Report to the Legislature

Workplace Safety in State Hospitals

Chapter 187, Laws of 2005, Section 1

September 2012

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Executive Summary

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

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

(1) By November 1, 2000, each state hospital shall develop a plan for implementation by January 1, 2001 to reasonably prevent and protect employees from violence at the state hospital. The plan shall be developed with input from the state hospital's safety committee, which includes representation from management, unions, nursing, psychiatry and key function staff as appropriate. The plan shall address security considerations related to the following items:

(a) The physical attributes of the state hospital;
(b) Staffing, including security staffing;
(c) Personnel policies;
(d) First aid and emergency procedures;
(e) Reporting violent acts, taking appropriate action in response to violent acts, and follow-up procedures after violent acts;
(f) Development of criteria for determining and reporting verbal threats;
(g) Employee education and training; and
(h) Clinical and patient policies and procedures.

(2) Before the development of the plan required under subsection (1) of this section, each state hospital shall conduct a security and safety assessment to identify existing or potential hazards for violence and determine the appropriate preventive action to be taken. The assessment shall include, but is not limited to, analysis of data on violence and worker's compensation claims during at least the preceding year, input from staff and patients such as surveys, and information relevant to subsection (1)(a) through (h) of this section.

(3) In developing the plan required by subsection (1) of this section, the state hospital may consider any guidelines on violence in the workplace or in the state hospital issued by the department of health, the department of social and health services, the department of labor and industries, the federal occupational safety and health administration, Medicare, and state hospital accrediting organizations.

(4) The plan must be evaluated, reviewed, and amended as necessary, at least annually.

RCW 72.23.451 – Annual report to the Legislature

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

Overview

This report includes activities related to the three state psychiatric hospitals as follows:

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

The Report updates last year's report by adding data for June 2011 through April 2012.

Eastern State Hospital: located in Medical Lake, Washington, has a capacity of 287 beds;

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

Initial workplace safety plans from the three state hospitals were submitted to the legislature in November 2000 and have been evaluated, revised and updated at least annually. These plans provide a safety assessment, detailed security activities undertaken, and also identify further plans of action. These plans are available for review upon request.

Creating a safe working environment in state hospitals remains a top priority for the Governor's office, the Department of Social and Health Services the Department of Labor and Industries (L&I), leadership of all three state hospitals, Western State Hospital (WSH), Eastern State Hospital (ESH) and Child Study & Treatment Center (CSTC) and local labor unions.

Implementing a Continuous Quality Improvement Plan (CQI Plan) is a top priority for DSHS leadership including implementation of a strategic plan to improve risk management outcomes related to state hospitals. Strategies are being implemented to improve patient care, quality management, data management and workplace safety, as well as increased individualized treatment planning, active psychosocial rehabilitation treatment and training, monitoring and adequate staffing. Each hospital is implementing strategies to improve care and services, and ultimately safety, as part of their individual Continuous Quality Improvement Plans.

Safety programs at all three hospitals are a priority and funded within current resources. The Return to Work program provides employees, who have either an occupational injury or illness and are unable to return to full regular duties immediately, with a safe, timely transition back to work with modified duties based on medical restrictions until medically

released to full duties. The program involves monitoring an injured employee's progress and identifying temporary modified duties that are suited to physical capacity guidelines established by the designated physician or medical provider.

The goal of the state hospital return to work program is to reduce the cost of Labor and Industry (L&I) premiums for the state hospitals and reduce costs for L&I compensation for injuries. Premiums are determined by L&I on a three year rolling average and based on the combined performance of all DSHS institutional staffs. The state hospitals are currently paying premiums based on the cost of claims for all DSHS institutions for 7/1/2007 through 6/30/2010. Full impact of cost savings due to RTW state hospital programs is not expected until 2012 or 2013 and will be influenced by the performance of other DSHS institutions.

Safety programs, other than increased challenges related to back filling for staff on light duty or attending safety training, remain intact at all three hospitals.

Summary

The state hospitals continue to collaborate on several projects:

- Workplace Safety Initiatives
- Reduction of Seclusion and Restraint Initiatives
- Standardized policies and procedures

The state hospitals are planning to collaborate on new projects:

- Evidenced Based Practice treatment interventions for medication management.
- Creating a Tobacco-Free Campus
- Participating with L&I's SHARP program in a research project through an approved grant to assist the hospitals with workplace violence prevention

Challenges

Recent budget reductions make maintaining past gains a challenge. At WSH, Return to Work FTE's provide injured staff a funded, light duty position, to return to on a temporary basis as prescribed by their healthcare provider. The positions also allow for current positions to participate in safety training without impact to patient care by assigning a Return to Work FTE to backfill during training. While all three hospitals are struggling, Western data indicate a loss to past gains in the ratio of compensable vs. non-compensable assault claims and an increase in the number of days missed from work due to an assault. ESH has maintained a dynamic Return to Work program offering Transitional Return to Work utilizing existing funded positions while backfilling critical positions during an injured worker's recovery. The current economic climate will impact ESH's ability to maintain its program at the current level resulting in increased time loss.

Child Study & Treatment Center

CSTC Summary of Accomplishments

- Principles of an Effective Treatment Milieu: Child Study & Treatment Center has developed into a nationally recognized model of a successful public sector-academic (University of Washington) mental health collaboration. CSTC provides state of the art care for the most psychiatrically complex youth in Washington State. Our professional staff are involved in clinical and translational research and are active nationally in developing standard of care guidelines and practices for diagnosing and treating youth with serious emotional disturbances.

  In 2010 CSTC developed a treatment manual that works to translate this knowledge into day to day treatment strategies. Principles of an Effective Treatment Milieu describes how nursing and counseling staff can utilize evidenced based treatments in every interaction with children and youth. The manual describes the elements of an effective treatment milieu and describes the foundational knowledge necessary for treatment teams to more quickly implement individualized behavior support plans for youth displaying disruptive behaviors. CSTC has continued to train staff to the model. Through 2011, the clinical leadership at CSTC has continued to refine the manual and work to emphasize the need for a behavioral understanding to aggressive behavior. Treatment teams conduct functional behavioral analysis when patients present with assaultive or aggressive behavior in an effort through analysis to understand the function of the behavior and work quickly to extinguish the behavior.

