

Report to the Legislature

Workplace Safety in State Hospitals

House Bill 1160, Chapter 187
Laws of 2005, Section 1

September 1, 2014

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Background

The Behavioral Health and Service Integration Administration (BHSIA) within the Department of Social and Health Services (DSHS) provides prevention, intervention, inpatient treatment, outpatient treatment and recovery support to people with addiction and mental health needs.

BHSIA operates three state psychiatric hospitals. Eastern State Hospital and Western State Hospital deliver high quality inpatient psychiatric care to adults who have been committed through the civil or criminal court system for treatment and/or competency restoration services. The Child Study and Treatment Center provides high quality inpatient psychiatric care and education to children ages 5 to 17 that cannot be served in less restrictive settings in the community due to their complex needs. The hospital locations and bed capacities are:

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

Eastern State Hospital (ESH): located in Medical Lake, Washington, has a capacity of 287 beds; 192 for civil commitments and 95 for forensics patients.

Western State Hospital (WSH): located in Lakewood, Washington, has a capacity of 827 beds; 557 for civil commitments and 270 for forensics patients.

Creating a safe working environment in the state hospitals is a top priority for DSHS, BHSIA and leadership of all three state hospitals. The state hospitals are committed to engaging in collaborative partnerships with stakeholders including the Department of Labor and Industries (L&I) and local labor unions in efforts to prevent and reduce workplace violence and protect employees.

Chapter RCW 72.23.400 -Workplace Safety Plan requires each state hospital to develop a plan to reasonably prevent and protect their employees from violence and directs the Department of Social and Health Services (DSHS) to evaluate, review and amend the plans as necessary, at least annually, and to include specified security considerations.

Chapter RCW 72.23.451 – Annual report to the Legislature requires that by September 1st each year, the department shall report to the House Committee on Commerce and Labor and the Senate Committee on Commerce and Trade, or successor committees, on the department's efforts to reduce violence in state hospitals.

Annual Report Overview

Initial workplace safety plans from the three state hospitals were submitted to the legislature in November 2000 and have been evaluated, revised and updated annually. This report updates the state hospitals efforts to reduce violence for the time period of July 2013 through June 2014 and updates the workplace safety success measures tracked in the BHSIA Strategic Plan. Security considerations specified under RCW 72.23.400 are found in Appendix A. (CSTC), Appendix B. (ESH), and Appendix C. (WSH).

BHSIA 2013-2015 Strategic Plan and Success Measures

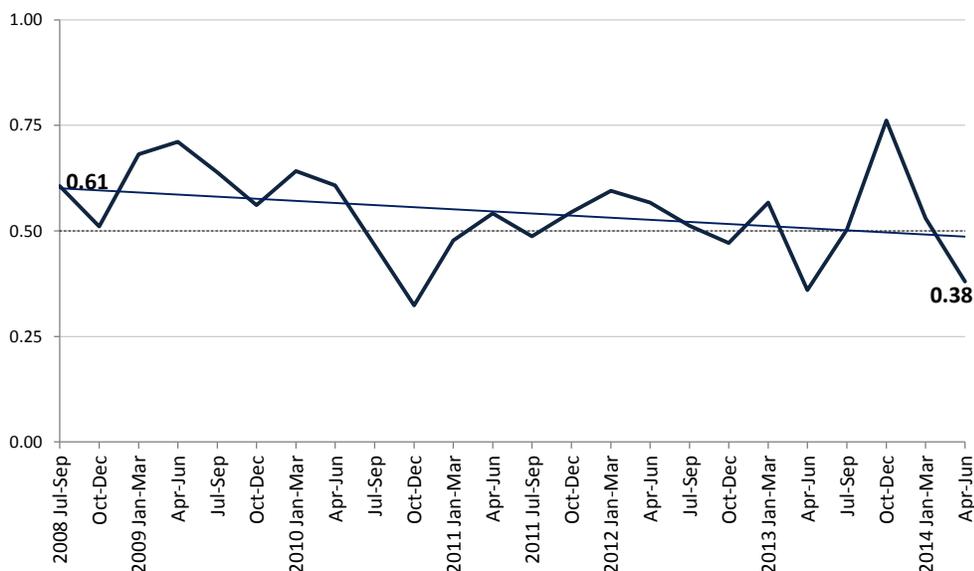
The BHSIA 2013-2015 Strategic Plan includes strategic objectives and success metrics designed to improve safety at the state hospitals and to reduce and prevent workplace violence. The following success measures are tracked by the Behavioral Health and Service Integration Administration (BHSIA) and reported to the Secretary of DSHS in support of the DSHS Goals of Health, Safety, Protection, Quality of Life and Public Trust:

Strategic Objective 1.7: Decrease the number of patient-to-staff assault claims filed at Eastern State Hospital, Western State Hospital, and the Child Study and Treatment Center

Reducing patient-to-staff assaults will increase staff safety and well-being, as well as reduce expenditures for workplace related injury claims. The success measure for this objective is to decrease the number of patient-to-staff assault claims filed at the three hospitals from the third quarter FY 2013 rate of 0.57 assaults per 1,000 patient days to 0.50 assaults per 1,000 patient days by June 30, 2015.

The following chart shows the rate of patient-to-staff assault claims filed at the three hospitals.

**Patient-to-staff assault claims filed at Eastern State Hospital,
Western State Hospital, and the Child Study and Treatment
Center per 1,000 patient days**



The hospitals were at or below the June 2015 target for three of the four quarters of Fiscal Year 2014. The increased rate during the October 2013 - December 2013, period is attributable to an increase in claims filed at all three hospitals during this quarter. There were no patient care related policy or practice changes that occurred during this period and as can be seen, the rate dropped back below the target in subsequent quarters and the trend line continues to decrease.

Strategic Objective 1.8: Decrease the quarterly rates of patient seclusion hours at Eastern State Hospital and Western State Hospital;

and,

Strategic Objective 1.9: Maintain the quarterly rates of restraint use at Eastern State Hospital and decrease the quarterly rates of restraint use at Western State Hospital

Reduced use of patient seclusion and restraint promotes a therapeutic recovery environment that results in fewer assaults by patients and lessens the need for physical interaction between the staff and patients thereby reducing the likelihood of injury.

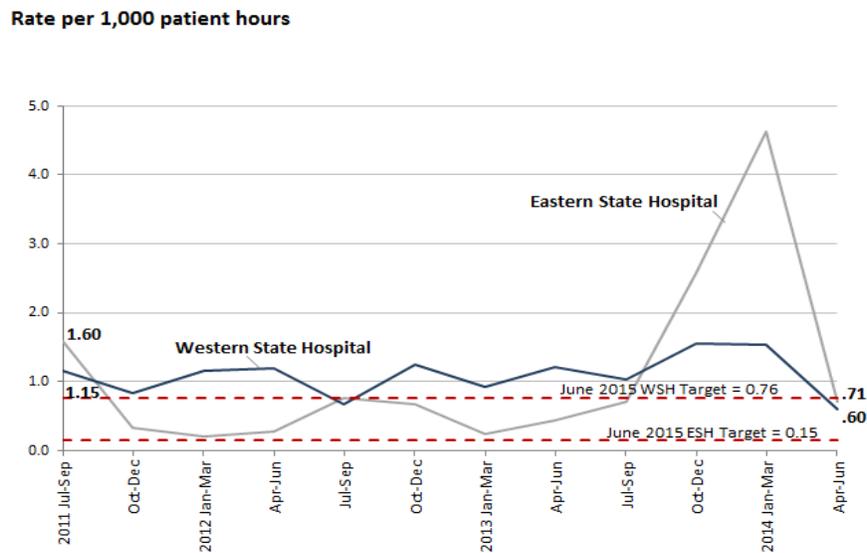
The success measures for **Strategic Objective 1.8** are to decrease the quarterly rates of seclusion hours at Eastern State Hospital from the fourth quarter FY 2013 rate of 0.24 per 1,000 patient hours to 0.15 by June 30, 2015, and to decrease the rates of seclusion at Western State Hospital from the fourth quarter FY 2013 rate of 1.05 hours per 1,000 inpatient hours to

0.76 by June 30, 2015.

The success measures for **Strategic Objective 1.9** are to maintain the quarterly rates of restraint hours at Eastern State Hospital at 0.17 per 1,000 patient hours and to decrease the quarterly rates of restraint hours at Western State Hospital from the fourth quarter FY 2012 average of 3.02 per 1,000 inpatient hours to 2.18 by June 30, 2015.

The following chart shows rates of patient seclusion at the two adult hospitals.

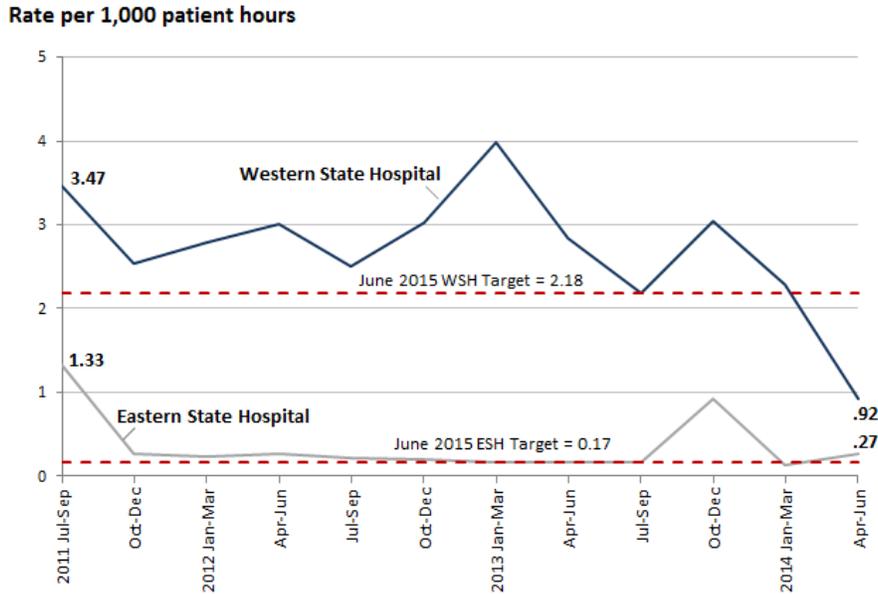
Seclusion hours per 1,000 patient hours at Eastern State Hospital and Western State Hospital



Western State Hospital is close to meeting the June 2015 target rate of 0.76, and did fall below the target for April 2014 - June 2014. Eastern State Hospital is also close to meeting its target; the January 2014 - March 2014, increase in hours of seclusion are primarily attributable to a single patient subsequently discharged in March 2014.

