Workplace Violence Prevention Programs Review

Washington State Department of Social and Health Services

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I. Executive Summary

AJ Rosen & Associates LLC was employed by Washington State Department of Social and Health Services and SEIU Healthcare 1199NW to evaluate the Eastern State and Western State Hospitals workplace violence prevention programs. This project was the result of a collective bargaining agreement. The goal of the evaluation was to identify gaps in the workplace violence prevention programs and provide a detailed set of recommendations for consideration by labor and management officials.

Jonathan Rosen, MS CIH is the principal consultant for AJ Rosen & Associates LLC and performed all of the work reflected in this report. His background and credentials are detailed in Appendix A.

The steps in the evaluation included:

- an extensive review of policies, committee minutes, and injury and employment data.
- a site visit that featured meetings with management, focus groups and interviews of direct care staff, inspection of the physical plant, and a training session on best practices in violence prevention in mental health facilities.
- data analysis and development of 27 key findings and recommendations.

The key findings and recommendations are in the following major categories:

a. Staffing and Acuity
b. Leadership and Organizational Culture
c. Workplace Violence Prevention Policies and Procedures
d. Specific Workplace Violence Risk Factors
e. Support for Staff Exposed to Traumatic Events
f. Training

Patient-to-patient and patient-to-staff violence is a constant disruption to the well being of staff and patients at the two State hospitals. Violence interferes with patients progress in recovering from mental illnesses and it creates a stressful environment for staff who are subjected to abusive and assaultive behaviors. The costs are significant in negative patient outcomes, staff dissatisfaction, patient law suits, workers' compensation, excessive use of overtime, injury, disability, and traumatic stress.

Increased staffing, improved leadership and accountability, and development of a robust workplace violence prevention program are key. Agency and union officials should commit to a well defined implementation plan.

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1. Key Findings and Recommendations

The key findings and recommendations are based on an analysis of the data that was provided and collected in this evaluation, as well as experience in developing and implementing workplace violence prevention programs in other state operated psychiatric hospitals. Many of the recommendations are related. Therefore, it would be advisable to consider the relationship between the recommendations so that any follow-up implementation reflects an integrated approach.

a. Staffing and Acuity

1. Both hospitals operate with a "lean staffing" model, driven by state budget cuts. The hospitals frequently use overtime and on calls to cover scheduled and unscheduled leave and often cannot meet their own minimum staffing plans. The "lean staffing model" is in conflict with the mission, vision, values of the hospitals to "help patients recover from mental illness" as well as the hospitals' stated approach to provide "patient centered care" and "trauma informed care".
   Recommendation: Pilot a richer staffing model on a number of wards. The pilot should include a training and mentoring component so that the increased staffing is accompanied by a renewed focus on staff/patient interaction. Clinical leadership should focus on helping staff to recognize early warning signs of patient agitation and understanding patient traumatic triggers, as well as identifying individual interventions that help calm and restore patient self-control. There should be an evaluation component to track progress and adjust the pilot accordingly.
2. The hospitals' approach to acuity based staffing requires that each ward will "absorb" the first one-to-one supervision of a patient. This policy does not conform to concepts of acuity based staffing and is causing stress on staff and patients.
   Recommendation: Create "float pools[1]" hospital wide that can be used to provide additional staffing for one-to-ones, when acuity increases on a ward, and to fill in for staff who are on vacation, absent, or L&I[2]. Planning to determine the appropriate mix and number for the float pool should be based on historical data. To ensure the most productive use of the float pool, there should be contingencies to use float pool staff to help with documentation or other projects when they are not needed on the ward.

[1] Note: ESH has 4 RN FTEs who float, 2 on days, 1 on evenings, and 1 on nights and WSH has committed to developing one float pool in Forensics. Float pools were discussed in collective bargaining..
[2] L&I refers to Washington State's Workers' Compensation Program

3. The hospitals policies require patients to go to the treatment mall, even when they are psychotic, assaultive, or on "monitoring status". In part, it appears this is due to staff shortages that make it difficult to supervise patients on the ward and also properly transport and supervise patients in the treatment malls.

   Recommendation:

   The hospitals should have the capacity to safely supervise patients on the wards when they are not capable of participating in treatment mall programs or when they cannot be engaged without the potential escalation to loss of control and violence. Planning can be tied into the pilot and float pool recommendations in 1 and 2 above.

b. Leadership and Organizational Culture

4. The senior managers at the facilities employ a hierarchal model of organizational leadership. Union leaders, middle managers, nursing supervisors, and rank and file staff expressed that the hospitals' leadership personnel seldom seek their input, rarely make rounds on the units and wards, and frequently are punitive and discouraging when staff express concerns or ideas for improvement.

   Recommendation:

   Employ a qualified consultant to provide organizational leadership training to senior management and union leadership, middle management, and ward leadership. The goal will be to develop a robust, cooperative, team approach to hospital leadership that refocuses on the mission and outcomes, encourages communication and improvement, and promotes an open, non-punitive culture of patient and staff safety.
5. Direct care staff have a difficult time being released to attend meetings, including safety committees and others that work on workplace violence prevention issues. This was evidenced by the recorded absences in committee minutes[3] as well as testimony of the staff that were interviewed.

   Recommendation:

   Senior leadership should make a priority out of involving direct care staff in hospital committees and projects so that their experience and knowledge interacting with patients is brought to bear. Acting on the recommendations for the staffing pilot and float pools may also help to address this issue.
6. Some treatment team leaders do not involve staff from evening and night shifts in treatment team meetings. This excludes affected staff from providing input

[3] Recorded absences may have been due to scheduled or non-scheduled time off as well as difficulty in staff being released to attend meetings.

into treatment plans and also from learning firsthand about treatment strategies and approaches and triggers for individual clients.

Recommendation:
Require that treatment teams schedule some of their meetings so that evening and night shift may participate. Also, provide an opportunity for direct care staff to participate.

7. The hospitals' Treatment team leaders are all physicians. This reflects a hierarchal approach to team leadership, based on position and job title rather than abilities at leading the team. In many states the model of having treatment teams led by physicians was abandoned decades ago.
   Recommendation: Select team leaders from a variety of disciplines based on their leadership and team building abilities. In addition to improving team leadership and cohesiveness, this will also create additional career promotional pathways for nurses, social workers, and other professions that are appropriate to include as potential team leaders.

c. Workplace Violence Prevention Policies and Procedures

8. The hospitals have a spider's web of duplicative policies, procedures, and committees that address elements of the workplace violence prevention program. At WSH the Safety Committee spends about 70 percent of its time on workplace violence issues, but lacks clinical managers who can address clinical risk issues related to patient-to-patient and patient-to-staff violence. At ESH the Safety Committee does not focus on workplace violence prevention, rather it is addressed by the Executive Committee.
   Recommendation 8 (a): Review workplace violence prevention policies, procedures, and committees to eliminate unnecessary duplication. A starting point should be to establish a process dedicated to workplace violence prevention. This committee must have strong management commitment, include senior managers and union leaders, as well as department heads (including clinical leadership), and direct care staff. The committee's sole agenda should be workplace violence prevention issues. As necessary, the committee should assign subcommittees or delegate project work to appropriate hospital departments or committees.
   Recommendation 8 (b): There should be a Workplace Violence Prevention Policy and Program that integrates all elements of the workplace violence prevention plan including a statement of commitment, union and employee involvement, details on risk evaluation and control, reporting and responding to

threats and assaults, training, support for employees exposed to traumatic incidents, and working with criminal justice authorities. The document should be developed jointly with the unions and include definitions and reference related policy, laws, and regulations.

9. Neither ESH or WSH were in compliance with the Workplace Violence Safety Plan in Public and Private Facilities for the Mentally Ill: **RCW 72.23.400.** They have not published updated plans for 2012 as required.

   Recommendation: A short deadline should be set and personnel assigned to complete the task of updating violence safety plans as required by the regulations.

10. The process for conducting workplace violence risk evaluation is inconsistent, incomplete, and ineffective. State-of-the-art risk evaluation[4,5,6,7,8,9] is fundamental to violence prevention and includes assessment of clinical, environmental, and administrative risk factors as well as robust processes for researching solutions and implementing feasible improvements. Both hospitals use a variety of committees, policies, and instruments to assess workplace violence risk factors. However, there is minimal effort expended on integrating the committees' work and acting on their reports and findings

    Recommendation: Develop a comprehensive, integrated risk evaluation program that includes assessment of clinical, environmental, and administrative risk factors. The program should be clear about the frequency of all activities, who will lead and participate in them, and how they will be documented and followed up. The follow up should include a responsible person and a realistic timeline, understanding that solutions may be immediate, intermediate, or long term depending on the urgency and complexity of the risk factor.

11. Patient assessment procedures and forms do not include a specific section on history of violence, violence risk factors, and current risk level.

    Recommendation: Modify the current patient risk assessment procedures to include a specific evaluation for risk factors for violence and develop a plan to communicate the information to staff.

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[4] K.McPhaul, et al, Environmental Evaluation for Workplace Violence in Healthcare, Journal of Safety Research 39 (2008)

[5] The Joint Commission, Protecting Those Who Serve, Healthcare Worker Safety, Chapter 3 Human-Factor Related Risks, Violence in the Workplace, 2005

[6] R. Simon, Patient Violence Against Healthcare Professionals, Psychiatric Times, Vol. 28, 2, 2011

[7] C. Webster, et al, Violence Risk Assessment in Everyday Psychiatric Practice, Psychiatric Times, Vol 12, No 12

[8] OSHA 3148, Guidelines for Preventing Workplace Violence for Healthcare and Social Services Workers, 2005

[9] C. Tishler et al, Managing the Violent Patient: A Guide for Psychologists and Other Mental Health Professionals, Professional Psychology Research and Practice, 2000, Vol 31, No 1

12. The environmental survey form does not include specific checks for workplace violence related issues.

    Recommendation: Modify the form to ensure the workplace violence risk factors are assessed.

13. Nurses complained about the volume of paperwork consuming time that would be better spent interacting with patients and staff. It is understood that regulatory requirements must be met, but efforts to streamline and computerize documentation may reduce time spent on it.

    Recommendation: Initiate a project to streamline documentation. One important aspect would be developing electronic systems that transfer demographic data onto forms so that the same information does not have to be entered for each related form. For example, when a staff is assaulted the injury report and assault report form could be connected electronically. Another example is the restraint documentation. It is 7 pages and related to it is the debriefing form, ARI[10], and suicide assessment forms.

14. The Quality Management (QM) Program does "root cause analysis" or drill downs on unusual occurrences affecting patients. However, there is no equivalent program for evaluating patient assaults on staff. The QM investigators have had no formal training in these techniques.

    Recommendation: Just as the hospitals are required to evaluate unusual occurrences impacting patients, there should be a program that evaluates assaults on staff. There should be clear criteria for when these reviews are required, the timeframe for their completion and to whom they will be presented for action.

