Report to the Legislature

Workplace Safety in State Hospitals

RCW 72.23.451

September 2008

Department of Social & Health Services
Health and Recovery Services Administration
Mental Health Division
PO Box 45320
Olympia, WA 98504-5320
(360) 902-8070
Fax: (360) 902-0809

REPORT TO THE LEGISLATURE
WORKPLACE SAFETY IN STATE HOSPITALS

TABLE OF CONTENTS

Report to the Legislature

WORKPLACE SAFETY IN STATE HOSPITALS
2008 UPDATE

BACKGROUND

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

Specific statutory language 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.

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

Western State Hospital: located in Lakewood, Washington, has a capacity of 962 beds, including the Program for Adaptive Living Skills;

Eastern State Hospital: located in Medical Lake, Washington, has a capacity of 317 beds;

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

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.

OVERVIEW

Creating a safe working environment in state hospitals remains a top priority for the Governor's office, the Department of Social and Health Services (DSHS), the Health and Recovery Services Administration (HRSA), the Mental Health Division (MHD), 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 and includes 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. Under the leadership of the Mental Health Division, each hospital is adopting strategies to improve care and services, and ultimately safety, as part of their individual Continuous Quality Improvement Plans.

DSHS appreciates the support and involvement of the Washington State Legislature in approving additional funding in the 2007-2009 biennium and the 2008 Supplemental budgets. Funds granted will be utilized as follows:

- Western State Hospital:
  - Re-instituting a Return-to-Work Program including the addition of seventeen new staff.

- Adding 12 new food service aides to provide additional staffing support during patient meal times for several wards.
- Installation of a personal alarm system in the Center for Older Adult Services. This provides for further implementation of the personal alarm system that had already been installed in the Center for Forensic Services and the Center for Adult Services.
- Re-instituting the Behavior Management Intervention Team, including the provision of ward level training and mentoring.
- Developing a project to use the additional direct care positions funded through 2008 Supplemental Budget staff for two High Intensity Treatment wards.
    - The wards will be used for either direct hospital admissions or developing a clinical culture/morale dedicated to shorter length of stays.
    - An Ad Hoc staffing workgroup is underway to analyze which two wards would have the highest safety impact.
    - The Ad Hoc workgroup is comprised of management and labor representatives.

- Eastern State Hospital:
    - Recruiting and assigning the additional direct care positions funded through 2008 Supplemental Budget (6.7 FTEs) to be on a high risk ward.
    - Implementing behavioral intervention training.

- Child Study & Treatment Center:
    - Addition of a Safety & Risk Officer specific to CSTC to promote a culture of safety through effective analysis and use of injury data to effect change and continuous review of workplace safety plans at the cottage level.
    - Implementation of a Return-to-Work Program at CSTC to reduce time employees are away from the hospital and the cost of orienting new employees.

DSHS continues to work closely with employees, unions, other key governmental agencies, such as Labor & Industries, as well as other stakeholders to find long term solutions to these complex and difficult workplace safety issues. Discussions are currently underway to have the Department of Labor & Industries replicate their ground breaking 1993 study, Study of Assaults on Staff in Washington State Psychiatric Hospitals (December 1993) later this year.

Important Data Notes pertaining to this report: At this time, data presented in this report cannot be directly compared to data presented in Government Management Accountability Program (GMAP). This report continues to use RCW 72.01.045 to define assaults while the GMAP report uses employees who received assault benefits. This report represents assaults per 10,000 bed days and GMAP uses assaults per 1,000 bed days. In addition, data presenting assaults is collected each month and represents

incidents reported in a month. The data in this report is consistent with prior year Workplace Safety Reporting. Incidents that occur in a given month may be reported up to six months later. The hospitals have data regarding incidents that occur in a given month. The MHD is working to ensure that all future reporting of workplace safety data, including this report and GMAP is presented in a consistent manner.

The following section of this report describes ongoing safety improvement efforts at the state hospitals and includes data with safety related information covering the years 2000 through April 2008. The data shows that although some progress has been made, a great amount of work is still required to meet the hospital goals. All three hospitals share the goal of improved workplace safety and all three hospitals will continue to be engaged in safety related continuous quality improvement plans.

WORKPLACE SAFETY: SUMMARY OF IMPROVEMENT EFFORTS

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

- For 2008, all 3 hospitals have Return to Work programs in place.
- Physical security continues to be reviewed and enhanced at each hospital, with staff and patient safety a high priority.
- On-going quarterly meetings have been established between the State Hospital CEOs and the Mental Health Division Director to facilitate communication about shared issues and concerns related to workplace safety
- As funding for the Seclusion & Restraint Reduction Grant comes to an end in September, each hospital site continues to work on its own personalized transition plan to continue to further the gains made with the incorporation of alternative methods. In each hospital, safety committees are overseeing this process.

In addition to the above, the following information summarizes efforts to continually improve workplace safety at each of the three hospitals.

WESTERN STATE HOSPITAL FOCUS ON QUALITY IMPROVEMENT

In 2008, WSH's Comprehensive Workplace Safety Plan has evolved into the hospital's overall Continuous Quality Improvement Plan (CQI.) Action plans are developed for each of five operational pillars: 1. safety, 2. active treatment/documentation, 3.

staffing/resource procurement, 4. development and utilization, 5. recovery and continuity of care and environment of care.

Progress report cards have been, or are in process of being, developed for each of these pillar areas. The Progress report cards track key indicators by category (active treatment, safety, recovery, financial resources, environment of care) to assess whether improvements are needed or have been made and sustained. In this way, the CQI plan remains a dynamic, fluid process and WSH is able to incorporate the recommendations and opportunities identified from internal as well as external sources into an ever-evolving process improving strategy that ensures continued progress in these areas. The Safety Progress report card was created in 2007. Since then, an Active Treatment/Medical Record Progress Report was developed during the first quarter of 2008, and a Recovery/Continuity of Care Progress Report has been developed for the second quarter of 2008. A Staffing and Staff Utilization Progress Report and Environment of Care Report is being developed and is due for presentation during the third and fourth quarters of 2008.