The following chart shows rates of patient restraint at the two adult hospitals.

Restraint hours per 1,000 patient hours at Eastern State Hospital and Western State Hospital



Although the rates at both hospitals increased in October 2013 - December 2013, Eastern State Hospital has maintained the target for most of the year and Western State Hospital's rates decreased to well below its target in January 2014 - March 2014 and reduced even further in April 2014 - June 2014.

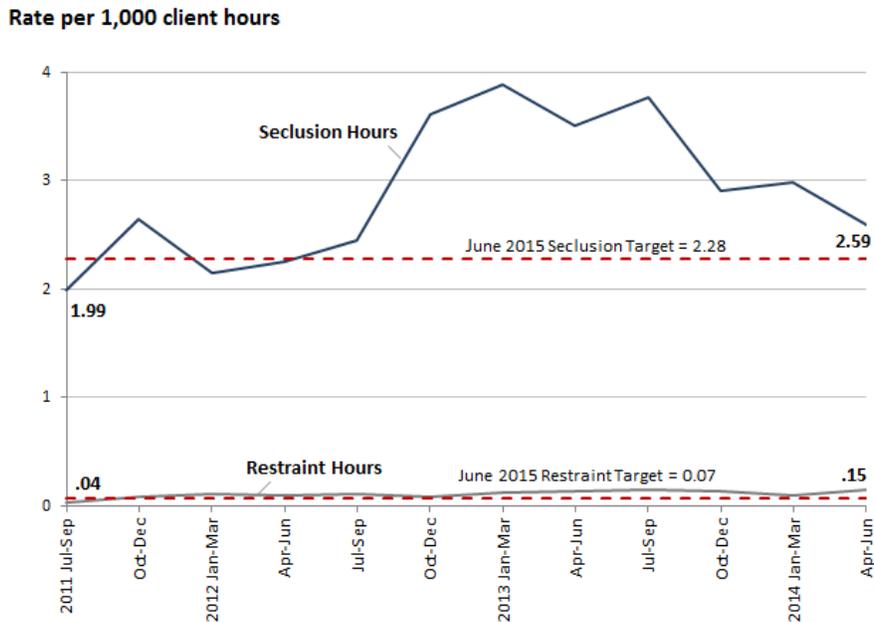
Strategic Objective 1.10: Decrease the quarterly rates of seclusion hours and restraint hours at the Child Study and Treatment Center

As with the adult hospitals, reduced rates of patient seclusion and restraint promote a therapeutic recovery environment that results in fewer assaults by patients.

The success measure for Strategic Objective 1.10 is to decrease the quarterly rate of seclusion hours from the fourth quarter FY 2013 rate of 3.69 per 1,000 patient hours to 2.28 per 1,000 patient hours by June 30, 2015; and maintain the quarterly rate of restraint hours at the third quarter FY 2013 rate of 0.07 per 1,000 patient hours.

The following chart shows rates of patient seclusion and restraint at the Child Study and Treatment Center.

Seclusion and restraint hours per 1,000 patient hours at the Child Study and Treatment Center



The rate of seclusion and restraint hours at CSTC steadily dropped during 2013 and into 2014, and with restraint maintaining at very close to the target for June 2015.

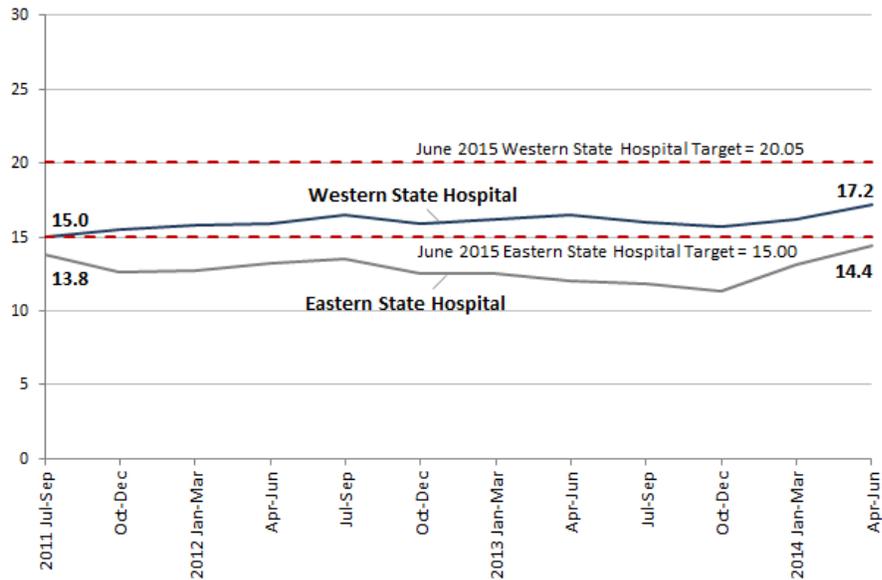
Strategic Objective 1.11: Increase the rates of active treatment hours delivered at Eastern State Hospital and Western State Hospital

Active treatment includes cognitive behavioral therapy, daily living skills, recreational activities and other programs and interactions which assist patients in achieving recovery. Active treatment contributes to a safe work environment and the reduction and prevention of workplace violence at the state hospitals.

The success measure for Strategic Objective 1.11 is to increase the average number of active treatment hours received per patient per week at Eastern State Hospital from the fourth quarter FY 2013 average of 12.01 to 15.00 hours by June 30, 2015; and increase the number of active treatment hours received per patient per week at Western State Hospital from the fourth quarter FY 2013 average of 15.85 hours to 20.05 by June 30, 2015.

The following chart shows rates of Active Treatment at the two adult hospitals.

Average active treatment hours per patient per 7 days at Eastern State Hospital and Western State Hospital
Rate per 7 patient days



The rate of active treatment hours at Eastern State Hospital has steadily increased in 2014 and came close to the June 2015 target in the April 2014 - June 2014, quarter. The rate of active treatment hours at Western State Hospital has gradually increased in 2014.

Violence Reduction Efforts - Update

Over the last year, in collaboration with key stakeholders, significant efforts have been undertaken by all three state hospitals to reduce violence, including:

Ad Hoc Safety Committee

In December 2013, BHSIA chartered the Ad Hoc Safety Committee, with the intent of reviewing previously published recommendations by L & I, The Joint Commission and consultations with identified experts for the reduction of violence at the state hospitals and to develop additional proposals for violence reduction.

Committee membership consists of hospital management and represented employees from BHSIA, WSH, ESH and CSTC, and representatives from Service Employees International Union (SEIU), Washington Federation of State Employees (WFSE) and Health Care 1199 Northwest, the Union of Physicians of Washington (UPW) Coalition. With a commitment to a transparent process and

opportunities for all staff to provide feedback, the Committee has prioritized the following goals:

1. Identify rapid improvement initiatives within current resources or with the reallocation of current resources;
2. Identify tangible actions that would reduce workplace violence over the next 24 months;
3. Identify safety and security initiatives that require legislative support and funding with a focus on staffing, staff training and the physical environment.

The committee developed recommendations for the reduction of violence, including enhanced staff training, expansion of the Psychiatric Emergency Response Team (PERT) at WSH, implementation of a PERT at ESH, creation of a Psychiatric Intensive Care Unit (PICU) at WSH to serve the critical care needs of patients from across the state, and establishment of safety-related support positions. The recommendations have resulted in decision packages that will be decided upon in the next legislative session

Safety Management/Accident Prevention Programs

Each hospital enhanced existing Safety Management/Accident Prevention Programs (APP). The programs, published in May, 2014, aligned the hospital safety management plans to comport with OSHA's Accident Prevention Program (APP). The APP also comports with applicable standards under The Joint Commission Standards, the accrediting body for all three hospitals. Each hospital's APP includes a section on workplace violence reduction, including staff responsibilities, risk assessment, patient treatment planning, staff training and data tracking. In addition, each hospital has individualized workplace violence prevention policies modeled on information and guidelines contained in the OSHA publication "Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers" (OSHA 3148-01R2004).

Safety and Security Enhancements

BHSIA received funding in the 2013 – 2015 Biennium for the purpose of workplace safety enhancements in order to reduce and prevent workplace violence at the state hospitals. The hospital spending plans for this funding includes new safety related positions and facility improvements.

Facility and safety equipment improvements implemented or in progress includes patient hardware safety improvements at all three hospitals for anti-ligature projects include replacing door hinges, handrails, shower valves, flush valve covers, sink faucets, and installing shrouds around sink pipes. Flooring at ESH with a known tripping hazard is being replaced and 30+ years old bathroom flooring is being replaced due to cracking & damaged linoleum. Radios and

cameras were ordered and received, primarily in the forensics units to increase staff safety. Additional personal alarms for staff were ordered and received at both ESH and WSH. Moduform furniture, a safer type of furniture that is less likely to be used to harm staff or other patients, was purchased and received at both ESH and WSH.

At WSH a total of 14 positions were created for the new PERT in the Center for Forensic Services. A total of 28 positions were created at ESH under the 2013-2015 Safety and Security Enhancement funding, including eighteen positions for the evening and night shifts in the forensic wards. Seven positions have been filled and are working evenings and night shift on the ESH civil wards. Three security guard positions have been filled increasing evening & night shift security coverage hospital wide.

The impact of the hiring and facility improvements will be reported in subsequent Workplace Safety in State Hospital reports through BHSIA safety related success measures.

DSHS-Injury and Illness Incident/Assault Report form

In 2013, the DSHS-Injury and Illness Incident/Assault Report forms were significantly revamped in order to ensure that more thorough accident investigations are completed for all workplace injuries and illnesses that occur within DSHS. All three hospitals participated in a 6 month pilot of the new forms and provided feedback to the appropriate parties for refinement. In March 2014, the new forms were distributed DSHS-wide. These new forms will assist each area with conducting accident investigations for their workplace injuries. Improved accident investigations will inform planning efforts to develop violence prevention strategies.

Summary

Reducing workplace violence and staff injuries at the state hospitals continues to be challenging due to the nature of the state hospital workplace environment, the complexities involved in preventing violence, funding limitations and competing resource needs.

Even in light of those challenges, BHSIA and the state hospitals will continue to be actively engaged in developing and sustaining efforts to reduce workplace violence. BHSIA is committed to continuously improving workplace safety and working to achieve targeted safety related outcomes in collaboration with stakeholders including local labor unions and the Department of Labor & Industries.