- Staffing Patterns / Reducing Vacancies: Clinical leadership recognizes the impact a strong and stable workforce has on the treatment milieu and ability to more safely manage assaultive patients. An emphasis on maintaining stable shift teams began in 2010 with a focus on reducing the number and duration of vacant positions. The center experienced a period of greater stability as turnover rates decreased with the difficult economic situation.

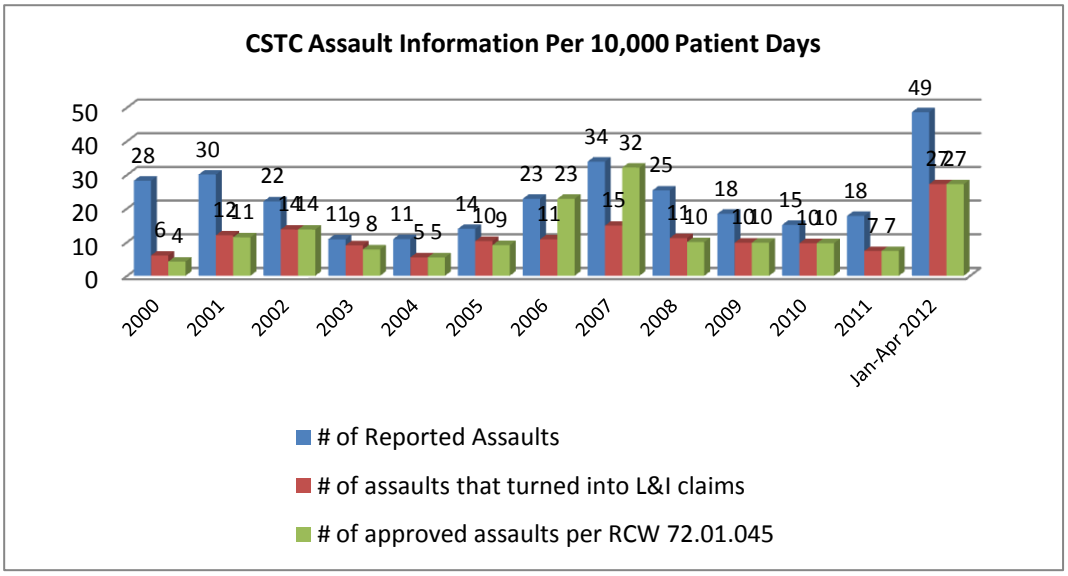
CSTC Continued Challenges

Analysis of the data of assaults toward staff demonstrated to clinical leadership at CSTC, the significant impact a few, highly acute patients can have on the overall milieu and number of injuries. During the beginning of 2012, 2 patients account for 58% (14 of the 25) reported assaults.

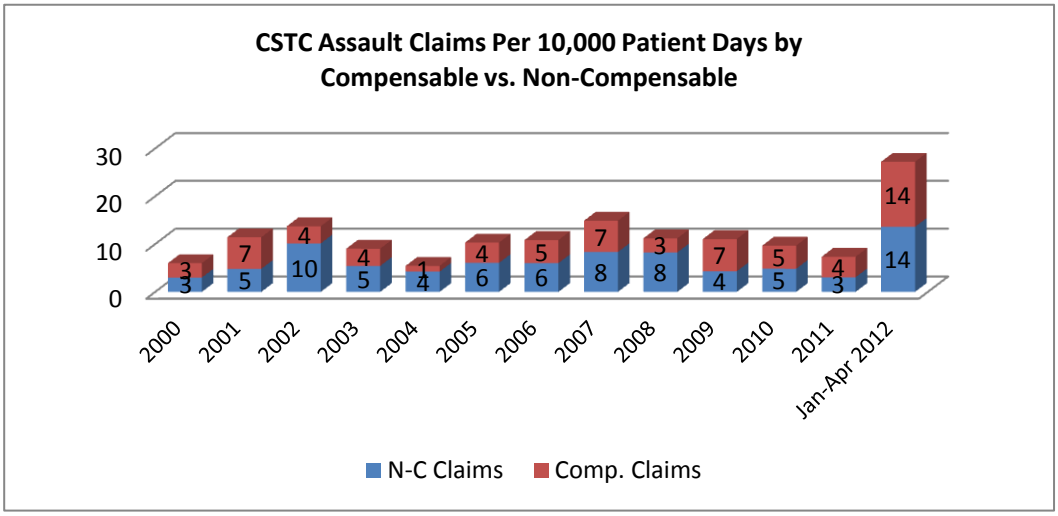
CSTC Data Summary

Number of reported assaults, assaults that turned into L&I claims and approved assaults per 10,000 patient days.

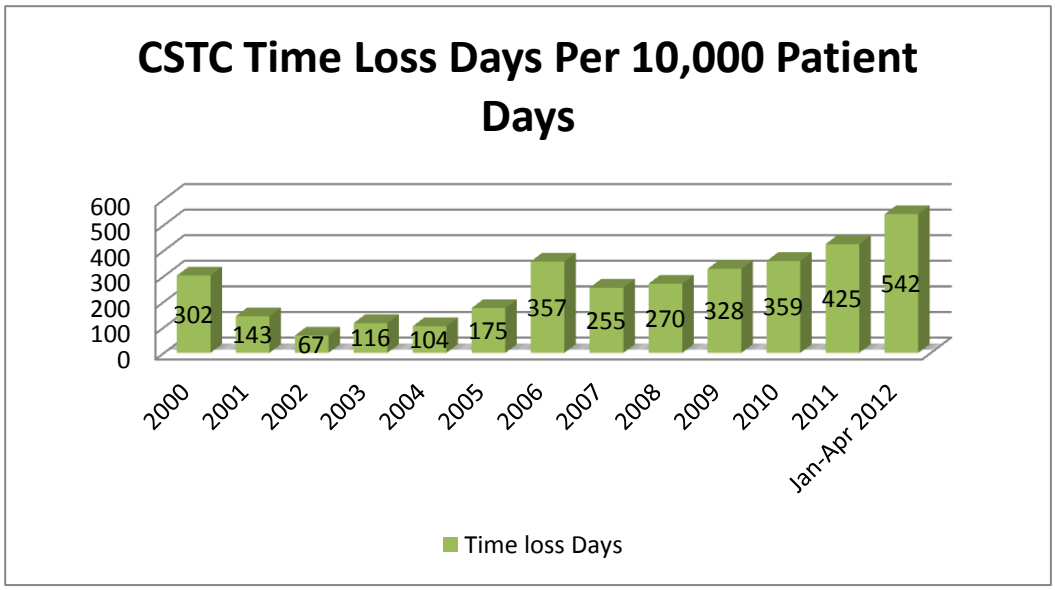
There was a slight increase in the total number of reported assaults in 2011. Of concern are the significantly higher rates of incidents of assault on staff during the first 4 months of 2012. As stated previously in the report, 58% (14 of the 25) reported assaults involved 2 patients. The treatment teams continue to work with these two patients to reduce the incidents of physical violence. In both instances the teams are beginning to see improvement.