15. The hospitals reporting on occupational injury and workplace assault statistics uses a rate based on number of incidents per 10,000 patient days. While reporting this way is valuable in that it account for changes in the patient census However, it inconsistent with the norm for presenting occupational injury data. Also the lost time is not counted after 180 days.[11] This undercounts the problem. The two hospitals use different data collecting and reporting systems.

    Recommendation: Develop the capacity to produce additional regular reports on employee occupational injuries and illnesses and specifically patient-to-staff assaults. These reports should be produced monthly or at least quarterly so that trends can be evaluated. Sufficient detail such as experience by unit and ward, job title, time of day, activities, and other factors should be included. The standard rates below should be used and presented in a user friendly format for

[10] Unusual incident report
[11] Report to the Legislature, Workplace Safety in State Hospitals, September 2012, page 8

the benefit of senior management and union leaders, safety and other concerned committees, and the workforce as a whole. The two hospitals should use the same standard collection and reporting systems. Standard reporting of patient-to-patient assaults should also be improved.

The proposed measures should include:

1) an incident rate per 100 FTEs per time period.

2) a lost time case rate per 100 FTEs per time period.

3) a severity rate which is calculated by dividing the number of lost work days by the number of days available per 1 FTE per time period. For example, for an annual rate the number of lost days would be divided by 250. Two hundred and fifty = 1 FTE working for a full year. This rate will tell you the number of lost full time equivalents per year. Given the staffing shortages, this measure should be particularly useful.

d. Specific Workplace Violence Risk Factors

16. In both hospitals there were many instances where chairs and tables were unsecured and posed a risk factor for use as a weapon. This condition was observed in many interview rooms and some common areas. This hazard creates a potential for serious injury. Career ending injuries and permanent disability have occurred in similar settings where furniture was used as a weapon.
    Recommendation: Conduct a survey of all wards and areas of patient access to document where chairs and tables are unsecured and pose a risk of being used as a weapon. Determine if the furniture should be secured or replaced with appropriate alternative furniture.
17. The new chairs purchased for staff to use when doing one-to-one patient monitoring are a safety hazard. They were purchased because light weight chairs were often left on the wards, posing a risk that they might be used as weapons. The new chairs must be moved around the wards and due to their weight pose a lifting hazard and also may potentially obstruct egress.
    Recommendation: The Safety Committee is already working on addressing this problem, looking for an alternate chair or other solution.
18. Ward staff, union representatives, and the Nursing Practice Committee recommended erecting a Plexiglas barrier on the nurses' station on ward C6 at WSH. The recommendation followed a violent incident where a patient jumped over the nurses' station and assaulted 3 staff. The recommendation was denied by the clinical leadership, and according to the staff who were interviewed, there

was insufficient discussion or justification. It was observed that other wards in the same building have such barriers.

Recommendation: Hospital administration should meet with the affected staff, union representatives, and Nursing Practice Committee to review the proposed corrective measure, discuss the impact on patient care and safety, and attempt to develop a consensus on how to prevent future exposure to the risk of patients jumping over the nurses' station and assaulting staff.

19. The ESH 2010 Workplace Safety Plan documented a number of physical plant improvements that were not completed due to lack of funding.

    Recommendation:

    These items should be revisited to determine whether they pose a risk factor for violence and develop a plan to address those that do.

20. In some of the high risk / injury units and wards, it would be useful to evaluate the extent that assaults and violence are caused by multi-assaultive patients. In evaluations of other adult facilities, multi-assaultive patients have been responsible for 50 to 70% of assaults.[12]

    Recommendation: Assign appropriate personnel to conduct an evaluation of multi-assaultive patients including looking at injury and incident data to determine the frequency that multi-assaultive clients are involved, the amount of lost time, and relevant factors. Use this data to initiate a project to try to reduce the frequency and impact of assaults.

21. Many staff at both facilities raised that patients refusing medications was a risk factor for violence. There appears to be a wide variation in the length of time to appeal to the courts to get an order for medication over objection. This may relate to the approach of individual physicians as well as the processing of paperwork by facility personnel and the courts.

    Recommendation: Evaluate the length of time for obtaining court orders for medication over objection, determine the bottlenecks in the processing of the petitions, and develop proposals to improve the process.

22. Patient smoking policies are not in conformance with current best practices and fail to recognize the negative impact on patient health, drug interactions, and disruptive patient behavior.[13,14,15,] A study in 2011 conducted by the National

[12] Based on internal reports from several New York State psychiatric hospitals Workplace Violence Prevention Committees developed in 2010 - 11.

[13] AM Hehir, et al, Implementation of a smoke-free policy in a high secure inpatient mental health facility: staff survey to describe experience and attitudes, BMC Public Health, 2013

[14] E. Ratschen et al, Smoke-free policy in acute mental health wards: avoiding the pitfalls, Gen Hosp Psychiatry, 2009

[15] S. Voci, et al, Impact of a smoke-free policy in a large psychiatric hospital on staff attitudes and patient behavior, Gen Hosp Psychiatry, 2010

Association of State Mental Health Program Directors Research Institute, Inc. (NRI)[16] showed that 79% of state psychiatric facilities had banned patient smoking. At the Washington State hospitals staff reported that taking patients on smoking breaks was disruptive to ward activities and exacerbated staffing shortages. The current practice requires a staff member to escort six patients at a time off ward to smoke. Additionally, smoking is still used by some staff as a behavioral tool. The research literature shows that banning smoking in psychiatric hospitals helps reduce incidents, improve patient outcomes, and is accepted by staff.

Recommendation:

Begin working with the unions, staff, and patient representatives to develop a plan for ending smoking in the hospitals. The plan should include a phased in approach that is rich with communication and supports for smoking cessation as well as consideration of the impact on staff and patients who are addicted to tobacco products.

e. Support for Staff Exposed to Traumatic Events

23. The programs for providing support to staff who are exposed to traumatic events are based on the Critical Incident Stress Management (CISM) model that has been widely critiqued since 9/11[17,18,19]. The CISM programs at the institutions appear to be underutilized, although there was no utilization data available.

    Recommendation: Develop a program to provide support to staff who are exposed to traumatic events that is state-of-the-art, peer based, available 24/7, provides individual service as opposed to group psychological debriefing, using psychological first aid, led by qualified and trained team leaders. The development of this program will require a revision of policy, assignment of team leaders, recruitment and training of team members, and a communication plan for implementing the program. The purpose of the program is to provide organizational support for assaulted staff, help them to regain a sense of well being and safety, return to work, and avoid post traumatic stress disorder.

[1616] V. Hollin, Effects of adopting a smoke-free policy in state psychiatric hospitals, Psychiatric Service 2010

[17] T Fawzy and M Gray, From CISD to CISM, Same Song Different Verse, The Scientific Review of Mental Health Practice, Vol 5, No 2, 2007

[18] S Regel, Post-trauma support in the workplace: the current status and practice of critical incident stress management (CISM) and psychological debriefing (PD) within organizations in the UK, Occupational Medicine 2007, 57

[19] ACFASP Scientific Review, Critical Incident Stress Debriefing, American Red Cross 2010

24. The facilities do not have separation policies to assess, on a case by case basis, the need to separate staff from patients who have assaulted them, are targeting them, or to separate staff from each other in instances where staff conflict is disruptive.

    Recommendation: Develop a separation policy in cooperation with employee labor unions, that describes an effective process for evaluating requests for separating staff from patients or each other and provides criteria and a mechanism for making such determinations and putting them into action.

25. The hospitals return-to-work programs have been disrupted by loss of key personnel. The WSH Safety Committee has had an agenda item on this topic for more than a year.

    Recommendation: Establish an effective return-to-work program that matches the injured staff with work tasks that are within their physical restrictions. This will require that managers, supervisors, and union representatives work together to identify meaningful and appropriate light duty assignments. This will help injured workers to return to productive work as soon as possible, benefiting them and the hospitals. For example, develop the capacity to assign staff who cannot work with patients to do documentation, thereby freeing up nurses or Mental Health Technicians to spend more time interacting with patients.

f. Training

26. Staff indicated inconsistencies in the frequency and effectiveness of the Therapeutics Options training.

    Recommendation: This program should be updated to state-of-the-art on preventing and managing crisis situations. It should focus on prevention, teaching non-verbal and verbal intervention skills and acceptable defensive physical maneuvers to be used when prevention fails. The training should be comprehensive and include participative techniques such as small group activities and role plays as well as hands on practice of the defensive maneuvers. The training should be required prior to assignment on a ward and there should be a mandatory annual refresher. Systems for tracking training, following up on staff who miss assigned training, and releasing participants for training should be reviewed and strengthened as needed.

27. The Workplace Violence Prevention Training is an electronic offering and listed as one of many in the ESH Safety Management Program. Hands on violence prevention training is provided to staff at orientation and staff are required to participate in Therapeutic Options training at least once every two years.

Recommendation: Review the goal and objectives of these training programs and consider whether the curriculum, delivery methods, and frequency that they are offered are effective.

2. Next Steps

An Ad Hoc work group, comprised of administration and union representatives, should be formed to develop a plan to take appropriate action based on this report. This Ad Hoc workgroup should meet periodically to review and coordinate statewide initiatives regarding these objectives. The workgroup will also review recommendations and issues contained in the Joint Commission Recommendations and Standards, Washington State Labor & Industries Reports, and the 2012 Washington State Psychiatric Hospital Work, Stress, and Health study.

II. Introduction

1. Background

AJ Rosen & Associates LLC[20] was contracted to evaluate the workplace violence programs at the two state operated psychiatric hospitals in Washington State. The consult was prompted by a collective bargaining agreement between Service Employees International Union (SEIU) 1199NW and the Washington State Department of Social and Health Services.

Patient and staff violence have garnered significant attention at the two facilities due to the serious impact on patient care, quality of work life, and disruptions to operations. Additionally, several sentinel events occurred in the past year in the two facilities including two patient homicides committed by patients and a patient suicide in the Forensics Services Unit at ESH.

2. Evaluation Objectives

The evaluation's purpose is to identify gaps in the hospitals workplace violence programs and develop recommendations for management and union leaders to consider how to reduce violence and the related negative impacts.

[20] A description of AJ Rosen & Associates LLC and the report author's bio is in Appendix A

3. Methodology

The methods used in the evaluation featured data collection from management and direct care staff. Management provided documentation, policies, and injury and employment data. Management also provided input during opening and closing conferences. Direct care staff were interviewed during focus groups and during environmental tours[21]. The information gathering focused on staffing, the environment of care, the structure and implementation of the two hospitals workplace violence prevention programs, and the organizational culture and leadership. The staff input obtained in focus groups, training programs, and during the tours were not verified for accuracy.