Data relating to safety are presented monthly to the Safety Committees with analysis and recommendations submitted to the safety representatives each month from the Safety Claims office. Safety Committee members are expected to follow up on recommendations made and recommend any additional prevention strategies. Safety related data is also reported through the Quality Council reporting structure. An analysis of safety trends is provided quarterly. Indicators that show a significant negative change, or sustained negative trend require a corrective action plan and are incorporated into the Continuous Quality Improvement Plan.

WSH 2007 - 2008 ACCOMPLISHMENTS TO DATE

Since the implementation of the WSH Safety/CQI plan in 2007 the following improvements have been made:

- An Incident Manager function has been created and a Lead Investigator position established to facilitate timely and thorough investigations of staff to patient allegations. The Incident Reporting Policy was updated and due for finalization June 2008. This has resulted in increased timeliness of investigations, allowing for more expedient resolutions, including returning staff to patient care areas once cleared of any unsubstantiated allegations.

- An Employee Safety and Claims Handbook has been developed. Finalized July 2008, it is being distributed to all employees via the Safety Committee structure. New employees shall begin receiving a copy during orientation beginning August 2008.

- All three clinical centers – Adult, Older Adult and Forensic - continue to operate Recovery Centers for needs-based patient treatment. As of May 2008, 660 patients were receiving active treatment in the recovery mall setting. Additional course offerings and weekend and evening social events are provided through the Infinity Center.

- Accident Investigation Training is now offered quarterly to all supervisors. This training focuses on employee injury investigation and how employees and supervisors can develop plans of actions to help prevent future injuries.

- The CEO is sending sympathy cards to injured employees who have been off work for 3 or more days. The CEO continues to hold monthly supervisory meetings communicating updates to the CQI/safety plan. The CEO continues to conduct monthly walk rounds on all three shifts and publishes a weekly newsletter which includes safety related updates.

- Seventeen (17) new positions have been funded by the 2007-2009 biennium to implement a Return to Work Program (RTW). The number of employees who were out on leave due to on-the-job injuries as of April 2008 was 77 (down from 102).

- An Employee Wellness Committee has been established. Health and well-being programs continue to be offered and expanded on and off campus. These include: providing healthy snack alternatives in vending machines, providing reduced membership fees at local health club facilities, offering diet and exercise programs on campus, and participating in area walk-a-thons.

- Behavior Management Intervention Team (BMIT) has been re-instituted, and is now called the Safe Alternatives for Everyone (SAFE) Team. It is comprised of up to 90 recognized leaders, with representatives from each ward & all three shifts. The function of the team is to provide training, mentorship and support. As of June 2008, over 1100 employees have received training in Module 1: Therapeutic Relationships designed to assist staff in understanding patient behavior, understanding aggression and engaging in de-escalation. In addition, over 955 staff have participated in Module 2: *Safety Movement and Mechanics* – designed to assist staff in avoiding patient assault.

- Improved communication between management and employees by:

    - Implementing several hospital-wide newsletters (including one published weekly by the CEO).
    - Facilitating CEO-led mandatory monthly supervisor meetings.
    - Conducting CEO/executive management and Safety Manager ward rounds ('walkarounds') on all 3 shifts.
    - Installing safety bulletin boards on all wards and service areas for posting safety committee minutes, data, and action plans.
    - Restructuring the Safety Committee to include four patient care area and two support area sub-committees with representation from both management and labor. A central safety committee consists of sub-committee co-chairs and other hospital staff. Formalizing safety representative roles and responsibilities to include reviewing safety related data, conducting safety related audits and reviewing incident

reports and debriefings.
    - Implementation of a Support-Our-Safety hotline.

- Wiring and installation of a personal alarm system for building 29 – which completes all patient care areas.

- Improved and expanded treatment opportunities for patients, including implementation of 4 separately located recovery malls, re-opening the ceramic center, opening a recovery-oriented after-hours recreation, education and resource center.

- Expansion of the Critical Incident Stress Management Team (CISM), to include additional peer support, including compassion calls to injured employees. The CEO is sending get well cards to injured employees. Center Directors and direct-supervisors are also making contact to show compassion and support for employees injured on the job.

- Re-instatement of the Return-to-Work program on 7/1/07, funded by the Legislature for two years. The additional positions have been established to provide temporary fill-behind positions until persons who have been placed on alternative light-duty assignment return to their permanent post. Two of the seventeen positions will be dedicated to supporting the Return-to-Work program. As of April 2008, the number of time-loss days has decreased to 1282 days (down from 1,671), and 2008 has experienced the lowest number of time-loss days in over three years. It is expected that effective claims management/return-to-work programs will provide favorable benefits for both the employer and employee. These benefits include:

    - A faster return to productive activities for the employee.
    - A faster medical recovery for the employee.
    - Maintains the skills & productivity of trained employees.
    - Maintains the employer/employee relationship.
    - Shows the employee that the employer values him/her.
    - Provides a resource to perform tasks not otherwise able to be completed.
    - Reduces costs associated with hiring and training new personnel.
    - Reduces time loss costs which impacts future industrial insurance premiums for both the employer and employee.

- Creation of a "Safety Report Card" and other data reports to be utilized to identify risks, opportunities for improvement, and to track improvements implemented. Revision of the Performance Reporting process to include data analysis, identification of action plan needs, and communication of process improvements. Integration of the CQI (Safety) Plan with hospital-wide process improvements and feedback mechanisms.

- Development and implementation of a Staff Wellness Committee which has organized onsite Weight Watcher meetings, negotiated reduced fees to local

health clubs, organized onsite walking groups, supported employee bowling and basketball leagues, and support for & focus on smoking cessation.

- Creating a Lead Investigator position to oversee internal investigations and formalizing the role of Incident Manager.

- Development of an Employee Safety & Claims Handbook to assist employees with understanding their roles and responsibilities in the safety and claims program at WSH. A Supervisor Safety Handbook is being developed.

- Installation of additional outdoor lighting and stop signs in cross-walk areas and additional lighting at east campus exits.