Appendix A
Child Study and Treatment Center
Workplace Safety Update
June, 2014

RCW 72.23.400 requires each state hospital (WSH, ESH, CSTC) to develop a plan to reasonably prevent and protect employees from violence. The law requires completion of a security and safety assessment to identify existing or potential hazards for violence in the workplace. Each state hospital must provide an update to the legislature annually.

<p><u>Elements of the plan per law.</u> (Items a through h are part of the security & safety assessment)</p>	<p><u>Assessment – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence.</u></p>	<p><u>Plan – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence.</u></p>
<p>a. The physical attributes of the state hospital including:</p> <ol style="list-style-type: none"> 1. Access control 2. Egress control 3. Door locks 4. Lighting 5. Alarm systems 	<p>Physical safety and security reviews of Child Study and Treatment Center (CSTC) campus buildings and grounds revealed the following:</p> <ul style="list-style-type: none"> • Access, egress control and door locks were found to be in good order. • Lighting is adequate on all wards, offices, and shop areas. Outdoor lighting is adequate. • Alarms have undergone routine inspection and are in working order. 	<p>Physical safety and security is assessed at a minimum of a quarterly basis through audits conducted by CSTC’s Safety Committee. These “walk-throughs” assess access and egress, door locks, fire extinguisher check documentation and lighting in addition to other elements. These audits are managed by CSTC’s Safety Committee Chair and results are communicated to the Environment of Care committee which is held once per month. Any findings are addressed immediately upon discovery by submitting the appropriate work order which is routed through the CEO for advisement and signature.</p> <p>CSTC Leadership Team, including the CEO, Director of Quality Management and Director of Nursing conducts a detailed annual safety review of all patient care areas that identifies any concerns, assigns level of risk and takes immediate action to correct and/or mitigate. This audit is directed toward both patient and staff safety with care taken to observe for any risk of injury, accident or entrapment as well as patient risks such as self-harm suicide or unauthorized leave.</p> <p>Since the last report to the legislature, CSTC instituted an “Anti-Ligature Project” installing upgraded hardware on the two units with the greater risk of patient self-harm or suicide by hanging. The third cottage is due to be fully upgraded in 2014. In 2013 improvements were implemented on Orcas Cottage and campus-wide to improve safety and maintain upkeep on equipment subject to wear and tear. In 2014, a project was undertaken to design floor plan improvements to Orcas where most of the staff injuries by patient assault occur.</p> <p>The DSHS Enterprise Risk Management Office conducts an “Annual Loss Control Evaluation (ALCE). This audit is conducted every Fall. It covers elements 1-5 under “a” as they relate to standards for: Environment of Care, Emergency Management, Life Safety and Training related to Safety , Security, Dealing with Assaultive Behavior, Accident/Injury Reporting, Hazard</p>

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		<p>Communication (including MSDS) and Emergency Action Procedures.</p> <p>Alarm systems are tested and monitored by the Consolidated Maintenance Operations (CMO) headquartered at WSH. CSTC has a Maintenance Supervisor who is responsible for conducting and coordinating maintenance and life safety operations at CSTC including all preventive maintenance and overseeing contracted projects. The CMO Supervisor and the Lakewood Fire Marshall conduct the annual fire inspection at CSTC. This inspection evaluates fire safety issues and satisfies Joint Commission accreditation. All areas are inspected on an annual basis and where indicated corrective action plans instituted. Finally, since the last report CSTC enhanced emergency communication capacity with the purchase of approximately 40 additional battery-operated handheld radios. This includes those dedicated to emergency preparedness and classrooms in the elementary and high schools.</p>
b. Staffing, including security staffing	Nursing management constantly monitors staffing for safe staffing levels.	<p>CSTC Personnel Policy 310 addresses Staffing Levels for Patient Care and delineates variables that are important to modification of staff levels in response to fluctuating acuity. Some of these variables are staff experience and skill mix, diagnoses and co-occurring conditions of the patients on each cottage, patients requiring “close observation” or “maximum precautions (1:1) circumstances around new admissions, developmental age of patients off campus activities including need for transport.</p> <p>The CEO authorizes staffing levels outside the usual range, overtime and call back. CSTC Policy 410 governs Levels of Observation, whereby patients with active high risk behavior that threatens safety to self or others are identified and actions taken to mitigate risk. To maintain safety and security for CSTC patients, staff visually checks each patient on the cottage every 30 minutes and document findings on the security check sheet for each shift. Timing of checks is varied to enhance reliability. Staff also checks the environment for potential hazards at the same time. Patients who require more intensive observation may be assigned by their physician to one of three levels, each with specific time intervals and restrictions.</p> <p>In 2014, the 2 staff positions were created - a PCCC1 “float” for day shift and a PCCC2 (lead) for swing shift. Both positions work hours that span shifts so that coverage is maximized during the most critical and incident-prone hours (e.g. during transitions). “Rover” positions were also created among permanent staff to cover unanticipated absences.</p> <p>CSTC relies on WSH Security to respond to security incidents, including those patient incidents which require additional staff to intervene with a violent patient or involve an elopement off of the property. WSH provides CSTS with security incident reports that are reviewed by the QM Director and at the monthly Safety Committee.</p>
c. Personnel policies	All safety-related policies have been reviewed and updated Sunset review dates will be monitored for completion by the Director of Quality Management who chairs the Policy Committee.	Updated and new policies are made available to staff hospital-wide via Intranet with hard copy distribution and/or Staff Development training. CSTC requires new staff to review safety and direct care policies as part of New Employee Orientation.
d. First aid and emergency procedures	CSTC Policy 203 covers “Responding to Medical Emergencies for patients, staff and visitors at CSTC.	In a medical emergency at CSTC, the individual(s) on the scene with the most medical training and experience will assume the role of first responder. Child Study and Treatment Center provides nursing coverage on campus at all times. First Aid supplies are located in the nursing office on each cottage, in

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	<p>CSTC actively plans/ prepares and participates with the Community for disasters.</p>	<p>the schools and the administration building. Sufficient numbers of employees are trained in First Aid, CPR and every two years, recertified. Staff is also trained on the use Automated External Defibrillators (AED) on campus. A third AED was added this year. CSTC activates the local emergency medical services system for emergency medical care beyond basic life support.</p> <p>CSTC updates the Emergency Management Plan annually. The Emergency Preparedness Committee meets regularly to plan and organize disaster drills, which occur a minimum of twice a year. Since the last report, CSTC an “Active Shooter” drill and a coordinated “Shelter in Place Drill” with the Clover Park Schools on campus. CSTC maintains emergency supplies which are inventoried annually.</p>
<p>e. Reporting violent acts, taking appropriate action in response to violent acts, and follow-up procedures after violent acts: analysis of data on violence and workers compensation claims during at least the preceding year</p>	<p>CSTC Policy 204 – Employee and Volunteer Injuries and Accidents</p> <p>Patient Incident Reporting</p> <p>Violent Acts Log</p>	<p>CSTC Policy 204 governs full documentation for internal risk management and the processing of industrial insurance (L&I) claims. The Employee / Volunteer Personal Incident report (DSHS 03-133) was revised, piloted and implemented in 2014. It is completed within 24 hours whenever an injury occurs while the individual is working. All reports are reviewed by the CEO and may warrant additional investigation. In addition when an injury is caused by a patient assault report form 03-391 is submitted. Information about aggressive behavior by patients is also tracked via the patient incident report form information from which is entered into the Incident Report Data Base. When a staff injury occurs information is entered from both data bases into the “CSTC Violent Acts Log”. This log is instrumental in analysis of staff injuries, causes, location, patients involved, type and seriousness of injuries and care needed.</p> <p>The CSTC Workplace Safety Workgroup, a subgroup of the Safety Committee continues to meet twice monthly. A second annual safety survey is being conducted in the summer of 2014. The results of this survey will be analyzed to identify themes of concern and indicators for mitigation. Internal injury tracking is conducted by the Director of Quality Management on a monthly basis utilizing staff personal incident reports (03-133), and reports from ERMO/Riskmaster. This data is reviewed at the monthly Safety Committee. Data for previous 2 years has been updated in the body of this report.</p>
<p>f. Development of criteria for determining and reporting verbal threats.</p>	<p>CSTC Incident Report Form (CSTC 30-37(A) is utilized to report both verbal and physical aggression.</p>	<p>In December 2013 CSTC initiated an Incident Reporting Process and Format improvement to increase accuracy, timeliness and efficiency in the reporting of patient incidents including acts of aggression. The new form is being piloted over the 2nd half of 2014 while an electronic process is being explored for recording and transporting data. Verbal aggression is defined as “...makes clear threats of violence toward others or self (e.g. “I’m going to kill you.”). This includes verbal aggression directed at staff, other patients and families of other patients or staff whether or not the patient has the current means to carry out the threat.</p> <p>In 2014 CSTC developed a “Culture of Safety” Policy to augment our Annual Safety Plan consolidating safety constructs across a number of existing policy and reinforcing the priority CSTS places on safety in our environment and programs.</p>
<p>g. Employee education and</p>	<p>All employees are required to complete</p>	<p>CSTC implemented a new Crisis Intervention Program in March 2013 in which all new staff are</p>