4. Benchmarks

Benchmarks used in this evaluation include Washington State health and safety and staffing laws and regulations, Joint Commission standards, and best practices within the industry. Washington State has been a leader in promulgating cutting edge health and safety standards addressing key hazards that are causing injury, illness, and workers' compensation claims. These are considered 'minimum' standards for compliance purposes.

Similarly, some relevant Joint Commission standards are listed below. These standards and their enforcement are tied to the hospitals accreditation that is necessary for Medicare and Medicaid reimbursement.

Compliance with relevant laws and regulations and Joint Commission standards in itself does not equate to excellence in violence prevention. The true measure is in the effectiveness of the program in reducing assault injuries and related costs. The goal of compliance activities is to meet regulatory requirements, to obtain continued accreditation, and avoid fines and negative publicity. The goal of improved performance is better patient outcomes and staff job satisfaction.

a. Hospital Mission, Vision, Values

The stated "mission, vision, values"[22] of the hospitals emphasizes the goal of assisting patients in recovering from mental illness, trauma informed and patient focused care, non-violence, respect, and empowerment of patients and staff.

[21] The site visit schedule is in Appendix B
[22] DSHS website, ESH Mission: http://www.dshs.wa.gov/mhsystems/eshmission.shtml

b. Washington State Laws and Regulations

- Workplace Violence Safety Plan in Public and Private Facilities for the Mentally Ill: **RCW 72.23.400**

  This law requires employers in these settings to develop and implement a plan that would reasonably prevent and protect employees from violence. The plan must include:
  - A hazard assessment of their facilities.
  - Employee training on the plan.
  - Follow up on any workplace violence incidents.
  - A review of the plan at least annually.

- **WAC 296-800-14025** requires employers "to establish, supervise, and enforce your accident prevention program in a manner which is effective in practice."

- **WAC 296-800-14005** requires employers to "develop a formal [written] accident prevention program, tailored to the needs of the particular plant or operation and to the type of hazards involved." The program must include "a safety orientation program" that contains (among other things) information about reporting injuries and unsafe conditions, the use and care of personal protective equipment, and emergency procedures.

- **WAC 296-800-11005** requires employers "to furnish to each employee a place of employment free from recognized hazards that are causing or likely to cause serious injury or death" to employees.

- **WAC 296-800-11010** requires employers "to adopt and use practices, means, methods, operations, and processes which are reasonably adequate to render such employment and place of employment safe" and to "do every other thing reasonably necessary to protect the life and safety of employees."

- **WAC 296-800-16005** requires employers "to assess the workplace to determine if hazards are present, or likely to be present, which necessitate the use of personal protective equipment (PPE)" and to select appropriate PPE and require its use.

- **WAC 296-27-01101** requires employers to maintain records of occupational injuries illnesses.

- **WAC 296-360-020** prohibits an employer from firing or otherwise retaliating against an employee for reporting unsafe work conditions, including concerns about potential workplace violence.

- Staffing Regulation **RCW 70.41.420** and **RCW 70. 41.020**.

- Each hospital, by September 2008, must establish a nurse staffing committee composed at least half direct care nurses. This committee will develop, oversee and evaluate a nurse staffing plan for each unit and shift of the hospital based on patient care needs, appropriate skill mix of registered nurses and other nursing personnel, layout of the unit, and national standards/recommendations on nurse staffing.
- If the staffing plan developed by the staffing committee is not adopted by the hospital, the CEO must provide a written explanation of the reasons why to the committee.
- The staffing information must be posted in a public area and must include the nurse staffing plan and the nurse staffing schedule, as well as the clinical staffing relevant to that unit. It must be updated at least once every shift and made available to patients and visitors upon request.

c. Joint Commission standards

Some of the many relevant standards include:

- **EC.02.01.01, EP 1** The hospital manages safety and security risks. The hospital identifies safety and security risks associated with the environment of care that could affect patients, staff, and other people coming into the hospital's facilities.
- **EC.02.01.01, EP 3** The hospital takes action to minimize or eliminate identified safety and security risks.
- **LD 02.04.01** The hospital manages conflict between leadership groups to protect the quality and safety of care.
- **LD.03.01.01** Leaders create and maintain a culture of safety and quality throughout the hospital.
- **LD.03.01.01, EP 3** Leaders provide opportunities for all to participate in safety and quality initiatives.
- **LD.03.06.01, EP 3** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services.
- **LD.04.04.05, EP 6** The leaders provide and encourage the use of systems for blame-free internal reporting.
- **APR.09.04.01** "The hospital provides care, treatment, services, and an environment that poses no risk of an 'Immediate Threat to Health or Safety'

d. The 2012 Washington State Psychiatric Hospital Work, Stress, and Health study

A 2012 study,[23] funded by NIOSH, was conducted by the Washington Department of Labor & Industries SHARP program and supported by ESH and WSH, the Union of Physicians of Washington, SEIU 1199NW, and WFSE Unions. It documented short staffing problems, disruptive behavior, and impacts on patient-to-staff and patient-to-patient assaults, negative patient and staff outcomes, and quality of care. The key recommendations included:

1. Increase staffing adequacy including development of a float pool.
2. Address disruptive behavior.
3. Seek to achieve cultures of work-life engagement[24], flexibility, and integration.

A participatory intervention development team is continuing to meet and reportedly is focusing on developing supervisory training. The study's recommendations are an important reference that should be considered in addressing the related problems identified in this report.

III. Data review

Overall, patient-to-patient and patient-to-staff assaults occur frequently.[25] It will be important for the hospitals to record and report this data in a consistent manner, so that it may be used to help guide and measure efforts to reduce violence.

Both hospitals provided data on reported patient-to-staff assaults and also the number of staff, reported in full time equivalents (FTEs)[26]. The data provided by the two hospitals is not comparable because each hospital provided different sets of data.

Chart 1 shows the number and rate of assaults at WSH for 3 years (2010 - 2012), for the first quarter of 2013, and a projected rate for 2013. The rates reflect the number of assaults per 100 employees per year. The data show that the rate of assaults has been increasing and is projected to be 7.7% higher in 2013, compared to

[23] Yragui, N. L., Silverstein, B. A., Foley, M., Johnson, W., & Demsky, C. A. (2012). The Washington State Psychiatric Hospital Work, Stress, and Health Project: Final Report to Washington DSHS Mental Health Division and Western State Hospital. Unpublished Technical Report

[24] The concept is to create a workplace culture where staff are encouraged to participate, identify problems, without fear of retaliation.

[25] There is no national database of assault statistics in state operated psychiatric hospitals to use for comparison purposes.

[26] One FTE is equal to the number of hours worked by one full time employee for a particular time period, such as one year.

2010. NOTE: the projected number of assaults for 2013 may be skewed by a spike in assaults in January 2013 associated with the removal of ligatures[27] from patient rooms.

Chart 1: Western State Hospital Patient-to-staff Assaults 2010 - 2013

Year	Number of Assaults	Total FTEs*	Rate per 100 FTEs per year**
2010	301	1,934	15.6
2011 ****	345	1,953	19.1
2012	322	1,873	17.7
2013 Actual	103		
2013 Projected	412	1,917	21.5

*Total FTEs is the average for the FY for 2010 - 2012 and for 9 months of 2013 ** The rate was calculated by dividing the number of assaults by the average number of FTEs per year. *** First quarter 2013. **** One hundred and fifty-one FTEs were affected by the consolidation of maintenance and institutional business services in November, 2011. These FTEs continue to work at WSH, but are assigned to CIBS and CMO.
Data Source: Consolidated Institutional Business Services (CIBS)

Information was provided on the number of assaults by job title. Chart 2 details the number of assaults for the six job titles with the largest number of assaults: Institution Counselors, LPNs, RNs, Mental Health Technicians, Psychiatric Security Attendants, and Psychiatric Security Nurses. Overall 31 different job titles had at least one assault during the 3.25 years. Overall these data illustrate that the probability of being physically assaulted by patients is a significant problem at WSH, especially in direct care staff jobs.

Chart 2: Western State Hospital Patient-to-staff Assaults by Select Job Titles

Job Title	2010	2011	2012	2013 Actual	2013 Projected*
Inst Counselors	26	22	21	6	24
LPN	46	48	36	24	96
RN	56	60	47	18	72
PSN	18	18	12	6	24
MHT	94	111	116	30	120
PSA	48	64	62	16	64

* The projected number for 2013 was calculated by multiplying the first quarter number by 4

Chart 3 shows the rate of assaults per year for the six job titles. Rates are used so that the experience of different sized populations, such as Institutional Counselors and RNs, can be normalized.

[27] The term ligature describes any clothing, wire, cord, or item that can be used for self-strangulation or self harm.

Chart 3: Western State Hospital Rate of Patient-to-staff Assaults per 100 employees per year, by Select Job Titles

Job Title	2010 FTEs*	2011 FTEs	2012 FTEs	2013 Projected FTEs	2010 Rate	2011 Rate	2012 Rate	2013 Projected Rate
Institution Counselors	52	53	46	48	50.2	41.6	45.6	50.0
LPN	174	154	151	128	26.5	31.3	23.8	75.1
RN & RN3	276.8	275.2	270.3	279.8	20.2	21.8	17.4	25.7
PSN	71.7	70	66.6	76.2	25.1	25.7	18.0	31.5
MHT	263.9	236.7	249.3	266.1	35.6	46.9	46.5	45.1
PSA	147.7	148.2	151.7	155.4	32.5	43.2	40.9	41.2

* FTEs is the average for the FY for 2010 - 2012 and for 9 months of 2013. ** The rate is calculated by dividing the number of assaults by the average number of FTEs.

Eastern State Hospital did not provide the same data set as WSH. Therefore, a comparison review is not possible. The source of the data ESH provided was the DSHS Enterprise Office of Risk Management (ERNO). The information included a summary of all patient-to-patient and patient-to-staff incidents. There were a total of 758 incidents over the 3 year period summarized in chart 4. For the 3 year period, the total number of patient-to-patient assaults was 466 and the total number of patient-to-staff assaults was 292. The number of incidents varied by unit and ward as illustrated in chart 5.

Chart 4: Eastern State Hospital, Number of Patient-to-patient and Patient-to-staff Assaults, 2010 - 2012

Year	Total	Patient-to-patient	Patient-to-staff
2010	321	213	108
2011	199	105	94
2012	238	148	90
3 Year Total	**758**	**466**	**292**

Chart 5: Eastern State Hospital, Number of Patient-to-patient and Patient-to-staff Assaults, 2010 - 2012 by ward

Units	Ward	Number of Assaults	Total by Unit
Adult Services Unit	1N1	129	288
	2N1	93	
	3N1	66	
Forensic Services Unit	1S1	62	88
	2S1	16	
	3S1	10	
Geriatric Services Unit	B	79	382
	D	110	
	E	118	
	HMH	75	

Chart 6: Eastern State Hospital Patient-to-staff Assaults for Select Titles (direct care staff) 2010 - 2012

Year	Number of Assaults	Total FTEs*	Rate per 100 FTEs per year**
2010	108	434	24.9
2011	94	429	21.9
2012	90	431	20.9

*Total FTEs are for direct care titles: LPN, RN, PSN, MHT, and PSA ** The rate was calculated by dividing the number of assaults by the average number of FTEs per year.
Data Source: Enterprise Risk Management (ERNO)

Additional data that was provided detailed the L&I (workers' compensation) claims for the 3 year period. There were 350 claims filed: 72 in 2010, 76 in 2011, and 102 in 2012. Of the total claims 150 were compensable, including 79 of the 158 claims that were classified as patient assaults on staff. Assault related claims by job title and the rate of claims are in charts 7 and 8.

