control	Security reports and security related Unusual Occurrence reporting have identified interior and exterior building doors found unlocked. These occurrences are potentially related to the door not closing properly (HVAC air pressure related), door lock malfunction or the door being left unsecured by staff. Some doors require manual locking and some locks are self-locking.	Refer to access prevention listed above.
b) 3. Door Locks	<p>The current employee key control and tracking system is completed manually by Security staff. This system documents initial issue of keys at hire, changes in keys issued to an employee based on need (position and area worked), and return of keys when employees leave ESH employment. Manual tracking is labor intensive and leaves potential for employees to have access to keys that they are not authorized to have if changes not reported to Security by employee supervisor, information not entered into the Security database in a timely manner or not entered at all (human error).</p> <p>All FSU wards have ward-specific keys checked out by staff when they arrive on the ward using a “chit” system. Missing keys are reported through security break memos and forwarded to the FSU Security committee and via UOR. There have been reported incidents of staff leaving at the end of their shift and forgetting to turn in their ward keys.</p>	A Capital Program request has been made for funding to install an electronic “Key Watcher” issuance and tracking system for internal building keys and to install an electronic card reader building access system throughout the hospital. This will require Legislative approval and funding.

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
a) 4. Lighting	<p>Burned-out or malfunctioning outside lighting decreases staff ability to monitor outdoor patient activities in the evening, Security’s ability to conduct campus surveillance and staff’s ability to monitor parking lots or other campus areas for hazardous conditions when arriving or leaving.</p> <p>Monthly Security reports have revealed areas where the lighting has not been corrected for extended periods of time.</p> <p>The Linden Hall parking lot is poorly lit. The upper terrace of the Westlake parking lot, the north side of the Eastlake parking lot and some parking areas near the AT building are dark despite the presence of several pole lights.</p>	<p>Security monitors lighting during daily Security rounds and reports burned out exterior lighting to CSS for replacement. All lighting work orders are prioritized based on location risk. Delays in lighting repair impacted by extent of repair e.g. light bulb only or need for more extensive electrical repair and/or height of perimeter lighting requires use of a bucket truck to complete repair. The Director of Facilities meets with CSS weekly to review work order status and adjusts priority as needed.</p> <p>Existing exterior lighting has been improved with installation of LED lighting campus-wide and installation of additional lighting in new parking areas</p>
a) 5. Alarms	<p>The existing staff duress alarms on Eastlake South (FSU) and Eastlake North (APU/FSU) were installed in four different phases of remodel with the APU alarm system installed during Phase 3 building renovations over 20 years ago. The APU system is currently beyond its life expectancy, non-functional and assessed as non-repairable. The north FSU wards, 1N3, 2N3 and 3N3 were installed during recent renovation projects and are unable to be tied into the existing, adjacent APU wards.</p>	<p>To ensure reliability, the existing staff duress alarms are tested daily on all wards by ward staff (APU & FSU) and Pharmacy; and weekly on GPU per Nursing policy. Alarm deficiencies identified during these tests are reported to the Director of Facilities and CSS for immediate repair. Testing is monitored by the Safety office and action plans and/or staff awareness of deficiencies reported to all staff via News Flash and communicated to affected area supervisors.</p>

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
a) 5. Alarms	<p>The FSU duress system must interface with the old APU system to enable reporting emergencies to the south FSU and north APU wards. Wiring, equipment inadequacies and failures, specific to the APU duress system, have been identified during the FSU 1N3/3N3 Ward Renovation Capital Programs project and prevent this interface.</p>	<p>A Capital Programs request (ESH Integrated Safety and Security Controls) for the 2023-25 Biennium has been made to replace the existing, antiquated staff duress systems on the all wards and install a “personal duress alarm” system in all (on and off ward) locations that provides wider coverage, ease of activation and electronic location tracking for quicker emergency response. Scope and design are currently under review by Capital Programs for request to Legislature for 2021-2023 biennium.</p> <p>Staff utilize two-way radio communications to report requests for staff assistance in escalating patient behavior events. Radio policy and procedures were revised to move the FSU Competency Restoration wards, 1N3 and 3N3, and north NGRI ward, 2N3, to the existing APU channel for daily coordination and expedited emergency response from adjacent north wards; June 8, 2020.</p>
a) 5. Alarms	<p>The FSU alarm system requires use of a proximity card with readers located throughout the corridor. The APU wards have a keyed system with key boxes located throughout the corridor.</p> <p>The existing systems do not provide a method of activation for off-ward and/or outdoor escort/activities i.e. yard group, etc. The Activity Therapy Building (Eastlake Treatment Mall) does not have existing staff duress devices.</p>	Refer to prevention listed above.

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
a) 5. Alarms	<p>The existing staff duress alarm notification only indicates the ward; it does not identify specific/exact location of staff activating the alarm. The Eastlake PBX is currently unable to hear the FSU south alarms at their local panel due to the non-functioning APU system interface; visual alarm to PBX only.</p> <p>Alternative reporting requires staff to use radio or phone which is not always feasible dependent on emergency.</p>	
a) 5. Alarms	<p>Daily tracking of staff assigned to radios is in place but there is no ability to electronically track the exact location of staff.</p> <p>The existing Westlake staff duress alarm consists of one location on wards for activation; a “push to activate” button at each nurses station. The location of activation devices makes the system difficult if not impossible for staff to use if involved in a patient-to-staff assault.</p>	Refer to prevention listed above.
a) 6. The Physical Attributes of the State Hospital: Environment of Care	There are potential risks associated with the Environment of Care and high-risk processes that present a threat of physical injury to persons, damage to property, or a threat to general safety.	The comprehensive Environmental Proactive Risk assessment was reviewed and updated November, 2020. This is in addition to any individual assessments initiated as a result of Sentinel Events or drill downs, data from hazard reports, environmental safety surveys, unusual occurrence and injury reporting, and individual building evaluations. Acton plans are developed based on assessment and monitored by EOC and Safety Committee and Quality Council.