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<p>training</p>	<p>comprehensive mandatory DSHS training that occurs at the time of hire (new employee orientation) and annually. This includes Workforce and Domestic Violence and Sexual Harassment. In addition, CSTC requires the following:</p>	<p>rained. Refresher courses are provided as needed, or every 3 years. All direct care and selected administrative staff have been trained as of August 1, 2013. This \$14,000 investment replaces the “ProAct” program that was previously in place.</p> <p>Curriculum was developed for a campus-wide interactive emergency preparedness training that was held 7/24/14. The emphasis was on the incident command center, employee home preparedness and individual responsibility at work during a major crisis.</p>
<p>h. Clinical and patient policies and procedures including those related to:</p> <ol style="list-style-type: none"> 1. Smoking 2. Activity, leisure and therapeutic programs 3. Communication between shifts <p>4. Restraint and seclusion</p>	<p>CSTC Policy 306 – Smoking Restrictions</p> <p>Activity, leisure and therapeutic programs – CSTC Policy 406 Recreation Therapy Services (RT)</p> <p>Improved communications between shifts may lead to fewer violent incidents. Other safety precautions as part of milieu management. (CSTC Policy 438)</p>	<p>CSTC promotes an environment of health and wellness. Policy 306 defines restrictions of the use of tobacco products on CSTC grounds by all employees, visitors and patients. Patients are not allowed to smoke or use tobacco products at CSTC or while in the custody of CSTC staff. Employees and visitors are required to restrict their smoking or tobacco use to designated areas having proper receptacles and situated outside of the 25 foot rule in compliance with Washington State law. In addition, smoking areas are placed where the smoking is not observable by patients. CSTC makes available resource materials on wellness and smoking cessation to employees and patients requesting such information.</p> <p>Recreation Therapy Services provide opportunities for patients to develop skill generalization through participation in activities, leisure education and recreation groups and classes. RT Plans are based on initial assessment within 14 days of arrival. Each client sets recreational goals and RT therapists motivate and engage clients, introducing new leisure opportunities. Activities are designed to be developmentally appropriate and are identified on the patient’s interdisciplinary treatment plan. The RT staff promote a positive social community through planning and facilitating cottage-wide and all-center activities. Before new activities are conducted with patients, a RT Risk Assessment must be conducted to ensure that appropriate safety precautions and conditions of participation are established. Outings with patients include such things as the YMCA, museums, camping and hiking and are sufficiently staffed for numbers and patient vulnerabilities. Only patients who are able to manage behavior and have demonstrated a level of confidence are able to go on outings. Decision making about participation depends on team collaboration and coordination.</p> <p>The structure and schedule of the cottage milieu is carefully designed to maintain a safe environment. Shift reports occur at the time of transition from one shift to the next. Each patient currently in the program and their current emotional and behavioral status, changes in treatment planning / response, observation status restrictions and precautions. Significant incidents are discussed as well as restrictive interventions and injuries. Potential stressors are identified and updates in individualized interventions to more effectively manage patient behaviors are explained. Supervision hand off is carefully managed. Hand operated radios are assigned to patient care staff and any staff leaving the cottage with a patient is required to carry a radio. In 2014 additional hand held radios were purchased for each classroom. Motion detectors and door alarms are utilized during quiet time, after bed times and before wake up to augment supervision of patient movement. Searches for contraband are conducted routinely and as indicated and governed by Policy 439.</p> <p>Shift change communication is augmented by written processes on each cottage. In response to the 2013 direct care staff safety survey team, leadership and communication changes were instituted to better use this critical interface between shifts. In addition each cottage team preserves a regular weekly 2-hour inter-shift meeting for dialogue and clinical consultation. “Safety Issues” is a</p>

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		<p>mandatory part of the agenda on all cottages. These meetings allow time for updates along with education and training in key concepts and models in use on the cottage (e.g. 2014 implementation of Motivational Interviewing). This is also a time that center-wide feedback (for example safety information, debriefing from emergency preparedness drills, etc., or quality improvement projects can be shared.</p> <p>Restrictive interventions are used only when clinically necessary and adequately justified to protect the safety of the patient and/or others. Restrictive interventions generally refer to the use of seclusion and restraint (Policies 444 and 445) but when a less restrictive, or preventive alternative is possible, such as “Time Out (Policy 443) it is the first option used to manage escalating behavior. Mechanical (leather) restraints are NOT used at CSTC. Rarely and only when security officers are involved, handcuffs may be utilized for brief periods of time to contain an unsafe situation. Seclusion and/or restraint may be used only for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or others and may never be used as a punishment, discipline or convenience to staff. Restraint must be conducted according to training so that there is no undue physical discomfort or harm to the patient. A physician’s order is required and 15 minute checks conducted by the cottage nurse monitor the patient’s condition while in seclusion. The patient is returned to the milieu as soon as the behaviors are no longer in evidence and/or documented behavioral outcomes are attained. The use of seclusion and restraint are routinely evaluated and trends reviewed by the leadership team.</p>
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Appendix B
Eastern State Hospital
Workplace Safety Update
June, 2014

RCW 72.23.400 requires each state hospital (WSH, ESH, CSTC) to develop a plan to reasonably prevent and protect employees from violence. The law requires completion of a security and safety assessment to identify existing or potential hazards for violence in the workplace. Each state hospital must provide an update to the legislature annually.

Elements of the plan per law. (Items a through h below are part of the security & safety assessment)	Assessment – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence.	Plan – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence.
<p>a) The physical attributes of the state hospital including:</p> <ol style="list-style-type: none"> 1. access control 2. egress control 3. door locks 4. lighting 5. alarm systems 	<p>Potential risks associated with the Environment of Care and high-risk processes that present a threat of physical injury to persons, damage to property, or a threat to general safety</p>	<p>The Safety/Risk Management Manager and representatives of Safety & Patient Safety Committee, Administration, Unit Management and CSS conduct an annual pro-active risk assessment in addition to individual risk assessments initiated as a result of a Sentinel Event, to identify and rate all known physical plant deficiencies and problems determined to present a threat of physical injury to persons; damage to property, or a threat to general safety.</p> <p>The Environmental Proactive Risk Assessment is reviewed by Safety/Risk Management, hospital Leadership and Safety, Patient Safety and unit management committees. The assessment was completed utilizing data from hazard reports, environmental safety surveys, unusual occurrence reporting and individual building evaluations. Plan of Action(s) and/or interim measures were identified and implemented, as indicated. Recommendations for improvement include, but are not limited to:</p> <p>"Armored", wall mount phones with stainless steel cords were purchased to replace existing patient phones to prevent use as a weapon and/or removal of the cord for use as a ligature; December, 2013.</p> <p>In April, 2014, ESH purchased Moduform furniture which consists of molded vinyl chairs and sofas and one-piece dining room tables and chairs specifically manufactured for Department of Corrections and Behavioral Health. The molded vinyl furniture can be "sand-ballasted (weighted) to prevent being thrown. The intent is to remove lightweight, metal framed and plastic chairs that can be picked up and thrown and older wooden furniture that can be broken apart and used as a weapon.</p>

<p>I. Access Control</p>	<p>Escort to ward is completed by Security or ward staff on APU dependent on availability. Walk-through detectors are not available on 2N, 3N, and all GPU locations. Walk-through detector on APU frequently alarm (false) due to physical location and metal building features in elevator sally port location. Relocation/installation of detectors not feasible due to egress requirements in alternate locations (APU/GPU)</p> <p>GPU ward locations do not have visitor lockers.</p> <p>Open campus/ location (rural), multiple buildings & locations (multiple areas isolated after dark). Problem identified with Security staffing (one per shift, hospital-wide).</p> <p>There are occurrences of stolen, misplaced, lost or not turned in employee identification badges and/or keys assigned to individual employees.</p> <p>Increased potential hazards at Westlake Switchboard due to limited visibility of in-coming visitors, patients and staff.</p> <p>The parking areas on the north side of Eastlake Administration building are not under surveillance of the main building and are bordered by woods and an unsecured road/access trail.</p>	<p>All visitors are notified of what items constitute contraband (signage posted at Switchboard locations) and must walk through the metal detector (APU/FSU). Visitors have the option to leave these belongings in their vehicles or they can lock them up in the lockers provided outside of the ward (APU/FSU). Once this is done they are allowed into the visitor's room (FSU visitor room separate from the ward) or on the ward to join the patient they are here to visit.</p> <p>Request Security and Nursing evaluate risks (APU) and identify potential solutions to ensure consistent monitoring for approval by Safety Committee. TARGET: August, 2014</p> <p>Refer to GPU Management for POC. TARGET: August, 2014</p> <p>Submit work order to install visitor lockers at GPU locations. TARGET: August, 2014</p> <p>Security staffing increased to two per shift to provide back up. ESH Security Guard staff is primarily responsible for the security and safety of the external campus, including patrolling the campus, watching for trespassing, ensuring vacant buildings are secure, and that hospital entrances are safe and secure. They are not assigned to patient care wards but are available to go to the wards if requested by Nursing Management. Additional security guard positions established for all shifts, seven days per week, to ensure two per shift.</p> <p>Install security cameras in high-risk locations (off-ward) based on usage and access. Capital Programs project lost partial funding for Phase I installation of exterior cameras. Re-submit a Capital Programs request for additional cameras identified for future planning. Target for installation pending funding approval.</p> <p>All occurrences reported to Security and Unusual Occurrence Report completed.</p> <p>Key control transferred from Administration to Security Department. Security tracks key issuing & return to/from employees when transferred to other areas/departments or leaving ESH employment on a database. All keys stamped for tracking purposes. FUTURE PLANNING: Request Capital Program funding for installation of "Key Watcher" system.</p> <p>Identify exterior doors that do not close properly and place work orders to repair or replace. Monitoring is ongoing - weekly environmental surveys (worksite inspections), Security rounds (24/7)</p> <p>Turn Switchboard/reception desk 180 degrees to increase visibility of parking lot and in-coming visitors, patient and staff. Due to the location of utilities/infrastructure, it has been identified that this will not be feasible. The current plan is to install wireless cameras so that Switchboard staff can monitor the parking lots and main entrances. REQUEST FOR COST ESTIMATE SUBMITTED TO CSS: July, 2014</p>
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		<p>Identify high-risk areas and install surveillance cameras. Capital Programs project lost partial funding for Phase I installation of exterior cameras that have been prioritized by Safety & Security. FUTURE PLANNING: Will re-submit a Capital Programs request for additional cameras identified. Target for installation pending funding approval.</p> <p>As a component of a Capital Programs project, thirty eight additional cameras were installed in FSU including in the hallways on all three wards as part of the FSU Security Enhancement project.</p>
<p>2. Egress Control</p>	<p>The area between the Therapy Pool and the unused Interlake building has no surveillance and is not well lit.</p> <p>No physical control over egress (visitor/staff) on campus. Remedy would essentially require a security fence around entire perimeter of hospital and this is not consistent with hospital mission, vision, or values.</p> <p>There is a potential for violence when apprehending patients that have gone on unauthorized leave.</p>	<p>Install eight foot high chain link fence to block access to this area. Interlake building currently being abated (asbestos) prior to demolition: June, 2013</p> <p>Security personnel log daily activity and report trends monthly & quarterly to the Safety Committee and department managers for follow-up and plans for improvement as indicated.</p> <p>ESH policy 1.8, Patients' Visitors, outlines procedures for visitor restriction from ward or campus by clinical OD, AOD or CEO/COO due to history and/or current behavior.</p> <p>Increase Security staffing to two per shift to provide back up. Additional security guard positions established for all shifts, seven days per week, to ensure two per shift.</p> <p>Unauthorized leave data tracked and reported monthly to Safety and Patient Safety Committees for trend analysis and drill downs to identify Plans for Improvement.</p>
<p>3. Door locks</p>	<p>Current employee key control and tracking system with regard to change of employee need/status is inadequate.</p>	<p>Key control transferred from Administration to Security Department. Security tracks key issuing & return to/from employees when transferred to other areas/departments or leaving ESH employment on a database. All keys stamped for tracking purposes. FUTURE PLANNING: Request Capital Program funding for installation of "Key Watcher" system.</p>