Chart 7: Eastern State Hospital Patient-to-staff Assaults Resulting in L&I Claims by Select Job Titles

Job Title	2010	2011	2012	Total
LPN	3	2	4	9
RN	14	10	14	38
PSN	1	0	0	1
MHT	32	27	27	86
PSA	5	4	6	15

Chart 8: Eastern State Hospital Rate of Patient-to-staff Assault L&I Claims per 100 employees per year, by Select Job Titles

Job Title	2010 FTEs*	2011 FTEs	2012 FTEs	2010 Rate	2011 Rate	2012 Rate
LPN	37	36	35	8.1	5.6	11.4
RNs	143	146	147	9.8	6.8	9.5
PSN	10	10	9	10	0	0
MHTs	190	185	187	16.8	14.6	14.4
PSA	54	52	53	9.3	7.7	11.3

* FTEs is the average for the FY for 2010 - 2012. ** The rate was calculated by dividing the number of assaults by the average number of FTEs.

The ESH data for the 3 year period documented 5,383 lost work days associated with the injuries. Based on an average 250 days per year, this is equivalent to the loss of 22 full time employees or about 7 per year. The number of restricted work days for the 3 year period was 2,740. Another data set provided by EHS listed 10,664 lost work days, equal to the loss of 42 full time employers or about 14 per year. That data set also indicates 5,326 restricted work days for the 3 year period.

IV. Document Review

1. List of documents received and reviewed

The letter requesting documentation from the two hospitals is in Appendix C and a list of documents received and reviewed is in Appendix D. WSH did not provide copies of policies that were substantially the same as those from ESH. Rather, they sent a chart of comparable WSH policies, attached in Appendix E. Because WSH did not provide their comparable policies, the comments referring to ESH policies should be considered by both facilities.

2. Observations from the document review

a. Redundant and uncoordinated committees and policies

In general, the document review revealed that both hospitals have many redundant policies, authorities, and committees. In several instances the same data was presented in multiple committees working on the same issues. For example, the safety and the patient safety committees are covering a lot of common ground.

Workplace violence prevention in particular does not have a single coordinating, accountable leadership authority. For example, Quality Assurance is responsible for 'patient safety and clinical risk management' and the Security Department at ESH

coordinates assessment of the physical plant in activities such as pro-active risk assessment. In addition, absent from both hospitals safety committees are management leaders[28] who are qualified to address clinical risk factors for violence.

The function and accountability of various committees that are involved in workplace violence prevention is not well defined. For example, the ESH Safety Committee Charter does not specifically address its role in violence prevention activities and a review of committee minutes revealed it is not a significant agenda item. The structure at ESH is for the Executive Committee to address workplace violence issues and for the Safety Committee to deal with physical plant issues. Conversely, the WSH Committee spends more than half of its time on these matters.

Additionally, a significant number of direct care staff on both hospitals Safety Committees were unable to obtain release to attend meetings. This was reflected in the frequent absences documented in committee minutes[29] and mentioned in the focus groups.

The WSH Safety Committee minutes revealed that the issue of light duty assignments was carried on the agenda without action for more than a year. It was referenced that the individuals who provided support for the return to work program had been laid off. This is an example of a process problem and also a failure to recognize the value of assisting injured employees return to work which is key to employee well being and alleviating short staffing problems.

b. Data analyses and trending

The hospitals data trend reporting on occupational injury and workplace assault use a rate based on number of incidents per 10,000 patient days. This presentation of data is confusing and inconsistent with the norm for presenting occupational injury data. Typically, the raw numbers would be enhanced with injury rates per 100 employees including an incident rate, lost time case rate, and a severity rate that calculates the number of lost FTEs per time period. Given the staffing shortages, this measure should be particularly useful.

Another issue with data reporting is that lost time is not counted after 180 days. This undercounts the problem.[30] According to OSHA, employers may cap the number of

[28] Clinical leaders include Directors of Psychiatry, Psychology, Social Work, and Nursing.
[29] These absences may have been due to scheduled or unscheduled leave as well as difficulty in getting released to attend meetings.
[30] This practice was documented in the 2012 Annual Environment of Care Report and also the 2012 "Workplace Safety in State Hospitals" annual report to the Legislature.

days after lost time, job transfer, and restricted duty reaches 180. However, employers are not required to do so.[31]

Tracking and trending injury and assault data is included in the ESH Environment of Care (EOC) Plan Review and Safety Committee minutes where raw numbers are reported. The hospitals also have an Unusual Occurrence Reporting System that is primarily for reporting patient related serious injury, death, assaults, and restraints.

c. Risk assessment tools and corrective action

The hospitals environmental survey instruments do not specifically include any checks for workplace violence risk factors.

The ESH Safety Management Plan indicates that individual department managers and supervisors are responsible for corrective action when hazards are identified. There should be an organizational system for tracking, follow-up, and accountability. The i categories describing the injury are "unsafe act" or "unsafe condition". These are not useful categories and may discourage reporting, as staff avoid being accused of engaging in unsafe acts or allowing unsafe conditions.

The ESH Pro-Active Risk Assessment activity is focused on physical plant issues and not human interactions. The one item relating to workplace assaults was a drill down report by the Quality Management Director, but this report was not made available and it was unclear if it led to any improvement activity.

The Joint Commission found safety deficiencies related to a patient homicide that occurred at ESH in the fall of 2012. Additional deficiencies related to patient safety culture and leadership issues. The facility established new procedures for inspecting wards for ligatures, hired 28 additional staff, and developed a number of new policies to address the deficiencies. At the time of the Joint Commission survey there were 86 nursing vacancies. The DS&HS also is taking action to hire new CEOs at both facilities.

The Patient Monitoring Policy states that the level of patient supervision is determined by the physician or nurse based on patient monitoring. However, the requirement for units to absorb the first one-to-one defies this stated policy.

WSH reported that its SAFE initiative, Safe Alternatives for Everyone resulted in a savings of $600,000 in reduced overtime costs.

[31] OSHA 29 CFR 1904.7 (b)(3)(vii)
http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_id=9638&p_table=STANDARDS

d. Response to traumatic events

The Critical Incident Management Programs follow a model that has come under significant scrutiny. The practices that are no longer considered appropriate include a) group psychological debriefing, b) need for supervisory action to initiate the intervention, c) team members are not peers, and d) inadequate follow-up. There was no data available from either hospital on utilization or effectiveness of their teams. Appropriate trauma response programs provide essential organizational support for assaulted staff. They can play a pivotal role in helping staff return to work, regain a sense of safety and security, and avoid disabling PTSD.

e. Organizational Culture: Leadership, teamwork, communication, and training

The WSH 2011 HSPCS Patient Safety Survey documented evidence of a deterioration since 2009. The data suggests a perception of poor staffing and lack of management support of patient safety by survey participants.

The WSH Culture of Patient Safety Policy reflects a fundamental lack of understanding of the subject matter in that it talks about creating a "non punitive" environment where staff will report safety risks on one hand and later talks about taking disciplinary action against staff who fail to comply with the policy.

The ESH Psychosocial Treatment Manual included little about teamwork and communication in interactions with team members and clients. This item requires patients to go to the treatment mall, regardless of their immediate risk of assaultiveness or ability to participate in programs. The Patient Monitoring Policy states, all patients on "monitoring status" continue to attend treatment mall. Sending patients on monitoring status who are acutely psychotic or violent to the treatment mall would appear to be a significant risk factor for violence and should be re-evaluated.

The ESH Safety Management Plan lists Workplace Violence training as just one of many electronic offerings.

f. Compliance with RCW 72.23.400

The ESH Workplace Safety Plan was last updated in 2010, even though it is required to be updated annually. The plan does not include a comprehensive approach to workplace violence prevention. Rather, it lists existing hospital policies without explaining how they related to each other. It also included a number of physical plant improvements and documented that many of the identified hazards were not acted upon due to lack of funding. WSH also has not updated its plan as required by statute.

g. Patient acuity and movement

The ESH Nursing Standards refers to "patient intensity acuity". It listed the following staffing totals: RN 118.2, LPN/PSN 40, MHT/PSA 203.5, OA3 9 total: 370.7: 287 beds. The WSH has 827 beds: 557 civil and 270 forensic. Its Child Study and Treatment Center has 47 beds.

The WSH was cited by Washington State Labor & Industries for short staffing and lack of safety and security assessments. The violation is being appealed.

V. Site Visit

The site visit was conducted May 6 -10, 2013. An initial meeting was held with Jane Beyer, Assistant Secretary, DSHS; Laura Wulf, Assistant Director, Human Resources Division; Margaret Cary, SEIU Healthcare 1199NW Counsel; and Ryan Weber, SEIU 1199NW Organizer. The schedule was reviewed and the agency's efforts to refocus on "patient focused" and "trauma informed" care models was discussed. It was announced that Ron Adler would be starting as new CEO at WSH on July 1, 2013. A new CEO for ESH is in the selection process. The new CEOs will play a key role in leading the facilities in a new direction.

1. Meetings with Senior Management

At each facility there were pre and post meetings with the hospitals' senior management that were attended by SEIU Healthcare 1199NW representatives. The managers were given an opportunity to discuss gaps in their workplace violence prevention programs and respond to focus group prompts described below.

At WSH the senior manager in attendance was Chief Operating Officer Dale Thompson, Labor Relations Specialist Kelly Rupert, Nurse Executive Julia Cook, Safety & Environment Manager Pam Rieta, Human Resources Manager Lori Manning, DSHS Assistant Human Resource Director Laura Wulf, and SEIU 1199NW representatives Organizer Ryan Weber, and RNs Paul Vilja, Tal Chun Kim, Linda Holbrook, and Kerry Gaines. Only the Nurse Executive, Julia Cook, reported having direct experience working on a ward with patients. Some of the gaps in the workplace violence prevention program identified by senior managers included:

- external threats
- threats from former employees
- programs to address active shooters
- difficulties in communication due to large campus
- aging workforce experiencing more physical problems

Regarding risk factors for workplace violence:

- big physical space
- line of site issues on wards
- no PA system on wards
- incomplete cell phone coverage
- PA doesn't reach all areas outside
- inconsistency during shift reports

Dale Thompson reported that regular safety surveys are conducted. However, he acknowledged that the survey form does not have specifics regarding violence risk factors. The Nurse Executive reported that rounds are required every 60 minutes on the wards. One of the SEIU nurses mentioned a 10 tips factsheet that had been placed in the nurses' station in CFS to remind staff about violence prevention measures.