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
a) 6. The Physical Attributes of the State Hospital: Environment of Care		A Capital Programs project has been funded to remodel the APU ward med rooms to address fire and smoke control, egress compliance and installation of a roll-up door and Lexan at the medication administration window to prevent patients from assaulting staff. Project started March 2020 with a completion date of January 2021. This was extended due to delays related to the COVID-19 pandemic.
a) 6. The Physical Attributes of the State Hospital: Environment of Care	Some APU and FSU south wards have blind spots, without camera coverage, to monitor for patient-to-patient and patient-to-staff violence or patient self-harm and investigation of incidents in all locations.	<p>ESH IT project, Phase 1, funded to increase cameras on FSU wards to mitigate risk of blind spots. Nine additional cameras ordered 2019 and target for installation is June 30, 2020. Additional cameras were purchased and installed via operational funding for the APU wards and 2S1, Phase 2 and 3. Phase 2 completed January, 2021 and Phase 3 is underway with an estimated completion of June, 2021.</p> <p>Phase 4 camera project covers additional cameras on 1S1 and 3S2. A quote has been received and is pending funding approval.</p> <p>Phase 5 camera project covers additional installation on APU ward locations and 2N3 (FSU north NGRI ward). Quote received and is pending funding approval.</p> <p>Phase 6 camera project covers zero level corridor areas, APU stairwells, court rooms, Patient Technology Center and Telehealth locations. Quote received and pending funding approval.</p>

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
<p>a) 6. The Physical Attributes of the State Hospital: Environment of Care</p>	<p>There is the potential for patient property to be used for self-harm or as weapon e.g. belts, large pieces of jewelry, CD's, drawstrings, etc.</p> <p>Furniture in patient care areas (chairs, tables, desks, beds) pose a risk for use as a weapon, barricading in the room or as a ligature point.</p>	<p>An Authorized Patient Property policy is in place and identifies patient belongings, personal care item, etc. and whether the item is not allowed or allowed. If the property is allowed, the policy/list identifies within what context (category based, staff supervision required, treatment team approval required, and other restrictions). The Authorized Patient Belongings list is updated at least annually or as indicated as the result of hazard reporting, or a Sentinel Event root cause analysis.</p> <p>Patient rooms on all APU and FSU wards have been systematically renovated for patient and staff safety and include purchase and installation of additional molded furniture. This furniture consists of molded vinyl beds and molded cubicles for patient storage which are specifically manufactured for Behavioral Healthcare. Health and Correctional facilities. The molded vinyl furniture is bolted to the floor/wall or sand-ballasted to prevent being thrown or broken apart and used as a weapon. The civil commitment wards are complete and FSU target for completion is July, 2021.</p> <p>All electric beds cords shortened to three feet and secured to the bed frame on all purchased and rental medical beds to mitigate risk of use for self-harm or as a weapon.</p> <p>The length of electric bed cords has been added to the EOC Audit Tool and monitored during the EOC rounds and reflected in the Environmental Proactive Risk Assessment.</p> <p>As the result of a TJC survey, a plan of correction is being implemented to replace all electrical, medical beds with</p>

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
a) 6. The Physical Attributes of the State Hospital: Environment of Care		molded vinyl beds on all GPU wards unless a doctor's order is in place based on patient need. Beds and mattresses have been ordered and target for arrival and installation is June, 2021.
a) 6. The Physical Attributes of the State Hospital: Environment of Care	<p>Potential for patients to access Woodshop equipment during patient groups and use for self-harm or as a weapon.</p> <p>There is the potential for coat hangers (plastic hangers are currently in use on 2N3 ONLY) to be used for self-harm or as a weapon if broken.</p>	<p>A checklist is utilized to document security and location of equipment located in the woodshop that present a staff and patient safety risk. This checklist is completed pre and post group. Completion compliance of the Woodshop security checklist is audited during EOC rounds to ensure the log is completed in real time.</p> <p>Hangers on 2N3 remain in place based on risk assessment. Patients on 2N3 are Level 8 and allowed on campus and into the community without escort on approved leave as outlined in the Treatment Plan; "No Risk, or Such Minor Risk as to be a serious consideration. A plan is in place to replace 2N3 furniture to be consistent with newly renovated wards. Renovated wards were designed and furnished based on best practices. This change will remove the need to utilize hangers on this ward as each patient will be provided with individual molded plastic storage units (cubicles).</p>
a) 6. The Physical Attributes of the State Hospital: Environment of Care	There is the potential for identified sharps drawers/cabinets to be left unlocked or for sharps not to be accounted for in patient accessible areas e.g. treatment rooms. Sharps in staff breakrooms that are not secured provide the potential for access by patients if they managed to push by staff and gain access into the room as staff are entering or leaving.	All sharps are required to be in locked drawers/cabinets in treatment rooms and staff breakrooms and inventoried and/or shadowed in patient care areas and Treatment Malls to ensure they are secure, present and accounted for. Compliance is monitored during weekly environmental surveys and by Core Team members at Treatment Mall and non-compliance reported to unit Administrative Directors, the unit Director of Nursing or Treatment Mall Manager for follow-up.

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b) 6. The Physical Attributes of the State Hospital: Environment of Care	Plastic tooth brushes, combs, and hairbrushes can be broken and used for self-harm or as a weapon.	<p>An alternative toothbrush manufactured for use in Behavioral Health and Corrections facilities is in place for use by all patients on APU and FSU wards. A “finger cot” type toothbrush used in DOC facilities has been identified for use on FSU admissions (1S1) for patients in seclusion or for patients at high-risk for use of the toothbrush as weapon or for self-harm.</p> <p>Environmental checks are conducted and documented hourly on all wards and incorporates risks identified on the hospital-wide Environmental Proactive Risk assessment.</p> <p>Weekly EOC rounds conducted by Director of Facilities and Safety Manager and findings reported to department/area supervisor and Leadership for action as identified.</p> <p>Ward/room search policy in place for addressing concerns/reports of potential contraband that could be used for self-harm or as weapons.</p>
a) 6. The Physical Attributes of the State Hospital: Environment of Care	Existing carpet is worn and dirty creating an infection control concern and slip/trip hazards. GPU ward carpet replaced under previous Capital Programs and operational funding.	Replacement of GPU carpets throughout the off-ward locations completed March, 2020.
a) 6. The Physical Attributes of the State Hospital: Environment of Care	Risk for religious rosaries to be used as a ligature or as a weapon.	A Rosary Risk Assessment was completed by the Safety Office October, 2020. The intent of this assessment was to identify hospital provided rosary that presented a lower risk for use as a ligature or weapon but still allow patients to practice faith/religion. Identified rosaries provided by hospital in lieu of allowing personal rosaries to decrease risk.

