Washington State Department of Social & Health Services

Report to the Legislature

Workplace Safety in State Hospitals

RCW 72.23.451

September 2009

Department of Social & Health Services

Health and Recovery Services Administration

Division of Mental Health Systems

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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.

OVERVIEW

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

Western State Hospital: located in Lakewood, Washington, has a capacity of 887 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.

The Report updates last year's report by adding data for July 2008 through June 2009.

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 (DSHS), the Health and Recovery Services Administration (HRSA), Division of Mental Health Systems, 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. Under the leadership of the Director of Mental Health Systems, each hospital is adopting strategies to improve care and services, and ultimately safety, as part of their individual Continuous Quality Improvement Plans.

While safety programs at all three hospitals are a priority and funded within current resources, recent legislative mandates to cut administration and FTE's (WSH only) to backfill for staff on light duty Return to Work programs (RTW) or safety training may have created challenges for maintaining past gains. Further funding cuts may increase the difficulties for maintaining improvements to the state hospital safety programs.

The goal of the 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. So the state hospitals are currently paying premiums based on the cost of claims for all DSHS institutions for 7/1/2004 through 6/30/2007. 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.

Eastern State Hospital and Child Study and Treatment Center were both required to cut administrative costs. Backfilling for safety, other mandatory trainings and RTW is the resulting challenge.

The Western State Hospital (WSH) budget was reduced by $1.7 million and 17 FTE's originally appropriated to operate a RTW program. This was a significant reduction to a much larger hospital program. Out of remaining current funding WSH is funding 6 FTE's for backfilling while implementing other administrative cuts.

Safety programs otherwise remain intact at all three hospitals.

Summary Points

The state hospitals are planning to collaborate on several projects:

- Joint Report on the High Intensity Treatment Wards
- Recovery Centers/Treatment Malls
- Workplace Safety Initiatives
- Guiding Principles for the creation of the Treatment Plan
- Reduction of Seclusion and Restraint Initiatives
- Standardized policy and procedure for adult Forensic programs

Child Study & Treatment Center

CSTC Summary of Accomplishments

- In 2008, the Medical Director implemented a process of weekly reporting of every incident of seclusion and restraint. This process is now routine allowing for rapid identification of patients with challenging behaviors and patients more likely to be involved in aggressive behaviors toward staff. As a result of the weekly reporting, patients that repeatedly present with unsafe behavior are presented for a peer-to-peer consultation in Executive Medical staff meeting. Through this improvement activity, the hospital is working to reduce the number of patients that have repeated incidents of staff assault.

- A face-to-face introduction and orientation with the Safety Officer was added to the CSTC New Employee Orientation. Within the first three days of being hired, every new CSTC employee meets with our Safety Officer. The Safety Officer reviews safety policies and practices, to include the issues of working with hostile clients and employee injuries. The Safety Officer reinforces the messages presented to staff during clinical trainings that hands-on interventions are the last option due to the immediate increase in risk of injury to both the patient and staff.

- CSTC completed the final draft of the Effective Treatment Manual – an overview of treatment philosophy of CSTC. The manual describes how components of cognitive behavioral treatment are utilized within the therapeutic milieu and as the basis of individual behavior plans to proactively work with clients to reduce incidents of unsafe behavior, including incidents of assault. Implementation of the Effective Treatment Manual will include training for all direct care staff bringing a common language and common understanding of the behavioral strategies across all three programs.

- In June 2008, CSTC implemented a Return-to-Work program that supported employees who had been injured on the job to maintain the connection and relationship with the workplace during their recovery. The Return-to-Work program identified meaningful work tasks that an employee could accomplish within the restrictions set by his/her physician. During the first year of implementation, the Return-to-Work program reduced the time-loss to 367 days over all. While there is an initial cost to the agency in having the employee working in an alternative capacity, the reduction of time-loss days works to reduce overall L&I rates for DSHS.

- CSTC continues to monitor and improve the team debriefings that occur following every incident of seclusion and restraint. With the completion of the final draft of the Effective Treatment Manual, the committee working to implement debriefings recommended that the process be revised to parallel the treatment philosophy and strategies outlined in the manual. The committee is in the process of receiving input from the three cottage programs

CSTC Continued Challenges

- CSTC serves a population of children and youth that can present with extreme behavioral issues. While staffs continually update their de-escalation skills, there remain situations where patients become physically aggressive and are unresponsive to these strategies. Implementation of the Effective Treatment Manual is expected to improve consistency in treatment interventions to help us more successfully teach children and youth the skills necessary to replace aggressive behavior with behaviors that are more effective and result in less risk both to the patient and our staff.

- CSTC Leadership remains committed to a process of debriefing that will benefit the patient and the staff team. To date, the process is perceived as time

consuming with limited resources. The committee working to implement the debriefing process is responding to feedback for direct care staff and hopes to make revisions for the coming year to make debriefing into a formal process.