Regarding Culture of Patient Safety:

- employees are reluctant to bring up problems. Don't want to "tattle on each other"
- employees are worried about being blamed or experiencing "peer" punishment
- better to be paralyzed and "safe", then stick your neck out

Regarding staffing:

- absenteeism is a big issue
- L&I leave
- FMLA
- main problem is unscheduled leave
- quality of staff's performance is also a factor
- staff want more staff
- Tried increasing staffing in adult psych in 2008-09 and it did not improve outcomes.

Regarding training:

- Employees' skill set and education is a factor
- New employees receive a 3 week orientation

- Forensics requires a 2 year background, but only 3 weeks for nursing
- Not enough staff to release people to attend training

The value of doing cross shift training, bringing together staff from all 3 shifts so that they can benefit from each other's knowledge and experience working with the same patient population was discussed.

Regarding acuity:

- When wards have multiple one-to-ones, it is difficult to find enough overtime available staff to provide coverage
- Julia Cook reported that staff use Johnson's Sub system model and assess suicide every shift
- RN2s and 3s and doctors make decisions regarding increasing staffing due to patient acuity. However, quite often extra staff is not available to provide coverage
- More overtime is used on weekends due to scheduled time off. This also results in more pulled staff[32].

Regarding work with criminal justice authorities and trauma response:

- A specific detective Lee is assigned to work with the facility.
- No specific relationship or agreement with the district attorney has been formalized
- The facility does not have utilization data on its Critical Incident Management Program
- There is perception that it is underutilized and usually the employee experiencing the trauma must request the service

Discussion covered the value of management and labor formalizing a relationship with the District Attorney and also the new approach to providing support to employees exposed to traumatic events. This approach features peer based teams, led by team leaders, available to all employees 24/7, using psychological first aid on an individual service basis as opposed to the group psychological debriefing approach of CISM that may lead to negative outcomes for some participants.

[32] "Pulled staff" refers to pulling staff from one ward to another in which they are not familiar with the patients.

At ESH the attendees from senior management included acting CEO Kamal Floura, COO Shirley Maike, Nurse Executive Lori Johnson, Nurse Managers Bob Mair and Julie Carlberg, Safety Manager Sharon Mandarino, Labor Relations Specialist John Myers, Human Resource Managers Julie Allan and Jamie O'Dowd. In addition to the consultant, Ryan Weber of SEIU and Sharon Silar, RN and local SEIU leader attended. Two additional SEIU local reps were not released to attend the meeting. A number of the senior managers had direct care experience in their resumes.

Regarding gaps in the workplace violence prevention program:

- In FSU[33] staff and patient interactions often still use the "corrections model" and lack respect and understanding.
- Some staff focus on patient's criminal history in FSU, and believe they don't deserve any privileges.
- We are five years into the change from the behavioral to the recovery model of care.
- Aging staff typically have 20 or more years.

Regarding support for staff exposed to traumatic events:

- We are very interested in psychological first aide.

Regarding safety culture:

- We started to do rounds for safety and environment of care every week where we talk to the staff about safety.
- We have had town hall meetings, which serve as an open forum, on day shift. We go on the units on days and evenings.

Regarding risk factors for workplace violence and staffing:

- The CEO or Medical Director approves outside medical appointments.
- Forensics has "Risk Review Board and Panel"
- In 2009, a Forensic patient eloped to a community fair. This led to legislative and policy changes.
- Proactive risk assessment checklist doesn't have specifics on workplace violence prevention.
- We look at what leads up to assaults.

[33] Forensic Services Unit

- Even with the 28 new positions, staffing will still be short. We are short psychologists and other professions as well. We have a lack of leaders for the treatment mall.

2. Focus Groups

The schedule included two focus groups held at WSH and one at ESH. Two focus groups scheduled at ESH were not conducted due to staff not being released to attend. Prompts were used to obtain staff's perception of workplace violence risk factors. They were:

1. Describe specific violent incidents that have occurred at work.
2. Identify workplace violence risk factors.
3. Describe preventive measures that are in place and how they are working.
4. Suggest other preventive measures that could be implemented.
5. Describe the hospital's safety culture and the ability for direct care staff to raise safety concerns and get them addressed.
6. Does the staffing plan adequately provide for patient and staff safety?
7. Describe the hospital's system for assessing patient acuity and adjusting staffing when necessary?
8. Describe the hospitals system for supporting assaulted/traumatized staff and its effectiveness?

The detailed Focus Group reports are in Appendix F and contain summaries or direct quotes from the staff who participated.

3. WSH Safety Committee meeting

The committee meets the 4th Thursday of each month. The Chair, Union Representative Jim Sprague, described that about 70% of the committee's work is on workplace violence prevention. The committee looks at trends, overtime use, and pulled staff. About 25 participants attended the meeting and the management chair is COO Dale Thompson. A number of other committees are also working on workplace violence prevention issues such as Environment of Care, Security, and Patient Safety Committees.

The committee does not have access to workers' compensation data, but mentioned that it may be available through DSHS in Olympia.

Dale Thompson acknowledged that the streamlining of committees is an important issue to be worked on. Also, improving communications among committees and to the workforce as a whole.

The Washington State Psychiatric Hospital Work, Stress, and Health Project follow-up committee is developing a supervisory training, targeted for the fall.

Although a number of nurses and MHTs attend, there is no one from the clinical leadership on the Safety Committee.

Several committee members described the hospital culture as punitive, and decision making and communications as unilateral. As an example, a participant described that the Nursing Committee had recommended installing a plexiglass barrier on C6 and that consensus was overruled by the leadership.

4. Tour of hospital units

WSH Forensic tour participants included the consultant, Dale Thompson, RN3 Cynthia Forsythe, Ryan Weber, and local SEIU representative and RN3 Paul Vilja. Dan Gapsch, Director of Security provided an overview of the security operations. There was a census of 246 patients at the time of the visit and the maximum is 265. There are 9 wards including a community program and 4 admissions wards. It was reported that patients are not allowed to be in the courtyard without staff supervision. Many nurses and technicians were informally interviewed during the tours.

Emergency calls use a PA system and duress buttons. A staff is assigned to monitor the bathroom due to a concern that with two stalls in the bathrooms it is necessary to allow only one patient to use the bathroom at a time to avoid incidents or allegations.

Smoking is only allowed outside the building. On the civil side it is allowed if a patient has earned the "privilege" to smoke. A system of "Levels" is in place that runs from 1 to 7 based on a patient's behavior. All doors in FSU are alarmed.

The new chairs that were purchased for one-to-one patient monitoring were reported to be uncomfortable and too heavy to move. Previously, office chairs were used, but often left out on the ward, posing a risk that they may be used as a weapon.

The medication room had a sliding port installed to provide a barrier between the RN and patient receiving the medication.

A 2nd staff is deployed when entering a patient's room. Doors to patient rooms open out to prevent patients from barricading doors. All patients' beds are restraint capable. Nora floors which are softer and water resistant have been installed. Electronic door locks control patient bedrooms and communications systems are in place. F1 and F2 have installed a video monitoring system.

Staff indicated that there are typically 5 or 6 high risk patients on most wards. The staffing for a ward of 29 patients included 8 nurses and MHT[34]s, 3 social workers, and 2 doctors.

Interviewees indicated they often have to use pulled staff and staff on overtime to meet minimums. When a Code is called, all available staff come running. The staff assigned to the unit have to absorb the first 1 to 1.

The treatment team leader is not part of the transfer committee.

An SEIU RN who is on the Safety Committee reported it is very difficult to get a replacement so that she can attend committee meetings.

The chairs and desk in the conference room were not secured and could be used as a weapon. This ward has a Plexiglas barrier in its nurses' station. Staff mentioned the need for monitoring cameras in the dining area and Dale Thompson indicated this project is already underway.

An RN reported she was hit with a chair, out for 2 months, and experienced a brain injury. She obtained a restraining order against the patient and the administration was responsive about keeping them separated. This same patient recently stabbed 2 people on a Seattle bus. The RN reported frustration when she emailed management and the patient safety committee about her concerns and received no response.

[34] Mental Health Technician

It was noted that there were locations on the ward with unsecured chairs that could be used as weapons.

Tour of North Yard and Forensic Services Unit

Participating were the consultant, Dan Gapsch, Dale Thompson, Ryan Weber, and RN (SEIU representative) Barbara Yates. We viewed the new fencing and gates that were recently installed to better secure the yard for the FSU. The gate did not have an electronic locking control, but rather was secured with a padlock.

F4 houses males who are NGRI[35] or undergoing competency restoration. The capacity is 30 patients. Staffing at the time of the tour included 1 in the kitchen, 1 in the medication room, 1 in the yard, 2 on the floor, and one charge nurse. There were no one-to-ones. They have employed a contract nurse for about 7 months.

When asked "Do you feel safe", the charge nurse responded, "about 75% of the time".

When asked about risk factors for violence, a PSN[36] communicated that there was a problem with two patients on the ward not taking their medications. It was detailed that the doctor had not processed the paperwork for the court to review medication over objection, telling staff to continue working to persuade patients to take medications. Another risk factor identified was housing NGRI and competency patients together. The person interviewed did not know why these patients are housed together.

A PSA[37] indicated he was the only male on the ward and that staffing was not adequate. He also raised a concern about patients who stop taking medications.

F6 is a co-ed ward. The charge nurse raised concerns about documentation,

> "Every time L&I comes in, new forms are created! I spend 3 hours on paperwork, much of which is covering the same things. The restraint paperwork is 7 pages and related is the debriefing form, ARI, and suicide assessment forms. It's a marathon of paperwork."

[35] Not guilty by reason of insanity
[36] Psychiatric security nurse
[37] Psychiatric security assistant

"Some days, I am so busy with paperwork, I don't have time to talk to patients."

At this point this documentation is not electronic and so demographic information must be re-entered on each form.

Staff reported there was a near riot on F2 a couple of weeks ago and that a patient on F8 was being paid $100 per week not to assault. This ward has one extra staff assigned full time to do one-to-one monitoring of this patient. Staff reported that this patient was not taking his medications and sometimes "cheeks" (hides medication in his cheeks). When he refuses to eat, paranoia kicks in.

Another risk factor mentioned was patients trying to get food from another patient. Also, racial tensions among patients. Another patient was found to be selling chewing tobacco, which is contraband. Staff reported some specific assaults between patients involving racial slurs. They took place in the bathroom and ward areas. This ward allows 2 patients to use the bathroom at the same time.