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a) 6. The Physical Attributes of the State Hospital: Environment of Care	The Eastlake boiler plant building is original stone build with significant structural deficiencies. The steam plant provides heating to the Eastlake building and is critical for Continuity of Operations.	A Capital Programs project has been funded to replace the Eastlake boiler plant. This started February, 2021 with a completion date of fall, 2022.
b) Staffing, Including Security Staffing	<p>Variations (changes to staffing due to staff call in, vacations, ward acuity, etc.) in Nursing and Security staffing can potentially impact patient care and hospital-wide Security and emergency response.</p> <p>Security staffs two positions per shift. Security personnel provides security and safety of the external campus which includes patrolling the campus to monitor potential trespassing and ensuring ESH facilities, vacant buildings and hospital entrances are secure.</p>	<p>Additional tools/systems used in nursing include:</p> <ul style="list-style-type: none"> • Policy/procedure on how to acquire staff • Acuity based staffing plan • Guidelines for safe staffing levels • Use of contracted Nursing services. <p>In FY20 ESH hired 223 new staff to fill direct-care vacancies and newly established positions in order to improve the provision of patient care, active treatment and workplace safety and security. New positions hired in FY20 include 122 Nursing (direct patient care), 101 clinical and non-clinical staff including medical providers, social workers, food services, rehab, EVS and other support staff.</p> <p>Positions included staffing for two newly opened Competency Restoration wards; July 2020 and August 2020.</p>
b) Staffing, Including Security Staffing	Security personnel are not assigned to patient care wards.	Security responds to requests for staff assistance on the wards via radio communication initiated by ward staff or Nursing Management in an emergency event requiring their assistance.
b) Staffing, Including Security Staffing		Eastern State and Western State subject matter experts from nursing, education, and information technology contributed to the development of HART, from participating in initial development workshops to piloting the tool on select

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b) Staffing, Including Security Staffing		wards in both hospitals. HART consists of both a job aid that functions as a decision support tool, and a technical solution known as the HART application where patients' acuity scores are entered. HART replaced the existing acuity systems at Eastern State and Western State Hospitals, with the intent to increase both the consistency and reliability of acuity scores and staffing needed to provide adequate patient care and staff safety.
b) Staffing, Including Security Staffing		HART meets legislative requirements to develop a single acuity-based staffing tool that was implemented at both hospitals, and provides patient acuity data required prior to approval of funding for hospital staffing. All future funding for direct care staffing is tied to this acuity tool and the data it generates over time. This is expected to be a multi-year process to allow extensive analysis of staffing trends and follow-up on budget requests from the state legislature. HART will generate total overall care hours needed based on the acuity scores, and reflect activities that drive staffing. HART was implemented hospital-wide at Eastern State Hospital, November 18, 2019.
b) Staffing, Including Security Staffing	Potential for staffing to result in adverse patient events.	During analysis of adverse patient safety events, an assessment is conducted to determine whether staffing played a role in the adverse event. A subsequent report and action plan is provided to the Patient Care committee, Quality Council, and Governing Body.
b) Staffing, Including Security Staffing	Potential for staffing to result in adverse patient events. Overtime average for FY20 was 5.5% which is unchanged from FY19.	Use of on-call staff Eastern State Hospital has a pool of on-call employees for utilization when required.

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<p>b) Staffing, Including Security Staffing</p>		<p><u>Pre-Arranged Overtime</u> Staff notifies the staffing office in writing when they want to work voluntary overtime. Staff is offered overtime on a rotational basis by classification need and the employee's position on the rotational list to ensure equitable distribution on eligible shifts.</p> <p>Skills, abilities, and competencies are considered and may be a reason to skip to the next qualified individual until the next available overtime (for example staff must meet the HMH training needs requirement to work on HMH, staff must have 2 years' experience working with patients with behavioral health issues and/or qualifying educational background. When a staff member is contacted for overtime, a computerized record is maintained noting the staff member's full name, title, date contacted, and the results of that call. Overtime is assigned based on staffing and acuity.</p>
<p>b) Staffing, Including Security Staffing</p>	<p>Use of on-call, voluntary and involuntary overtime.</p>	<p>Every attempt will be made to accommodate preferences. Due to various factors, this may not always be possible.</p> <p><u>Voluntary Overtime</u> When Nursing has exhausted the on-call availability and pre-arranged overtime, they solicit volunteers currently at work to arrange voluntary overtime on the upcoming shift.</p> <p>Voluntary OT and Involuntary OT Call back is before Involuntary. A group text for staff that have signed themselves up for call back is in place. This is to be utilized prior to initiating Involuntary OT.</p>

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b) Staffing, Including Security Staffing		<u>Involuntary Overtime</u> When voluntary overtime does not meet patient care/workload demands, involuntary overtime is assigned based on an in-verse seniority rotational schedule in compliance with the Collective Bargaining Agreement.
b) Staffing, Including Security Staffing	Difficulty hiring clinical and non-clinical staff to fill vacant positions.	Eastern State Hospital’s Staffing and Performance Operations team partnered with DSHS Human Resources Talent Acquisitions and collaborated with ESH Organizational Development and Communications to develop marketing strategies and materials, for an ad in the Journal of Business, position handouts, and posting available positions on the DSHS Facebook and Twitter pages.
b) Staffing, Including Security Staffing		<u>Agency Nurses</u> A contract with travel and local agencies is in place and utilized to ensure staffing levels are suitable for provision of patient care and to avoid mandatory overtime; registered nurses only.
c) Personnel Policies	<p>DSHS, BHA, and ESH hospital, unit, and discipline specific policies addressing workplace safety, security, emergency response and workplace violence are in place to mitigate risk.</p> <p>All three (3) state hospitals (ESH, WSH, and CSTC) have collaborated to align their comprehensive Workplace Safety Plans encompassing Workplace Violence Prevention.</p> <p>ESH has improved the process for creating, reviewing, revising, communicating, distributing and posting of policies, protocols and procedures</p>	<p>The following list is not all inclusive, refer to individual policy manuals for additional information:</p> <ul style="list-style-type: none"> • Behavior Undermining the Culture of Safety • Seclusion/Restraint • Workplace Safety Plan, including Accident Prevention, and Workplace Violence Prevention • Crisis Prevention and Intervention training (TEAM) • Psychiatric Emergency Response Team (PERT): A plan of response for patients during a psychiatric crisis or anticipated crisis • Code Gray Response (Escalating Patient Behavior Response) • Critical Incident Stress Management (CISM)

