

Washington State Department of Social and Health Services

Transforming
Lives

WESTERN STATE HOSPITAL
WORKPLACE SAFETY PLAN



Washington State
Department of Social
& Health Services

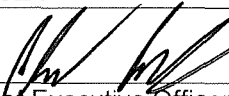
Transforming Lives



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APPENDIX A. SECURITY AND SAFETY ASSESSMENT

1.0 PURPOSE

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

2.0 SCOPE

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

The WSP incorporates:

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

3.0 HOSPITAL LEADERSHIP COMMITMENT

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

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

4.0 SAFETY AND HEALTH RESPONSIBILITIES

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

4.1 Executive Leadership Responsibilities

Executive Leadership responsibilities to create and maintain workplace safety include:

- Maintaining a safety committee in accordance WAC 296-800-13020 and providing employees sufficient time to participate on the committee.
- Ensuring injuries and illnesses are recorded and reported and an OSHA Summary is signed by the highest ranking official at the facility and posted per WAC 296-800.
- Reviewing workplace safety data and implementing prevention and mitigation measures to improve workplace safety.
- Providing guidance and supervision to hospital personnel to ensure compliance with the WSP.
- Recruitment and retention of qualified staff to ensure effective patient care and maintenance of a safe workplace.
- Creating, maintaining, and promoting of a Culture of Safety

4.2 Manager and Supervisor Responsibilities

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

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

4.3 Employee Responsibilities

Employee responsibilities to create and maintain workplace safety include:

- Immediately reporting to supervisors any unsafe conditions, injuries, near miss incidents and threats or acts of violence.
- Using personal protective equipment (PPE) as required and immediately reporting equipment malfunctions or need for service or replacement to supervisors. In addition, removing or interfering with any PPE or equipment safety device or safeguard is prohibited.

- Utilizing situational awareness to maintain a safe and respectful work environment and behaving respectfully to patients and co-workers at all times, reinforcing a culture of safety.
- Understand and follow patient treatment and safety plans to improve patient care outcomes and decrease safety risks.
- Understand and comply with safety policies, procedures and training and encourage co-workers to use safe work practices.

5.0 SAFETY COMMITTEES AND SAFETY INFORMATION

5.1 Employee Safety Committee

The purpose of Employee Safety Committees is for employees and management to mutually address safety and health issues, in compliance with WAC 296-800-130. The committees are responsible for evaluating the effectiveness of the Workplace Safety Plan and for developing, implementing and overseeing action plans in order to create and maintain a safe workplace.

Everyone at WSH has the ability to bring safety issues up through their respective Center level safety committees by either e-mailing their safety issues to the WSH Safety Concerns e-mail or, by reporting them to the safety office or, safety committee members. Any safety issues brought up that cannot be resolved at the center level are reported to Hospital-wide safety committee. The hospital-wide committee reviews all concerns that have been rolled up from the center levels and assigns responsible parties to ensure action plans to address these concerns are completed. Information is communicated back down to the center levels committees, for a top-down and bottom-up communication chain. The hospital-wide Safety Committee consists of employee-elected representatives and management designated representatives, in an amount equal to or less than employee elected representatives. Guests (Ad-hoc members) are invited as required. Each committee meets on a monthly basis and membership is re-appointed or replaced at least annually.

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

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

5.2 Environment of Care Committee

The Environment of Care Committee (EOC) performs retroactive and proactive safety reviews, performs risk assessments of the Environment of Care, makes safety recommendations and develops action plans to improve workplace safety. The EOC has oversight responsibilities for life safety, environment of

care, and emergency management regulations of the Centers for Medicare and Medicaid Services (CMS).

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

5.3 Safety Bulletin Board

Western State Hospital has four physical bulletin boards that are specifically devoted to safety in each center. The locations of the 4 physical bulletin boards are:

PRTC East	<i>Building 28, 1st Floor Between East Campus Nursing Admin and East Campus Pharmacy</i>
CFS	<i>Building 29, 1st Floor Outside of CFS Nursing Admin</i>
PTRC Central	<i>Building 9, 3rd Floor Outside of Central Campus Nursing Admin.</i>
PTRC South & HMM	<i>Building 21, 2nd Floor, S-2 Outside of South Hall Nursing Admin.</i>

The bulletin boards contain the following OSHA required postings:

- Notice to Employees – If a job injury occurs (F242-191-000).
- Job Safety and Health Protection (F416-081-909).
- Your rights and a Non-Agricultural Worker (F700-074-000).
- OSHA 300A Summary of Work Related Injuries and Illnesses (required from February 1 through April 30 of each year).
- Safety Committee meeting minutes.
- Any Department of Labor and Industries citation or complaint documents for the required time frame per OSHA/WISHA regulations

Staff can find many safety topics to include some of the information above by visiting the WSH Share point site under Safety and Security; Meeting Minutes and then choosing the topic of interest on the left hand column. All employees have access to the WSH share point site.

6.0 REPORTING AND RECORDKEEPING – INJURY, ILLNESS AND NEAR MISS

6.1 Employee Responsibilities

- Employees involved in an **on-the-job injury, or a near miss incident** must immediately report the incident to their supervisor and complete a current Safety Incident/Close Call Report (DSHS 03-133), located on the WSH Share Point site under “in case of emergency” icon. Employees must then submit the form to their supervisor and they will fill out the supervisors review portion of the Safety Incident/Close Call Report (DSHS

-133) Completed forms must be scanned and emailed or forwarded in the hospital mail to the WSH Safety Office within three (3) working days of the injury or near miss.

- Employees involved in a **near-miss or close call incident** must immediately report the incident to their supervisor and complete a WSH Form 1-100 “Administrative Report on Incident” (AROI).
- The Employee Report of Possible Client Assault (DSHS 03-391) form must be completed for all incidents resulting from a potential client assault as outlined in DSHS Administrative Policy 9.02 and attached to the Injury and Illness Incident Report.
- A Post Exposure Packet must be completed by employees in cases resulting in an exposure incident or blood borne pathogen exposure. This is defined as an eye, mouth, other mucous membrane, non-intact skin, or contacts with blood or other potentially infectious materials that results from the performance of an employee’s duties.
- A Labor and Industry (L&I) Form 242-130-1111 is initiated at the healthcare provider’s office, urgent care or emergency room when receiving medical or emergency treatment for a work-related incident/injury or exposure. The physician completes the form with the employee and mails a copy to Labor & Industries for processing.

6.2 Supervisor Responsibilities

Supervisors are responsible to investigate all injury, illness and near-miss occurrences and complete DSHS 03-133 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 incident that results in death or serious injury the supervisor must ensure a preliminary investigation is conducted.