<p>4. Outside Lighting</p>	<p>Burned-out/malfunctioning outside lighting.</p> <p>Amount of time for replacement.</p> <p>The parking lot to the north of the Therapy Pool is dimly lit and cannot be seen from any building that is typically occupied at night.</p> <p>The Linden Hall parking lot is poorly lit.</p> <p>Upper terrace and the north side of the Westlake parking lot are dark despite the presence of several pole lights.</p>	<p>Security provides a monthly report to Consolidated Support Services regarding their submission and CSS’s completion of campus lighting work orders to ensure timely replacement.</p> <p>All lighting work orders are prioritized based on overall lighting requests/needs.</p> <p>Forensic Services Unit perimeter lighting has been increased and is immediately replaced when not working.</p> <p>Prioritize areas for installation of additional lighting</p>
<p>5. Radios</p>	<p>Low/dead battery Dead Spots (lack of repeater coverage)</p> <p>Subject to malfunction and accidental activation. Existing staff duress alarms on Eastlake South (FSU) and Eastlake North (APU) were installed in two different phases with the APU alarm system installed during Phase 3, over 20 years ago. FSU was installed under Phase 4 .The system is beyond its life expectancy.</p> <p>The FSU alarm system requires use of a proximity card with readers located (need to verify how far apart) throughout the corridor. The APU system requires the system to be activated by “keying a box/switch” located (need to verify how far apart). The alarm is relayed to “reader boards” on each ward and the Eastlake Switchboard denoting the ward activated on.</p> <ul style="list-style-type: none"> • Location makes the system difficult if not impossible for staff to use if involved in a patient-to-staff assault. • The alarm notification only displays the ward; it does not identify specific/exact location of activation. • Wiring/equipment inadequacies/failures were identified during the FSU Security Enhancement project (need to get specifics from Bill unless you can get me specifics) • The existing system does not provide a method of activation for off-ward and/or outdoor escort/activities i.e. yard group, etc. <p>The existing Westlake staff duress alarm consists on one location for activation; a “push to activate” button at each nurses station.</p> <ul style="list-style-type: none"> • Location makes the system difficult if not impossible for 	<p>Initial training is provided by the ESH Safety Officer and Security personnel and reinforced by supervisors. Annual competency of staff in the use and maintenance of radio equipment is evaluated by supervisors.</p> <p>Radio distribution, maintenance & ordering are coordinated by Security, hospital-wide.</p> <p>In June of 2014, ESH purchased new digital two way radios to replace antiquated communication equipment and ensure continuity with local emergency response agencies. This best practice approach will improve signal quality, coverage, staff safety and security of patient healthcare information (PHI). Additional repeater equipment is targeted for purchase fiscal year 2014 to decrease “dead spots” in communication coverage.</p> <p>The duress alarm is currently tested daily on all wards by ward staff (APU & FSU) and weekly (GPU) per Nursing policy.</p> <p>Capital Programs project currently in planning stages to replace existing duress systems and install in locations without existing system in all locations with a “personal duress alarm” system that provides wider coverage and location identification system to allow quicker emergency response.</p>

	<p>staff to use if involved in a patient-to-staff assault.</p> <ul style="list-style-type: none"> • The alarm notification only announces the ward location via automated overhead PA announcement; it does not identify specific/exact location of activation. • The duress alarm is tied into the existing Simplex nurse call system which is frequently malfunctioning and potentially affects the duress alarm system, dependent on the issue. If impacted and requires Simplex service, historically, overall service support from Simplex has been poor. The existing system does not provide a method of activation for off-ward and/or outdoor escort/activities i.e. yard group, dining room, etc. <p>GPU Treatment Mall – No Existing Duress Alarm</p> <ul style="list-style-type: none"> • The existing Westlake duress system was not installed in the GPU Treatment Mall as it was not utilized as a patient care area at the time of the project. <p>Activity Therapy Building/Eastlake Treatment Mall</p> <ul style="list-style-type: none"> • No Existing Duress Alarm <p>Hardware (environmental risk factors for use as weapon or for patient self-harm)</p>	<p>Ongoing efforts to mitigate environmental risk factors to prevent suicide and increase staff safety continue at ESH. A Capital Programs project, Phase 1, for patient safety hardware improvements (anti-ligature door handles, closet rods, grab bars, stainless steel mirrors in lieu of glass mirrors) was completed June, 2013. Phase 2 installation (continuous hinges, faucet and shower handle replacement, covering exposed sink and toilet plumbing, toilet paper holder and corridor handrail replacement) was completed in all high-risk locations; October, 2013. Projected start for Phase 3 installation (continuous door hinges, faucet and shower handle replacement, covering of exposed sink and toilet plumbing and toilet paper holder replacement) on all remaining wards: July, 2014.</p>
<p>b) Personnel policies</p>	<p>Systems for identifying variances in staffing and responding to these in a timely manner are in place and appear to be adequate in general.</p>	<p>No additional actions required</p>
<p>c) Staffing, including security staffing.</p>	<p>Increased security presence on campus is beneficial to maintaining a safer environment for staff and patients</p> <p>Systems for identifying variances in staffing and responding to these in a timely manner are in place and appear to be adequate in general.</p> <p>Additional tools/systems used in nursing include policy/procedure on how to acquire staff, acuity based staffing plan, and guidelines for safe staffing levels</p>	<p>Security staffing increased to two per shift to provide back up. ESH Security Guard staff is primarily responsible for the security and safety of the external campus, including patrolling the campus, watching for trespassing, ensuring vacant buildings are secure, and that hospital entrances are safe and secure. They are not assigned to patient care wards but are available to go to the wards if requested by Nursing Staff.</p> <p>Additional security guard positions established for all shifts, seven days per week, to ensure two per shift.</p> <p>Staffing Effectiveness Committee established as part of Safety Adhoc initiative; 2014</p> <p><u>Use of on-call staff</u> Eastern State Hospital has a pool of on-call employees who work when required. .</p> <p><u>Voluntary Overtime</u> At the beginning of shift, staff available for overtime on the following shift will notify the Nursing Staffing Office of their availability.</p> <p>In addition, the following steps are used to determine who is offered prearranged voluntary overtime:</p> <ul style="list-style-type: none"> • Staff notifies the staffing office in writing that they wish work voluntary overtime. • Names are added to the rotation list in order received.

		<p>Compliance for control of equipment and materials in corridors to ensure a clear means of egress (exit) for patients, visitors or staff leaving the building under emergency conditions continues to be monitored and documented daily by designated ward staff in addition to weekly Environmental Safety Rounds conducted by the Safety office.</p> <p>The Safety/Risk Management Program Specialist and Infection Control Coordinator continue to actively participate in the Region 9 Healthcare Coalition. The Region 9 Health Care System Coordination Plan is an operational resource tool for Region 9 health care system partners to reference in planning, response and recovery efforts. It provides guidelines for coordinating the emergency response of health care system partners.</p>
<p>e) Violent acts:</p> <ul style="list-style-type: none"> • Reporting of violent acts • Taking appropriate action in response to violent acts • Follow-up procedures after violent acts 	<p>All elements pertaining to reporting of violent acts are documented utilizing Employee Injury, Unusual Occurrence and Internal Hazard reporting.</p> <p>Critical Incident Stress Management policy/procedure in place. Inconsistency in initiation</p>	<p>Workplace violence of any kind is reported through administrative channels and tracked in incident data bases providing the capacity to compile data for analysis of frequency, severity and circumstances</p> <p>Monitor follow-up procedures and compliance.</p> <p>All incidents are investigated at time of occurrence & findings. The ESH Safety Committee established an Assault Injury Workgroup, June of 2014 that meets monthly to initiate in-depth reviews of patient-to-staff assault occurrences and develop prevention strategies to mitigate future occurrences. A narrative summary with recommended action plans is presented to Safety Committee, Quality Council and at quarterly Governing Body meetings.</p> <p>Policies/procedures are implemented as directed. Critical Incident Stress Management (CISM) procedure is in place and team members identified for response. July 2014 Safety Committee recommendation to increase awareness of team and clarification of process for initiating process. Referred to CISM team leader for action.</p> <p>Psychiatric Security Attendants (PSA) and Psychiatric Security Nurses (PSN) staff is assigned to the Forensic Services Unit wards. In addition to providing psychiatric care and support to patients, the staff have additional security and safety responsibilities specific to the forensic population they work with. The job specifications for the PSA job classification include these duties:</p> <ul style="list-style-type: none"> • Maintains order and discipline in housing and treatment area; protects employees and patients from acts of violence from recalcitrant patients; • Inspects patient quarters for cleanliness and order; searches quarters and persons for contraband; escorts patients on outside trips; Observes patients for unusual or significant behavior; prepares reports to supervisor
<p>f) Development of criteria for determining and reporting verbal threats</p>	<p>ESH has been using criteria for reporting assault in the Unusual Occurrence Reporting System (UORS) for the past 20 years as identified in the MHD Quality Steering Committee definition.</p>	<p>Verbal threats are tracked when reported. Staff determines risk potential.</p>