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c) Personnel Policies	<p>through development and implementation of an intranet/SharePoint site, “News Flashes”, and posting of communications on safety and communication boards throughout the hospital. The Learning Center (replaces The Learning Management System LMS) is utilized for ensuring employee compliance with mandatory training and changes to policies/procedures for employee awareness.</p> <p>Environment of Care plans (Safety, Fire/Safety, Medical Equipment, Utility Systems, Security and Hazardous Waste Management) are in place and assessed annually for objective, scope, performance and effectiveness. Data is reviewed by the EOC and Employee Safety committee to identify trends and develop a plan for improvement, if indicated, to correct deficiencies and mitigate risk</p>	<ul style="list-style-type: none"> ● Disruptive And Intimidating Behavior By Staff ● Incident Reporting ● Key Control ● Visitor Access ● Background Checks ● Law Enforcement Notification ● Benefits for Employees Assaulted by Residents/Clients <p>Workplace Personnel Security Program Emergency Operations and Specific Emergency Response Procedures</p> <ul style="list-style-type: none"> ● Active Threat ● All Hospital Lockdown ● Bomb Threat ● Evacuation <p>Emerging Infectious Diseases (e.g. Ebola, COVID-19, etc.)</p>
c) Personnel Policies	<p>The 2020 annual evaluation of the Workplace Safety Plan validates the plan is adequate and effective in practice.</p> <p>Assault data at Eastern State Hospital (ESH) indicates that 2020 had a slight decrease in staff reported assault rates in comparison to 2019 from 110 to 102. Non compensable claims continue to be higher than compensable claims which may be attributable to a decrease in injury severity and a successful Transitional Return to Work Program.</p>	

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d) First Aid and Emergency Procedures	There is a potential for exposure to communicable diseases, Bloodborne Pathogens (BBP), Hepatitis B/C, HIV, and TB during provision of patient care.	<p>Infection prevention measures are implemented on wards as required based on daily shift reports.</p> <p>Vaccinations for Hepatitis B and TB testing are required at hire and assessed annually.</p> <p>Plans and procedures are in place for emerging infection diseases and were implemented for emergency response and Continuity of Operations (COOP) related to COVID-19 in 2020 and are ongoing in accordance with the Governor's directive, CDC and DOH guidelines.</p>
d) First Aid and Emergency Procedures	An Infection Control Risk Assessment is completed annually to assess communicable diseases in the community as well as any prioritized risks within ESH based on surveillance data. Updated April, 2020.	<p>Employees potentially exposed to a BBP must complete an Exposure Reporting form and all incidents investigated by the Infection Preventionist or Employee Health Nurse for follow-up as required.</p> <p>Flu and COVID-19 vaccinations are available to staff at no cost.</p>
d) First Aid and Emergency Procedures	Emergency medical response procedures for Code Blue and Code Rapid Respond are in place and activated by contacting PBX by radio or the emergency phone number (x4333). PBX staff relays requests for nursing and medical provider response via two-way radio, overhead annunciation and radio paging alerts.	The Medical Emergency Response Committee (MERC) reviews all emergency response events and develops and implements a Medical Emergency Response action plan, as indicated.

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d) First Aid and Emergency Procedures	Emergency medical supplies, including AEDs, are maintained on all wards or can be obtained from “jump bags” maintained in the security vehicles in the event of an outdoor (campus) medical emergency in lieu of wheeling on ward carts to outside locations. Security staff are been trained as first responders.	<p>The MERC has developed and implemented “Mock Codes”, to improve medical emergency response preparedness.</p> <p>Medical providers are required to complete ACLS classes with bi-annual recertification. ECG rhythm and emergency response training is provided to shift nurses.</p>
d) First Aid and Emergency Procedures	Emergency procedures are in place based on a Hazard Vulnerability Assessment (HVA). The HVA is reviewed and updated annually or as required based on evaluation of staged or actual events and includes evaluation of community and regional events provided by Region 9 Healthcare Coalition.	The HVA was last revised October, 2020 and updated to include Emerging Infectious Diseases e.g. COVID 19.
d) First Aid and Emergency Procedures	A minimum of two (2) emergency response drills are conducted annually. A Plan for Improvement is developed for all identified deficiencies related to emergency response activities (staged and actual) related to internal/external communication, availability of and access to materials, safety & security of patients and staff, staff roles and responsibilities (assignment and performance), managements of critical utilities, management of clinical and support activities, transportation and personal protective equipment.	<p>The following actual events, emergency response drills and Emergency Operations and Response participation with community partners occurred in 2020:</p> <ul style="list-style-type: none"> • On 7.29.2020, a Pharmacy fire occurred due to a malfunctioning light. The fire was quickly reported and put out by Pharmacy staff limiting damage. Fire District #3 arrived on-scene, evaluated the fire location and gave an All Clear for return to normal operations. • On 10.21.2020 and December, 2020, emergency staff response drills were conducted to ensure the process for transfer of the panel control to the adjacent ward conducted according to procedures in addition to proper donning and doffing protocols occurred without delay to ensure