The evening supervisor reported this to be the most violent ward, all male NGRI. Many patients express fear about being here. The privilege system was not working as designed. Patients are allowed to drink coffee until 6 pm. A particularly violent patient was being paid $35 per week not to get violent and allowed to stay on the ward, rather than go to the treatment mall. Patients use the money to buy coffee and food out of the vending machines.

The treatment team meets every week during swing shift to determine levels. This treatment team leader arranged his schedule so he could include evening and night shift in treatment team meetings. However, this practice is not done uniformly across the hospital.

One PSA recommended reducing patient census on the wards to a maximum of 25 to relieve the staffing problem and reduce tensions and violence.

Tour of Building 18, Central Campus, Psychiatric Rehabilitation Treatment Center (PRTC)

Participants included the consultant, Dale Thompson, Ryan Weber, Paul Vilja, and RN2 Linda Holbrook. We toured C3, a ward with 30 patients that is staffed by 2

RNs, 1 LPN, and 3 MHTs. This is a high acuity ward with new admissions. The charge nurse stated that most shifts there are times when there is only one nurse on the ward.

The nurse stated,

> "The volume of paperwork and phone calls pulls me from patients and the office assistant has been out for a month. We have to absorb the first one-to-one with no extra staff."

The psychiatric assessment that is conducted does not include a specific section assessing history and risk factors for violence and assaultiveness.

The doors are equipped with mortise locks and anti-ligature handles were installed throughout both facilities for suicide prevention purposes.

A nurse described being punched in the face by a patient who reached over the nurses' station.

The shared kitchen area also pulls staff off the ward if there is no food Aide available. In those instances, the MHT or nurse prepares the food. Staff expressed concern that this may violate county food standards, although this was disputed by management.

C6 staff described that on May 2, 2012 there was a major incident involving a 350 lb, 6' 3" patient who had a history of murder and assault. This patient wanted to go back to Forensics. He jumped over the nurses' station and knocked out the RN3. The RN2 who was assaulted subsequently developed PTSD. The psychiatrist was also assaulted and taken to the emergency room. The doctor, RN3, and RN2 all agreed that the design of the nurses' station poses a risk factor for violence. However, their efforts to get a Plexiglas barrier installed were denied by the clinical leadership. They expressed frustration and anger over this denial and especially that they were never given any explanation or communication on the basis for the denial.

The psychiatrist described the event as follows.

> "The nurses and I met with him and he demanded additional food, said he didn't want to go to the treatment mall, and wanted to return to Forensics. He had been in a group home and attacked his roommate with a frying pan, which is why he was given a 90 day civil commitment to WSH. As he was getting agitated, we moved him

out of the small conference room and that's when he jumped over the nurses' station and attacked us. He punched me and pulled me down".

Regarding this patient, one staff interviewed stated,

"A chill goes through you. I saw him on the grounds. He has two felony assaults, but was ruled not competent to stand trial."

The team leader described the ward as having the lowest number of assaults. He ascribed this to the team approach of the staff. The staff are supportive of each other and close knit. There is no rankism `and treatment team meetings are held on all 3 shifts.

Tour South Hall

Tour of ESH Adult Psychiatric Unit (APU) and Geriatric Psychiatric Unit (GPU)

RN4 Kurt Cogswell accompanied the tour. APU consists of 10 wards, including an admission ward. Kurt reported that some managers were sent to leadership training put on by Fierceinc.com that focused on communication and holding staff accountable.

1N1 has 31 beds and 32 patients at the time of the tour. The bathroom has 3 toilets and 3 showers. There was a patient on one-to-one in the quiet room. This unit takes direct admissions from counties and elsewhere. There are 3 step down wards. The patients are 50 years old or younger and go to the treatment mall 5 times per week.

The furniture in the assessment room and back office was not secured and could be used as a weapon.

Eleven staff are assigned to this ward because the patients are "acute". The mix included 5 RNs and 6 MHTs. Space is very constricted on the ward. The CDMHP (County Designated Mental Health Professional) has authority to hold patients for 72 hours pending court action. One nurse does admissions, one treatment, and one monitoring one-to-one. Staff check the patients every 15 minutes.

Staff reported that many patients are violent inmates brought in from jails. They manipulate jail personnel to get in here. Shanks have been found on the ward.

"We used to have EPERT training and equipment including riot gear, helmets, and a shield. The training was provided by law enforcement personnel. It was eliminated a month ago. I was told not to call the police. We call staff from other APU wards to assist. We have no contingencies for riots or weapons."

"We have 3 males and 1 female currently who are high risk for assault. They are on "assault observation". One nurse was out for 6 months. The patient was sent to jail, but the prosecutor didn't press charges, so the patient was moved to a different ward."

Staff described taking groups of six patients to smoke at a time.

The small dining room had unsecured furniture that could be used as a weapon.

Staff raised that they do not have personal alarms.

An evening shift MHT stated that he doesn't attend the "shift report" meetings, but that he knows the patients well. He just completed the annual "Therapeutic Options" 8 hour training last week.

Regarding safety culture he stated,

"A lot of people cut you off when you try to speak. If they don't like what you have to say they cut you off."

"Many of the patients are not getting their needs met due to personal internal struggles due to short staffing".

The charge nurse and RN3 agreed that there was not adequate staffing. They had 7 that night: 1 LPN, 2 RNS including the RN3, and 4 MHTs. One MHT was being oriented. There is a lot of turnover as staff want to work days or get more money working FSU.

An MHT with one year of service stated,

"When the acuity is high, I don't feel safe and that's about 3 to 4 days a week".

Another MHT:

"The ward is hard to work. There are 3 patients whose behavior is volatile. "

The RN3 reported,

"On Saturday everyone on the ward was float staff, except for me. There was not enough staff to do groups or take patients outside. We had 6 staff on Saturday and one had an angina attack. There was a patient on one-to-one and that left only 4 staff. When we called for help around 7 pm, they had no one to send."

An RN testified,

"I got really badly beat up on this ward 2 years ago. A patient was refusing to do medications. We were walking with him when he hit me so hard I flew six feet through the air and broke my arm. We called for help and no one came."

Tour of ESH Forensic Services Unit

The patient census was 25 and there were 10 staff including 4 RNs, 1 LPN, and 5 PSAs.

An RN2 explained that staffing is inconsistent. "

We operate with a skeleton crew, pulled staff, and on calls."

At the time of the tour there were no one-to-ones, but 5 high risk patients. Several had refused taking their medications. Nurses reported there had been delays in getting court orders for medication over objection. Two patients were gang members.

The ward doctor explained that when the petition is filed with the court, the court date set for hearing may not be timely. He said that the court sometimes denies the petition if the patient has not assaulted recently.

The RN4 mentioned that Spokane County has a mental health judge and there was discussion about labor and management working together to educate the judge about violence in the hospital.

A PSA stated that it is "an absolute joke" to try to redirect the patients because they come in handcuffs and chains from jail. He felt that the corrections approach was more effective.

One RN stated that she had not had Therapeutic Options training for 3 years.

Another staff mentioned that 15 day patients often come without medications directly from a jail isolation cell.

There were 30 patients on 3S1. The Local 783 president, noted that there were 5 patients who were not going to the treatment mall.

The design of the medication room posed a risk of patients jumping through the window. It was not fitted with a Plexiglas barrier as had been done on other wards such a 1S. An RN3 said that she had requested the barrier 3 years ago and never received a response. The same risk factor was observed on 2S.

It was reported that cameras are being added to the hallways and seclusion rooms.

To address the staffing shortage, FSU has hired 28 additional staff, has 20 on call, and 3 contract staff, in addition to using overtime.

Staff complained about having to absorb the first one-to-one.

The medical room posed a risk of entrapment. If the door locks the nurse could be harmed before help arrives. The Physician's Assistant stated he usually brings a staff with him when in the room.

The Charge RN said there were 8 staff and 39 patients today, which she thinks is inadequate.

The Treatment Team does not afford evening or night shift personnel an opportunity to participate in team meetings.

The direct care staff who were interviewed expressed that staffing was inadequate and it became critical when patients refused to go to the treatment mall. They reported that at times an emergency code green was called and no help was forthcoming.

2S has 40 patients. In the treatment room on 2S1 the door cannot be kept open when a patient is in the room. The chairs in this room and the visitor's room could be used as weapons.

Tour of Westlake Geriatric Psychiatric Services (GPU)

Westlake GPU has four Wards. The ward we visited had 28 patients. The Charge Nurse reported that many incidents are not reported because:

"there are so many of them, we would do nothing else".

The staff take patients out on the patio to smoke in groups of six. Staff expressed that the Therapeutics Options training should have an annual refresher component.

The staffing on the ward was 7 today including 2 orientees. The RN3 expressed there was not enough staff to facilitate the mandated groups on the treatment mall and on the ward. The concern is how to do all the mandates and provide good patient care too:

> "There is too much patient programming, taking nurses off the ward. We have two patients who are incontinent and hit us every day. We don't have time to do all the paperwork. At 7:10 AM we get reports and go on the floor, from 8 to 8:30 we feed the patients, then we do medications and smoke breaks, groups at 9:30, and take patients to the treatment mall at 10:20. We often skip breaks and lunch."

The nurses' station had a Plexiglas barrier in place. The door handle to the seclusion room had not been replaced with the new safer handle.

5. Input from Training

A one hour interactive training was held on best practices on violence prevention in mental health settings at each facility. About 20 staff, including union and management personnel attended each program and provided the following input:

- At ESH the hospital never addressed the fatality that occurred in 2012. It needs to be addressed as there is unresolved trauma. The new CEO should deal with this organizational trauma.
- After CMS[38] and TJC[39] surveys following the death of a patient in restraints in 2006, investigations were taken out of the hands of management and give to the Washington State Police. This has caused lots of problems in getting timely investigations and resolutions.
- We are not pro-active. It is a crisis operation without vision.
- The qualifications of people are an issue. We used to have Central Nursing Services ward management meetings.
- There is resistance to establishing a float pool at WSH. It would help, because the float pool would get to know patients and operations across many wards.
- TJC requires contraband searches, but we do them on Friday - Monday so it won't disrupt the treatment mall schedule.
- MHTs can't get a weekend off.
- A nurse was taken off the ward and put in the kitchen for a year. This demoralized the kitchen staff and the nurse who was never informed about the charges or the findings. It used to be the CEO could stop the process when it was clearly unfounded.
- APU safety issues include mentoring and education of staff.

6. ESH Safety Committee Meeting

The Committee meeting was attended by about 20 personnel and chaired by Kim Cogswell, Local 782 representative and facilitated by Sharon Mandarino, Safety/ Risk Management. Injury statistics were reviewed and comments were made on improving the presentation of that data for future meetings. There were no recommendations for action or research based on the incident review.

[38] Centers for Medicaid and Medicare Services
[39] The Joint Commission

The QM representative noted there were 3 pending drill downs and root cause analysis presentations pending for review by executive management. One involved an attempted patient suicide.