- The twelve food service aide positions were filled beginning in July 2007 and have been assigned to the wards.

- Additional positions funded through 2008 Supplemental Budget: An Ad Hoc Staffing Workgroup is underway to analyze which wards would have the highest safety impact. The Ad Hoc workgroup is comprised of management and labor representatives. A phase-in of the allotted positions to match with the budget allocation is planned beginning in July 2008.

ESH 2007 - 2008 ACCOMPLISHMENTS TO DATE

- High-risk doors have been identified and locks prioritized for replacement.

- Two walkthrough metal detectors purchased for 1N1/1N3 (admission wards) and 2N1.

- Defibrillators & AED's are located on all wards and in the Security vehicle for emergencies away from the ward.

- All current employees (dependent on position title) are required to take the initial 8-hour *Therapeutic Options* training and updates every year. Current tracking system is in place to monitor compliance

- Centralized patient programming in a treatment mall in the Activity Therapy Building has been implemented. Doors are secured and main entrances are continuously staffed.

- A Safe Patient Handling Program was implemented January, 2007. Based on the original needs assessment additional sit-to-stand lifts, portable lifts, height adjustable exam tables and overhead lifts have been purchased. The 2007 Annual Program Review shows a 60% decrease in total patient handling incidents, 62% decrease in L&I claims filed due to patient handling and a 72% decrease in total time loss.

- Security cameras installed in highest priority areas identified by both Safety and Security.

- Replacement of the exterior doors that were identified has been funded and is scheduled for installation.

- A sub-committee of the Safety Committee assessed several personal staff alarm systems and made recommendations to the Safety Committee and Administration.

- Additional protective equipment was purchased for the use of managing assaultive behaviors to increase staff and patient safety.

- Ergonomic MediMar stations were purchased for all wards to prevent staff injuries related to repetitive motions during medication administration.

- The GPU nurse call system is currently underway. The new system is programmed to self-test and report errors.

- Quality Management is tracking seclusion, restraints, staff injuries, assaults, to measure outcomes related to the implementation of the Treatment Mall.

CSTC 2007 - 2008 ACCOMPLISHMENTS TO DATE

- The CEO and Executive Management Team continue to work toward effective treatment practices that reduce violence and the need for seclusion and restraint. Analysis of staff injury data shows the majority of staff injuries occur after hospital staff initiates hands-on interventions with patients. Following a review of the clinical programs and staff training, each of the 3 programs have developed plans to improve implementation of evidence-based practices by milieu staff that help to reduce incidents of violence. Consistent in the plans for all 3 programs is training toward a more sophisticated understanding of cognitive-behavioral principles and their use in milieu treatment, the use of validation to de-escalate agitated patients and a culture where individual staff members have the authority to suspend a rule to avoid power struggles with patients that result in physical aggression.

- The hospital has committed resources toward improved communication capabilities on campus. Each staff member has been assigned new radio equipment to allow for more effective communication. The improved equipment has decreased response time when a staff member calls for a Show of Support.

- Last year, the Medical Director implemented a weekly report of every patient involved in a seclusion or restraint episode. As a result of this action, there is a culture that promotes more critical review of patients with challenging behaviors with colleagues outside their program. On two occasions this year, the reviews have led to the decision to transfer a patient to a different program that was a better match for the needs of the patient. While this has occurred in the past, the culture that has been set around regular review of patients with challenging clinical presentations has led clinical leadership to consider an intervention such as a transfer earlier than would have been done in the past preventing a level of escalation that makes staff more vulnerable to injury.

- CSTC implemented a Return-to-Work program that will support employees who have been injured on the job to maintain the connection and relationship with the workplace and result in fewer days time-loss due to injury.

- CSTC has implemented team debriefing following every incident of seclusion or restraint. This process will assist staff to identify triggers that lead to violent behavior and help identify strategies that are more effective with individual patients.

- CSTC committed resources to train two direct care staff as Pro-ACT trainers. Pro-ACT is the training provided to every staff member prior to their work with patients that teaches strategies to avoid escalation, crisis communication and safe techniques to avoid injury when required to intervene with a violent patient. Having cottage-based staff trained as trainers brings the expertise to the milieu in real-time and allows for more continuous coaching and supervision of staff.

WORKPLACE SAFETY: DATA SUMMARY

Important Data Notes pertaining to this report: At this time, data presented in this report cannot be directly compared to data presented in Government Management Accountability Program (GMAP). This report continues to use RCW 72.01.045 to define assaults to assure cross year trends are more apparent. The GMAP report uses employees who received assault benefits. This report represents assaults per 10,000 bed days and GMAP uses assaults per 1,000 bed days. In addition the following changes have been made in order to provide better clarity and consistency in this and related reports:

- The date has been defined as the date of injury, rather than the date reported to facilitate consistency in counting and reporting data.
- Rejected assault claims will be included in the number of assault claims filed.
- Data shall be retroactively updated to include claims that are submitted months, or even years, past the time of the injury, since injured employees have up to 1 year from the date of injury to file an injury claim, and 2 years to file an illness claim.
- GMAP Link - http://www.accountability.wa.gov/reports/vulnerable/default.asp

Staff reported assault information (See Appendix A)

Data for the Workplace Safety Report is normalized (per 10,000 Patient Days). Graphs are reporting rates of assault claims (rather than total figures). Therefore, changes between years are reported based upon rates rather than total claims.

At **WSH** through March 2008, the staff reported assault rate has significantly decreased from 2007 (19.8 per 10,000 patient days) down to 14.5. Staff reported assaults for L&I claims and approved assault claims continue to be variable but the most recent data indicates a modest decrease compared to 2007. This holds true when the PALS program is included as well.

(Note: Past reports have included staff injury data from injuries sustained in the PALS program. However, the patient day-bed information used to normalize the data did not include PALS bed-days. This is true for all previously submitted Legislative Update reports. In 2008, this discrepancy was noted, and the reports have been updated. Included below are two reports, one reflecting information with both PALS injuries and PALS bed-days, and one that only has Western State Hospital data included.)