		<p>The assigned clinical security staff from the on-coming and off-going shifts together completes a security check and document on the Security Board.</p> <p>FSU Security Committee establishes reviews and makes recommendations for changes in unit security policies and procedures. This committee is composed of representatives of line staff from each ward and shift, representative from Rehabilitation Services, FSU MHT 5 and FSU Nurse Manager. This committee receives input from line staff (and others) to address safety and security issues. There is a Security Break Memo review process in place to address safety and security concerns.</p> <p>A “<i>Safety Huddle</i>” policy was created February, 2014. Safety Huddles are conducted prior to morning report on each ward to share safety concerns and provide information regarding potential safety issues. Additional Nursing observation is occurring by placing nursing staff mid-distance in each of the two hallways on the FSU wards. This allows the staff member to hear both ends of the hallway. The requirement to maintain this observation has been provided in writing and verbally to Nursing Staff. On the night shift, employees are assigned to these areas on the assignment sheets under different titles such as hall security north and hall security west. The purpose of these assignments is not only to be able to hear patients better throughout the ward, but also to make sure they aren’t entering other patient’s rooms. Staff is also there to provide the patients with a sense of safety by being visible out on the wards throughout the night.</p> <p>While the psychiatric security attendants are monitoring patients on Assault observation (AO), location observation (LO), or suicide observation (SO) they are doing this in an unpredictable manner (instead of every 15 minutes for example, they randomly complete the checks several minutes earlier).</p> <p>Existing ESH policy requires implementation of a “<i>Code Green</i>” whenever a patient is escalating and may require seclusion or restraint or whenever seclusion or restraint is initiated. A “Code Green” is in response to a critical incident and immediate response is required. Debriefing of the patient and staff and an intensive analysis of the event is completed. The CEO, Medical Director, Quality Management Director, and Nurse Executive review all Code Green incidents (with or without seclusion/restraint) during the following morning report.</p> <p>A <i>Statement of Caring & Safety</i> is provided to all patients upon admission. The statement encourages patients to share their concerns with staff if they do not feel safe for any reason including if another patient tells them that he or she wants to harm him/herself or others.</p> <p>Purchase of a presumptive narcotics identification kit (type used by law enforcement in their field operations) was approved by Leadership and on-site June, 2013. The kit contains multiple individual test units which can be used to test for various unlawful drugs such as marijuana, LSD, amphetamines, opiates, etc. They are designed to be used safely by medically untrained persons. The Contraband Policy was revised to reflect procedures for use of the kit and all Security personnel trained effective September, 2013. Approval to test a suspected substance found in patient care areas or</p>
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	<p>There is an increased risk for patient unauthorized leave and/or negative patient behavior during community outings.</p> <p>Placing patients in seclusion/restraint increases potential for employee injury</p> <p>Non-therapeutic interactions with patients increase the potential for employee injury.</p>	<p>on the hospital property requires the approval of the administrative OD.</p> <p>While out monitoring the environment if staff notices a patient who is having a difficult time, they alert not only the charge nurse, but all the staff who are present in hallways as described above. This assists staff in intervening in a timelier manner.</p> <p>A community outing planning tool has been developed and is utilized for all outings to identify potential risks and methods of managing/reducing these risks i.e. cell phones, personal protective equipment, patient-to-staff ratios. COMPLETE: 12.2009/</p> <p>Unauthorized leave data tracked and reported monthly to Safety and Patient Safety Committees for trend analysis and drill downs to identify Plans for Improvement</p> <p>A LEAN Project is being initiated to review the existing escort policy to identify risks with the current process and develop recommendations for improvement. The goal is to have a consistent policy hospital wide to ensure safe escorting of patients to all off campus activities. July, 2014</p> <p>Increase staff training in use of less-restrictive alternatives.</p> <p>As part of a 2014 Safety Workgroup PFI, the following recommendation was submitted to Staff Education July:</p> <ul style="list-style-type: none"> Identify/develop training and implementation plan to train all direct-care staff, at-hire and annually in Physical containment techniques and procedures. This would be in addition to Therapeutic Options <p>In collaboration with the Substance Abuse Mental Health Services Administration (SAMSHA) Training Grant and Washington Institute for Mental Illness Research and Training (WIMIRT), ESH developed a plan to change from a Bio-Psycho-Social Model to a Recovery Model to reduce the number of seclusion/restraint events. Eastern State Hospital has implemented a Recovery Model, tracking multiple outcomes; seclusion/restraint, staff injuries, patient-to-patient assault, patient-to-staff assault.</p> <p>As part of a 2014 Safety Workgroup PFI, the following recommendation was submitted to Staff Education July: Identify/develop training and implementation plan to train all direct-care staff, at-hire and annually to enhance staff communication skills when performing identified high-risk activities. This training would be in addition to Therapeutic Options.</p>
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Appendix C
Western State Hospital
Workplace Safety Update
June, 2014

RCW 72.23.400 requires each state hospital (WSH, ESH, CSTC) to develop a plan to reasonably prevent and protect employees from violence. The law requires completion of a security and safety assessment to identify existing or potential hazards for violence in the workplace. Each state hospital must provide an update to the legislature annually.

<u>Elements of the plan per law.</u> (Items a through h are part of the security & safety assessment)	<u>Assessment</u> – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence.	<u>Plan</u> – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence.
<p>a. The physical attributes of the state hospital including:</p> <ol style="list-style-type: none"> 1. Access control 2. Egress control 3. Door locks 4. Lighting 5. Alarm systems 	<p>Physical security tour of Western State Hospital (WSH) campus revealed the following:</p> <ul style="list-style-type: none"> • Access, egress control and door locks were found to be generally in good order. • Lighting is adequate on all wards, offices, and shop areas. Outdoor lighting is adequate. 	<p>The Environment of Care (EOC) Committee conducts a year-round assessment of access control, egress control, door locks and lighting during monthly walkthroughs. All areas are inspected at least once a year. In addition, every ward does their own (EOC) inspections on a monthly basis and produces work orders and/or follow ups based upon their findings. Each Safety Sub-committee reviews the EOC’s done by the ward and follows up on any unresolved issues. Ward staff also conduct safety rounds at least once per shift looking for important safety items (i.e. Unsecure exits/windows door, inadequate light in environment, broken furniture and/or broken glass, etc.)</p> <p>The EOC Committee also conducts an annual Physical Risk Assessment of every patient care area to look for other safety/security risks that take into consideration our patient population. Recent staff/patient safety projects include the following:</p> <ul style="list-style-type: none"> • A Capital Project with \$2.7 million allotted by the legislature. With the funding we have scoped the project to include: <ul style="list-style-type: none"> ○ Re-locating, or in some cases removing, door closures in all patient care area to the corridor side of the room. (A total of 880 doors (20%) completed by June 30, 2014). ○ All plumbing fixtures replaced with anti-ligature type to include faucets, bathtubs, showers, and valves in all patient care areas (As of June 30, 2014 all items were identified and ordered. Installation is scheduled to be completed by June 30, 2015.) • Purchased and installed mirrors in high risk areas that were identified to help reduce blind spots throughout the hospital. Continue to Monitor. • Purchased and installed Knox boxes that houses main keys to building for West

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		<p>Pierce fire to provide access during a fire emergency.</p> <ul style="list-style-type: none"> • Key rings with locking key hubs were changed over for approximately 25% of all key rings throughout the hospital so that keys cannot be taken off of the ring and lost. The hospital will continue to work on this issue over the next year. • Purchased 18 new radios and placed on every ward to ensure emergency communication. • The following items were purchased and received: <ul style="list-style-type: none"> ○ 136 oasis cafeteria tables to replace dangerous loose chairs for all patient dining rooms ○ 300 (60%) of the needed safe lounge chairs ○ Key Watcher System Upgrade: Inventory has been purchased and received on campus to upgrade current system ○ \$35,000 of Safety equipment/Ergo furniture was purchased and received (i.e. Bullox Fire Extinguisher training system, adjustable furniture/Ergo equipment, carts with spring loaded platforms to be used for delivering supplies, etc.) ○ \$35,000 of Emergency Management equipment and supplies were purchased and received (i.e. Temperature Controlled Conex unit, Private Medication Center kit, Carts to store and easily deploy EM equipment and supplies, Command Center kits etc.) <p>Alarm systems are tested and monitored by the Maintenance Department. The Maintenance Department monitors and prioritizes work requests to maintain current condition.</p> <p>Since 2001, the annual Lakewood Fire Inspection has been conducted by the Lakewood Fire Marshall and a team from WSH comprised of the Safety Manager, a Facilities Representative, and others as needed. This inspection evaluates fire safety issues. Shortcomings are identified and corrected to preclude a fire emergency. All areas are inspected on an annual basis.</p>
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	Annual Lakewood Fire Inspection is required.	
b. Staffing, including security staffing	Nursing management constantly monitors staffing for safe staffing levels.	<p>As treatment models, census and acuity changes, staffing levels will be adjusted appropriately.</p> <p>WSH Nursing Department uses a program for staffing developed for WSH Nursing Department in 2012 called Scheduler. The program enables ward needs to be anticipated and tracked to ensure safety of patients and staff alike. The Nurse Manager responsible for staffing the hospital is able to review the needs of the hospital down to the individual wards enabling the Nurse Manager to deploy staff based upon ward needs.</p> <p>The Scheduler Program has a base staffing number for each skill level on every ward and every shift. The Psychiatric Nurse Executive (PNE) and Center Nurse Managers review patient care needs of each individual ward in deciding the number of base staff needed per ward. The base staffing is reviewed periodically as needs of the wards change and base staffing numbers are adjusted accordingly.</p> <p>The base staffing level is also discussed at the Joint Nurse Staffing Committee co-chaired by labor and management and affords both parties the opportunity to share views and ideas. The Joint Nurse Staffing Committee is mandated by legislature, the guidelines can be found in RCW 70.41.420.</p> <p>The PNE and Nurse Managers also consider the OSHA guidelines preventing Workplace Violence for Healthcare and Social Service workers when establishing baseline staffing.</p> <p>To cover areas that are in need of staffing, a float pool of 10 non-permanent Registered Nurses (RN) and 5 permanent Psychiatric Security Attendants (PSA) were established for the Center for forensic Services (CFS). In addition, a float pool of 10 permanent Mental Health Technicians (MHT) were established in the three (3) PTRC centers. The float pool staff were established in April/May of 2014 and are deployed as needed within their own center so that staff familiar with the center and their patients are working in those areas.</p> <p>The process that is followed when there is not enough coverage is to deploy float staff, on-call staff then over-time staff. The overtime staff is selected in accordance with the Collective Bargaining Agreement (CBA) and requires the Nurse Manager to activate the overtime wheel. When other resources have been exhausted, an RN3 must cover the wards to ensure there is adequate staffing on the floor. (Note: WAC 246-840-710, 5 c, states . . . Nurses cannot willfully abandon clients by leaving a nursing assignment when continued nursing is required by the condition of the client(s), without transferring responsibilities to appropriate personnel or care giver).</p> <p>In addition all staff are required to attend the below training before reporting to their duty station. This training provides them with what is needed to work safely in our environment.</p> <p>The following is a listing of training required:</p> <ul style="list-style-type: none"> • New Employee Orientation (1 – 3 weeks depending upon job class)