CSTC Budget cuts – impact on corrective actions

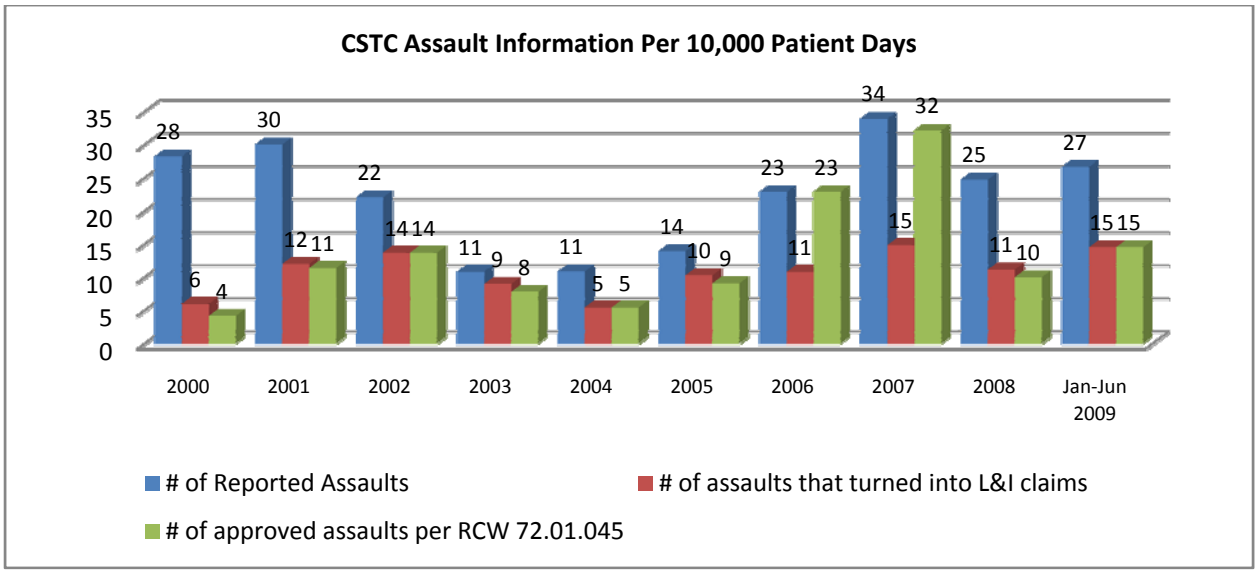
- CSTC Leadership is excited about the finalization of the Effective Treatment Manual. Implementation of the manual includes a significant staff training component. Training direct care staff requires additional staffing resource. We have reduced the number of on-call staff due to the budget cuts. This reduction will impact how quickly and how much training we will be able to provide to the direct care staff.

- CSTC implemented a Return-to-Work program in June 2008. The program allowed employees with approved assault claims to return to the work place in an alternative work assignment prior to the day their physician released them to full-duty. It is uncertain whether or not CSTC will have the funding to continue with the program. Saving time-loss days has the potential for future savings for DSHS as an agency, however, the program costs CSTC in the immediacy as the injured employee is paid for their work-time in the alternative assignment and CSTC pays an on-call employee to work their permanent shifts.

CSTC Data Summary

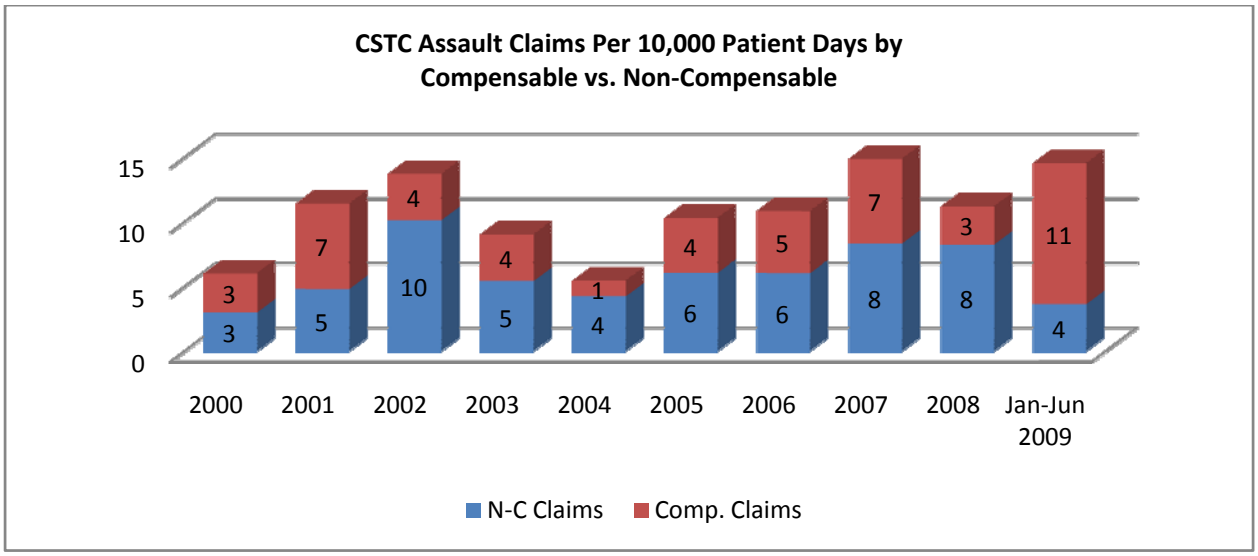
<u>Number of Reported Assaults, Assaults that turned into L&I claims and L&I approved assaults Per 10,000 Patient Days</u>

CSTC had a decrease in the rate of reported assaults in 2008, compared to 2007. The first six months of 2009 have shown an increase in the rate of reported assaults. While the rate of reported assaults was higher, the number that turned in to an L&I claim was lower than in the previous year. CSTC will emphasize training staff on assessments of patient functioning and behavioral patterns to focus treatment efforts to further reduce assaultive behavior.