- This may include participation by union representation, safety manager/officer, ERMO staff and others.

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

6.3 Safety Manager Responsibilities

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

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

6.4 DSHS Enterprise Risk Management Office (ERMO) Responsibilities

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

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

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

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

Chief Executive Officer (CEO) or Designee Responsibilities:

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

Staff Responsibilities:

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

Staff must not:

- Disturb the scene except to aid in rescue or make the scene safe.
- Clean up bodily fluids or pick up other items.
- Move equipment involved (e.g. personal protective equipment, tools, machinery or other equipment) unless it is necessary to remove the victim or prevent further 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 mark off with tape or ribbon and a guard posted.
- Keep unnecessary persons out of the area before and after securing the area.
- Record the names of persons who have entered the area during and after the incident.
- Record the names of persons who have witnessed the incident.
- Keep records of any items leaving the area before investigators arrive (e.g. clothing, bloody items, equipment and weapons).

6.6 Patient and Visitor Injuries

All patient and visitor injuries are reported to the Quality Management Department through the Administrative Report of Incident (ARO) System and analyzed by the Critical Risk Management Team. Reports are provided to Patient Care Quality Council Committee on at least a quarterly basis and action plans developed as required.

7.0 HAZARD PREVENTION AND CONTROL

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

7.1 Statement of Conditions

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

7.2 Basic Safety Rules for Employees

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

- Always use safe work practices in performing duties including understanding and using proper lifting techniques, using personal protective equipment (PPE) when required, following safety warning signs and reading and following product labels.
- Manufacturer's instructions must be followed when using or operating equipment. Unsafe equipment must not be operated and equipment shall only be operated when trained and authorized. Supervisors must document training before an employee is considered competent to perform duties of the job.
- Unsafe work conditions, practices and hazard conditions must be immediately reported to supervisors and may be reported to safety committee representatives.

- Understand and follow the procedures for reporting accidents (section 6.0).
- Staff must comply with applicable collective bargaining agreements and DSHS Administrative Policy 18.75 Drug and Alcohol-Free Workplace.
- Firearms or explosives may not be on hospital property.
- Smoking inside the building or within 25 feet from any entry or ventilation intake is prohibited in accordance with DSHS Administrative Policy No. 18.65 and RCW 70.160.
- Refrain from behavior that is distracting to other employees.
- Maintain good housekeeping and keep emergency exits, aisles, walkways and working areas clear of slipping or tripping hazards. Replace all tools and supplies after use, and do not allow debris to accumulate where it will become a hazard. Clean up spills immediately.
- Refrain from horseplay, fighting and distracting fellow employees
- Know the location and use of:
 - First aid supplies
 - Emergency procedures (chemical, fire medical, etc.)
 - Emergency telephone numbers
 - Emergency exit and evacuation routes
 - Firefighting equipment

7.3 Discipline for Failure to Follow Basic Safety Rules

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

7.4 Environment of Care (EOC) plans

WSH has developed detailed Environment of Care (EOC) plans required by rules and regulations set by DOSH and CMS. These plans are located in the Facilities Coordinator's Office and/or the Safety Office and are updated annually. The EOC plans address:

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

7.5 Equipment Maintenance

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

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

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

Interim Life Safety Measures (ILSM)

To assure the safety of all WSH building occupants, Interim Life Safety Measures (ILSM) will be implemented as appropriate when construction activities, maintenance activities, or other conditions that compromise the level of life safety protection provided by the building occur. These conditions include significant deficiencies/impairments to the fire detection, suppression, and notification/alarm system or, when a route of egress is obstructed. Implementation of appropriate ILSM may be required in or adjacent to all construction areas. Required ILSM's apply to all personnel, including construction workers and must be implemented if required upon project development, and continuously enforced throughout the project as appropriate. The Safety Manager coordinates the planning, implementation and monitoring of all interim life safety plans in coordination with others (e.g. MOD, Facilities, Security, etc.) as indicated.

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

- a. Emergency exits are obstructed.
- b. Fire detection, suppression or alarm systems are inoperable or impaired.
- c. Current fire-fighting equipment is insufficient.
- d. Temporary construction partitions are not smoke tight or made of non-combustible or limited combustible materials.
- e. Increased risks of fire is present in buildings, on grounds, and with equipment, giving special attention to construction and storage areas, excavation activities, and field offices requiring increased surveillance.
- f. Increase in the building's flammability and combustible fire load.
- g. Situation requires additional fire safety training for individuals on the use of fire-fighting equipment.

- h. Situation requires an additional fire drill for each shift in each quarter.
- i. Activities require inspection and testing of temporary systems monthly.
- j. Building deficiencies, construction hazards, and temporary measures implemented require additional education to promote awareness of fire and life safety activities.
- k. Impaired structural or compartmental fire features require additional measures and or training of hospital staff.

When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the Life Safety Standards will be evaluated and ILSM's put in place using the guidelines outlined in the **INTERIM LIFE SAFETY MEASURES MATRIX GUIDE (Attachment B of WSH policy 12.06)**. Appropriate ILSM's are determined and implemented as follows:

1. The hospital evacuates the building or notifies the fire department (or other emergency response group) and initiates a fire watch when a fire detection/notification system is out of service more than 4 out of 24 hours or a sprinkler system is out of service more than 10 hours in a 24 hour period in an occupied building. Notification and fire watch times are documented.
2. Posts signage identifying the location of alternate exits to everyone affected.
3. Inspects exits in affected areas on a daily basis, when appropriate.
4. Provides temporary but equivalent fire alarm and detection systems for use while a fire system is impaired, when appropriate.
5. Provides additional fire-fighting equipment, when appropriate.
6. Uses temporary construction partitions that are smoke-tight, or made of Non-combustible material, or made of limited combustible material that will not contribute to the development or spread of fire when appropriate
7. Increases surveillance of buildings, grounds, and equipment, giving special attention to construction areas and storage, excavation, and field offices, when appropriate.
8. Enforces storage, housekeeping, and debris removal practices that reduce the building's flammable and combustible fire load to the lowest feasible level, when appropriate.
9. Provides additional training to those who work in the hospital on the use of fire-fighting equipment, when appropriate.
10. Conducts one additional fire drill per shift per quarter, when appropriate.

11. Inspects and tests temporary systems monthly, when appropriate. The completion date of the tests is documented.
12. The hospital conducts education to promote awareness of building deficiencies, construction hazards, and temporary measures implemented to maintain fire safety, when appropriate.
13. The hospital trains those who work in the hospital to compensate for impaired structural or compartmental fire safety features, when necessary. Note: Compartmentalization is the concept of using various building components (fire rated walls and doors, smoke barriers, fire rated floor slabs, etc.) to prevent the spread of fire and the products of combustions such as to provide a safe means of egress to an approved exit. The presence of these features varies depending on the building occupancy classification.