These decreases in staff reported assaults and assault claims in 2008 are due to a number of programs implemented at WSH this past year. Some of these programs include: reinstating the SAFE Team, restructuring the Safety Committee, implementing an effective Return To Work program, and utilizing Risk Manager to track all safety and

claims data in one system. Risk Manager provides WSH with the ability to easily review specific safety and claim data in real time.

Specific injury data continues to be analyzed to identify injury cause, type, body part injured and when and where the injury occurred. The data is provided to management and safety committees to review and assist with making recommendations/improvements for a more pro-active, comprehensive safety prevention program.

At **ESH** through March 2008, the staff reported assault rate has decreased from 2007 (14.7 per 10,000 patient days) down to 12**.**1 and is consistent with the previous five year average. In addition, there are also significant downward trends in staff reported assaults for L&I claims and approved assault claims from 2007.

At **CSTC**, the data indicates an increase in the number of reported assaults by employees in 2008, compared with 2007.[1] The rate of reported assaults for 2007 and 2008 are both higher than the previous 5 years. The number of assaults resulting in L&I claims is down a little in the first quarter of 2008 suggesting while reporting has increased, assaults resulting in actual injuries has slightly decreased.

Ratio of compensable and non-compensable claims (See Appendix B)

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 at least 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**, early 2008 data (through March 2008) indicates that the rates of assault claims for both compensable and non-compensable claims have held constant and non-compensable claims have decreased significantly since 2007. In addition, the ratio between the compensable and non-compensable claims continues in a favorable ratio of non-compensable claims comprising approximately 50% of all assault claims. Implementation of an effective Return To Work program along with the recent safety improvements mentioned above should ensure this trend continues. This holds true when the PALS data is included with WSH data, and when it is excluded.

(**Note:** Past reports have included staff injury data from injuries sustained in the PALS program. However, the patient bed-day information used to normalize the data did not include PALS bed-day. This is true for all previously submitted Legislative Update reports. In 2008, this discrepancy was noted, and the reports have been updated. Included below are two reports, one reflecting information with both PALS injuries and PALS bed-days, and one that only has Western State Hospital data included.)

[1] 2007: 34 per 10,000 patient days; 2008: 43 per 10,000 patient days (for CSTC).

At **ESH**, the early 2008 data (through March 2008) shows a slight increase in non-compensable claims, but significant decrease in the rates for compensable claims. In addition, the ratio of compensable to non-compensable claims for early 2008 has decreased, with the compensable claims at one quarter of the non-compensable claims.

At **CSTC**, the early data from 2008 (through March 2008) indicates the rate of assault claims has decreased slightly from 2007. The data also shows the ratio of compensable to non-compensable claims is higher than desired (more than 50%). However, in 2007, compensable claims made up less than 50% of the total claims, and it remains to be seen what the overall trend in 2008 will be, as in the past (2000-2007, with the exception of 2001), CSTC has consistently maintained a desirable ratio.

Time Loss Days due to assault (See Appendix C)

Time loss days are directly related to compensable and non-compensable claims. A compensable claim means time loss (wages) had to be paid to an employee on their claim due to the on-the-job injury.

At WSH, early 2008 data (through March 2008) shows a dramatic decrease in the number of days missed from work due to an assault at WSH. Time loss days increased steadily from 2000 to 2006, with the exception of 2005 when a Return To Work program was in place. With the reinstatement of the Return To Work program in July 2007, a slight decrease was seen in the number of time loss days in 2007. The remarkable decrease in time loss days in early 2008 reflects the full implementation of a Return to Work program. It is expected that this trend will continue as the Return To Work program continues to reduce the amount of days employees are off work. As of March 31, 2008, there were 78 employees on time loss, decreased from an average of 107 employees in previous years. Efforts to work with community care providers, employees and L&I continue to focus on reducing this number further.

(**Note:** Past reports have included staff injury data from injuries sustained in the PALS program. However, the patient bed-day information used to normalize the data did not include PALS bed day. This is true for all previously submitted Legislative Update reports. In 2008, this discrepancy was noted, and the reports have been updated. Included below are two reports, one reflecting information with both PALS injuries and PALS bed-days, and one that only has Western State Hospital data included.)

ESH 'time loss days' rate for early 2008 data (through March 2008) shows a very significant downward trend in the rate of 'time loss days' to date (from 63.4 in 2007 to 5.8 in 2008) .This represents the lowest rate of the past 8 years. ESH continues to manage a robust RTW program for employees.

CSTC rate of ‘time loss days’ for early 2008 data (through March 2008) shows a significant increase over 2007 (312 for 2008, while 2007 was 255 for the entire year). In 2007, there was a significant reduction in the rate as compared with the previous year (2006). CSTC has implemented a Return to Work program which is expected to eventually result in a fewer lost days due to staff injury in the future.