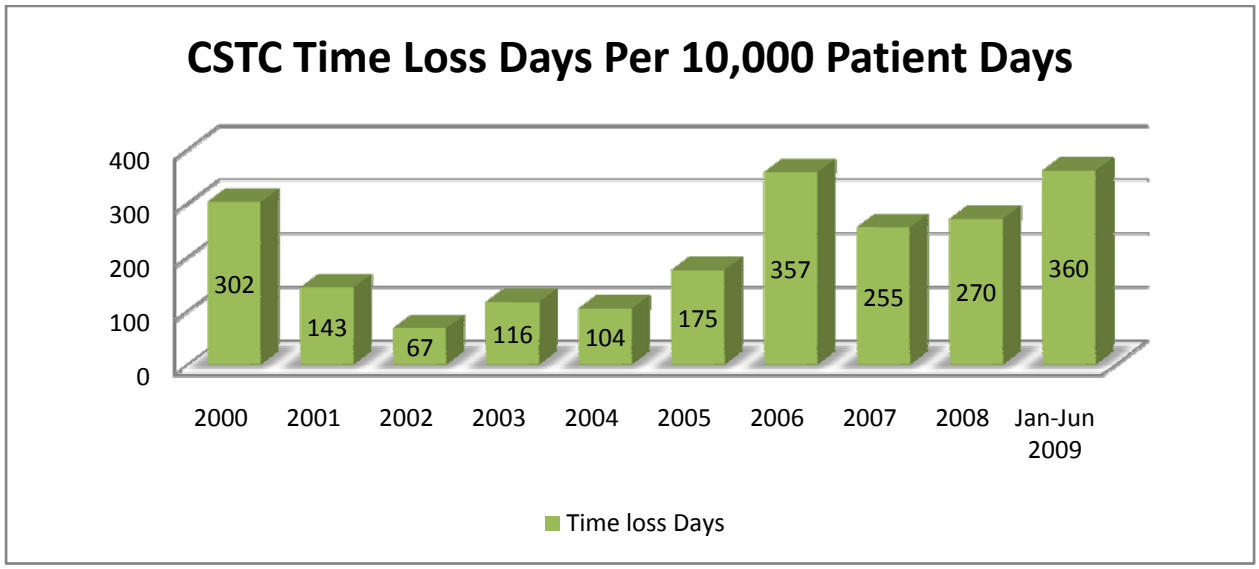
Compensable vs. Non-Compensable Assault Claims

CSTC monitors the severity of employee assault injuries based on the proportion of Compensable claims to Non-Compensable claims. A Compensable claim indicates that the employee had 3+ days of time-loss. For the past 7 years over 50% of the assault claims at CSTC have been non-compensable. During the first 6 months of 2009, 66% (6 out of 9 approved assault claims) were compensable. While the severity of injuries is concerning, it cannot be seen as a trend at this time. CSTC reviews each employee injury event and uses findings to reduce future events.



Time Loss Days

There was an increase in the rate of Time Loss Days per 10,000 patient days in 2008. Although the number of approved assault claims did not increase dramatically, two CSTC employees injured in 2007 were on full-time, time-loss during 2008 and the beginning of 2009 awaiting reasonable accommodations and disability separation. The small size of CSTC results in greater volatility in the data. The significant increase in time-loss days is a reflection of these two injuries that occurred in 2007 and both employees were out on time-loss for extended periods of time. CSTC time-loss data is expected to show a reduction the second half of 2009.



EASTERN STATE HOSPITAL

ESH ACCOMPLISHMENTS

Projects:

- Westlake Fire Alarm Upgrade/Westlake Nurse Call & Staff Emergency Alarm Replacement
- Westlake Exterior Door Replacement to increase Security
- Westlake Helistop for emergency medical transport
- Activity Therapy Building and Therapy Pool Fire Alarm Installation: Capitol Program project approved and in plan development.

Risk Assessments:

- A Statement of Conditions, an assessment of the buildings based on the National Fire Protection Agency Life Safety Code, was completed through Capital Programs for

both the Activity Therapy Building and the Therapy Pool. Plans for Improvement have been identified and prioritized for Capitol Program approval.
- Hazard Vulnerability Analysis (HVA) was reviewed and updated for Emergency Management planning.

Workgroups:
- Riskmaster (Incident Reporting System) Data Reporting Group implemented changes for data reporting to ensure consistent and accurate reporting and improved trend analysis.
- The Safety Officer, Infection Control Coordinator and QM staff continues to actively participate in the Region 9 Healthcare Coalition to assist in the development of a regional Emergency Response Plan.