Infection Control Risk Assessment (ICRA)

Potential hazards related to construction, renovation or maintenance activity are assessed through the Infection Control Risk Assessment (ICRA) process that identifies potential new or altered risks related to infection control, utilities or building systems, fire safety or interim life safety, general safety issues, emergency preparedness or response, and security. The ICRA is reviewed and monitored by the COO, Safety Manager, Security and Infection Control Coordinator and reported to the Safety, Infection Control and Environment of Care Committee.

Job Hazard Analysis and Personal Protective Equipment

A Job Hazard Analysis (JHA) form is utilized to evaluate each type of job task employees perform. The JHA is completed by a supervisor and/or safety committee member along with an employee familiar with the task. The JHA defines the steps of the task, what hazards may be present during the task and what can be done to eliminate or protect workers from those hazards. Employees are trained if there are changes to current procedures or PPE.

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

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

8.0 HAZARD RECOGNITION AND REPORTING PROCEDURES

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

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

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

8.1 Environmental Safety Inspections

Western State Hospital is committed to identifying hazardous conditions and practices. In addition to reviewing injury records and investigating accidents for their causes, Ward Administrators and the Facilities Coordination Office, regularly check the workplace for hazards.

Environmental safety inspections are conducted to ensure that all patient care areas are inspected for hazards at least quarterly and all non-patient care areas are inspected at least annually. The inspections evaluate staff knowledge and skill, observe current practice and evaluate environmental conditions/hazards. Inspections are conducted in patient care areas by Ward Administrators monthly and the Facilities Coordination Office Quarterly. Inspections for Non-patient care area are at least annually. These inspections are in addition to documented fifteen minute to hourly environmental checks completed by nursing staff in all patient care areas. The results of the inspections and any action(s) taken are reported to the area supervisor(s), department manager, EOC and Employee Safety Committee and the CEO. MOD and CIBs environmental inspections are conducted in accordance with procedures outlined in their Workplace Safety Plan/APP.

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

8.2 Periodic Change Process

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

8.3 Proactive Risk Assessment

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

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

8.4 Annual Safety & Health Performance Assessment (SHPA)

Safety staff from the DSHS ERMO/Safety conducts an annual inspection of the hospital to include all associated buildings on the WSH campus and the workplace safety program to ensure compliance with applicable regulations, DSHS policies and hospital policies. The inspection provides the hospital with information about hazards and compliance issues that may be missed during routine inspections. Action plans are developed for all inspection findings with identified target dates to ensure each hazard is corrected in a timely manner.

9.0 EMERGENCY PLANNING

9.1 Evacuation Maps

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

9.2 Hazard Vulnerability Analysis

A hazard vulnerability analysis (HVA) is completed to determine which hazards require special attention. The HVA provides a systematic approach to recognizing hazards that may affect demand for the hospitals services or its ability to provide those services. The risks associated with each hazard are analyzed to prioritize planning, mitigation, response and recovery activities. The

hazard vulnerability analysis is evaluated annually, at a minimum, to assess the hospital's emergency management activities and to identify necessary changes, additional planning activities and specific exercise scenarios if required.

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

9.3 Response to Injuries

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

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

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

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

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

9.4 Infectious Disease Exposure Hazard

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

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

The most frequent contagions employees can 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 WSH staff and productivity.

Employees should also expect to occasionally be conducting business with patients, other staff, contractors, or general members of the public who may be infected with more severe, though less common, contagions, including: Human Immunodeficiency Virus (HIV), Hepatitis B virus (HBV).

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

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

10.0 SAFETY AND HEALTH TRAINING AND EDUCATION

10.1 Safety Training

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

10.2 Basic Orientation

On the first day of hire, and annually or as required by job class and training type, employees are required to attend New Employee Orientation (NEO) that

includes all OSHA required Safety, Accident Prevention, Workplace Violence prevention, Infection Control and other required training. Training includes procedural knowledge regarding practices, policies, procedures, use and maintenance of personal protective equipment, behavioral intervention techniques, safe operation of equipment and emergency management and response plans. All WSH training curriculum is maintained by the WSH Organizational Development.

10.3 Orientation for Clinical and Nursing Staff

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

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

10.4 Site-Specific Training for MOD and CIBS

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

11.0 WORKPLACE VIOLENCE PREVENTION

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

Prevention of workplace violence is based on principles of:

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

11.1 Definition of Workplace Violence

The National Institute for Occupational Safety and Health (NIOSH) defines workplace violence as “violent acts directed toward persons at work or on duty.” Washington State Department of Social and Health Services (DSHS) defines workplace as any location, permanent or temporary, where an employee performs work-related duties, including but not limited to buildings and surrounding perimeters, parking lots, field locations, home and community activities, alternate

work locations, agency vehicles, and travel to, from and during work assignments (DSHS Administrative Policy No.18.67).

11.2 Workplace Safety and Security Assessment

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

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

11.3 Risk Assessment and Treatment Planning

Patients with an increased risk for assault have treatment plans formulated to address the risk and includes safety plans to identify triggers and prevention and de-escalation. Violent acts are tracked to identify frequency and severity of assaults. Weekly inter-shift meetings include the interdisciplinary team and psychiatric consultation to develop treatment strategies, tailor responses, develop staff safety strategies and examine and debriefing interventions or critical events.

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

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

report for ongoing situational awareness and tools to mitigate the risk of patient and staff injury.

11.4 Special Population Considerations

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

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

11.5 Effective Patient Care

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

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

11.6 Administrative and Engineering Controls, Work Practices, Security

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

11.6.1 Administrative Controls

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

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

11.6.2 Environmental Controls

Environmental controls include:

- Entrance security (locks)
- A system of visitor or contractor access control
- Identification badges worn by all Western 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

Western State Hospital has one Violence Reduction Team (VRT) and two (Civil/CFS) Psychiatric Emergency Response Teams (PERT) that report to the WSH Violence Reduction Manager. These two teams are additional resources to be used by the hospital when necessary to assist with reducing violence throughout the hospital.

VRT is an interdisciplinary team extensively trained in crisis intervention skills, incident management, analysis of antecedents for violence and aggression, and de-escalation techniques. VRT provides the below resources to the hospital:

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

The Psychiatric Emergency Response Team (PERT) is designed as a first-responder system to promote a culture of safety for patients and staff. This highly skilled team is trained in crisis intervention skills, incident management skills, analysis of the antecedents for violence and aggression, and de-escalation techniques.