Compensable vs. Non-Compensable Assault Claims: CSTC monitors the severity of employee assault injuries based on the proportion of compensable claims to non-compensable claims. For the past two years, the number of compensable claims (representing a more serious injury) was either greater or equal to the number of non-compensable claims. The rate of compensable claims to non-compensable was higher in 2011 and equal in the beginning of 2012.



Time Loss Days: The number of time loss days per 10,000 patient days increased in 2011. The trend during the first 4 months of 2012 shows a significant increase.



Eastern State Hospital

Summary of Accomplishments

- The reduction in patient to staff assaults exceeded the 2011 performance improvement activity target (5% decrease in incidents; 122) with 105 reported. The total number of all reported incidents in 2011 was 224 compared to 238 in 2010. The total number of days away from work decreased from 1475 in 2010 to 1361 in 2011. Reported days away from work are based on the OSHA 180 day reporting rule (time loss reporting ends when days away from work, job restriction, or a combination of both, reaches 180 days).

- Memorandum of Understanding (MOU) was developed and signed collaboratively among Chief Operating Officers and Superintendents of department residential programs on November 22, 2011. The MOU is intended to promote sharing of facilities and other resources during disasters and to foster ongoing collaboration in continuity of operations planning and provision amongst department residential programs.

Projects:

- A Capital Programs project continues for installation of patient safety/suicide prevention hardware improvements (door handles, closet rods, grab bars, mirrors).

- Numerous security improvements were implemented in 2011, including, but not limited to:

    - Westlake Geropsychiatric Unit upper level patio security upgrade.
    - The unoccupied Primate Center was hardened to prevent unlawful entry. Some doors in this vacant building were welded, others barricaded from the inside.
    - Broken windows boarded over on vacant buildings throughout the campus to discourage unlawful entry including Roosevelt Hall and Interlake.
    - Additional locks installed in some interior doors of Westlake to prevent unauthorized leave.

- A Plan for Improvement was developed and Capital Programs project implemented 5.27.10 to replace inoperable damper assemblies due to mechanical issues and/or actuator failures. Interim Life Safety Measures were in place during replacement until project completion; 2.24.11.

Performance Improvement Activities:

- Level of compliance with control of equipment and materials stored in corridors continues to be monitored and documented daily. The hospital reviews the results of the monitoring and documents compliance on the quarterly Environment of Care Performance Improvement Activities Report.

- Thirty Environmental Surveys were conducted in 2011 in both patient and non-patient care areas hospital-wide. As part of the 2011 EOC Performance Improvement activities, environmental surveys as well as additional surveys were used to monitor level of compliance with maintaining reliability of collapsible closet rods in FSU patient rooms on 2S1 and 3S1.

- A drill down focusing on increases in patient-to-staff assaults as well as increases in patient-to-patient assaults and patient falls on GPU was initiated by the QM Director. The performance improvement team included the Director of Social Work, Rehab Services, Medicine and Nursing. Data was gathered from staff across all disciplines and shifts to analyze changes, e.g. population, staffing, processes, etc., that may be influencing increases in order to develop a systematic and sustainable Plan for Improvement.

- Flexible pens were issued to patients for individual use and group activities to reduce the risk of use for self-harm or as weapons.

- As part of the 2011 EOC Performance Improvement activities, environmental surveys were used to evaluate staff knowledge of and ability to access Material Safety Data Sheets (MSDS) on-line (hospital-wide).

- Continuous recruitment of Emergency Protective Equipment Response Team (EPERT) members is occurring on a scheduled basis to ensure the pool of members does not fall below target numbers. The following are recommendations from the Department of Corrections staff that have been implemented:

    1. Only staff properly fitted and who receive specialized training use the equipment. The equipment is assigned to individual team member(s) and is located in a secured area that can only be accessed by the members.
    2. All of the EPERT members carry specialized pagers in order to respond. NOTE: When the team is paged out, nursing management also receives the page.
    3. Prior to the EPERT being paged, the use of the equipment must be approved through the process listed in the ESH policy.
    4. A minimum of three EPERT members with Emergency Protective Equipment (EPE) must respond.
    5. The current number of EPERT members per shift includes eight staff on day shift, nine on afternoon shift and six and night shift.

6. Additional consultation regarding EPERT function and impacts on safety of the environment and patient rights was provided by national clinical, psychiatric experts. The outcome of their findings is being reviewed for action by the Director of State Hospitals

- A Plan for Improvement was developed for two 2011 emergency exercises (staged and actual) for all identified issues related to internal/external communication, availability of and access to materials, safety and security of patients and staff, staff roles and responsibilities (assignment and performance), managements of critical utilities, managements of clinical and support activities.

- Fire drill activities occurring during 2011 focused on reducing time (four minutes or less) required for staff to complete fire procedures on the wards. While improvements were made on some wards there was no consistency from quarter to quarter. This will continue to be monitored and addressed during 2012 quarterly drills.

- Performance improvement activities related to Medical Equipment Management processes were developed based on the Failure Mode Effectiveness Analysis completed in 2010. Changes were implemented January, 2011 with a target of decreasing the number of cannot-locate equipment identified during preventative maintenance checks by 5%. There were 21 reports of equipment that could not be located by CSS during preventive maintenance checks in 2011 compared to 38 in 2010. A 45% decrease.