Purchases:
- Paraslydes (Emergency Evacuation Equipment for Mobility Impaired Patients)
- Ergonomic (Adjustable) MediMar Stands
- Hi-Lo Beds that can be used at a standard height or in a low position to reduce staff injury when lifting/repositioning.
- Emergency Protective Equipment purchased for managing extreme assaultive and/or dangerous behavior, or when an individual has a weapon and is hurting him/her self or others (or threatening to do so) and when interventions based on the Recovery Model of Care or Therapeutic Options have failed to de-escalate the situation.
- Emergency Protective Equipment Response Team (EPERT) identified and target for implementation is October, 2009.

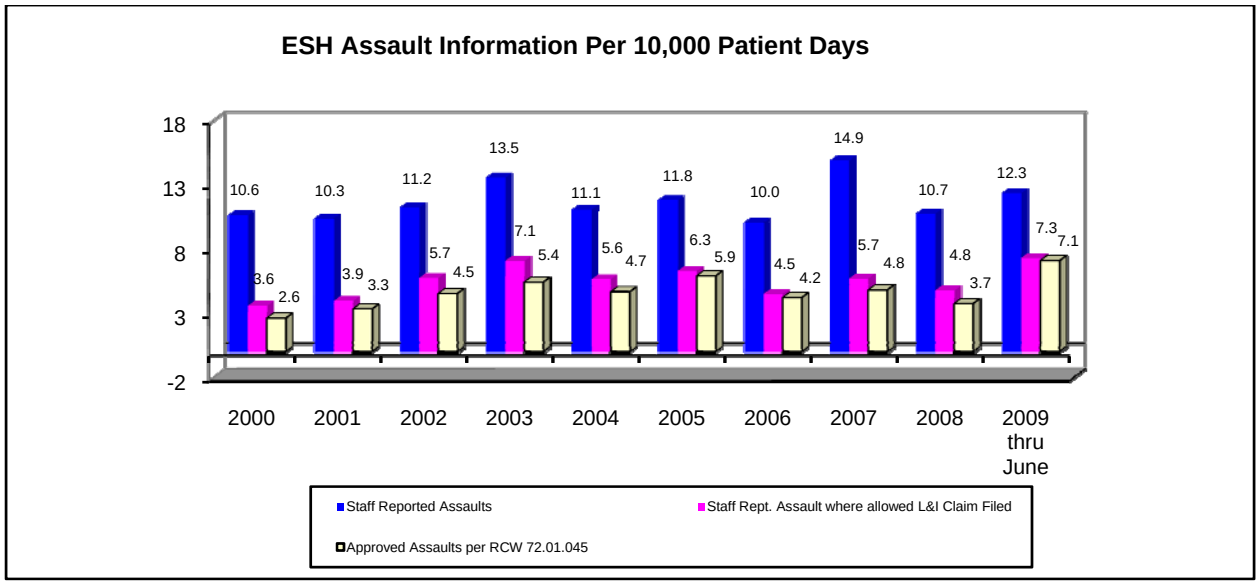
ESH Challenges/Impact to Corrective Actions:

- Mandatory Budget Cuts
  To date, mandatory budget cuts have not impacted Safety, but continued deeper cuts may impact the programs. Reduced staffing resources (ability to utilize on-call staff) may influence how quickly and how much safety training ESH will be able to provide to the direct care staff.

ESH Data Summary

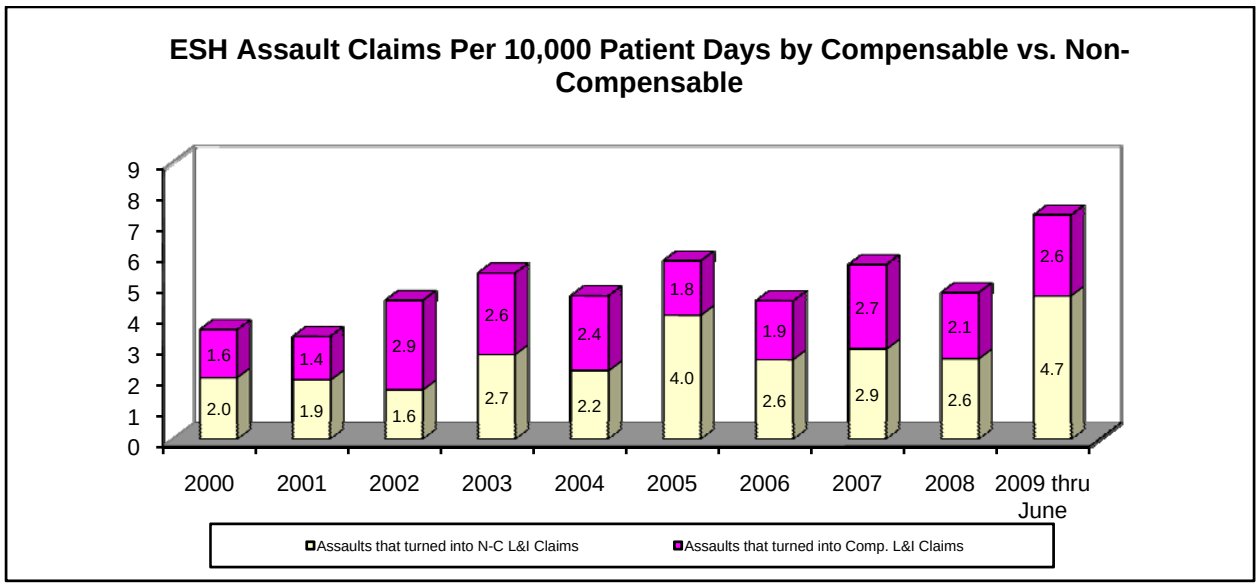
<u>Number of Reported Assaults, Assaults that turned into L&I claims and L&I approved assaults Per 10,000 Patient Days</u>

At ESH through June 2009, the staff reported assault rate has increased from 2008 (10.7 per 10,000 patient days) to 12.3. In addition, there are also increases in staff reported assaults for L&I claims and approved assault claims from 2008. To date, in 2009, 34% of the total staff reported assaults were the result of five patients who assaulted staff in three or more incidents.