When containment is necessary, this team will facilitate seclusion and restraint if necessary, and work with floor staff to re-integrate the patient back to the ward environment, utilizing appropriate evidence-based practice. When not actively responding to incidents, team members provide direct, therapeutic engagement with patients, often modeling best practices for staff.

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

11.6.4 Security

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

11.7 Support to Employees

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

All employees injured at work have access to first aid measures and emergency medical response. In the event that an employee sustains a more serious injury, the supervisor assists the employee to obtain additional medical attention if indicated.

Supervisors provide employees who are victims of workplace or domestic violence information regarding resources including access to the Employee Assistance Program for counseling and referral on an individual and confidential basis. A Critical Incident Stress Management (CISM) team is in place and may be initiated to provide assistance to staff on a voluntary basis to individuals, team members or as a group who have been impacted by workplace violence.

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

The Department of Social and Health Services (DSHS) must report annually to the House Committee on Commerce and Labor and the Senate Committee on Commerce and Trade on the Department's efforts to reduce violence in state hospitals (RCW 72.23.451). This report, "Workplace Safety in State Hospitals" encompasses all three state hospitals, Eastern State, Western State and Child

Study and Treatment Center and is submitted to the Legislature by September 1 of each year.

11.9 Training to Reduce Workplace Violence

Patient care staff is trained at hire and annually in prevention practices that include, but are not limited to: strategies for effective communication, situational awareness of the environment, ongoing risk assessment, understanding baseline behavior, safe application of restraints, defensive tactics, preventing patient abuse and neglect and how to operate emergency equipment.

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

11.10 Data and Surveys Addressing Workplace Violence

Data Review:

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

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

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

Workplace Safety Surveys:

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

12.0 WORKPLACE SAFETY GOALS AND PERFORMANCE IMPROVEMENT (PI)

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

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

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

13.0 WORKPLACE SAFETY PLAN – ANNUAL EVALUATION

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

Western State Hospital

Appendix A: Workplace Safety Plan

June, 2021

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

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
<p>(a) The physical attributes of the state hospital including:</p> <ol style="list-style-type: none"> 1. Access control 2. Egress control 3. Door locks 	<p>In FY 21, an annual Security Assessment was completed and no new areas for improvement were found that addressed access, egress and door locks.</p>	<p>Access/Egress N/A for July 2020 thru June 2021</p> <p>Door Locks: N/A for July 2020 thru June 2021</p>
<p>(a) The physical attributes of the state hospital including:</p> <ol style="list-style-type: none"> 4. Nurse Station Enclosure Project 	<p><u>Nurses Station Enclosure Project:</u> Due to several recent incidents of patients climbing over nurses stations and injuring staff, a decision was made to enclose all nurses station throughout campus</p>	<p>Nurse Station Enclosure Project: Ongoing: The following Nurse Station Enclosures were completed this past year (FY 21): Wards C-5, C-6, C-3, E-5, S-7, C-7, C-8, S-8</p> <p>The following Wards are scheduled to be completed by August 30, 2021: Wards W1N, W1S, C-2, S-3, S-4 and S-5.</p>
<p>(a) The physical attributes of the state hospital including:</p> <ol style="list-style-type: none"> 5. New Fire System(s) 	<p><u>New Fire System(s):</u> New Fire Systems were installed in Building 17 due to aging system</p> <p>20-416 WSH-Multi Bldg.: Fire Door Replacement</p> <p>Upgrade to Fire Alarm Notification System with new Head in</p>	<p><u>New Fire System(s) New:</u> New Fire Systems were installed in Building 17. This project began in October 2020 and passed the Final Fire Inspection on April 1, 2021.</p> <p>Fire Door replacement project in multiple buildings is still in the design phase. There is a potential construction start date listed of 08/2021. However, currently, it is unknown how many doors will be replaced as the project is still in design and OCP has not shared the print set.</p> <p>The start date for the Upgrade to the Fire Alarm notification system with new head replacement</p>

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
	replacement (Back bone upgrade). Campus Wide	(campus wide) still needs to be determined. Building 18 is where head in equipment is located. This project will require long periods of power outages that will be coordinated with the Hospital. It has been in design phase since 2020.
<p>(a) The physical attributes of the state hospital including: 6. Patient Safety Projects</p>	<p><u>Patient Safety Projects:</u></p> <p>Building 22 (Support Services Building) was completed in late 2020/early 2021.</p> <p>Wards E-3 and E-4 were totally gutted and remodeled for a Forensic population. This included exterior fencing to Building 29 South. These projects were completed in March 2021.</p> <p>The start of two new Forensic Ward addition to Building 28, Wards F-9 and F-10 began construction in September 2020</p> <p>CFS Building 29 Entry Project began in 2020.</p> <p>A new East Campus Treatment mall is needed in order to provide active treatment for Forensic population that will be housed in Building 29.</p>	<p>Patient Safety Projects- On-going:</p> <p>Building 22 the Support Services Building that will house Main Kitchen, Commissary, Central Services and Pharmacy was completed. Kitchen moved into the new facility in March 2021.</p> <p>Ward E3 and E4's remodel was completed and Exterior Fencing upgrade to Building 29 South was completed</p> <p>Ward F-9 and F-10 construction has begun.</p> <p>CFS Building 29, Entry Project is under construction and scheduled to be completed May 24, 2021.</p> <p>Design for new East Campus Treatment Mall was completed and sent to City of Lakewood for approval. Approval has now been given. Full funding has been appropriated and construction should begin in January 04 2022.</p>
<p>(a) The physical attributes of the state hospital including: 8. Elevator Modernization</p>	<p><u>Elevator Modernization:</u></p> <p>Elevator Project was designed to modernize the following Elevators: Building 21 Elevator 21-1 Building 9 Elevator 9-1 Building 29 Elevators 29 – 1, 29-2, 29-3, 29-4.</p>	<p>Elevator Modernization:</p> <p>The Elevator modernization will begin in June 2021. Please note that Building 21 Elevators 21-2 and 21-3 were removed from this project due to the building being scheduled to be demolished.</p>
<p>a) The physical</p>	<p><u>Additional paved areas:</u></p>	<p>Additional Paved Area:</p>