	<p>The WSH Security Department assessment of staffing concluded that increased security presence on campus is beneficial to maintaining a safer environment for staff and patients.</p>	<ul style="list-style-type: none"> • <u>Annual on-line updates:</u> • DSHS BHSIA WSH 2014 CFS Security Essentials • DSHS BHSIA WSH 2014 Annual AROI Update • DSHS BHSIA WSH -2014 Annual Compliance Update • DSHS BHSIA WSH 2014 Annual DSHS Public Disclosure Update • DSHS BHSIA WSH -2014 Annual HIPAA Update • DSHS BHSIA WSH 2014 Annual Infection Control Update • DSHS BHSIA WSH -2014 Annual Safety and Claims Update <p>Nursing staff are also required to participate in an annual competency fair to ensure they are competent in procedures potentially impacting staff safety. Such as: observing patients at risk for suicide, self-harm, therapeutic observation for patients deemed to be aggressive and patients assigned to 1:1 due to aggressive or injurious behaviors, competency for use of padded shield, med sled, and proper method of applying restraints.</p> <p>The ward based nursing staff conduct environmental safety rounds and patient checks every 30 to 60 minutes. Wards considered acute (10 wards) conduct patient safety checks every fifteen (15) minutes. The environmental safety rounds and patient check form instructs staff to look for hazards and anything potentially unsafe to include ligatures, items that can be lifted and items with sharp edges that can be used to injure a patient</p> <p>Security staffing continues to be analyzed by the Chief Operations Officer and the Director of Security as part of an overall effort to identify risk of violence and address security needs. This included a review of needed safety/security on the grounds, court security, security response to the civil wards, and safety/security within CFS.</p> <p>As a result of this analysis the following areas were identified:</p> <p>Grounds/ Civil Wards Security.</p> <ul style="list-style-type: none"> • Because of the size of the WSH grounds and the need to provide safety/security related to patients, staff and visitors staffing levels were established as follows, minimum three on day shift, three on afternoon shift, and two on night shift. Two Security guards will approach any situation where there is a concern about violence. • Security guards assigned to grounds will respond to civil wards on an emergency basis as part of an emergency response requested by the switchboard. • Security Guards will respond to all fire drills • On a routine basis campus during swing and night shift security check all entry doors to ensure they are locked. If they are not locked, they lock doors, and complete a security incident report. <p>CFS Security</p> <ul style="list-style-type: none"> • Security Guards respond to all codes greens on the wards. • Escort of patients to outside medical appointments, court dates, visitations are staffed with a minimum of one Security Guard and one nursing staff. • On grounds court security requires two Security Guards for escort as well as two Security Guards providing security with in the court room. • In CFS there will be a minimum security staffing levels of 9 on day shift, 9 on evening
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		<p>shit and 4 on night shift. There is also a supervisor assigned to each of these shifts.</p> <p>Recent Activity in the Security Department includes:</p> <ul style="list-style-type: none"> • A new Security Director with extensive experience in law enforcement was hired at WSH in October 2013. • Review and update all Security Standard Operating Procedures is ongoing. • Revision and update of the active shooter plan is underway. All staff will be trained in the new procedure. <p>An additional Safety Officer Assistant was hired in the Spring of 2014 to assist with the reduction of injuries and assaults at the hospital. The addition of this position provides the hospital with someone who is available to provide safety rounds throughout the hospital on all 3 shifts. This provides the hospital with more direct input from the staff and immediate real-time action regarding their concerns. This position also reviews all injury report forms and accident investigations in a timely manner and provides immediate feedback to employees and supervisors regarding prevention strategies.</p>
<p>c. Personnel policies</p>	<p>All safety-related policies have been reviewed and updated Sunset review dates will be monitored for completion by the WSH Policy Committee.</p>	<p>Updated and new policies are made available to staff hospital-wide via Intranet with hard copy distribution and/or Staff Development Department training. The policies are presented in New Employee Orientation, during duty-site training or as stand-alone training.</p> <p>An Active Shooter/Hostage/Lockdown policy and procedure is currently in the process of being revised and updated to assist staff with managing this emergency if it may arise in the workplace. A live training component for all staff will go along with the new policy and procedure. Anticipated Completion: December 31, 2014. Once all training is completed, WSH plans to exercise this procedure with the local community in 2015 to test our response.</p>
<p>d. First aid and emergency procedures</p>	<p>WSH has Teams of clinical staff that will respond to Medical Emergencies to any person throughout the hospital.</p> <p>WSH actively plans/ prepares and participates with the Community for disasters.</p>	<p>WSH’s Code Blue (Medical Emergency of person presenting with respiratory distress) is requested when a person is found in cardiopulmonary or respiratory arrest. In 2014 WSH implemented an enhanced Code Blue drill process to make the drills more realistic and improve staff skills.</p> <p>WSH’s Medial Rapid Response team will be initiated for all medical emergencies, Life threatening, accident, injury or illness to any person.</p> <p>WSH participates with Department of Social and Health Services Office of Emergency Management Office, the King & Pierce County Northwest Healthcare Response Network Coalition, Pierce County Department of Emergency Management, Tacoma Pierce County Health Department, and the City of Lakewood Emergency Management Committee to plan/prepare for emergencies as well and participate in community-wide drills. Currently, WSH is in the process of developing our Continuity of Operations Plan (COOP), and a plan with the Tacoma Pierce County Department of Health Department to establish a Private Medication Center-for our patients, employees and their families during a health disaster, (i.e. pandemic, anthrax outbreak, etc.). WSH drills with the community at least twice per year.</p> <p>In 2013, WSH participated in 6 drills with the local community (See below):</p>

		<ul style="list-style-type: none"> • <u>National Disaster Medical Systems Tabletop Exercise April 26 & 29, 2013:</u> In support of the NDMS and the local Puget Sound Federal Coordinating Center (PSFCC), the Northwest Healthcare Response Network, Public Health – Seattle & King County and partners from local emergency management, fire/EMS, transportation and others, tested the Kind County International Airport NDMS patient Reception Area plan including patient distribution and movement through a full scale exercise, to prepare for circumstances when patients from other states may need to be flown into King County to receive care at area healthcare facilities. As part of the exercise, some email and WATrac bed updating and alerting were also tested. • <u>The Great Washington Shake out 2013, October 17, 2013:</u> On October 17, at 8:05 am a 6.5 magnitude earthquake occurs on the Tacoma fault and lasts approximately 38 seconds. At 10:17 am on October 17 an after-shock earthquake of 7.5 magnitude occurs and lasts for approximately 45 seconds. WSH tests their general response to an Earthquake affecting WSH and the surrounding community. • <u>Washington State Department of Health and Washington System for Tracking Resources, Alerting and Communications (WaTrac) May 1, 2013, July 10, 2013, September 4, 2013, and November 6, 2013:</u> The above drills tested the hospitals ability to effectively utilize the WaTrac system during drills, exercises and real events/incidents and if they communicated with outside agencies and facilities in a timely manner. <p>In addition, WSH completed 1 internal drill, 2 real events and 1 drill with DSHS-Office of Emergency Management:</p> <ul style="list-style-type: none"> • WSH IT Dept. Disaster Recovery Plan Table top, September 30, 2013 to test the WSH IT On Call Manual and the WSH IT Disaster Recovery Plan • Real Event: CFS Fire on F-8, July 1, 2013 • Real Event: PTRC Central C7 Fire, August 6, 2013 • Duty Station Status Report (DSSR) and Employee Emergency Information Line update, December 12, 2013. <p>A review of WSH’s Comprehensive Emergency Management Plan (CEMP) is currently underway to update changes that have occurred since last revision of the CEMP. This is the required 3 year review. Anticipated Completion date: 12/31/2014.</p> <p>A 1-800 number and DSHS Wide Website are available for staff to use during emergencies to find out information about the hospital.</p> <p>WSH is in the process becoming a Private Medication Center for all patients, staff and their families when a disaster occurs such as a pandemic where the mass dispensing of medication is required. This will assist the community with ensuring our patients staff and their families get the proper medications necessary in a timely manner.</p> <p>In 2013 the way Fire and Behavioral Crisis Drills are done has been modified in order to provide on-going and effective training that promotes staff and patient safety by concentrating on more realistic training. WSH departments are conducting training on all</p>
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		<p>shifts and all days of the week where more staff have the opportunity to participate in a more realistic way. It has improved staffs responses to incidents and events. Will continue to monitor.</p>
<p>e. Reporting violent acts, taking appropriate action in response to violent acts, and follow-up procedures after violent acts:</p>	<p>WSH has 5 different avenues for staff to report violent acts. (Administrative Report of Incident, Security Incident Report, 3-133 Employee injury report, Lakewood Police report, and the 1-888 Support our Safety Line.</p> <p>The Incident Management Office (IMO), Lakewood Police Department, Various Safety Committees and Safety Manager, ensures appropriate actions and follow up procedures are taken in response to violent acts</p>	<p>WSH has an Administrative Report of Incident (AROI) form which is to be filled out for any unusual occurrence. Below is a section of the Hospital’s AROI policy:</p> <ul style="list-style-type: none"> • All <i>serious and emergent incidents</i> . . . will be immediately reported (within 1 hour of becoming aware of the incident) to the nearest supervisor on duty. An Administrative Report of Incident (form DSHS20-192 will be initiated and hand delivered to the supervisor on duty no later than the end of the current shift. <p>In addition, Security Incident Reports (SIR’s) are used to report incidences of violence as well as the DSHS - Report of Employee, Volunteer . . . Personal Incident Report (3-133), when an employee injury is involved.</p> <p>Staff can also request police involvement for any patient to staff violent acts that are criminal in nature by completing a police report.</p> <p>Anyone can leave any type of safety issue anonymously on WSH Support our Safety Hot line as well.</p> <p>The Incident Management Office is tasked with reviewing the AROI’s and SIR’s on a daily basis and is comprised of Investigators and Clinical Risk Review Specialists. A daily triage team is made up of at least one investigator a Clinical Risk Reviewer, IMO Manager, Security representative, Safety representative, Consumer Affairs Director and Chief of Medical Services. The team determines which incidents meet serious/emergent criteria for further review by someone outside of the Centers where the incident occurred. Decisions are also made to refer incidents to other agencies for investigation when needed.</p> <p>WSH has 5 Safety Sub-Committees that are made up of both Management and Labor employees and meet on a monthly basis. The Management & Labor Co-Chairs from each Safety Sub-Committees Reports up to 1 Central Safety Committee. The Safety Sub-Committees are tasked with reviewing all 3—133 and other safety items and follow up on any unresolved issues. Issues that cannot be resolved at the Sub-Committee level are then brought to the Central Committee for Resolution. The WSH Safety Office also reviews all of the 3-133’s and makes recommendations to the hospital for corrections needed.</p> <p>Lakewood Police Department will investigate and determine when cases area forwarded to the Prosecutors office for a charging decision. The IMO is responsible for monitoring all Lakewood police reports filed by staff for status of each case. Lakewood will inform WSH IMO of status of open cases on a weekly basis. If the cases are declined by LPD, IMO, HR, and hospital management will review to determine if further action is needed.</p> <p>The Safety Manager is responsible for monitoring the SOS Hot line Monday through Friday 8:00 am to 4:30 pm. All issues reported on this hotline, must be followed up on by Executive Management.</p>