- As part of a 2011 performance improvement activity to comply with the Federal Communications Commission (FCC) Narrow-banding requirements, the following was implemented:

  1. Narrowband capable Icom FR4000 repeater installed 2/08/2011.
  2. Six narrowband capable Icom F6021 base station radios purchased 2/08/2011. Two to be used for replacing non-compliant equipment. Four to be used for replacing inoperable equipment or fill hospital communication requirements as the need arises.
  3. One heavy duty-cycle Icom FR4000 base station/repeater purchased and installed in the Administration Building, 1st floor, SE Executive Office as of 3/08/2011. Replaces non-compliant equipment.
  4. FCC Licenses amended for narrowband emission for 3 of 3 call signs assigned to ESH, WPVP286, KNNN241, and WNBC407 (pager) as of 3/29/2011.

Future Planning:

- Completion of the patient safety/suicide prevention stratified risk reduction Capital improvements.

- Capital Programs funding was requested and approved for the 2011-2013 biennium for FSU security upgrades (cameras and access control).

- Capital Programs funding was requested and approved for the 2011-2013 biennium for replacement of all Westlake height adjustable tubs.

- Reduction of employee injuries related to patient handling activities (lifting, re-positioning, transferring, preventing patient falls); 2012 Safety Management performance improvement activity.

- Monitoring high risk door locations for trends (unsecured) to evaluate need for snap-lock and/or door replacement.

- The Security Department will complete a risk assessment associated with medication security to include:

  1. Number and severity of medication security incidents
  2. Level of access
  3. Security hardware present (alarms, locks, video surveillance)
  4. Public traffic and degree of isolation
  5. Potential degree of loss
  6. Community risks
  7. Security risks associated with particular times of day

Risk Assessments:

- An annual Proactive Environmental Risk Assessment was completed November, 2011 to identify safety and security risks associated with the environment of care. Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts. These risks were prioritized utilizing a 5-point scale and include recommendations for improvement.

- The Hazard Vulnerability Analysis (HVA) was reviewed with the Safety Committee August, 2011 and results utilized for future Emergency Management response and recovery planning.

Workgroups:

- The Safety Officer and Infection Control Coordinator continue to actively participate in the Region 9 Healthcare Coalition. ESH participated in a region-wide, table top, medical surge exercise on May 5, 2012 with the following components required by the WA State Department of Health (DOH) ASPR grant: communications, emergency system for advance registration of volunteer health professionals, partnerships/coalition (MOU's), Alternate Care Facility (ACF) Planning, and at least two (2) of the following: fatality management, medical evacuation, and/or tracking of bed availability.

Continued Challenges

- There is currently one Security Guard on duty for both the afternoon and night shift due to lack of funding for additional positions. This reduces Security's ability to respond to emergencies and unauthorized leaves, monitor the campus for trespassing, unsecured doors, etc.

- Maintaining current level of Transitional Return to Work opportunities.

- Weighing purchases of safety equipment against purchases for direct care needs.

- EPERT

    1. Shift changes made by staff:
    2. Difficulty obtaining properly fitting equipment for trained individuals.
    3. More trained and equipped individuals to cover for scheduled and unscheduled leave usage are needed. Quality Management staff will work with administration and the nursing department to develop a system to provide consistent quarterly training.
    4. Consultation findings that indicate risk for use of this system are more significant than the risks of utilizing other approaches that are not modeled after a corrections approach.

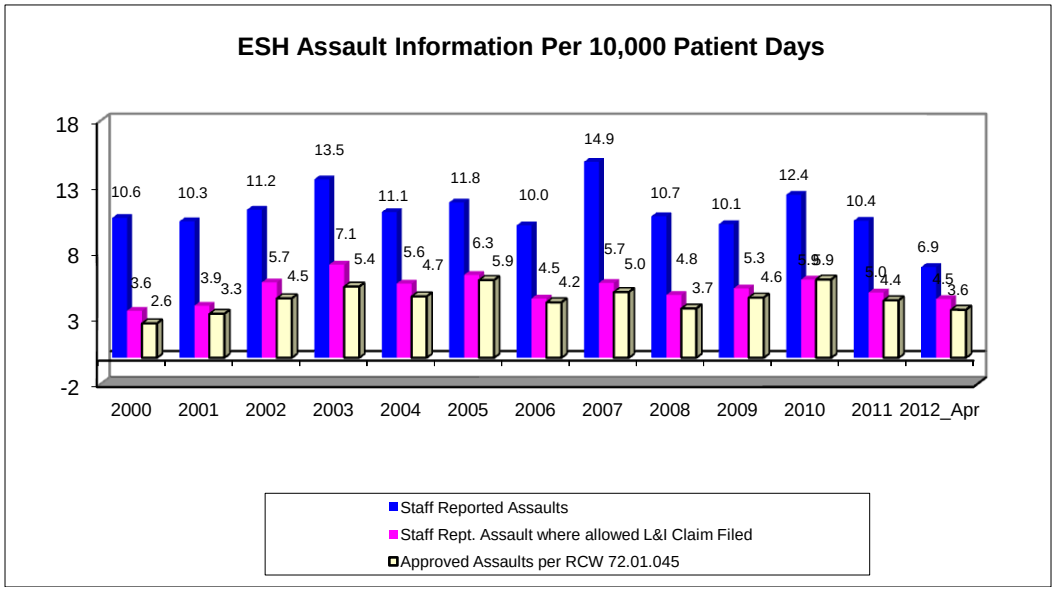
Budget:

The allotment for FY 2013 the second year of biennium 2011-13 is $1,358,000 less than FY12 the first year of the 11-13 biennium. The reduction is offset by planned reduction to personal service, procurement and PEBB funding rates. However, further reduction in expenditures will be needed to offset the anticipated loss of reimbursement to ESH ($700,000) from the RSNs for over census use. The hospital patient census has been near capacity (95-98%) for two years which requires continued emphasis on maintaining patient and staff safety. The reductions can limit backfilling for mandatory safety training and weighing purchases of safety equipment against purchases for direct care needs.