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
attributes of the state hospital including: 9. Paved parking lots	The gravel parking lot that serves CFS is full of pot holes. Needs regrading.	The gravel parking lot that serves CFS was professionally regraded and compacted. Asphalt skirting was added to the entry way of the parking lot in April of 2021.
(b) Staffing, including security staffing	<p><u>Nursing/Medical Staff :</u> Coverage for nursing staff for all wards has been difficult given vacancies</p> <p><u>Nursing/Medical positions are difficult to fill at WSH.</u> Due to national shortage of nursing/medical staff and competition with the private sector, many nursing positions have been difficult to fill. This continues to be a challenge.</p> <p><u>Acuity Staffing Model:</u> Hospital Acuity Resource Tool, (HART) has been developed and continues to be implemented for both Eastern and Western state hospitals. All future funding for direct care staffing will be tied to this acuity tool and the data it generates over time.</p>	<p><u>Nursing/Medical Staff:</u> WSH hospital currently to struggle with recruitment. We have continued to use the recruitment team to assist with talent acquisition.</p> <p><u>Nursing/Medical Positions Difficult to Fill:</u> We continue to use traveling nurse contactors to supplement RN vacancies.</p> <p>We have started pilots exploring the 'zoning' method of distributing staff as it has previously been successful for optimizing the use of direct care staff.</p> <p><u>Acuity Staffing Model:</u> Beginning March 2020, the HART Acuity Model required 2 RN2s every day, every shift. Data being collected over multiple years to allow extensive analysis of staffing trends and will inform future staffing recommendations at both hospitals. We are still in the data collection component of this process.</p>
(c) Personnel policies	<u>The WSH Policy Committee,</u> Policies are currently updated at WSH using manual type system.	<u>WSH Policies and Procedures:</u> New software was purchased by DSHS-Behavioral Health Administration to assist all areas of BHA with updating their policies. The software purchased is designed to allow for efficient distribution of policies, manuals and forms. Streamlining our policies and how we update them helps contribute to BHA/WSH overall quality assurance goals. The new system was launched at WSH in January 2021.
(d) First aid and emergency	<u>Emergency Preparedness:</u> The Emergency Preparedness Program was evaluated by CSM and the WSH Quality Team. It was determined that all but three CMS standards were met. The remaining three were partially met	<u>Emergency Preparedness:</u> WSH continues to participate and plan with our community partners to include the Northwest Healthcare Response Network, West Pierce Emergency Management Coalition and others when situations arise. The local WSH Emergency Management Committee

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
	<p>are currently being improved upon. The EPP continues to meet and in cases exceed the minimum requirements set forth by CMS with regard to emergency preparedness.</p> <p>There are three areas Emergency Management will improve in the next year to be compliant in all standards.</p> <p>E 0032, 007 More specific directions in ward evacuations and inclusive of access and functional needs.</p> <p>E 00320 A common way to account for staff after an emergency incident or natural disaster.</p> <p>E 0036 Update all curriculum that exist in NEO, Nursing Incident Management and Emergency Preparedness Plan, annual on-line course.</p>	<p>(EMC) reviewed, updated and accepted the Hazardous Vulnerability Assessment, this was updated March 2021.</p> <p>The WSH EPC conducted an annual review and update of the Comprehensive Emergency Management Plan (CEMP). The plan is current as of December 2020. Emergency planning is based on an all-hazards approach as a result of the risks identified.</p> <p>The Continuity of Operations (COOP) plan's annual review was conducted and updated August 2020 with new names, titles and contact information.</p> <p>The Administrator on Duty (AOD) manual was reviewed and updated January 2021.</p> <p>July 2020 – June 2021, there were 12 activations of the Hospital Command Center during this period. 8 emergency incidents occurred and 3 activations were for event planning.</p> <p><u>The emergency incidents consisted of:</u> Ward flooding, TPU Power Outage, South Hall Security Breach, Patient Death, Water Main Break, Covid-19 and Patient UL.</p> <p><u>Pre-planned events were:</u> Dietary Disruption Planning, Novel Coronavirus Outbreak, Power Outage-Electrical repair (x2) and a planned protest at Fort Steilacoom Park.</p> <p><i>The HCC was activated in stand-by mode when there were cascading incidents within the incident. Having ICS on hand and in place shortened the amount of time it took to get back to normal operations.</i></p> <p>Due to the COVID-19 Pandemic, most HCC operations were conducted via ZOOM. ZOOM or any telephone conferencing is not a preferred method for managing emergency incidents.</p> <p><u>Emergency exercises consisted of:</u> Emergency exercises conducted: Great Shake Out (earthquake), AOD Tabletop Exercise and a shelter in place exercise for a spontaneous Police Action</p>

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
		<p>incident.</p> <p>Quarterly reporting to the Quality Performance Review committee regarding the percentage of Improvement Action items completed or receiving action from After Action Reports. The After Action Reports are conducted after planned events, real incidents and emergency exercises. The target is 90% completions or active issues. The percentage varied from 92%-94%. Many of the completions and activity on issues took place during COVID-19 responses.</p>
<p>(e) Reporting violent acts, taking appropriate action in response to violent acts, and follow-up procedures after violent acts:</p>	<p><u>Reporting Violent Acts:</u></p> <p><u>Violence Reduction (VRT) Team:</u> To reduce Violence on the wards, the VRT in FY 21 continues to review all assaults and offers nursing staff preventative strategies, behavioral interventions, training/mentoring and coaching, when necessary, to mitigate future assaults.</p>	<p><u>Violence Reduction Team (VRT)</u> The Violence Reduction Team (VRT) is multidisciplinary team that specializes in the development and implementation of interventions rooted in evidence-based practices to provide support on wards experiencing higher rates of violence. Members of the VRT are highly skilled and trained in crisis intervention, incident management, de-escalation, and behavioral analysis. We work collaboratively with treatment teams and ward staff to assess factors associated with aggression and to identify specific strategies and interventions to mitigate these factors.</p> <p><u>VRT Operations:</u></p> <ul style="list-style-type: none"> • Review all incidents of assault across the hospital daily as captured by Administrative Reports of Incident (AROs), Security Incident Reports (SIRs), and the Nurse Manager Report • Perform daily functional behavior assessments in the format of an ABC (Antecedent – Behavior – Consequence) chart to ascertain the purpose or function of the assaultive behavior • Formulate evidenced-based interventions for mitigating assaultive behavior based on the identified function of the assaultive behavior and provide these recommendations to treatment teams and ward staff • Review data from AROs, SIRs, and Tableau