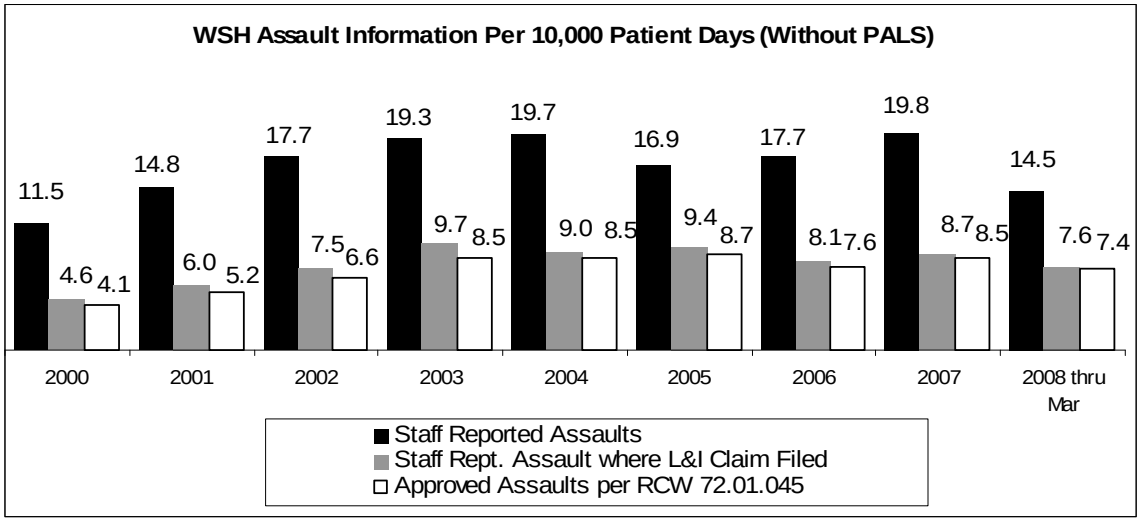
APPENDICES

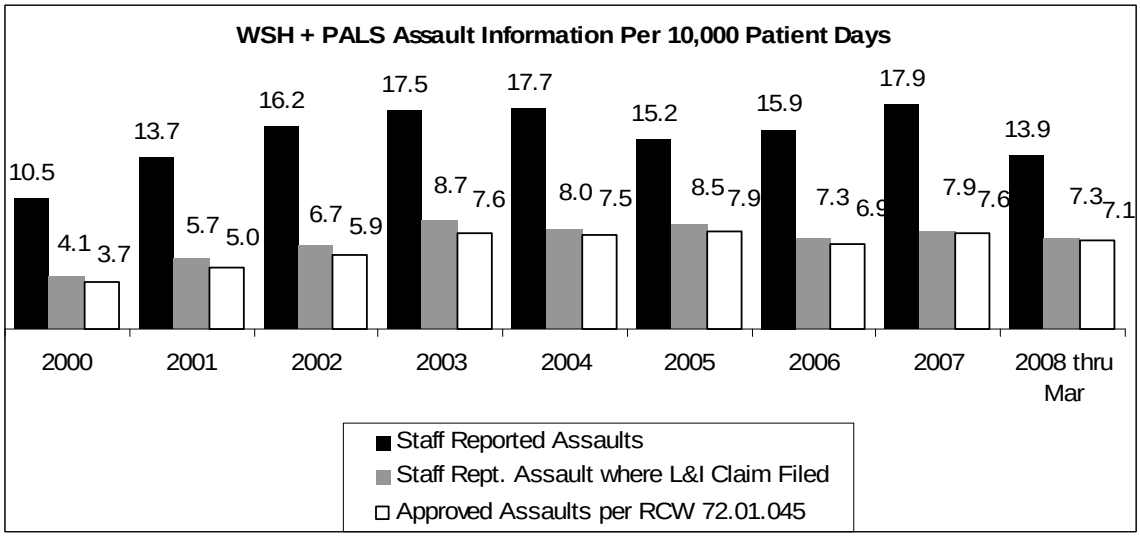
APPENDIX A:
Assault Information Per 10,000 Patient Days (normalized rates)

APPENDIX B:
Assault Claims Per 10,000 Patient Days by Compensable vs. Non-Compensable (normalized rates)

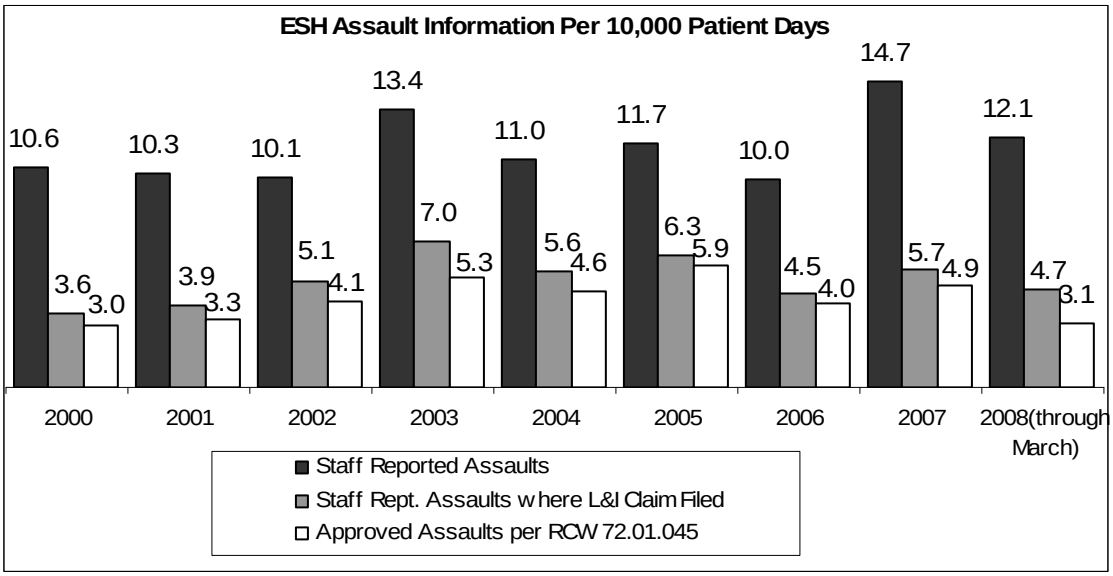
APPENDIX C:
Time loss Days Due to Assault Per 10,000 Patient Days (normalized rates)

<u>Appendix A</u>—Assault Information Per 10,000 Patient Days (normalized rates):