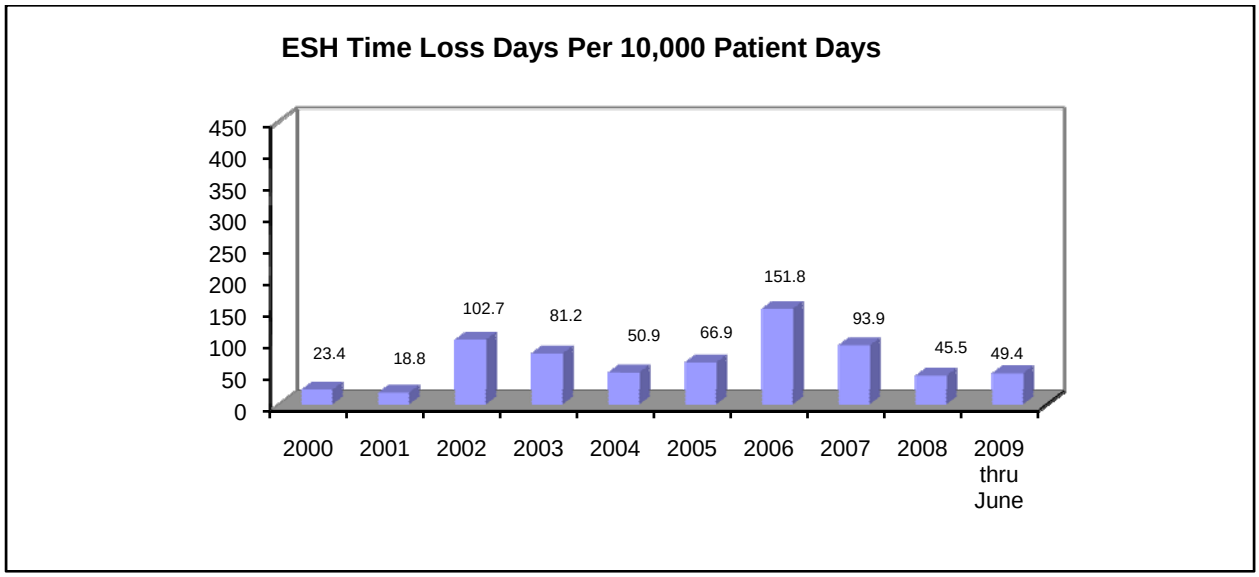
Compensable vs. Non-Compensable Assault Claims

At ESH, the early 2009 data (through June 2009) shows that there is an increase in the rates for both compensable and non-compensable claims. The ratio of compensable (time loss) to non-compensable claims continues to improve, with the non-compensable claims accounting for approximately two-thirds of total claims. The increase in rates is partially due to an overall increase in total incidents, increased number of patients assaulting on more than two occasions (48 incidents involving 11 patients in 2008 and 21 of 61 incidents involving 5 patients in 2009) and the severity of injuries resulting in increased compensable (time loss) claims.



Time Loss Days

ESH 'time loss days' rate for early 2009 data (through June 2009) shows there is an increase in the rate of 'time loss days' to date (from 45.5 in 2008 to 49.4 in 2009). To date, 75% of the total time lost for 2009 is due to seven incidents involving four different patients on the habilitative mental health ward for patients with mental and developmental disability disorders; 183 of 244 days.



A number of activities have been implemented in 2008-2009 to reduce assaults:

- Implementation of the Recovery Model of care, which focuses on patient-centered and patient-directed care, reduction of seclusion or restraint and the Treatment Mall concept for treatment. The Treatment Mall concept is aimed at risk reduction through enhanced treatment, increased structure, and improved coping for patients. Since the implementation of the Treatment Mall in 2008, incidents on wards that actively participate have decreased; one incident in 2008 and three to date in 2009 with only one of these occurring at the new Treatment Mall.
- Patient-to-staff assault data is reviewed by both Safety and Patient Safety committees and drill downs completed to identify need for process changes and recommendations for improvement.
- Mechanisms are in place for treatment teams to request in-house, difficult patient staffing.