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
	<p><u>Psychiatric Emergency Response Team (PERT):</u> PERT continues to assist with providing a safe, effective, and immediate plan of response for patients in psychiatric crisis or anticipated crisis. PERT works with Nursing in a coordinated effort to create a process of managing conflict safely in an atmosphere of recovery.</p>	<p>to monitor trends and changes pertaining to assault, seclusion, and restraint rates</p> <ul style="list-style-type: none"> • Provide individual behavior support and therapeutic engagement to patients who consistently engage in assaultive behaviors to <ul style="list-style-type: none"> ○ Identify triggers of aggression and, ○ Support the development of effective coping skills to reduce the number of assaultive incidents • Consult with treatment teams (as requested) and offer evidenced-based strategies for both individual and milieu intervention • Provide milieu support on wards experiencing higher acuity and, <ul style="list-style-type: none"> ○ Assess the milieu for early signs of crisis and offer immediate intervention ○ Assess the dynamics of the ward and identify possible environmental or systemic factors contributing to violence <p>Offer mentoring and coaching to ward staff on verbal de-escalation skills at taught through Advanced Crisis Intervention Team (ACIT) training and Crisis Prevention Institute (CPI) training.</p> <p>PERT: Safety continues to be the primary goal of the PERT. Verbal intervention tools such as VDSP are utilized prior to physical restraint techniques with the understanding that PERT will always use the least-to-most method. Physical restraint techniques will only be considered as a last resort and must be directed by the Charge Nurse, and will only be utilized when able to be performed as safely as possible. Once the call is made for restraints, PERT will hand off to ward staff or security for restraint application unless there is imminent danger. PERT members are trained in ACIT, CPI, and work closely with ward staff and treatment teams to assist patients in crisis.</p> <p>Civil/CFS PERT Team:</p> <ul style="list-style-type: none"> • Responds to all requests for PERT. • Identifies high acuity “hot-spots” and allocate resources accordingly. • Conduct rounds to assess ward milieu. • Check-in with Charge RN2 to discuss any

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
		<p>potential problematic patients on the ward.</p> <ul style="list-style-type: none"> • Provide therapeutic presence in “hot-spot” areas. • Support floor staff using VDSP method to de-escalate patients in crisis. • Engage patients to build rapport and trust. • Assist in turning IM back-up meds into a PO PRN. • Provide floor staff support for blood draws. • Respond to code Gray. • Assist floor staff with seclusion/restraints. • Respond to code Red, drills, and rapid response. • Assist staff clearing ward rooms and getting patients to safety during code Red. • Provide crowd control during rapid response. • Provide milieu management during ward search. • Support treatment teams during treatment meetings with patients. • Support staff with patients when delivering unfavorable news. • Assist staff with patient COVID testing. • Assist staff transferring positive patients to COVID ward. • Assist staff with problematic patient transfers. • Review Nurse Manager Report to identify high acuity patients/wards.
<p>(e) Reporting violent acts, Analysis of data on violence and workers compensation claims during at least the preceding year</p>	<p><u>Reporting Violent Acts:</u> WSH continues to manage the Critical Risk Management Team, and Safety Committees to assist with ensuring appropriate action in response to violent acts and follow-up procedures after violent acts are completed</p> <p><u>WSH’s Safety Committees:</u> The committees continue to review injury data and L&I claims information on a monthly basis to identify where the injuries are occurring and help formulate prevention recommendations on</p>	<p><u>Ongoing:</u> CRMT continues to review incident reports for patient safety concerns and WSH’s Safety Committees continue to review violent acts, injury & assault data and LNI claim information to follow up on safety concerns and staff injury prevention recommendations in order to create a safer environment for all.</p> <p><u>Update/New:</u> Safety Committees: The safety committees at WSH have been restructured to ensure all safety concerns are appropriately addressed. Everyone at WSH has the ability to bring safety issues up through their respective Center level safety committees by</p>

Security Consideration RCW 72.23.400(1)	Assessment	Preventative Action(s)
	<p>an on-going basis. Data is also captured and presented to WSH Safety Committee on a monthly basis.</p> <p><u>Tableau Reports:</u> Tableau Dashboards have been created to assist the hospital with focusing its efforts on increasing the availability and transparency of data at the hospital to ensure it is making data-driven decisions to improve patient and staff outcomes.</p>	<p>either e-mailing their safety issues to the WSH Safety Concerns e-mail or, by reporting them to the safety office and/or safety committee members. Any safety issues brought up that cannot be resolved at the center level are reported to Hospital-wide safety committee. The hospital-wide committee reviews all concerns that have been rolled up from the center levels and assigns responsible parties to ensure action plans to address these concerns are completed. Information is communicated back down to the center levels committees, for a top-down and bottom-up communication chain.</p> <p>Recommendations or concerns brought to the committee by employees are reviewed and the status of action plans is documented in the Employee Safety committee minutes.</p> <p><u>Tableau and Data Reports:</u> The hospital continues to use Tableau as a data visualization tool. Center Directors, Cabinet, and other staff on the leadership staff have been granted licenses for Tableau, which allows them to track data for their wards and centers, and drill down the data to identify patterns and trends. When these patterns and trends are identified, they can be addressed in order to prevent similar incidences from occurring in the future. Additional key staff, such as VRT members, has been granted licenses as well, ensuring that data is easily accessed and readily available for analysis.</p> <p>Data reports are also created on a monthly basis and posted to the Research, Evaluation, & Data Analysis (REDA) Office's SharePoint page, which is available to all WSH employees. The REDA Office has been focusing its efforts on increasing the availability and transparency of data at the hospital to ensure it is making data-driven decisions to improve patient and staff outcomes. Hospital-wide data trends for assaults and injuries are presented monthly at the Safety Committee meeting, in relation to our targets to assess our performance.</p>

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(f) Development of criteria for determining and reporting verbal threats.	<p><u>Reporting Verbal Threats:</u> Verbal threats continue to be tracked and reviewed to ensure appropriate actions and follow-up procedures are taken.</p>	<p><u>Ongoing:</u> Verbal threats continue to be tracked using the Security Incident Report and/or the Administrative Report of Incident and reviewed in the Critical Risk Management Office to ensure appropriate actions and follow-up procedures are taken in response to verbal threats.</p> <p>Verbal threats are also provided in Tableau in the incident report dashboard so they can be tracked, trended, and analyzed by key staff. REDA staff follow strict coding guidelines and procedures to ensure all incidents are coded the same way, based on established coding criteria and definitions.</p>
(g) Employee Education and Training	<p><u>Organizational Development:</u> In FY21, education and training continued to provide to New Employee Orientation (NEO) CPI, Personal Safety courses, and Advanced Crisis Intervention Training (ACIT).</p>	<p><u>Training Overview:</u></p> <ul style="list-style-type: none"> • The nationally known Crisis Prevention Intervention (CPI) Training Program was implemented in 2018. This and Advanced Crisis Intervention Training (ACIT) is delivered to all new hires in NEO with competencies for both. • Annual In-Service (AIS) launched in January 2020 to provide ongoing safety/violence prevention training to all direct-care employees. It is offered on dayshift and on evening and night shifts on a rotating basis every six months. AIS includes courses on personal safety, small team tactics, CPI, and ACIT. <p><u>Since July 2020, the Organizational Development (OD) department has experienced the following:</u></p> <ul style="list-style-type: none"> • Provided training plans and certified in-house Safety Trainers in ACIT, CPI, and BLS/CPR. • Provided AIS training to all three shift for a year. • Trained over 500 employees in ACIT total, over 450 in CPI, and over 550 in AIS total to-date. This includes current and exited staff. • Conducted 83 cohorts of varied NEO programs 2wk General NEO, 1wk Clinical NEO, 1wk Pharmacy NEO, 1day Affiliated Partner NEO, • Through use of outside curriculum development company, in-house curriculum development, writers, and subject matter experts (SMEs) have revamped nearly 90% of all currently used courses. • Certified all IC3 trainers as Basic Life Support (BLS/CPR) instructors. They are providing BLS/CPR renewal courses on all three shifts.