Dr. Floura reported that the TJC wants specialized treatment plans for certain patients.

Most of the agenda did not concern workplace violence matters.

The infection control nurse spoke about an incident where a patient assaulted 3 staff.

Lots of documentation was circulated including injury statistics, Security Management Plan, Proactive Risk Assessment, and Environment of Care Improvement Activities.

7. ESH Staffing Committee

The meeting was held on May 9th and attended by ESH Management Lori Johnson, Kurt Cogswell, Bob Mair, Julie Carlberg, John Meyers, Glen Christoferson from DSHS, and SEIU Healthcare 1199NW representatives Sharon Silar, Ryan Weber, Kathy Cornwall, and Ken Hall. The agenda included a review of the draft Staffing Plan, Policy 1.202, minutes from the meeting of April 18, 2013, and short staffing data from the first quarter of 2013.

The short staffing data sheet showed that of 32 days listed, the number of call-ins exceeded the overtime and call-in replacements on 21 days. Presumably, this was due to unavailability of replacements for those who called in. The shift listed was primarily the 11 pm to 7 am.

The committee reviewed the staffing plan matrix on page 3 of the policy. The SEIU representatives recommended changing the zero LPN item throughout the plan to 1 LPN. It was agreed that there is a shortage of LPNs and that these positions would have to be filled with RNs when LPNs are not available.

It was suggested that contingencies be explained for adjusting staff based on one-to-ones, absenteeism, L&I, use of overtime, on calls, and a float pool. Sharon Silar explained that there is a need for a charge, medication, and treatment nurse on each ward.

Lori Johnson agreed to make the recommended changes and add footnotes to the plan. It was pointed out that this would also be valuable so that outside evaluators would better understand the plan and its contingencies and assumptions.

8. Closing Conferences

At both hospitals a closing conference was held with the management and union leadership where the consultant reviewed some of the findings and potential recommendations. The consultant noted the final report would be prepared within 45 days after the site visit.

Appendix A

Biography: Jonathan D. Rosen, MS, CIH

Principal Consultant
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Jonathan is the Principal Consultant for AJ Rosen & Associates LLC, providing occupational safety and industrial hygiene services to unions and organizations throughout the U.S. Previously Jonathan served as Director, Occupational Health & Safety Department for NYS Public Employees Federation, AFL-CIO for 22 years. PEF is the labor union that represents 55,000 professional, scientific, and technical workers in New York State government agencies. Jonathan's department facilitated PEF's 130 joint health & safety committees and developed programs addressing infectious disease, chemical, ergonomic, and safety hazards, including workplace violence prevention. He has been co-investigator on several federal NIOSH intervention research grants and published peer reviewed articles, book chapters, and editorials. Jonathan serves as an adjunct faculty member for the National Labor College. Jonathan has completed a Master's Degree in Industrial Health at the University of Michigan and is a Certified Industrial Hygienist.

Appendix B

Schedule for Workplace Violence Prevention Consultation

Week of May 6 - 10, 2013

Date	Time	Activity	Notes	Needs to be done
Sunday 5/5/13		Arrive Seattle, stay in Renton, Ryan drive's to Olympia in am.		
Monday 5/6/13	9:00 - 10 AM	Meet with Agency & Union Leadership		
	10:00 - 11:00 AM	Travel to WSH		
	11:00 - 12:00 Noon	Meet with WSH management and union leadership	Discuss goals and steps in the consult	
	1PM - 2:30 PM	Tour the Forensics Wards		
	2:30 - 3:45PM	Focus group 1- (Forensics day/evening shift)		
	4pm- 6:30PM	Tour Forensics Ward and Civil wards.		
	6:30 - 7:30PM	Drive Back to Seattle		
Tuesday 5/7/13	8:00 –9:00AM	Drive to WSH		
	9:00-10:30AM	Tour Central/South/ East Wards		

	11:00-12:00PM	Focus Group 2-Civil Day Shift Units (East, Central, South)	Hamilton Conference Room Reserved.	
	12:00- 1:00PM	Safety Lunch-Open to all RN's to come discuss workplace and meet Jonathan.	Hamilton Conference Room reserved.	
	1:30-2:15PM	Special Safety Committee Meeting		
	2:30 -4:00PM	Training	In the Amphitheater	Include Hospital Managemen t, CEO, Nursing Director
	4PM-4:30PM	Closing Conference		
	6:00-7:00PM	Flight to Spokane		
Wednesday 5/8/13	8:00 –9:00AM	Meet with ESH management and union leadership	Discuss goals and steps in the consult	
	9:00 - 10:30AM	Tour forensics wards		.
	10:30-11:30PM	Tour civil wards		
	11:30-12PM	Lunch		
	12:00-1:30PM	Focus group 1-forensics day shift		
	1:30 - 3:00PM	Focus Group 2-civil day shift		
	3:00PM-5PM	Tour Forensics and Civil Wards		
	5:00-6:30PM	Focus Group 3-All Wards evening shift		
Thursday	6:00-7:00AM	Night Shift Tour		

5/9/13		
	9:00 - 10:30	Staffing Effectiveness Meeting
	11:00-12:00	Meet with Safety Committee
	12:00-1PM	Safety Lunch- Open to all RN's to come discuss workplace and meet Jonathan.
	2:30PM-4PM	Training
	4PM-4:30PM	Closing Conference
	5:30PM-6:30PM-Fly back to Seattle	
Friday 5/10/13	4AM-7AM	Night Shift Rounds@ Western State Hospital

Appendix C

Data requested to begin work on the workplace violence review:

1. Written workplace violence prevention programs for WSH and ESH and related policies.

2. Related policies include:

   a. Restraint and seclusion

   b. Acuity assessment and supervision of patients

   c. Emergency codes and procedures

   d. Staffing

   e. Environment of care

3. Available data for three to five years, including;

   a. WSHA Injury and illness logs

   b. Workers' compensation data

   c. Patient incident data

   d. Any data reports or analyses showing experience and trends

4. Any reports that describe the current patient and staff demographics, staffing, patient census, organizational structure, and climate of care in ESH and WSH.

5. Information about all committees that play a role in workplace violence prevention, the framework under which they operate, and copies of their minutes and any important projects they have conducted or are conducting relevant to workplace violence prevention.

6. Any Joint Commission reports or notices of deficiency, grievances, or notices of violation that relate to workplace violence.

Appendix D

Eastern State Hospital (ESH)	Western State Hospital (WSH)
Safety Committee minutes 12/2012 - 3/2013, Charter, Roster	1/26/12 through 2/2/2013, Charter, Membership Roster, Job Description. Western has 4 subcommittees
Environmental Surveys Schedule 2012	
Safety Management Plan 2012	
Environment of Care Performance Improvement Activities 2011 and 2012	
Quality Management System Annual Environment of Care Plan Review 2011	
Plan for Improvement Armed Assault / All Hospital Lockdown	
Enterprise Risk Management Annual Safety Program Review PFI Dashboard	
Hazard Vulnerability Analysis 2012	
Unusual Occurrence Report (UOR) QM policy	Administrative Incident Reporting (AROI) 2009
Confidential Report of Unusual Occurrence	
Emergency Management Plan	
Crisis Debriefing, Specific Procedures	Support for Staff who Experience Assault or Other Traumatic Event 2010 Serious Clinical Incident Debriefing 2012 Critical Incident Management Team 2010
Psychosocial treatment program, Manual	
Routine Patient and Safety/ Security/ Environment Checks	
Workplace Safety Plan, 2010	Workplace Safety 12/2012 Workplace Safety Training, annual computer based training
Nursing Dept Standards Vol I Administrative	
Seclusion & Restraint (GB)	Seclusion & Restraint 2011
Joint Commission Survey Report 12/2012, TJC Accreditation Decision Letter 1/4/2013	TJC Evidence of Standards Compliance 7/18/2012 Email to all employees from CEO Jess Jamieson re TJC acknowledges staffing shortage
45 day Evidence of Standards Compliance Form 2/18/2013 and Accreditation-Activity 60 day Evidence of Standards Compliance Form 3/5/2013	Undated letter to all staff re TJC survey, rebuts some staffing findings

Undated letter to all staff re TJC survey	
TJC Evidence of Standards Compliance 2/10/2013	
Workplace Safety in State Hospitals, Reports to the Legislature for 2011 and 2012	Report covers both hospitals
Specific Procedures, Armed Assault	
Annual Environment of Care Plan Review 2012	
All Hospital Lockdown	
HSPSC, Hospital Patient Safety Culture	Culture of Safety 3/21/2013
Patient Safety Program Committee, Charter, minutes for 2012 (5 meetings)	WSH Survey on Patient Safety 1/1/2013
Patient Monitoring	
Plan for Patient Care Services 2012-14	
Quality Management System, Annual Environment of Care Review	
Staffing Committee Minutes	Staffing Committee Minutes
Staffing Effectiveness 2011 and 2012	
Daily base guidelines for staffing and tracking form	
Routine Patient/Security/ Environment Checks	
Comparative Statistics Report 2012	
	Workplace Violence 3.4.10 2009
	L&I WISHA Violation 3/11/2013 Appeal letter, 5/25/2013
Excel files with injury data and employment data	Excel files with injury data and employment data

Appendix E

Washington State Hospital Comparable Policies

Documents that ESH provided	What we have
☐ Policy RE: Unusual Occurrence Reports	AROI policy 1.1.7
☐ Policy RE: Weapons	1.9.4
☐ Policy RE: Seclusion & Restraint	Seclusion/Restraint policy 2.4.1
☐ Policy RE: Routine Patient & Safety/Security/Environmental Checks	We have different terminology than ESH. Comparable policies and nursing standards are below.
☐ Policy RE: Safety Management Plan	
☐ Policy RE: Security Management Plan	
☐ Policy RE: Emergency Management Plan	
☐ Policy RE: Staffing Plan	
☐ Policy RE: Psychosocial Treatment Program	
☐ Procedures for "All Hospital Lockdown"	
☐ Procedures for "Hostage Situation"	
☐ Procedures for "Armed Assault"	
☐ Procedures for "Crisis Debriefing"	
☒ Plan for Patient Care Services 2012-2014	Plan of pt care svcs
☐ 2012 Annual Environment of Care Plan Review	E-mail sent
☐ Environment of Care Performance Improvements	
☐ Quality Management Systems – Annual EOC Plan Review	
☐ Document titled: Staffing Effectiveness	E-mail sent
☐ Document titled: Environment Surveys Schedule for 2012	E-mail sent
☐ Safe Patient Handling Program – Annual Review 2011	E-mail sent
☒ Hazard Vulnerability Analysis 2012	Same
☒ Hospital Survey on Patient Safety Culture	Survey instrument
☒ Assessment of Patient Safety Survey Results	Results summary
☐ Safety Committee Charter & Meeting Minutes for 2012-Present	E-mail sent
☐ Patient Safety Committee Charter & Meeting minutes for 2012-Present	We don't have something comparable
	Policies 1.9.1, 1.9.2, 1.9.9, 1.10.2, 1.10.3
	2.2.9, 2.2.10, 2.4.8
	3.4.10, 3.4.11, 3.4.13
	NS 108
	NS 204, 208, 213, 215, 216, 217, 221, 245, 253
	NS 301, 302, 303,

Appendix F

Focus Group 1 WSH

Six nurses including RN2s and RN3[40]s attended who worked Forensics, acute admissions, and civil wards.