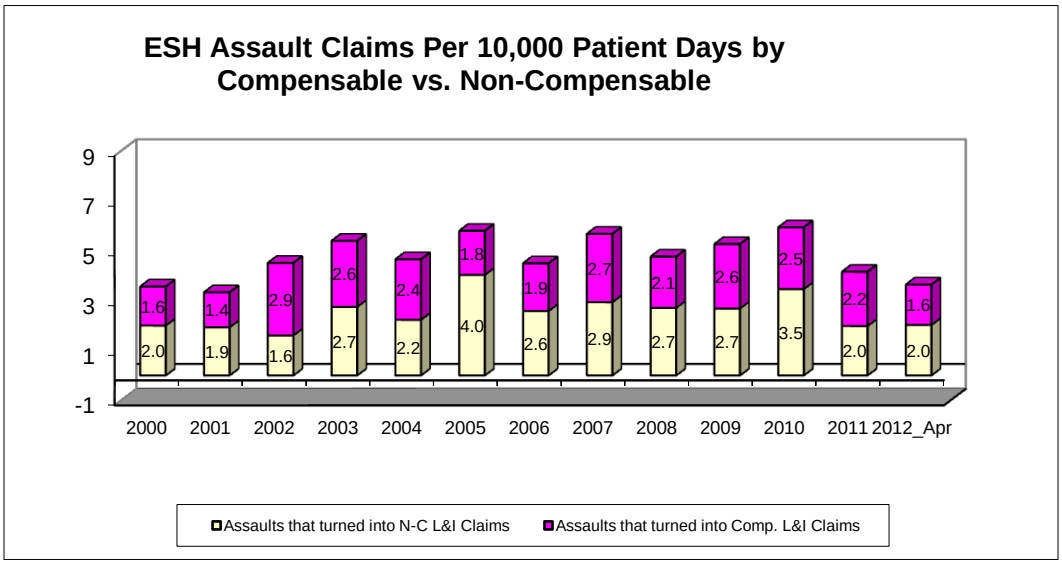
ESH Data Summary – 2012

Important Data Notes pertaining to this report: This report continues to use RCW 72.01.045 to define assaults and represents assaults per 10,000 bed days for all three hospitals. The data in this report is consistent with prior year Workplace Safety reporting with the exception of time loss days. Cumulative time loss for ESH incidents that occurs in a subsequent year is now being reported in the data for the year the time loss is **accrued** instead of the year the injury **occurred** to be consistent with WSH and CSTC reports. Due to the change in ESH time loss reporting, time loss comparisons to years prior to 2010 cannot be made in this year's report.

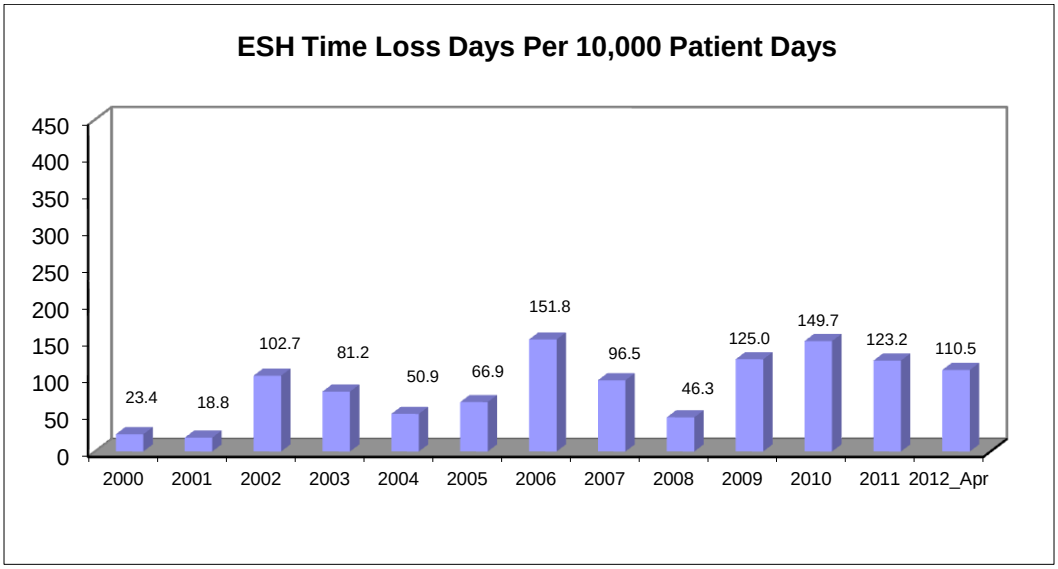
Staff Reported Assault Information: At ESH, data indicates that 2011 had a lower staff reported assault rate than in 2010 from 12.4 to 10.4. This trend appears to be continuing in the early 2012 data for reported assaults as well as assaults that turned into L&I claims and approved assaults. Sixty-one percent (760 days) of the total time loss in 2011 was due to 10 incidents that occurred in 2010; three of the ten were staff that was ineligible for Transitional Return to Work as they were non-permanent employees resulting in 281 of the 760 days.



Compensable vs. Non-Compensable Assault Claims: At ESH, the annual data through April 2012 shows that there is a decrease in the rate of non-compensable claims and a slight increase in the rate of compensable claims. The ratio of compensable to non-compensable claims indicates a slight increase with compensable claims accounting for approximately fifty percent of the total claims.



Time Loss Days Due to Assault: As stated in the "Staff Reported Assault Information", 61% (760 days) of the total time loss in 2011 was due to 10 incidents that occurred in 2010. Three of the ten resulted in 281 of the 760 days due to staff ineligibility for Transitional Return to Work as they were non-permanent employees. The remainder of time loss due to "staff reported as assault" incidents *by location* occurring in 2011 indicates 30% (142 days) was the result of assaults that occurred on a single civil commitment ward across day, evening and night shifts. Forty-five percent (214 days) was the result of assaults that occurred on another civil commitment ward; the majority of which occurred as the result of one incident (211 days) on the day shift and was due to the inability to accommodate the worker's restrictions. Time loss due to "staff reported as assault" incidents *by shift* through April, 2012 shows 69% (392 days) were the result of incidents that occurred during day shift.