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		<ul style="list-style-type: none"> • Incorporated an additional dose of Physical Intervention and Restraint Application training for Clinical NEO. • Partnered with the BHA headquarters and an outside production company to build and implement a Virtual Reality training program that is being offered as part of NEO. • Partnered with the WSH Lean Department to offer Zoom introductory LEAN courses. • To identify and address training needs: OD staff continue to attend the ward-level Safety Committee meetings, OD managers are attending center-level Ward Safety Committee meetings, and the Director of OD is attending the hospital-wide Safety Committee meetings. • Training noncompliance reporting continues and helps supervisors identify staff that has not completed mandatory training. Reports are shared with leadership for follow up and addressing noncompliance. This process assisted WSH in gaining significant compliance with the DSHS Diversity and Cultural Competence course.
<p>(h) Clinical and patient policies and procedures including those related to: 1. Smoking</p>	<p><u>Smoking: (Smoke Free)</u> Policy 4.05 Tobacco use, continues to be in place in all patient care areas. Patients are not permitted to use tobacco or electronic smoking devices on WSH grounds.</p>	<p><u>Smoking:</u> WSH's Smoke free initiative (initiated May 2019) to reduce violence related to staff demands is still in place with no negative impacts after 2 years after implementation.</p>
<p>(h) Clinical and patient policies and procedures including those related to: 2. Activity, leisure and therapeutic programs Vocation – 02.12</p> <p>Occupational</p>	<p><u>Treatment Services/Rehab:</u></p> <p><u>Vocational program:</u> Vocational Training Site in Central/Civil treatment mall with a mid-summer 2021 estimated launch. Policies and Procedures for this program are guided by treatment P&P's.</p> <p>Occupational Therapy:</p>	<p><u>Treatment Services/Rehab:</u></p> <p><u>Vocational program:</u></p> <ul style="list-style-type: none"> • No changes to policy or procedure. • Patient vocational opportunities are available only to the degree allowed under BHA/ Safe Start associated with on-going Covid-19 restrictions. • New vocational training center operating procedures are in progress. • Policies and Procedures that govern vocational programming include: 02.12. If changes are made to the CFS level system this policy will require revision. <p>Occupational Therapy (OT):</p>

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<p>Therapy- 8.12 (4.2.4) changed to 10.17</p> <p>Substance Use Disorders – Policy 15.04 changed to 02.130</p> <p>Policy 15.05 changed to 02.131</p> <p>Policy 15.06 changed to 02.133</p> <p>Policy 15.07 changed to 02.132</p>	<p>Mental Health OT programs remain unchanged this year and are governed by policy as it related to mental health treatment and treatment malls. Physical Function OT programs continue to provide services with no change to policy or procedure.</p> <p>Substance Use Disorders: No changes to program or policies in FY 21. The program meets CMS standards and DOH licensure. The program remains at 4 staff and utilizes other WSH rehab staff who are licensed for SUD to assist if available and able to complete assessment training through the SUD department. Continued challenges with meeting consultation requests (CRTS) remain the same as this is a function of staffing for the department.</p>	<ul style="list-style-type: none"> • Changed the dashboards for OT & SLP to reflect Patient Satisfaction Survey results to the Quality Council (August 2020). • Created a multi-disciplinary Choking Committee (Nov 2021-Present) to address Speech Language Pathology concerns. • Updated all of the OT Practitioners’ Position Description Form (Dec. 2020). • Collaborated with PT, SLP, and other OTPs to update the 30 Days Recertification Form for Physical Rehab services (May 2021). • Reduced the number of position types through re-allocation process to manage confusion over duties/PDFs. <p>Substance Use Disorders:</p> <ul style="list-style-type: none"> • No changes to policy, procedure or services within the SUD program. • Policies that govern the SUD program continue as: <ul style="list-style-type: none"> ▪ policy 15.04 changed to 02.130 ▪ policy 15.05 changed to 02.131 ▪ policy 15.06 changed to 02.133 ▪ policy 15.07 changed to 02.132
<p>(h) Clinical and patient policies and procedures including those related to: 3. Communication between shifts</p>	<p>Communication between shifts: Communication between shifts has been impacted by the COVID-19 pandemic.</p>	<p>Communication between shifts: WSH continues to explore different ways to meet the need and improve the communication that is provided between shifts given the restrictions imposed by COVID-19</p>