WESTERN STATE HOSPITAL

WSH ACCOMPLISHMENTS

Treatment:

- Center for Adult Services (CAS), Center for Older Adult Services (COAS) and Center for Forensic Services (CFS) continue to operate Recovery Centers for need-based patient treatment. Additional course offerings and weekend and evening social events are provided through the Infinity Center.
- Five pilot wards identified to participate in treatment and recovery planning process. Treatment teams trained as a whole on new individualized treatment planning process. Since implementing, treatment is more individualized with focus on patient input and their strengths. Pilot implemented 3/09; to be completed 7/09.
- Medical clinics operate in CAS Central and South Recovery Malls. Patients are seen for scheduled appointments to further enhance normalization/recovery focus of the Malls.
- Cognitive remediation techniques are in widespread use.

Staff Training/Resources:

- Annual nursing competencies updated, improved and implemented.
- Washington Institute provided specific training in Dialectical Behavior Therapy regarding management of chronic suicidal behavior and cognitive and behavioral techniques for managing residual psychotic symptoms.
- Department of Labor and Industries conducted a Safety and Health Assessment and Research for Prevention (SHARP) consultation review. Report to be provided later this fiscal year.
- Accident Investigation Training offered quarterly to all supervisors. A Supervisor Safety Handbook is being developed. Enhanced supervisor safety training is to be developed as resources allow.
- Behavior Management Intervention Team (BMIT) continues and is now called the Safe Alternatives for Everyone (SAFE) Team. 774 staff were trained in Module 3: “Understanding Behavior” by SAFE Team members.
- The Critical Incident Stress Management Team (CISM) has expanded to include peer support, including compassion calls to injured employees.
- Reorganization of Hospital Improvement to include a new position of Director of Patient and Employee Safety. This position will provide enhanced leadership in WSH ongoing commitment to safety.

Communications:

- The safety committee structure in place helps to ensure better communication. Minutes and safety-related data are distributed to all members monthly to share with those they represent. Data is presented to and discussed by the sub-committees on a monthly basis.
- Patient, hospital, nursing, staff development, hospital improvement and infection control newsletters are distributed hospital-wide.

Improved Processes:

- The Return-to-Work program funded for the 07-09 biennium continued to provide temporary fill-behind positions until persons who have been placed on alternative light-duty assignment return to their permanent post. Two staffs were hired in the Safety & Claims Office dedicated to supporting the Return-to-Work program.
- The Lakewood Police Department (LPD) met weekly with the WSH Security Department, WSH Investigations Office and the Washington State Patrol (WSP). All reports of patient abuse are reported to the LPD for first right-of-refusal to investigate. Reports are then referred to WSP. WSP, LPD, Human Resources and WSH Administration work together to ensure timely investigations.

Data:

- Database revised to track nursing care hours and acuity.
- "2008 Data in Review" Report presented to the WSH Governing Body & Quality Council.
    - **Decreased:** Overtime use, restraint hours and episodes, patient to staff and patient to patient assault, falls, patient injuries, staff injuries, claims and time loss.
- Prescription utilization data added to Progress Report to be reported through the Quality Council and analyzed by ward on a quarterly basis.
- Safety progress report created – includes all safety related data.

Re-Organization**:**

- Nursing staff supervision is centralized.
- Nursing supervision increased at the ward level.
- RN3s added to increase coverage to one per ward for dayshift.
- RN4 coverage increased for evening shift

Seclusion/Restraint:

- Review initiated to assess whether patients are released from seclusion/restraint at the earliest possible time.
- Safety plan and debriefing reviews conducted for patients restrained for 24 hours or more.

WSH CHALLENGES

Currently, the safety programs at WSH remain intact. The reduction in FTE's and funding appropriated for the RTW program creates a risk to the RTW program. WSH continues to fund a scaled back RTW program but may not be able to sustain the number of employees on light duty that full RTW funding did. If further cuts are required, maintaining recent gains may not be possible.