Western State Hospital

Summary of accomplishments

Continuous quality improvement efforts to advance workplace safety, including joint labor and management partnerships in reviewing and evaluating injury incidents, patterns and trends; and debriefing and consulting with direct treatment staff who work with challenging patients; receiving ongoing consultation with Department of Corrections staff to strengthen security and safety within the Center for Forensic Services; and implementing strategies that employ the use of evidence-based practices for maintaining a safe clinical environment.

Projects:

- To improve daily therapeutic interactions, all nursing staff were trained on the function of aggressive behavior (psychotic, instrumental, impulsive) and methods to engage patients to meet release criteria for seclusion and restraint.

- Improved individualized treatment in the form of early and appropriate response to escalating patient behaviors.

- Clinical leaders meet every morning to review clinical reports from the last twenty-four hours. For patients with violent episodes resulting in seclusion or restraint, the patient and treatment team is visited on the ward or an intensive case staffing is scheduled to determine if additional treatment strategies can benefit the patient.

- Implemented a behavioral consultation team led by the Medical Director and Psychology Supervisor and staffed with expert psychologists to provide consultation to treatment teams for challenging patients.

- Debriefing all serious incidents to determine precipitating factors, learn from our responses, celebrate and share successes and change practice as needed.

- Intensive administrative focus on a reducing use of seclusion and restraint.

Performance Improvement Activities:

- Ninety-five percent of staff completed an online training on safety practices and the revisions to the hospital's Comprehensive Emergency Management Plan.

- 2054 safety trainings. Ongoing training for staff on managing patients who may be assaultive, including training on the function and management of aggressive behavior, its antecedents and triggers (as conducted by the SAFE [Safe Alternatives

For Everyone] Team, comprising staff of various disciplines at WSH, of whom each is recognized by patients and peers for their leadership).

- During the course of FY 2011, WSH reduced the use of overtime for nursing staff and saved nearly $600,000. This accomplishment resulted from combined attention and energy of nursing administration, hospital leadership and the Information Technology Department, who created an electronic system for monitoring and implementing overtime use. Studies have shown that people who routinely work over forty hours are fatigued and have impaired judgment and thinking, which translates into medical errors and patient and staff harm in the hospital setting.

- Developed an electronic over-time request system to evenly distribute use of overtime among staff thus minimizing burn-out.

- The SAFE Team and SAFE Team training has continued to grow and strengthen, as recommended by SHARP study. A multitude of trainings have been offered that cover the spectrum of violence prevention. For example, 721 employees were trained on the SAFE Team Module, "Understanding Behavior"; 451 employees were trained in "Safety Movements and Mechanics" Module; 662 employees had their bi-annual competency assessment related to use of restraints. Behavioral crisis drills were also implemented. These are just some of the trainings provided in fiscal year 2011. In 2012 trainings included "Seclusion and Restraint Competency" (250 staff), "Safety Movements and Mechanics" (176 staff) and Padded Shield training (253 staff). Approximately 22 new SAFE Team members were nominated and indoctrinated into the WSH SAFE Team in 2010. They were provided a 40-hour training curriculum to prepare them for the role of SAFE Team member. New nursing employees receive three weeks of initial orientation training prior to being assigned to patient care. During orientation, mentors are assigned by the nursing supervisor so that experienced nursing staff can provide side-by-side mentoring upon assignment to a ward. Currently,

    - Debriefing policy completed
    - Pilot of new debriefing form completed.
    - FMEA- Ward access and contraband completed
    - 3-133 Employee Accident Investigations for Supervisors developed and training rolled out. 108 completed.
    - Behavioral crisis drills implemented quarterly per ward.
    - Critical Incident Stress Management (CISM) Team being revitalized -- training 34 participants.
    - 683 staff trained in seclusion and restraint competencies.
    - A statewide Employee Safety Survey was conducted. This survey covered a diverse number of questions related to safety as well as asking that respondents submit their ideas, recommendations and suggestions to help improve their

workplace safety program. Results specific to Western State Hospital have been received and a Plan for Improvement will be developed and submitted to the Safety & Executive committee for final approval.

Future Planning:

- Refining and simplifying the debriefing process to provide staff with vital information that will assist with better interventions for staff to use with patients.

- Additional accident investigation training is being developed for supervisors so that effective prevention recommendations can be implemented for safer outcomes for both patients and staff. This training will include how the debriefing can help bridge the gap for better prevention recommendations.

- Continued focus from clinical leadership to review clinical reports for patients with violent episodes resulting in seclusion or restraint.

- Continued focus on behavioral consultation from Medical Director and expert psychologists to provide consultation to treatment teams for challenging patients.

- Use of technology to assist in monitoring ingress and egress to the Center for Forensic Services.

- Development of a leadership academy to support positive changes in Culture of Safety.

- Strengthen collaboration between hospital administration and unions to increase collaboration on all projects that promote safety of patients and staff.

Risk Assessments:

- An annual Proactive Environmental Risk Assessment was completed in November, 2011 to identify safety and security risks associated with the environment of care. Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts.

- The Hazard Vulnerability Analysis (HVA) was reviewed with the Emergency Management Committee in February, 2011 and results used for future Emergency Management response and recovery planning.

- A Capital Programs project was requested, funded and is currently underway for installation of anti-suicide hardware (door handles, closet rods, toilet paper holders, grab bars, mirrors), enclosure to plumbing fixtures hospital-wide.

- Western State Hospitals (WSH) first risk assessment was completed in 2009. The 2010 risk assessment primarily focused on "loop able" objects. Work group members reviewed much literature and materials on Anti-ligature and formulated an audit document to be used in reviewing patient care areas. This document included a low, medium and high risk rating scale. This scale was defined as follows:

    - Low = Low possibility of injury or harm to patients and /or staff.

    - Medium = Possibility to create injury or harm to patients and/or staff. Mitigation review required.

    - High = Immediate threat/risk to life safety to patients and/or staff with an improvement plan to be initiated for corrective action.