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<p>d) First Aid and Emergency Procedures</p>		<p>immediate response during a staff or medical emergency on the COVID isolation ward.</p> <ul style="list-style-type: none"> Continuity of Operations activities were conducted throughout most of 2020 and are ongoing in accordance with the Governor’s directives. Two wards were repurposed for COVID respiratory observations for all new admissions and isolation of COVID positive patients as needed. An outdoor testing location was set-up for on-site testing of staff as identified through contact tracing. Resources are coordinated through DSHS Behavioral Health Administration incident command and internally as needs are identified. Screening stations were setup at all entrances for staff and visitors and personal protective equipment utilized per CDC and BHA guidance.
<p>d) First Aid and Emergency Procedures</p>	<p>A Communications Plan is in place and outlines the roles, responsibilities and protocols that guide the hospital in timely dissemination of information during an emergency. This plan is part of the Eastern State Hospital Emergency Operations Plan and COOP and is administered by the hospital Incident Command. The plan is consistent with REDi Healthcare Coalition partners.</p>	<p>The ESH Communications Plan (COOP) annual review was completed June, 2020.</p>

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d) First Aid and Emergency Procedures	<p>There is the potential for radio communications to be compromised due to:</p> <ul style="list-style-type: none"> • Low/dead batteries • Dead spots and outside locations (lack of repeater coverage) • Incompatibility with community emergency response agencies • Lack of assigned radio/pager for all staff 	<p>A daily digital radio assignment log is used by all wards and shift for assignment tracking enabling quicker emergency response if required. Rotating radio spares are fielded on an as needed basis for inoperable radios.</p>
e) 1. Reporting of Violent Acts	<p>All elements pertaining to reporting of violent acts are documented utilizing Safety Incident/Close Call Report, Unusual Occurrence Report, Uniform Law Enforcement Notification and Internal Hazard reporting forms.</p>	<p>Workplace violence of any kind is reported through administrative channels and tracked utilizing incident databases enabling compilation of data for analysis of frequency, severity and circumstances:</p> <ul style="list-style-type: none"> • Staff involved • Assailant identifier (patient, employee, visitor, other) • Incident date, time, shift • Use of restraint • Use of seclusion • Cause of injury • Patient assault involved • Object used in assault • Staff-initiated contact; containment • Injury severity rating • Type of injury • Body part affected • Description of precipitating events
e) 1. Reporting of Violent Acts		<p>Unusual Occurrence reporting has been transformed from paper copies to electronic completion and filing via the ESH SharePoint increasing timeliness of reporting. Electronic injury reporting via SMART forms is being initiated by ERMO and targeted to go-live at all BHA facilities June, 2021.</p>

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<p>e) 2. Taking Appropriate Action in Response to Violent Acts</p>	<p>Policies, procedures, and training are in place to ensure appropriate actions and response to violent acts occurs.</p> <p>According to the Joint Commission, Zero Harm is defined as follows:</p> <ul style="list-style-type: none"> • Zero complications of care, zero falls, zero infections, zero missed opportunities for providing effective care, zero overuse and even zero lost revenue. In other words, zero harm of any kind. • Humans do make mistakes, but zero harm does not mean zero mistakes. It means organizations develop systems and processes that reduce the likelihood of a mistake occurring. Highly reliable organizations have safety procedures that stop errors and prevent them from propagating and leading to harm. They also identify problems and unsafe conditions and correct them before they cause harm. 	<p>All incidents are investigated by the immediate supervisor, Security, Safety and/or other department(s) as indicated at the time of occurrence and reported to Leadership for action as required. Workplace violence data is monitored by the EOC, Employee Safety and Quality Council Committee.</p> <p>All seclusion/restraint, PERT, Code Gray, patient and staff injury incidents are reviewed by Leadership in daily morning rounds and actions implemented as required.</p> <p>ESH has created a Zero Harm Workgroup (ZHW). This group has focused its attention and efforts on reducing the usage of seclusion and restraint which can inadvertently contribute to worker and patient injury. This work was initiated by identifying a group of frontline employees that came together and brainstormed potential causes for the high seclusion numbers (based on state and national averages). The frontline employee group then drilled down and identified the potential root causes; and from those, developed potential solution ideas to address the root causes. From this, it was determined that creating a formalized debrief after each seclusion event that includes leadership and PERT to determine the antecedent to the event should be implemented.</p> <p>The ZHW has initiated review of Code Gray forms that have been submitted over the previous 24 hours after the morning Leadership huddle. This is an opportunity to learn about the process, and to identify what questions need to be asked/addressed to make the process more conducive to a learning environment that embraces Zero Harm.</p>

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e) 2. Taking Appropriate Action in Response to Violent Acts	<p>The Psychiatric Emergency Response Team (PERT) provides a safe, effective and immediate plan of response for patients during a psychiatric crisis or anticipated crisis. This is accomplished through a least to most intervention technique utilizing verbal de-escalation tactics while promoting and maintaining patient and staff safety.</p>	<p>A Psychiatric Emergency Response Team (PERT) is in place and is designed as a first-responder system to promote a Culture of Safety for patients and staff. This highly skilled team, comprised of Institution Counselor 3s, and Registered Nurses (RN), and a Supervisor, are trained in crisis intervention skills, incident management skills, analysis of the antecedents for violence and aggression, and de-escalation techniques. When containment is necessary, this team will facilitate seclusion and restraint if necessary, and work with floor staff to re-integrate the patient back to the milieu with appropriate evidence-based debriefing. PERT responded to 2,294 calls; April, 2020 through April, 2021.</p> <p>When not actively engaging patients the primary mission is primary prevention, and is accomplished by interacting with patients throughout the campus during the team member’s daily shift.</p> <p>A “Code Gray” is implemented whenever a patient’s behavior is escalating and may require seclusion or restraint or whenever seclusion or restraint is initiated. A “Code Gray” is in response to an actual or anticipated critical incident and immediate response is required. Debriefing with staff and an analysis of the event is completed to develop action plans as required.</p>
e) 2. Taking Appropriate Action in Response to Violent Acts	<p>Employees may require assistance when completing injury paperwork or seeking medical attention.</p>	<p>All employees injured at work have access to first aid measures as indicated. In the event that an employee sustains a more serious injury, emergency medical response is initiated or the supervisor assists the employee to obtain additional outside medical</p>