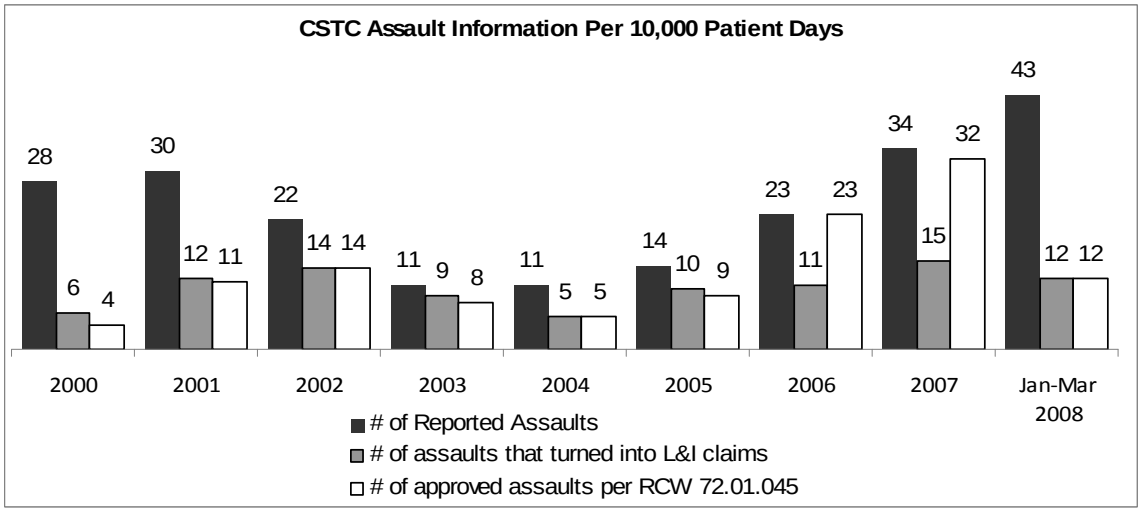




Appendix A (cont)—Assault Information Per 10,000 Patient Days (normalized rates):

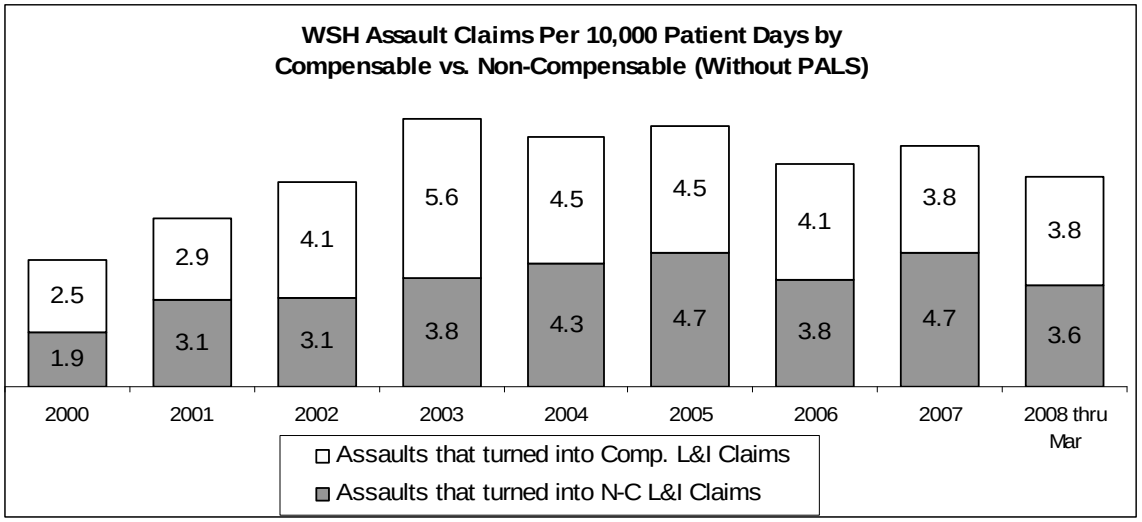


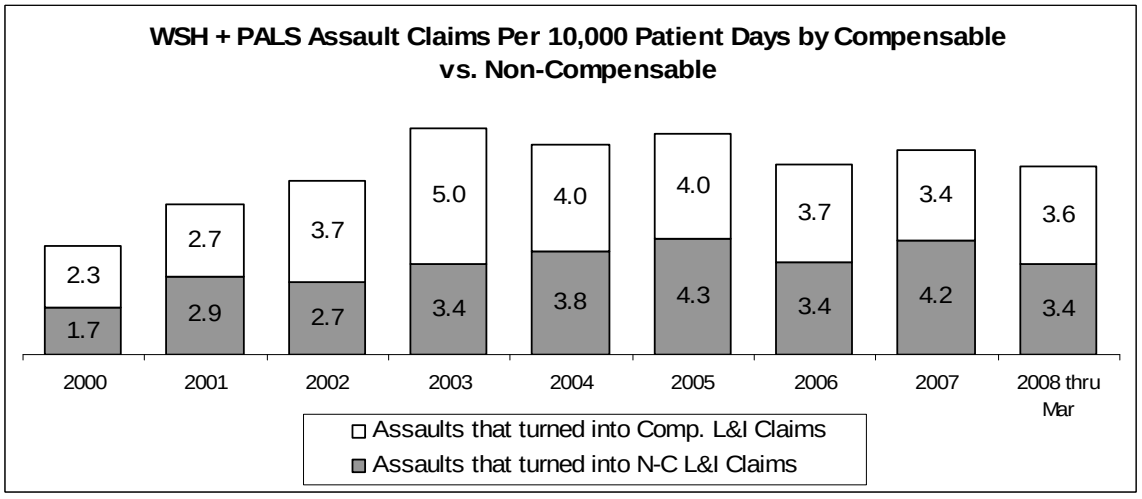
Note: The assault data is based upon the definition of assault per RCW 72.01.045:
"Unauthorized touching of an employee by a resident, patient or juvenile offender resulting in a physical injury."