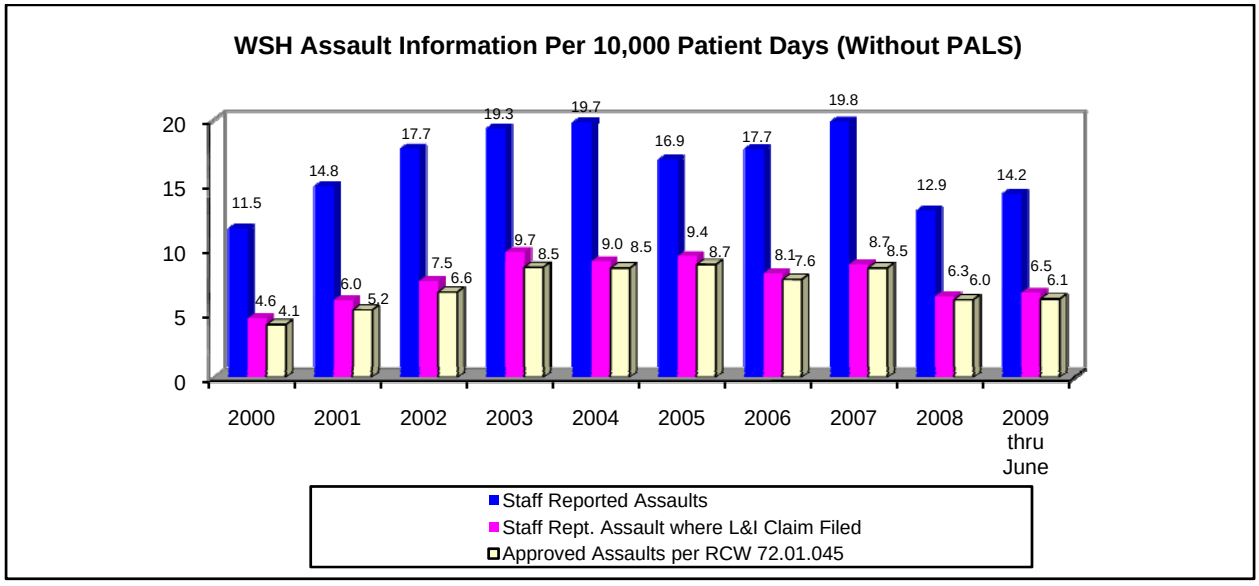
WSH DATA SUMMARY

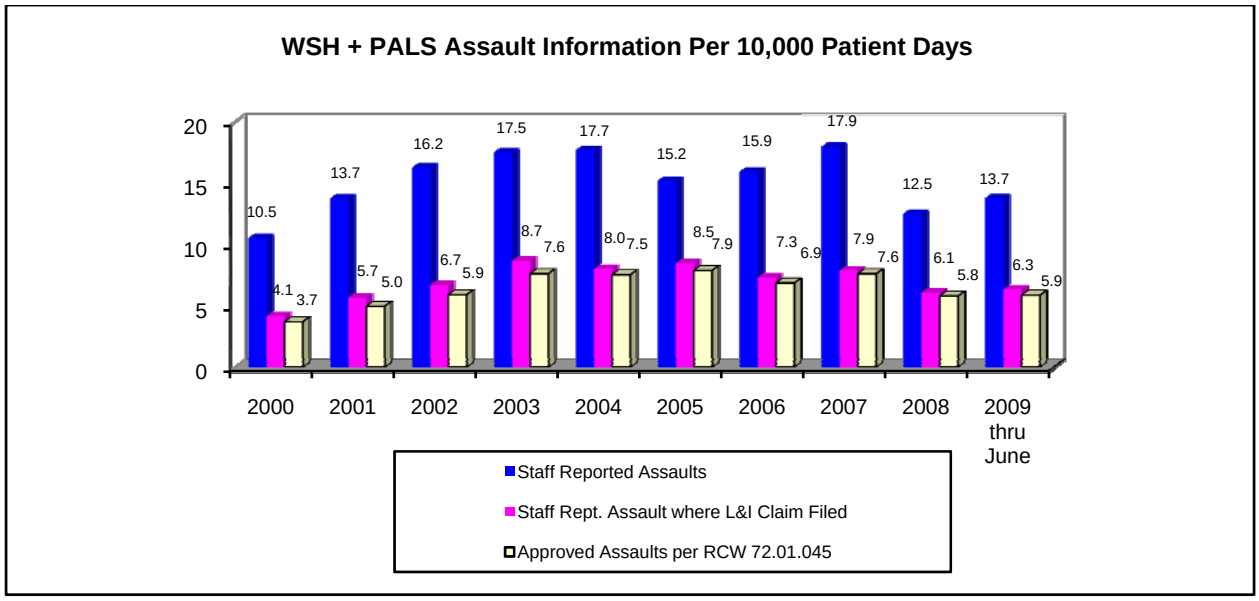
Number of Reported Assaults, Assaults that turned into L&I claims and approved assaults Per 10,000 Patient Days

At WSH in 2008 the staff reported assault rate significantly decreased when compared to 2007 (19.8 per 10,000 patient days, down to 12.9). When looking at early 2009 data (through June), the reported assaults are up when compared to 2008 (12.9 per 10,000 patient days to 14.2). However, staff reported assaults have not been this low at WSH since 2001.

In 2008, staff reported assaults for L&I claims and approved assault claims also significantly decreased when compared to 2007 (8.7 and 8.5 per 10,000 patient days down to 6.3 and 6.0). When looking at early 2009 data (through June), L&I claims and approved assault claims remain steady when compared to 2008 (6.3 and 6.0 per 10,000 patient days to 6.5 and 6.1). Again, these indicators have not been this low at WSH since 2001. This holds true when the Program for Adaptive Learning Skills (PALS) program is included as well.

These decreases in staff reported assaults and assault claims in 2008 and early 2009 are due to a number of programs that were implemented at WSH in late 2007 and continued through June of 2009. Some of these programs include: reinstating the SAFE Team, restructuring the Safety Committee, implementing an effective Return-to-Work program, and utilizing Risk Master to track all safety and claims data in one system. Continued support of these programs is imperative for continued success in reducing assaults at WSH.