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e) 2. Taking Appropriate Action in Response to Violent Acts		attention if indicated. Refer to section d) First Aid and Emergency Procedures for additional information.
e) 2. Taking Appropriate Action in Response to Violent Acts	<p>Critical Incident Stress Management (CISM) is an adaptive, short-term psychological helping-process that focuses solely on an immediate and identifiable problem. It can include pre-incident preparedness to acute crisis management to post-crisis follow-up. Its purpose is to enable employees to return to work quicker with less likelihood of experiencing post-traumatic stress disorder (PTSD). The program is <i>peer-driven</i>, designed to help employees deal with their trauma by allowing them to talk about the incident when it happens without judgement or criticism.</p>	<p>A referral request mechanism is located on the ESH SharePoint. All requests are initiated through the PBX Operator and then communicated to the CISM Coordinator/designee to initiate a response.</p> <p>In addition, affected staff is made aware of the Employee Assistance Program (EAP) and, on an individual and confidential basis, are encouraged to seek help from the Human Resource Department in accessing personal support.</p> <p>A communication site with worker compensation information and resources is located on the ESH SharePoint to include link to Labor and Industries (L&I) and DSHS Enterprise Risk Management (ERMO) safety and claims webpage</p> <p>Trained Subject Matter Experts, are available on all shifts, to assist injured workers with accurate information related to the reporting process and how to access additional information and resources at time of occurrence. Process communication posters and name badge cards for improved employee awareness are in place. LMS training outlining this information is included as part of mandatory annual Safety training for all employees.</p>

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e) 3. Follow-up Procedures after Violent Acts	Potential for safety concerns to not be passed on to other shifts or Leadership and other departments responsible for developing action plans as required.	<p>Safety Huddles are conducted prior to morning report on each ward to share potential safety concerns/issues.</p> <p>A risk management review and investigation report (RMRIR) is completed daily by the Patient Safety Manager. This is designed to ensure the severity of an injury or other incident is appropriately coded, reported to appropriate individual for follow-up and actions taken.</p> <p>The Employee Safety Committee meets monthly and conducts in-depth reviews of patient-to-staff assault occurrences and develops prevention strategies to mitigate future occurrences as identified. A narrative summary with recommended action plans, if indicated, is provided to the EOC Committee, Quality Council and Governing Body for review and monitoring.</p>
e) 3. Follow-up Procedures after Violent Acts		<p>The 2020 Employee Safety Committee goal is to create a sub-group of members to evaluate assault occurrence timeframes for identification of precursors or other contributing factors, any relationship to escalating patient behavior after civil conversion occurs and patients are transferred from forensic to civil wards, and length of employment. Nursing Leadership has been focusing on staff training needs, assaults occurring during a 1:1 patient assignment for assault precautions, other precursors to assault event and development of recommendations to decrease occurrences.</p>

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<p>e) 3. Follow-up Procedures after Violent Acts</p>	<p>Victims of domestic violence are supported under DSHS Administrative Policy No. 18.67 in its commitment to work with employees to prevent abuse, stalking and harassment from occurring in the workplace and offering employees who are victims of domestic violence referral to appropriate resources.</p>	<p>Employees who self-report to their employer as victims of domestic abuse are immediately referred to the Human Resource Business Partner (HRBP). HRBP will provide information regarding community resources for safety and assistance for the employee and their family as well as other resources. Additionally, they have access to the employee assistance program for referral to additional specialized resources. There is a safety plan in place to provide awareness for supervisors addressing safety and security concerns as appropriate.</p> <p>The DSHS-Enterprise Risk Management Office (ERMO) conducts investigation, in addition to facility investigation, of any assault on a DSHS employee which results in an employee's hospitalization or medical treatment beyond first aid. A drill down of the event is conducted to determine whether existing processes are effective or require modification. Data derived from the drill down is used by ESH, as appropriate, to develop an action plan for process improvement and reported to Employee Safety Committee and Quality Council.</p>
<p>e) 3. Follow-up Procedures after Violent Acts</p>	<p>ESH utilizes Unusual Occurrence (UOR) forms for reporting verbal threats, per RCW 72.01.045 and 74.04.790. Reporting staff determines risk potential. Definition and coding of UOR for verbal threat is identified as: "To express (orally, in writing, or by action) a specific intent to cause another person harm, trouble, or inconvenience". An abuse code is utilized if the threat is made by a patient or other to staff. An anti-safety culture code is utilized if the threat is made by a staff to another staff.</p>	<p>Workplace violence, including verbal threats, is monitored and analyzed daily by Quality Management, Safety, Security and Executive Leadership during morning rounds. Monthly reports are provided to EOC and Employee Safety Committee and quarterly to Quality Council. Action plans are developed as required.</p> <p>All new employees receive new employee orientation, or "at hire" mandatory training prior to working in assigned area and complete annual refresher training as required.</p>

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g) Employee Education and Training		All direct care (milieu) staff are trained at hire and identified intervals in prevention practices that range from situational awareness of the environment and milieu dynamics, ongoing risk assessment, and effective documentation to a formal non-violent crisis intervention training program.
g) Employee Education and Training	<p>A training plan is in place to ensure all staff are trained at-hire and on an ongoing basis as required. As part of the plan, ESH has adopted the TLC learning management system, which provides better access to and recordkeeping of participation in ongoing training. The TLC system also enables improved post-testing and timely feedback to participants.</p> <p>Educational Services has developed a matrix of mandatory training, at orientation and ongoing. Which is utilized to compile monthly compliance reports. New Employee Orientation is conducted at regular intervals, at least monthly.</p> <p>Due to COVID 19 restrictions related to social distancing, NEO was conducted twice monthly to ensure compliance.</p>	<p>ESH has implemented Crisis Prevention Institute (CPI) training which is evidence-based and incorporates philosophy, de-escalation, safe physical holds and self-protection training.</p> <p>Staff are 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: evasion techniques, hierarchy of physical intervention, physical containment procedures and application of mechanical restraints. All physical skills require return demonstration and documentation of competency.</p>
g) Employee Education and Training		Following the classroom portion of NEO, Nursing staff, MHT's, PSA's, LPN's, PSN's and RN's are assigned to precept on the wards for an additional two weeks for non-licensed staff and three weeks for licensed staff to complete the onboarding for new Nursing employees. This is designed to intermix mental health theory content