Identified risk areas included the following:

- All closet doors in patient bedrooms need to be removed to prevent tying anything around the doors and hinges. The sinks, showers, and tubs in all patient bathrooms, tub rooms, and showers need to be replaced with a fixture that has no access to plumbing and no tie off points to the fixtures.
- 106 toilets that have exposed plumbing that needs to be changed so that no tie-off point is exposed.
- Toilet paper holders present a twofold risk, tie off point and weapon opportunities. A toilet paper holder needs to be provided and installed in all bathrooms that decrease the opportunities for either risk.
- Open grab bars in bathrooms, tub rooms, showers and hallways need to be enclosed to prevent looping & tie off points.
- Door handles in all patient areas changed out to anti-ligature handle, both inside & outside the door.
- Change all door closures so that there is no tie off point in room. Most of these are tied to fire doors and fire alarm systems.

Once these areas were identified, members of the risk assessment work group presented findings to the Quality Council and the Governing Body in the fall of 2011. Western State Hospital began work to remove and or alter some of the risks identified within its operating budget. This included the removal of grab bars and closet doors throughout the facility. WSH then requested additional Capital funds to complete all of the identified risks with in the assessments. WSH received $600,000 and has been addressing the change out of the toilet paper holders, alteration of the grab bars, completed a pilot project for an anti-ligature door handles on Ward C-8.

In 2011 WSH completed the same type of assessment, which identified some of the areas noted in the 2010 risk assessment that had yet to be repaired and or replaced, as well as some additional risk areas. This risk assessment was reported to Quality Counsel and the Governing Body as well. An additional risk item was the use of trash can liners in patient care areas as they pose a possible suicide risk.

Auditors of the current risk assessment for 2012 have noted blind spots in patient care areas, where mirrors or a camera should be utilized for safety. In addition to the Patient Physical Risk Assessment a decision was made by the Chief Operating Officer through the Environment of Care Committee to have a Staff Risk Assessment Completed. A risk tool was developed to use for the assessment along with a tracking tool. The assessments began in February 2012 and from this assessment "blind" spots and need for cameras was assessed. Work orders were submitted for installation. Work orders are being completed as material arrives on campus to complete the work orders. As of May 2012 the mirrors have been installed in 80% of the locations identified for installation.

Work Groups:

- The Safety Manager actively participates in the Region 5 Pierce County Coalition for Healthcare in Emergencies committee to develop regional healthcare response plan during disasters. The Coalition participates in functional drills twice a year to evaluate the effectiveness of the plan.

Challenges:

- Reductions in Return to Work FTE's limit backfilling for mandatory safety training.

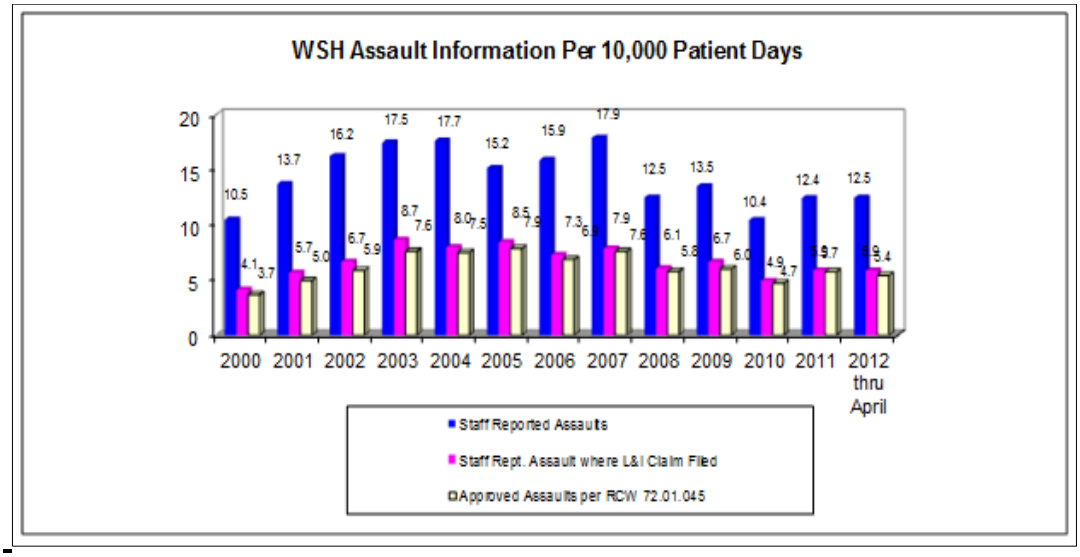
- Weighing purchases of safety equipment against purchases for direct care needs.

WSH Data Summary:

At WSH the staff reported assault rate has significantly decreased when compared to the years 2007 and prior (17.9 per 10,000 patient days, down to 12.5, 13.5, and 10.4). When looking at 2011 and early 2012 data, (through April), the rate of staff reported assaults increased from 2010, but have remained steady when compared to 2008 & 2009 (13.7 per 10,000 patient days). The last time these indicators were this low at WSH was in 2001.

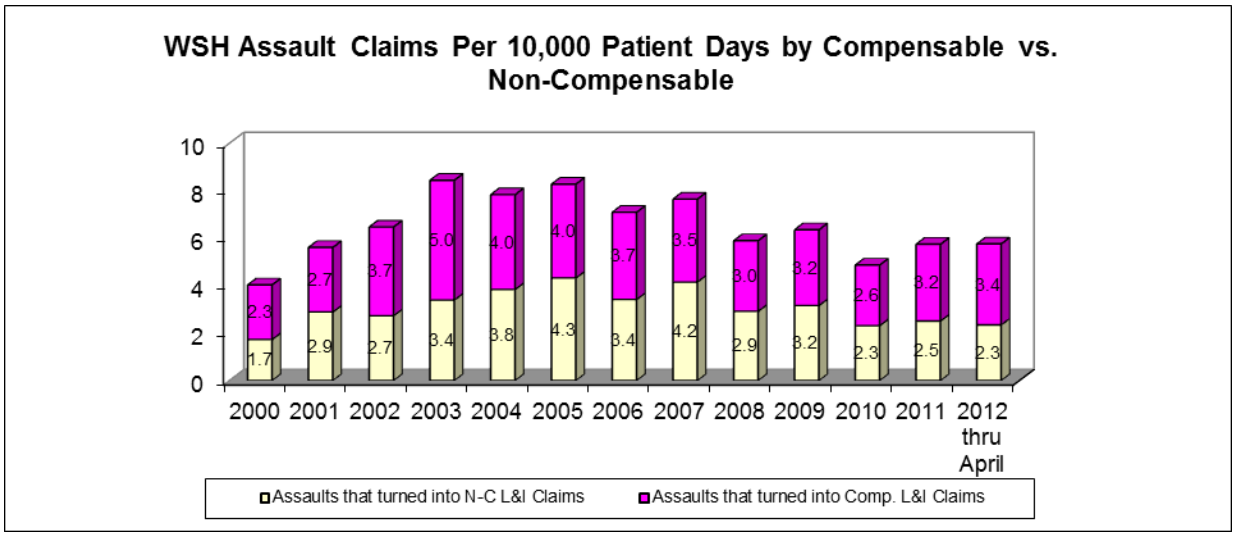
The staff reported assault rates for L&I claims and approved assault claims have also significantly decreased when compared to the years 2007 and prior (7.9 and 7.6 per 10,000 patient days down to 6.1, 6.7, 4.9 and 5.8, 6.0, and 4.7). When looking at 2011 and early 2012 data (through April), the assault claims and approved assault claim rates remain steady when compared to 2008 and 2009, (6.6 and 6.5) per 10,000 patient days). Again, these indicators have not been this low at WSH since 2001.