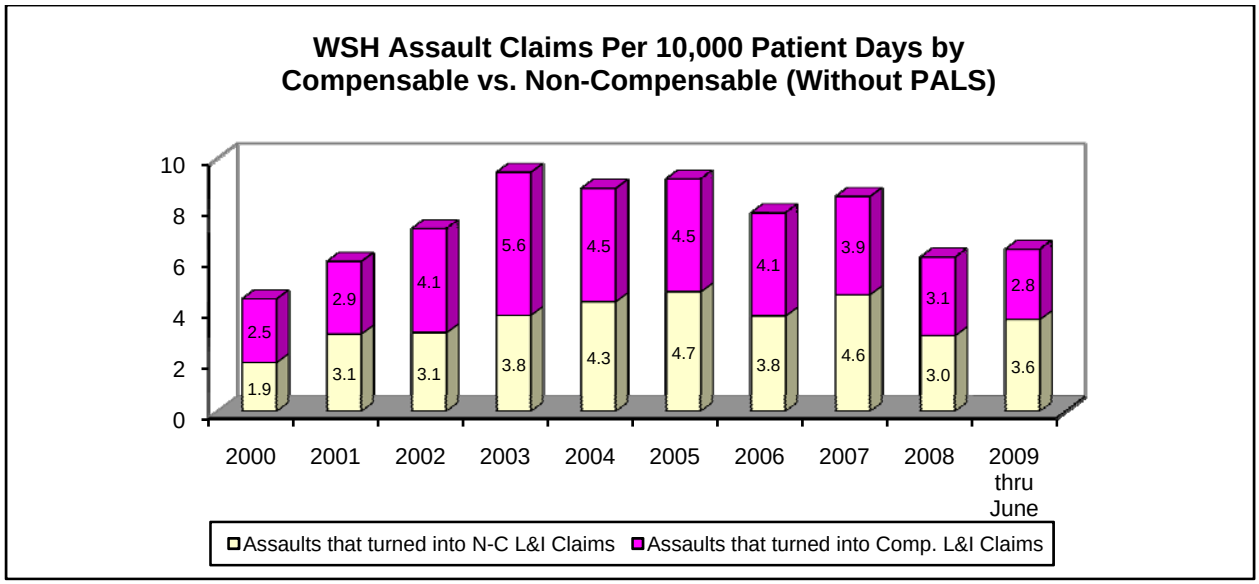


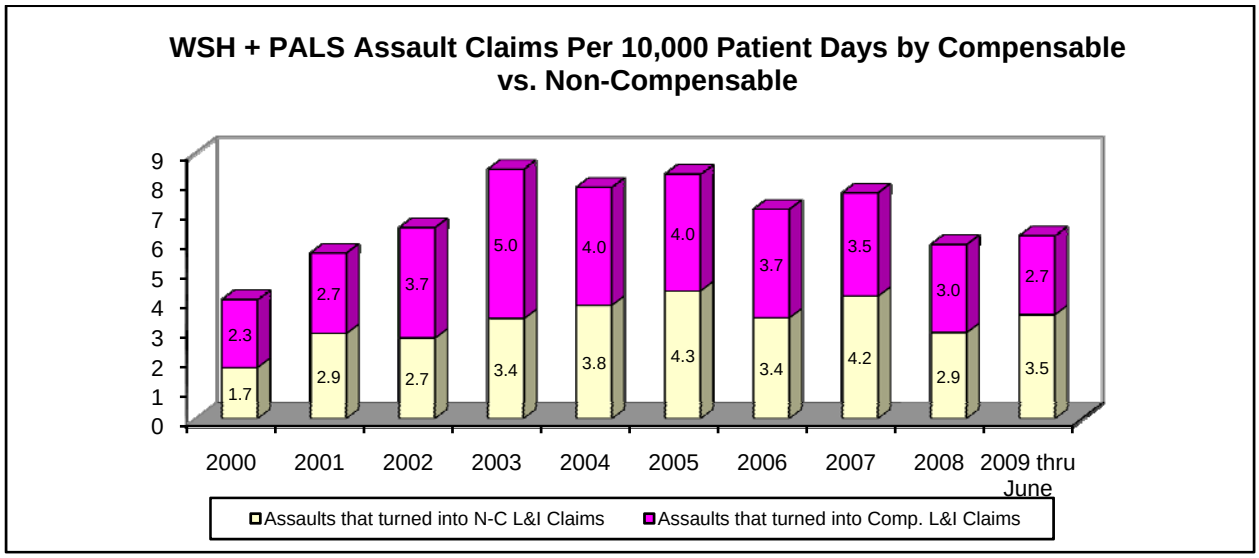


Compensable vs. Non-Compensable Assault Claims

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 2008 and early 2009 data (through June 2009) 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. The only other year where 50% or more of all assault claims were non-compensable was in 2005 and 2007 when WSH had a RTW program in place for at least one-half year. Every other year back to 2002, compensable claims made up 50% or more of all claims filed which means that WSH's claims were costing more. The implementation of an effective RTW program along with the recent safety improvements mentioned above is responsible for this current favorable ratio. With the funding of the RTW program ending on July 1, 2009, WSH risks loss of gains made the later part of 2009. This holds true when the PALS data is included with WSH data as well.





Time Loss Days

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 claims due to an on-the-job injury.

At WSH, 2008 data shows a dramatic decrease in the number of days missed from work due to an assault. Early 2009 (through June 2009) shows an increase in the number of days missed from work due to an assault when compared to 2008 (331.8 days per 10,000 patient days to 337.9). However, time loss days due to assaults at WSH have not been this low since 2002. 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. The decrease in time loss days in early 2008 reflects the full implementation of a Return-to-Work program. With the funding of the Return-to-Work program ending on July 1, 2009, there is a risk that time loss days will go up in 2009. This holds true when the PALS data is included with WSH data as well.