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g) Employee Education and Training		<p>with core competency training required for different levels of nursing practice.</p> <p>A preceptor (peer) training is conducted to provide practical actions that a front-line preceptor (peer trainer) can do to optimize a new employee's learning and enable them to achieve early success in demonstrating core job competencies.</p> <p>This class helps peer trainers understand what is needed to optimize on the job learning for new employees to create a supportive, safe work environment. An on-ward security awareness training is conducted including a walk-through of the FSU ward and yard.</p>
g) Employee Education and Training	Restraint events are high-risk and intermittent.	Application of Restraints is covered in conjunction with the crisis intervention program covering therapeutic relationship and boundaries, best practices for interacting with patients, effective interactions during difficult situations, functional behavioral assessment, trauma-informed care, situational awareness, Culture of Safety, and de-escalation. In addition, staff is trained to monitor patients in restraints for signs of physical distress.
g) Employee Education and Training	CPR training is required for all clinical staff.	The American Heart Association Basic Life Support (BLS) training is instructed for Healthcare Providers which results in certification of participants. This is required every two (2) years for all clinical staff.

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
g) Employee Education and Training		<p>Nursing skills training events are held two times a year for review of required nursing skill competencies. Education Services, in conjunction with nursing leadership determines content of the fair based on skill required; annually or every 2 or 3 years.</p> <p>Additional training resources utilized include a video series on Mental Health Nursing which provides common scenarios for successful patient/staff interactions including:</p> <ul style="list-style-type: none"> • Depressed/suicidal client • Verbally and physically aggressive client with/without delusions • Interactions with patients who have borderline personality disorder • Patients with dementia and agitation and/or anxiety • Patients experiencing mania <p>Milieu Management training is provided to all RN's at hire (New Employee Orientation) in support of provision of active treatment.</p> <p>RN3's and designees are offered a full day of training focused on the role and responsibilities of the Charge Nurse duties.</p>
g) Employee Education and Training	<p>ESH conducted a Culture of Safety Survey in March/April, 2021. In previous Culture of Safety surveys, ESH applied internal benchmarking (comparing results between workgroups), which can cause staff concerns regarding anonymity and confidentiality, and silo mentality (conflicting goals of different departments, instead of same goals across the entire organization). This year ESH determined that external benchmarking (comparing our</p>	<p>An overall report will be created comparing workgroup improvement initiatives, action plans, success measures, and the Culture of Safety principle that the action plan supports.</p>

Security Consideration RCW 72.23.400	Assessment	Prevention Action(s)
g) Employee Education and Training	<p>data with other hospitals across the nation) is key toward establishing a standard of excellence and exposure to safety best practices implemented in other hospitals. The AHRQ Patient Safety Culture Hospital survey 2.0 provides ESH the opportunity to submit its survey results to a central repository database that houses survey data from hospitals across the nation. The Culture of Safety Survey data is the best indicator to truly declare that ESH has successfully transformed to a safety culture where all employees report unsafe events, speak up about safety risks, and report errors and near misses across the entire hospital without fear of retribution.</p>	
g) Employee Education and Training	<p>The Strategic direction and pillars of focus for Eastern State Hospital include defining a Culture of Safety as a just culture where employees are not fearful to report adverse events, close calls, unsafe practices or conditions.</p> <p>A just culture is non-punitive, addresses the adverse event, cclose call, unsafe practice or condition by lookingg at the system not the person.</p>	<p>ESH Goals Include:</p> <ul style="list-style-type: none"> • Implementing a consistent rounding program for Executive leaders and supporting employees exposed to secondary violence. • Creating consistency between shifts and wards and consistent communication across the facility. • Empowering employees by providing training and education opportunities. • Using collected data to support more decisions and practices throughout the organization. • Creating a practice where Culture of Safety behaviors are mirrored by supervisors. • Involving front-line staff in solutions. • Creating and implement an organizational wide communication process/plan so the entire hospital, departments/wards and employees

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g) Employee Education and Training		<ul style="list-style-type: none"> • hear the same message. • Post reports and goals throughout the hospital for transparency, awareness and discussion.
g) Employee Education and Training		Specific measurements that support BHA/ESH strategic plans and Culture of Safety measurements are posted in all departments/wards.
h) Clinical and Patient Policies and Procedures Including Those Related to: 1. Smoking	Patient and Visitor smoking on ESH campus is not allowed. Staff smoking is allowed in designated areas only.	
h) 2. Activity, Leisure, and Therapeutic Program	Limited Rehabilitation Services may result in increased patient agitation due to decreased activity, leisure and therapeutic programming opportunities.	<p>A performance improvement plan is ongoing focusing on increasing the quality of active treatment offered, with better interface with the treatment teams and improved data capture and documentation. An Active Treatment Planning Council is in place and develops/implements additional methods to improve active treatment data capture and increasing average hours of active treatment per patient. Strategic goal target hours for active treatment are 20 hours. Data for 2020 indicates a decrease in hours related to COVID restrictions.</p> <p>An Active treatment dashboard is in place and utilized to monitor and analyze active treatment data. This data is monitored monthly and reported quarterly to Quality Council. A feedback system has been developed to report to unit management teams and includes increasing weekend/evening activity provision.</p>

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h) 2. Activity, Leisure, and Therapeutic Program	Risk assessments required prior to approval of conditional releases.	In order to demonstrate readiness for a conditional release to reside in the community, patients must demonstrate the ability to manage stress and symptoms associated with increased access to the public. A critical activity for this assessment is the Staff Escorted Community Outing (SECO). A SECO is an inter-disciplinary clinical intervention that requires coordination with nursing, recreation and social work staff. Community reintegration groups stopped March, 2020, but community reintegration outings are occurring during Phase 3 utilizing the Covid Risk Assessment.
h) 2. Activity, Leisure, and Therapeutic Program	<p>Inconsistency between ward and shift routines, ward guidelines, recovery levels, group offerings, etc. increasing patient frustration when transferring from ward to ward.</p> <p>Many patients are diagnosed with substance use disorders which often leads to recidivism and acuity upon admission</p>	<p>Unit Administrative Directors have cross-walked ward guidelines and identified shift inconsistencies and implemented action plans to decrease patient frustration and potential increased agitation when transferred to another ward or when inconsistencies occur shift-to-shift.</p> <p>SUD staff complete assessments for patients to be placed in SUD treatment upon discharge from ESH. ESH is working to decrease recidivism due to substance use issues. The SUD counselors work in conjunction with the treatment teams and patients to provide SUD assessments, individualized treatment planning and-groups to prepare patients for SUD treatment and recovery. SUD counselors have expanded services to provide groups to the competency restoration patients in an attempt to decrease recidivism due to substance use.</p>