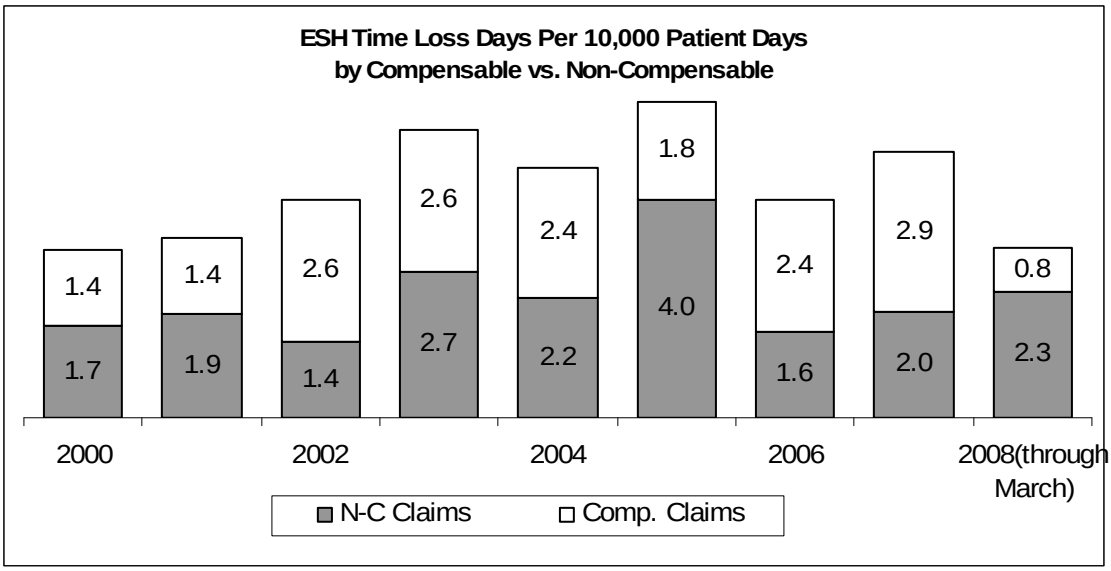
Note: The assault data is based upon the definition of assault per RCW 72.01.045:
"Unauthorized touching of an employee by a resident, patient, or juvenile offender resulting in a physical injury."

<u>Appendix B</u>—Assault Claims Per 10,000 Patient Days by Compensable vs. Non-Compensable (normalized rates):

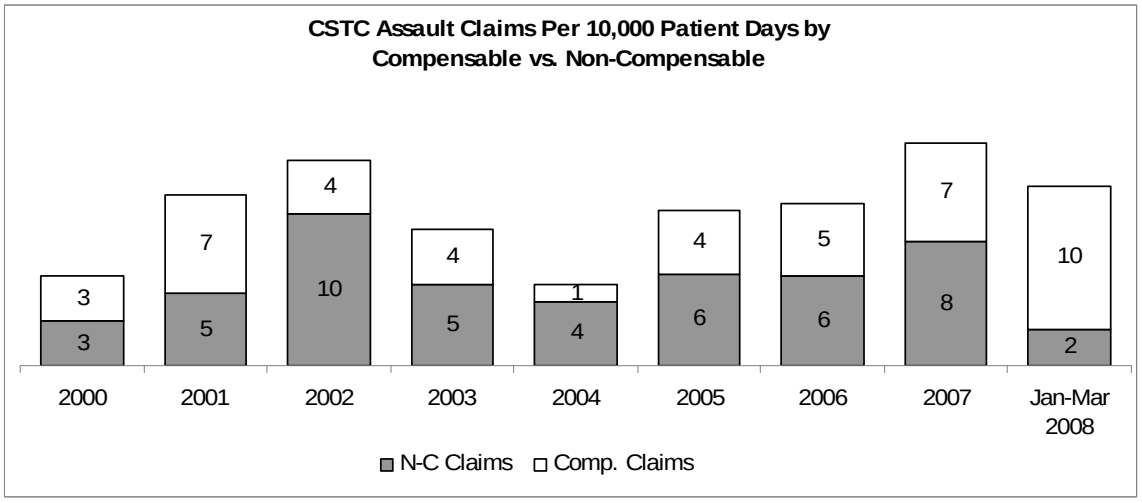




<u>Appendix B (cont)</u>—Assault Claims Per 10,000 Patient Days by Compensable vs. Non-Compensable (normalized rates):