These decreases in staff reported assaults and assault claims since 2007 are due to a number of programs that were implemented at WSH in late 2007 and continue through present. Some of these programs include: reinstating the SAFE Team, restructuring the Safety Committee, implementing a Return-to- Work program, (Although a RTW program continues, it has been cut due to budget), and utilizing Risk Master to track all safety and claims data in one system.



Compensable vs. Non-Compensable Assault Claims: Measuring the ratio between compensable (payable) and non-compensable claims is important as more non-compensable claims result in lower industrial insurance premiums and is an indicator of injured employees returning to work. Non-compensable claims should make up 50% or greater of claims filed. The most direct way to increase non-compensable claims is by having effective Return-to-Work (RTW) and Claims Management Programs. However, safety prevention efforts by an organization can also decrease compensable claims as less serious injuries allow employees to return to work more quickly.

At WSH 2007, 2008 and 2009 data indicate that non-compensable assault claims have made up 50% or more of all assault claims since the implementation of the RTW program in July 2007. 2010, 2011 and early 2012 data (through April) however, indicate this trend is reverting back to a less favorable ratio. This is directly due to the 17 FTE's that were appropriated for a Return-to-Work program during the years 7-1-2007 thru 6-30-2008 which increased the non-compensable claims.

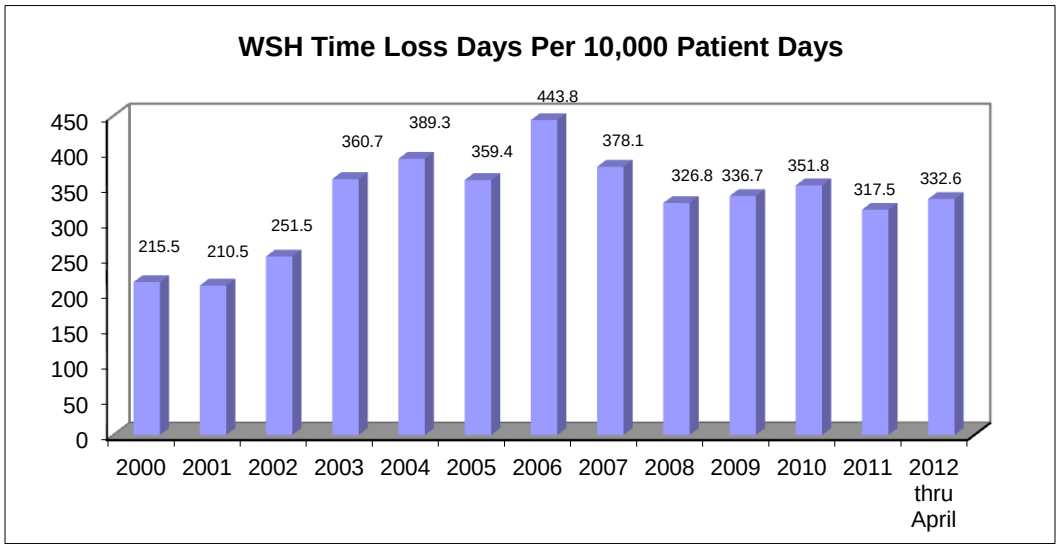


Time Loss Days: Time loss days are directly related to frequency and how many claims are compensable verses non-compensable. An effective safety program reduces the number of claims filed, and an effective return-to-work program directly reduces the number of compensable claims by returning employees back to work immediately after an injury negating the need for Labor and Industries to pay time loss.

A compensable claim means time loss (wages) had to be paid to an employee on their claims due to an on-the-job injury. At WSH, 2008 and 2009 data show a dramatic decrease in the rate of the number of days missed from work due to an assault. This is due to the 17 FTE's that were appropriated for a return-to-work program from July 1, 2007 thru June 30, 2008.

2010 data however, shows an increase in the rate of the number of days missed from work due to an assault when compared to 2008 and 2009 (326.8 and 336.7 days per 10,000 patient days to 351.8). This is directly due to the budget. WSH went from funding 17 FTE's to 6 FTE's for backfilling to operate the RTW program.

2011 data shows a dramatic decrease in the rate of the number of days missed from work due to an assault (317.5 per 10,000 pt. days) when compared to 2008, 2009, and 2010. This is due to a combination of factors. First, many of the old time loss claims have finally closed and are no longer affecting time loss rates. Secondly, the frequency of assault claims in 2010 saw a dramatic decrease which correlates to less time loss being paid out on claims in 2011. Early 2012 data shows a slight increase in time loss days when compared to 2011 which correlates with the slight increase in assault claims at WSH since 2010.


WSH Time Loss Days Per 10,000 Patient Days
450
400
350
300
250
200
150
100
50
0
215.5
210.5
251.5
360.7
389.3
359.4
443.8
378.1
326.8
336.7
351.8
317.5
332.6
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012 thru April