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h) 2. Activity, Leisure, and Therapeutic program	Lack of group facilitation training.	An introduction to group facilitation training has been added to the NEO utilizing a facilitation competency assessment tool. This has been on-hold during COVID due to reduction in NEO hours and will resume with normal NEO programming. Programs, treatment and care are provided by rehabilitation clinical staff focusing on anxiety and stress management, recovery, negotiating needs versus wants, processing loss and change, using methods including but not limited to exercise, relaxation, music and mood, socialization activities such as table games and activities, exercise, expressive arts and creativity.
h) 2. Activity, Leisure, and Therapeutic program	On-ward active treatment during the afternoon shift is limited or cancelled due to conflicts with ward routines e.g. medication distribution, snacks, etc. Rosters for afternoon shifts are not consistently being completed to document occurrences of active treatment or reasons for group cancellation.	There has been an increase in the number of groups offered during the day on the civil commitment wards for patients who are unable and/or refuse to attend and participate in the Treatment Mall
h) 2. Activity, Leisure, and Therapeutic program	There is an increased risk for patient unauthorized leave and/or negative patient behavior during unsecured or community outings.	<p>A Wellness Center for the patients was developed promoting physical as well as mental health well-being through groups, such as cardiovascular strengthening, yoga, tai chi.</p> <p>A community outing planning tool is utilized for all outings to identify potential risks and methods of managing/reducing these risks i.e. radios carried by escorting staff, personal protective equipment, patient-to-staff ratios policies. Community outings for Civil Commitment patients, Policy # 1.124, is in place. This policy includes safety and security procedures/protocols to ensure community outings are implemented safely and securely while</p>

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h) 2. Activity, Leisure, and Therapeutic Program		patient and staff safety during transport to/from patient activities, medical appointments, etc. A risk assessment is completed on patients who attend community outings.
h) 2. Activity, Leisure, and Therapeutic program	An Unauthorized Patient Leave policy is in place and addresses internal response and external communications and notifications.	Sentinel Events or drill downs are conducted for an attempted or accomplished UL and action plans are developed based on assessment and monitored by EOC and Safety Committee and Quality Council.
h) 3. Communication Between Shifts.	There is the potential for patient information including changes in recovery levels, acuity and identified safety risks to not be relayed to oncoming shifts/staff.	<p>Safety Huddles are conducted prior to morning report on each ward to share safety concerns and provide information regarding potential safety issues.</p> <p>All wards have introduced a patient “quiet/reflection” time during shift change between day and evening shift. This strategy encourages patients to spend time in their bedrooms during the fifteen minute shift change report allowing staff to focus on critical patient information and relay of potential safety risks.</p>
h) 3. Communication Between Shifts.		<p>Executive Leadership reviews ward report data from the previous evening during daily morning rounds and initiates actions or requests for additional investigation as indicated.</p> <p>Hospital-wide communication is conducted through the use of a hospital-wide “news flashes”, newsletter, use of an intranet/SharePoint site and postings on communications boards throughout the hospital.</p>

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h) 3. Communication Between Shifts.	Increased requirements specific to the forensic population requires additional staff knowledge and communication of FSU security requirements.	The FSU Security Committee establishes, reviews and makes recommendations for changes in FSU unit security policies and procedures. This committee receives input from line staff (and others) to address safety and security issues. There is a Security Break Memo review process in place to address safety and security concerns. All unit safety/security committee minutes are reviewed by the all-hospital Employee Safety committee for implementation of hospital-wide recommendations as required.
h) 4. Restraint and Seclusion	A Psychiatric Emergency Response Team (PERT) is in place and is designed as a first-responder system to promote a Culture of Safety for patients and staff. This highly skilled team, comprised of Institution Counselor 3s, and Registered Nurses (RN), and a Supervisor, are trained in crisis intervention skills, incident management skills, analysis of the antecedents for violence and aggression, and de-escalation techniques. When containment is necessary, this team will facilitate seclusion and restraint if necessary, and work with floor staff to re-integrate the patient back to the milieu with appropriate evidence-based debriefing. PERT responded to 2,294 calls; April, 2020 through April, 2021.	The PERT team provides situational awareness utilizing on-the-spot staff coaching, when applicable, to reduce overall patient-to-staff assaults and events resulting in patient seclusion or restraint. Both seclusion and restraint require employees to initiate physical contact with a patient and increases the potential for patient-to-staff assault. When containment is necessary, this team will facilitate seclusion and restraint if necessary, and work with floor staff to re-integrate the patient back to the milieu with appropriate evidence-based debriefing. Executive staff reviews all seclusion/restraint incidents occurring over the past 24 hours during the following morning report. The 24 hour shift report is screened for patterns or trends with Code "Gray" and PERT responses.
h) 4. Restraint and Seclusion	Existing ESH Code Gray policy requires implementation whenever a patient's behavior is escalating and may require seclusion or restraint or whenever seclusion or restraint is initiated.	The ZHW meets after the morning Leadership huddle to review the Code Gray forms that have been submitted. This is an opportunity to learn about the process, and to identify what questions need to be asked/addressed to make the process more conducive to a learning environment that embraces Zero Harm.

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h) 4. Restraint and Seclusion		<p>A “Code Gray” is in response to a critical incident and immediate response is required. Debriefing with staff and an analysis of the event is completed for action planning to prevent re-occurrence.</p> <p>For related policies and procedures and education refer to section “g”, “Employee education and training” and section “h”, “Clinical and patient policies and procedures”.</p>