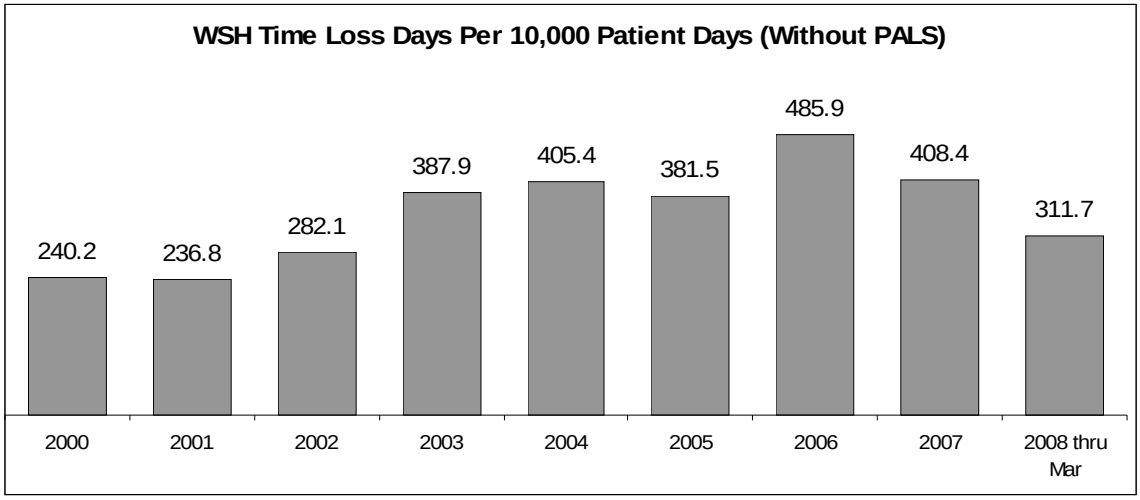


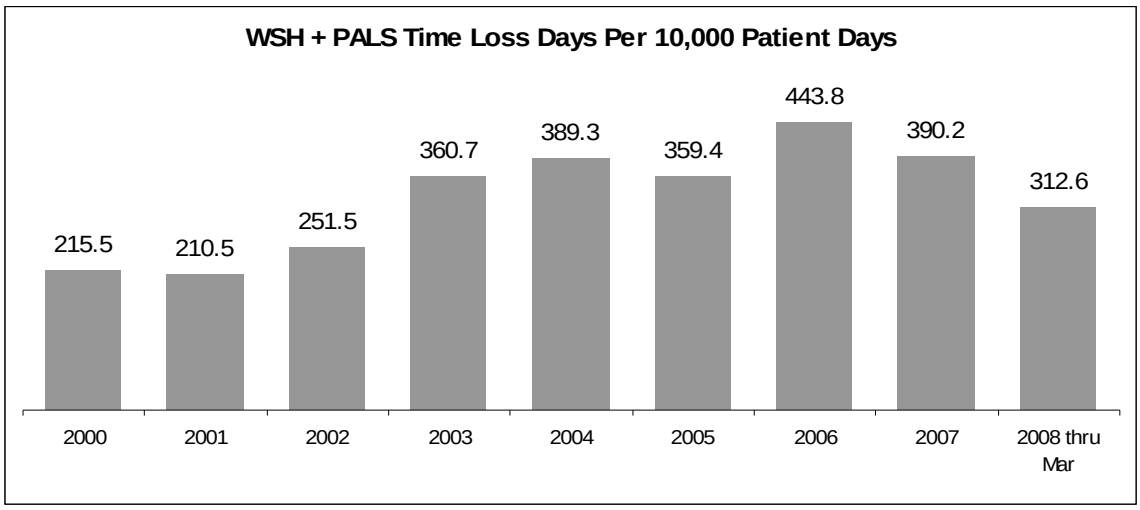
Note: The assault data is based upon the definition of assault per RCW 72.01.045:
"Unauthorized touching of an employee by a resident, patient, or juvenile offender resulting in a physical injury."



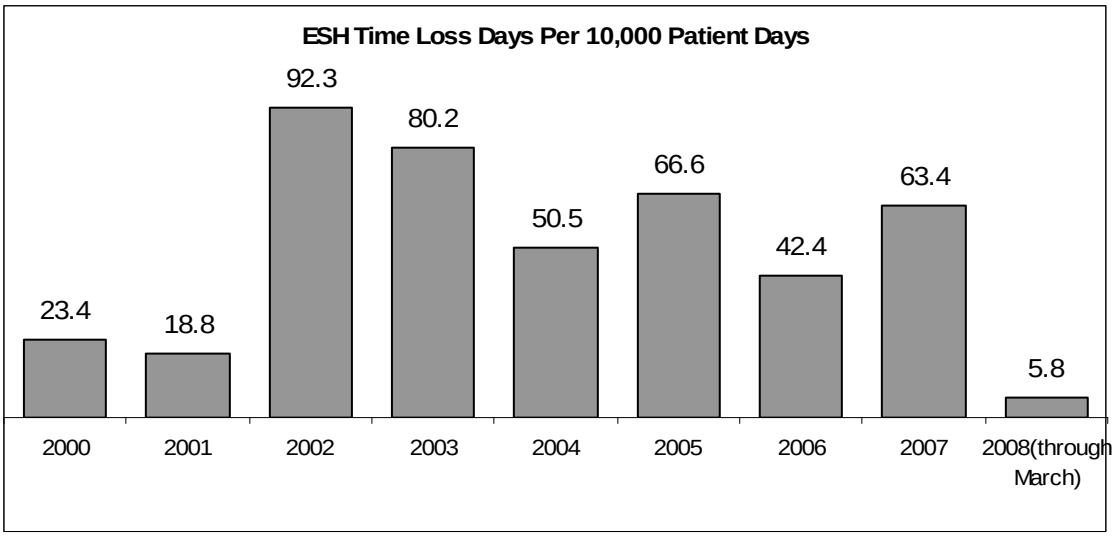
Note: The assault data is based upon the definition of assault per RCW 72.01.045:
"Unauthorized touching of an employee by a resident, patient, or juvenile offender resulting in a physical injury."

Appendix C—Time Loss Due to Assault Per 10,000 Patient Days (normalized rates)

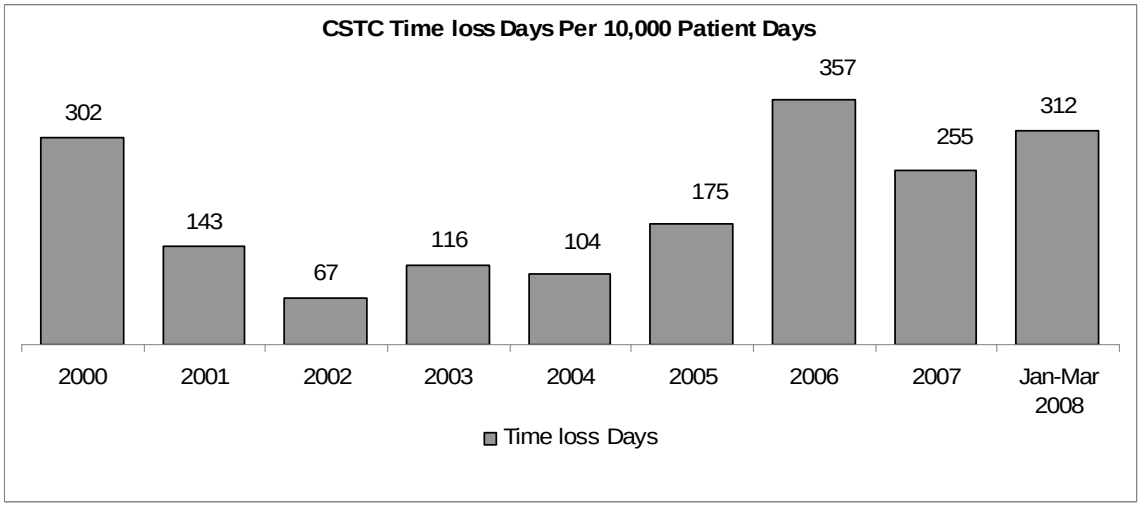




Appendix C (cont)—Time Loss Due to Assault Per 10,000 Patient Days (normalized rates)



Note: The assault data is based upon the definition of assault per RCW 72.01.045:
"Unauthorized touching of an employee by a resident, patient, or juvenile offender resulting in a physical injury."



Note: The assault data is based upon the definition of assault per RCW 72.01.045:
"Unauthorized touching of an employee by a resident, patient, or juvenile offender resulting in a physical injury."