Regarding experience with violence:

- A nurse reported having recently been assaulted and was on L&I[41].
- A nursing supervisor had been severely assaulted 15 years ago, suffering ruptured discs and was out on L&I for 1.5 years.
- "I was recently kicked in the back". There was no lost time.
- "Assaults are excessive...many I don't seek attention for".

Regarding staff support for traumatic incidents:

- "I believe up to 30% of the staff have untreated PTSD from being assaulted. They fear going on L&I".
- RN2: "I was angry. I tried to get the patient to take medications. But the Attorney General's office wouldn't pursue medication over objection, because he was taking some of his medications. He had assaulted another RN three to four years ago. When he came to my ward he stopped taking medications all together. I got clocked and landed on my hands and hip. I had to go to a therapist for treatment of PTSD."
- "When we go to the police and report an assault, nothing comes of it. The special liaison says it is not a felony because it was not a severe injury".
- Only about half the focus group attendees knew about CISM[42].
- "I was offered CISM by an RN4, but CISM never called me".
- One nurse was told by a doctor, "This is what L&I is for".

Regarding risk factors for violence and staffing:

- A big concern is the time it takes to get court order for medication over objection. "At the time there were pulled staff on the ward that I did not know.

[40] RN3s are nurse supervisors. RN4s are nurse managers.
[41] "L&I" is the term used to describe workers' compensation. The Washington State Department of Labor & Industries administers workers' compensation.
[42] CISM is the Critical Incident Management Team, established to provide support to staff who have been assaulted.

The client was on close observation and when he assaulted me the pulled staff didn't assist me. At the time there was insufficient staff. Only 1 RN and 1 LPN. There should never be less than 3. A big mandate now is you must have 3 staff to intervene with a patient. If two patients fight that will consume six staff."

- The RN paperwork burden takes away from patient focus: "It seems more important to treat paperwork than patients. We must meet our quota of paper".
- "I have 31 patients on each of 2 wards. I can't provide quality supervision covering 2 wards".
- Use of cell phones and I-Pads by staff is a problem in both Forensics and Civil units.
- "Patients coming in from jail for 90 day competency evaluations often arrive with no medication override. The medication orders used to be prepared before they arrived at the hospital. We need an MD in the jail".
- "The culture here tolerates tardiness and especially arriving late and departing early when on overtime."
- "RNs should be empowered to add staff based on acuity. Overtime is assigned using an overtime wheel which is a big circle of names and titles".
- "I recommend overtime should not be scheduled for Forensics using staff from civil. They used to have separate overtime wheels for Civil and Forensics".
- "On evenings we start out short everyday".
- "The new chairs for monitoring patients are not good. They obstruct egress and are too heavy to move".

Regarding safety culture and training:

- "We get staff who are untrained, don't know the patients, and we have to absorb the first one-to-one[43]".
- "We run on minimum all the time".
- "Environment of care rounds identify maintenance and housekeeping problems and those are addressed rapidly".
- MOAB (Management of Aggressive Behavior) training used to be 2 days and was cut back.

Focus Group 2 WSH

Six nurses including RN2s and 3s attended who worked South Hall, Geriatrics, and Male Assaultive wards.

[43] "One-to-one" refers to one staff member monitoring one patient. This is required when a patient poses a threat to the safety of others or self-harm.

Regarding experience with violence:

- "On my ward, a patient choked and bruised an RN who is out today".
- "Every week staff are assaulted. Staff are shutting down."
- "There are 3 out on L&I from my ward. My left wrist was pulled and I was bitten and scratched on Sunday".
- "A patient kicked staff, grabbed one by the neck and pulled her hair. That staff has been off since November".
- "Chairs were thrown on the patio. They are still there".
- "I was injured in September in a patient assault. A patient was assaulting another patient and I tried to intervene and hurt my shoulder. No one spoke to me for months. I was afraid of this patient. The team leader assigned me to charge nurse, even though I was on light duty and restricted from patient contact".
- "A forensic patient killed another patient and should not have been placed on that ward".

Regarding risk factors for violence and staffing:

- "E7 and E8 do not have any seclusion rooms. The psychiatry department is opposed to it because it would cost $15,000 to convert a patient room and also it would eliminate a patient room on the ward. ".
- "We have a calming room that is effective".
- "We work with a base of 6 staff, but have to absorb the first 1 to 1".
- "When you absorb the first 1 to 1 you are essentially working short staffed. You are denying proper care to other patients".
- "We have 8 staff, but two are 1 to 1s. Eighty percent of the time the nurses do breakfast on the male assaultive ward."
- "Pulled staff don't do restraints. We lost our psychologist and student interns".
- "I was on L&I for 3 years, and that left an RN3 position open for 3 years".
- "Patients who don't want to go to groups are not allowed to go to their rooms and they get angry".
- "The ward is so small that you can't ambulate around the ward without bumping into people. We have 32 patients".
- "Drop the census on units. Thirty is too many".

Regarding safety culture

- "I have written to the administration, CEO on down, and mainly there was no response. They are more concerned with statistics on restraint and seclusion than the issues we raise".
- "Senior leadership is not out on the wards, except when there is a sentinel event".
- "RNs are reassigned to desk work. There is no communication, no education. Staff who were involved in the sentinel event are still traumatized and there has never been any resolution".

Lunch discussion summary

- Three participants described that they had been reassigned off their wards for 3 months to a year. They described the reasons for their reassignments as unjustified, arbitrary, and vindictive.
- We used to do "out trips" with NGRI[44] patients and that was discontinued.
- Recreational therapists were cut three years ago during a restructuring.
- The pilot program with enhanced staffing did work.

Focus Group 1 ESH

Focus Groups 2 & 3 ESH

Most of the participants were not released to attend these two focus groups. The input from the few who attended has been integrated in the report from Focus Group 1.

Regarding experience with violence

- An Axis 1 patient with uncontrolled diabetes wanted carbs and assaulted a nurse and broke her arm. This raises issues about patient centered versus process centered care in that the patient was not supposed to have carbs, but denying them led to the assault. In a judgmental culture, staff are worried about retaliation if they don't enforce the rules. This also leads to staff feeling unsafe.
- A patient assaulted staff without warning and also assaulted peers on the APU[45] ward with 30 patients. He was on med watch because he spit out medications. I had bruising on my arm, but didn't lose time from work.

[44] Not guilty by reason of insanity (NGRI).
[45] Adult Psychiatric Unit

- "On a Saturday about a year ago a patient would not follow directions and was verbally abusive to patients and staff because he was denied the yard. He came into the nurses' station. He unlatched the half door and punched me on the side of my head. I had to contain him on the ground. I had back strain and rug burn. The next day he apologized to me. I had to finish the shift in pain, as there was no one available to replace me".

Regarding risk factors for violence and staffing

- The hospitals systems include a Quality Management Program (QM) that is responsible for the Risk Management Plan, Patient Safety Committee, investigating sentinel events, conducting root cause analyses and drill downs, and coding unusual occurrences.
- Root cause analysis is not done when patients attack staff, only when there are patient injuries and as requested by the CEO.
- The QM staff have not had formal training in these investigative techniques.
- A new management analyst has been hired to work in this program.
- Root cause analysis reports are presented to the Executive Team, but they are backlogged about 6 months. There is not a good process for follow-up.
- The handling of the removal of the ligatures after the patient homicide caused anger among patients and confusion among staff due to inadequate communication and planning. Patients were going to riot. On my ward 2 staff were sent to help and told me they didn't think they would get out alive. Patients stuff was thrown in trash bags. It was abusive. Ancillary staff and janitors were in there making decisions about what patients could and couldn't have.
- I have been removed from my ward and assigned to another for 3 months. The state police do the investigations for the facility. I have not received any communication on this. The new collective bargaining agreement requires specifics to be given within 60 days
- The level system is not working. It used to be if a patient's level was reduced they could not go to the yard for 24 hours. Now that's not the case.
- We had only five staff on Sunday and I was the charge nurse. "I didn't know if I should be there. It was going to be so hard. I don't have time to go into the milieu to de-escalate people".
- Six patients to one staff go to the yard to smoke.
- In GPU[46] there are line of sight problems on the ward, poor communications, and evening and night shift do not attend treatment team meetings. Evenings and

[46] Geriatric Psychiatric Unit

nights, we really don't have a say in the treatment plan. Day shift makes all the decisions".

- GPU brings an MHT[47] to treatment team meetings, but that is not the practice in APU.
- We use the PCS system to assess acuity. It is computerized and based on Johnson's behavioral model with a ranking from 1 to 5. A five is 1 to 1. We used it but don't have the resources to adjust staffing based on PCS.
- We don't wand visitors
- We have no seclusion room.

Regarding preventive measures:

- We make sure MHTs are doing ward checks. Make sure charge nurse is supervising staff and safety checks are done correctly. We do 15 minute checks on GPU as a result of the patient death.
- We need more qualified staff. There should be a minimum of 2 RNs per ward. On GPU on Friday, Saturday, Sunday, Monday we do not always have 2 licensed personnel. We are supposed to have a medication nurse, treatment nurse, and charge nurse, but they are often combined.
- We have walkie talkies, but no personal alarms.

Regarding safety culture

- "Truthfully, I don't think this hospital values people".
- EPERT was disbanded and we are not allowed to use the equipment.
- We don't have a posted staffing plan. On nights everybody is short staffed. One night a nurse in FSU[48] needed help, patients were going to fight. The RN4 threatened to fire the nurse if a code was called and told her to put the patient in the seclusion room. The RN quit.
- The nurse manager came out and said, "Can you not handle this ward?"
- An evening shift nurse said that "nothing ever gets done". The doctor doesn't medicate patients correctly. I requested a medication review and he said "No, they may take me to court."
- The doctor has a problem with women. He blows me off, but listens to the 2 male nurses who report to me.
- We are all here because we enjoy what we do, we care for the clientele.

[47] Mental Health Technician
[48] Forensic Services Unit

Regarding support for staff exposed to trauma:

- I got a call at home from my nurse manager. CISM? We don't have that when my staff get assaulted.
- I'm not aware of CISM. There were 2 deaths on my ward in GPU. An RN who had never been on my ward or oriented to my ward was made charge and she was very traumatized by that event.