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<p>(h) Clinical and patient policies and procedures including those related to: 4. Restraint and seclusion</p>	<p><u>Seclusion and Restraint:</u> Assessment of seclusion and restraint process is on-going to enhance the safety for the patient and staff</p>	<p><u>Seclusion and Restraint:</u> WSH continues to assess the hospitals seclusion restraint process to enhance safety for patients and staff. In FY 20, the hospital did the following to assist staff in reducing the use of seclusion and restraint</p> <ul style="list-style-type: none"> • Instituted more leadership presence in monitoring the process by reporting all seclusion or restrain events that were over 24 hours to cabinet for their input • Started two new seclusion and restraint improvement projects: one focused on rate reduction and the other on compliance to best practice/compliance. • Currently piloting the use of a wheeled restraint chair. The hospital is in the process of evaluating weather this product would be better for patient and staff safety • Ongoing ad hoc training for staff on Seclusion and restraint. • More training on de-escalation techniques has been ongoing.
<p>h) Clinical and patient policies and procedures including those related to: 5. Specialized Treatment Assessment and Recovery (STAR) & Step up Wards</p>	<p><u>Specialized Treatment Assessment and Recovery, (STAR) Ward:</u> The STAR ward was developed with comprehensive programming to address violence and antisocial behavior by staff with specialized training. Individuals with the highest violence are treated on this ward.</p> <p>STAR ward opened in Feb. 2020. The Step-up ward was planned to be mobilized in calendar year 2020. The step up ward on C4 opened very briefly for 1 week in 2020 (9/8/20-9/16/2020)</p> <p>As of May 2021, the STEP Up C4 ward is not open as the ward is currently occupied by E2 HB1114 due to construction/space issues at the hospital.</p>	<p><u>STAR Ward:</u> The Mission and Goal of the STAR ward is to reduce violence by providing individualized, evidence based treatment to empower patients to safely manage their lives.</p> <p><u>Violence Reduction Goals:</u> Decrease the rate of assaults for the hospital, centers, wards, and individual patients. In calendar year 2020, assault rates overall were reduced by approximately 5.2% when compared to calendar year 2019.</p> <p>Reduce the rate of violence for STAR ward patients by 50% during their stay on the STAR ward.</p> <p><u>Triad- Leadership</u> The STAR Program Director is tracking all assaults on the ward/AROI's, responding to violent acts, ensures hospital policies are followed and treatment team/staff debrief discuss alternative options for clinical interventions-implement interventions.</p> <p><u>Training Administrator-</u> Continues ongoing training to ensure newly hired staff receive the initial STAR Training to prepare them for working C1/C4.</p>

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		<p>Registered Nurse 4- oversees nursing staff, present providing training on nursing documentation, and training staff on the ward nursing procedures.</p> <p>Leadership is also available on the floor to assist, coach, mentor and train staff on a daily basis all three shifts when needed.</p> <p>Individualized treatment:</p> <ul style="list-style-type: none"> • Using a third party to review patient records for individualized treatment plans, (at least 80% compliance for 3 months, 95% thereafter). CSM completed first review verbal report that there were no deficiencies in treatment plans or timeliness. • C1 treatment plans are completed every 30 days vs 90 to ensure timely/accurate interventions are implemented to address behaviors. • Patient survey to measure feedback on treatment individualization. Survey has been completed and C1 received 72 surveys back from patients willing to complete the survey. • (80 % of the patients participate in the survey monthly- of the 2 that do not one patient consistently declines to participate, #2 rotates) • Treatment team is looking at underlying causes of trauma that may be contributing factors to violence and incorporate the <u>6</u> key elements of trauma informed care- • Safety. • Trustworthiness & transparency. • Peer support. • Collaboration & mutuality. • Empowerment & choice. • Cultural, historical & gender issues. • Realizing the prevalence and widespread impact of trauma on patients residing on C1 • Recognizing the signs and symptoms of trauma in the patients we treat • Responds by fully integrating knowledge about trauma into how we interact with our patients <p>ALL STAFF ARE TRAINED IN CPI- Nonviolent Crisis</p>

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		<p>Prevention Intervention training teaches safe, respectful and non-invasive management of disruptive and assaultive behaviors.</p> <p>Evidenced Based Practices-</p> <ul style="list-style-type: none"> • All Staff introduced to MRT Moral Resonation Therapy- MRT is a cognitive-behavioral treatment system that leads to enhanced moral reasoning, better decision making, and more appropriate behavior and • ACT-Acceptance commitment therapy-The theory behind ACT is that it is not only ineffective, but often counterproductive, to try to control painful emotions or psychological experiences, because suppression of these feelings ultimately leads to more distress. ACT adopts the view that there are valid alternatives to trying to change the way you think, and these include mindful behavior, attention to personal values, and commitment to action. By taking steps to change their behavior while, at the same time, learning to accept their psychological experiences, clients can eventually change their attitude and emotional state. <p>(Initial Trainers were from outside of WSH)</p> <ul style="list-style-type: none"> • Staff trained/introduced in EBP 100% # of staff 161- this includes VRT/PERT Staff, Hospital on call staff, and Agency nurses • Evaluate fidelity of staff implementation of EBP's (e.g., with a third party fidelity checklist with at least 50% compliance). • MRT provided fidelity checklist/ACT checklist was modeled off MRT for consistency. This is based upon the expectation of necessary variances in approach due to patient behavior and Milieu events. • Staff competency checks are completed in EBP practices, progress notes, and treatment plans • Anonymous Staff surveys are done every 3 months- STAR Ward Program Director created the following badge size cards in response to survey answers- STAR mission statement, fire safety cards, culture of safety, LRA, comments grievances and resolutions

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		<p>as well as Infection control hand washing</p> <ul style="list-style-type: none"> • STAR Leadership worked with NEO staff to get more training offered on the ward 50 staff trained. <p>Celebrations:</p> <ul style="list-style-type: none"> • C1 has discharged 4 patients and one is discharging within 30 days • Of the 4 patients discharge none have returned to the hospital this demonstrates reduced recidivism rates Patient 31 DC/d August 2020 Patient #2 DC/d August 2020 Patient #3 DC/d December 2020 Patient #4 DC/d February 2021 • 3 patients have received their food handlers card • Currently one patient has a level 3 (in total 7 have held a level 3) • One patient is working on his GED/ABE with PC instructor • All staff meetings held across all 3 shifts- safety and communication focused • 1 Patient is holding a vocational employment position • 10 patients have family involvement despite challenging times and limited visits due to COVID • Specialized Psychological testing has been done with the ward Psychologist • Psychiatrist completed DNA testing to look at genetic factors and diet/contributors to behaviors • Institutional counselors are utilizing all purchased materials and developing lesson plans to ensure readiness for more groups when opening C4 • Psychology Associates are meeting on a daily basis with their caseloads
<p>h) Clinical and patient policies and procedures including those related to: 5. Response to COVID-19</p>	<p>COVID-19 Response: WSH developed an action plan in coordination with the State Department of Health and the Behavioral Health Administration in response to COVID-19</p>	<p>WSH's COVID – 19 Action Plan:</p> <ul style="list-style-type: none"> • Continue to maintain an isolation ward for COVID-19 positive patients • Continue to use attestation station and for all hospital staff • Minimized ward movement to limit potential spread • Use Contact tracing to refine testing

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		<ul style="list-style-type: none"> • Continue with targeted patient and staff testing for COVID-19 • Continue to require mandatory face masks for all staff while working at WSH • Started and continue the use of eye protection for staff in area(s) with COVID-19 activity • Started and continue to administer Covid-19 vaccines to staff and patients <p>Participated in the safe start program and changed hospital operations to align with directive in the safe start plan to include use of COVID-19 preventive measures</p>