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<p>Analysis of data on violence and workers compensation claims during at least the preceding year</p>	<p>A Critical Incident Stress Management Program is established at WSH to prevent or minimize stress reactions in staff exposed to a critical incident in the course of their duties at WSH.</p> <p>WSH provides debriefings for serious clinical incidents to help reduce serious clinical incidents, prevent violence, and promote a safe and healing environment.</p> <p>WSH Safety provides monthly data regarding staff injuries and L&I claims information.</p>	<p>WSH has a team of individuals who are trained in crisis intervention to provide a one-time Stress Debriefing meeting designed to assist staff exposed to critical incidents. Stress Debriefing helps people to work quicker through acute stress reactions and return to normal functioning. Staff training in debriefing will sit down with the staff affected by the critical incident and as a group to process their reactions. Stress Debriefings are not public information. The entire process is confidential, Not mandatory. Participation is voluntary. Not a critique of job performance or part of an investigation. It is not open to outsiders. Only CISM team members.</p> <p>A Serious Clinical Incident is defined as including all episodes of seclusion and restraint, serious injuries which require medical attention, serious physical and serious property destruction. The debriefing process for Serious Clinical Incidents is a collaborative process in which staff and patients gather in a safe space to: assess immediate staff/patient needs; identify the facts; review how people responded as the serious incident unfolded. The intended outcome is to recommend specific, individualized treatment approaches, staff interventions and system changes that could reduce the likelihood of future serious incidents and promote safety.</p> <p>WSH Governing Body Sub-Committee (quarterly) and Safety Committees (monthly) continue to review injury data and L&I claims information on at least a quarterly basis to identify where the injuries are occurring and what can be done to reduce them.</p> <p>The DSHS Employee Incident Report form(s) have been significantly revamped .The new forms were distributed for staff and supervisors to use to report workplace incidents in April 2014. These new forms provide staff with a better tool for investigating accidents. Improved accident investigations lead to better prevention strategies in the future. One duty of the additional SOA is to review these forms as they come in and provide 1 to 1 coaching to employees and supervisors regarding their completion in order to provide the hospital with better prevention strategies.</p>
<p>f. Development of criteria for determining and reporting verbal threats.</p>	<p>Criteria has been identified within the Administrative Incident Reporting policy for reporting verbal threats.</p>	<p>Verbal threats are tracked using the Security Incident report and/or the Administrative Report of Incident. In 2003, the WSH Performance Measurement and Information Office added “threats’ to its incident coding defined as follows:</p> <p>An alleged incident reported of any communication or interaction between (persons) that is patently dehumanizing or that places a (person) under excessive duress, including name calling, use of derogatory of uninvited nicknames, racial slurs, demeaning remarks, inappropriate shouting, imitating or mocking (the person’s) behavior, or threatening physical abuse (communicated orally, in writing, or with body language, with intent to do harm, coming from a (person) who is able to carry out the threat, resulting in the other (person) being afraid). This definition was an amalgamation from various sources. Counts are kept for patient-to-patient threats, patient-to-staff threats, staff-to-patient threats, and staff-to-staff threats, among others.</p>
<p>g. Employee education and training</p>	<p>Curriculum has been developed for identifying and reporting violence in the</p>	<p>The Security Director provides training to all new employees in identifying and reporting violence in the workplace.</p>

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	<p>workplace, as well as supporting an environment of safety.</p> <p>TEAM Partnership for Violence Prevention is mandatory training for all new employees prior to reporting for assignment. All employees' records are reviewed for compliance.</p> <p>Ward-based job classifications are required to receive annual update training in TEAM.</p> <p>All Nursing Department staff (RN, LPN, PSN, PSA, MHT, IC) are required to complete an annual all-day training including standards of care, personal and workplace safety, and SAFE TEAM practice.</p> <p>All new employees are required to complete Safety, Accident Reporting, Workplace Civility, Culture of Safety trainings.</p> <p>All existing employees are required to complete annual Safety, Accident Reporting, Workplace Civility, and Culture of Safety training.</p> <p>Supervisory staff receives training in safety and accident investigation and reporting</p>	<p>TEAM (Training in Effective Aggression Management) is a mandatory requirement for all WSH new employees. TEAM training will be completed before reporting for duty at job assignment. TEAM training places emphasis on the creation of a safer, non-violent environment.</p> <p>The SAFE TEAM director has provided an enhanced training schedule to ensure all current employees assigned to ward based patient care receive annual refresher in TEAM during the monthly nursing competency fair. Further monthly TEAM trainings are available on the key elements of; Therapeutic Relationships, Safety Movements and Mechanics, Understanding Behaviors, De-escalation.</p> <p>DSHS BHSIA WSH Nursing Competency & SAFE TEAM Review is an annual all-day training with review of nursing policy procedure protocols along with personal safety, situational awareness, de-escalation, redirection, and Safe Team practices.</p> <p>New employee orientation provides new employees receive live instructor led training in Safety, Industrial Hygiene, Accident Reporting, Infection Control and Blood-borne Pathogens, Security Awareness, Workplace Civility, and Culture of Safety by content experts in these areas.</p> <p>All existing employees receive annual mandatory training in Safety, Accident Reporting, Infection Control and Blood borne Pathogens, Security Awareness, Workplace Civility, and Culture of Safety. These trainings are available by attending live classes or online with testing to ensure comprehension.</p> <p>3-133 Employee Incident Investigations for Supervisors is a live instructor led training where safety personnel instruct and coach managers and supervisors how to examine and correctly handle employee reports of safety concerns, injuries or unwanted events. Completion is recorded in the employee training record.</p> <p><i>Note: The Employee Incident Investigation form(s) have recently been revised and training is currently being developed to go along with the new forms. Anticipated completion date: 12/30/2014.</i></p>
<p>h. Clinical and patient policies and procedures including those related to:</p>	<p>WSH has improved communication regarding our smoking policy. WSH has</p>	<p>WSH Smoking Policy allows smoking in certain outdoor areas. (Areas in compliance with Washington state law prohibiting smoking within 25 feet of specified areas). To help</p>

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<p>1. Smoking 2. Activity, leisure and therapeutic programs 3. Communication between shifts 4. Restraint and seclusion</p>	<p>also added covered sheds and visual markings around the hospital to assist patients and staff with complying with the WSH Smoking Policy .</p> <p>WSH continues to improve active treatment and leisure programs to provide patients more meaningful and recovery-oriented activities.</p> <p>WSH continues to place a major focus to reduce the use of seclusion and restraint. A PERT Team has been instituted in CFS. In addition, a CFS Basics class was provided to all CFS-Based staff to give them the most current evidence-based treatment tools for working with the patients we serve.</p>	<p>patients and staff comply with the smoking regulations, WSH has provided outdoor storage areas for the patient cigarettes, matches, etc., covered smoking shed outside of the 25 foot rule, and periodic reminders sent to staff regarding our smoking policy. In addition, a green stripe was painted 25 feet away from all buildings to mark where people can smoke in order to be in compliance with the 25 ft. rule.</p> <p>Western State Hospital (WSH) provides approximately 240 active treatment groups weekly and 50,000-60,500 hours of active treatment as well as approximately 4,542 vocational hours monthly. This includes patients who participate in recreational activities. The WSH Art Center provided approximately 1,206 hours of active treatment this past month; this number is up from approximately 731 during the previous reporting period. WSH maintains its afternoon and evening programming to not only increase active treatment but also engage patients during times of the day when there have traditionally been more frequent violent incidents. Evening programming currently includes activities each evening of the week except Sunday. Outside of regularly scheduled events, staff and patients have most recently put together and successfully completed a softball and kickball game (PTRC South & Central). As well, PTRC anticipates hosting a patient carnival later this summer.</p> <p>A Psychiatric Emergency Response Team (PERT) was instituted in the hospitals forensic unit. PERT is designed as a first-responder system to promote a culture of safety for patients and staff. This highly skilled team, comprised of Psychiatric Security Attendants (PSA), Registered Nurses (RN), Psychiatric Social Workers (PSW), Psychology Associates (PA), Security Officers (SG), and a Supervisor, are trained in crisis intervention skills, incident management skills, analysis of antecedents for violence and aggression, and de-escalation techniques. When containment is required, this team facilitates seclusion and restraint if necessary, and works with floor staff to re-integrate the patient to the milieu with appropriate evidence-based debriefing.</p> <p>When not active, team members fold into the staffing model and provide direct, hands on therapeutic engagement of patients, often modeling a best practice for staff. A secondary benefit to establish the service is enhanced staffing on the more volatile patient treatment units of CFS. PERT is not included in the staffing ratio count.</p> <p>In addition, all CFS-Based staff in Spring 2014 and continues for all new CFS Based staff. CFS Basics is an evidence-based training that was provided to all. It is designed to give every person in the Center for Forensics Services an understanding of the unique aspects of the patients we serve. It also give them the most current evidence-based treatment and tools for doing this work. This is accomplished for both didactic and en-vivo trainings and evaluations. Each member of PERT has received a more intense version of this training. CFS Basics covers the following topics:</p> <ul style="list-style-type: none"> - General Vision, Mission, and Values of BSHIA and WSH - What is CFS and How Does Someone Come to CFS - Psychiatric and Behavioral Characteristics of Someone in CFS - How to Interact With Patients - How to Chart Behavioral Observations and Response to Treatment
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	<p>An Adhoc Safety Committee was established to review and evaluate previous workplace evaluation and studies and determine what initiatives can be done with current resources, and what items would require legislative support and funding.</p>	<ul style="list-style-type: none"> – A Cultural Competency Self-Assessment – Vicarious Trauma and Resiliency Training – Basic Skills Training – Problem Solving – Boundaries Training – Crisis Management – Risk Assessment and Management – Basic of PERT – Skills Practice <p>In December 2013, BHSIA chartered the “Ad Hoc Safety Committee” in response to a diverse group of partners concerned about workplace violence and multiple evaluations and studies that have identified gaps and need for improvement.</p> <p>Membership consists of teams from BHSIA, WSH ESH and CSTC, Service Employees International Union (SEIU), Washington Federation of State Employees (WFSE), Health Care 1199 Northwest, the Union of Physicians of Washington (UPW) Coalition, hospital management and represented employees. With a commitment to a transparent process and opportunities for all staff to provide feedback, the Committee has prioritized the following recommendations:</p> <ol style="list-style-type: none"> 1. Identify rapid improvement initiatives within current resources or with the reallocation of current resources; 2. Identify tangible actions that would reduce workplace violence over the next 24 months; 3. Identify safety and security initiatives that require legislative support and funding with a focus on staff training, physical environment and increasing staffing ratios.
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