

**WHITING FORENSIC HOSPITAL  
OPERATIONAL PROCEDURE MANUAL**

<b>SECTION I:</b>	PATIENT FOCUSED FUNCTIONS
<b>CHAPTER 1:</b>	Ethics, Rights and Responsibilities
<b>PROCEDURE 1.1:</b>	<b>Ethics, Rights and Responsibilities</b>
<b>Governing Body Approved</b>	6/4/18
<b>Revised</b>	

**PURPOSE:**

To ensure that staff are informed of patient rights and patient responsibilities. Staff members protect patient rights and educate the patients on their responsibilities as patients receive treatment at Whiting Forensic Hospital (WFH). WFH has a designated Client's Rights Officer (CRO) to educate patients and staff on patient rights issues and patient responsibilities while preserving the patient's dignity, autonomy, positive self-regard, and involvement in his/her own care.

**PROCEDURE:**

1. All staff attend new employee orientation on Patient Rights and Responsibilities.
2. All staff have access to the Director of Advocacy, the CRO or an Advocate for consultation.
3. All staff review and implement all Hospital policies regarding patient rights.
4. Staff ensures that each patient has access to a copy of the Patient Rights, Patient Responsibilities and the Patient Rights Information Handbook, upon admission to the hospital. Both documents are available in English and Spanish (see Patient Responsibilities attached).
5. Staff ensure that each patient is oriented to the Unit. This orientation includes information about reporting incidents including allegations of abuse, neglect or exploitation.

6. Upon admission patients are given the opportunity to provide authorization and release of information to send family members or others a copy of the informational brochure on "Do You Have a Concern or Complaint?" providing information on how to exercise patient rights and how to report concerns. All conservators are sent this information.
7. Staff provide the information in a language or alternate means of communication that the patient can understand.
8. Staff ensure that the Patient Rights and Patient Responsibilities Statements are posted on each unit in both English and Spanish.
9. In order to ensure that the patient rights are protected and that the patient is informed of his/her responsibilities, staff are required to:
  - a. to treat each patient with dignity, privacy, and respect;
  - b. to explain all aspects of care to each patient so they may make informed decisions;
  - c. give patients the opportunity to participate in their own care;
  - d. report any incident of patient rights violations.
10. Staff ensure that patients are educated about the mechanisms to address dissatisfactions both internally and through other advocacy services, such as Connecticut Legal Rights Project (CLRP) and the Office of Protection and Advocacy. (See *Operational Procedure 1.9 Patient Grievance*)

When a patient is unable to participate in treatment decisions because of mental or physical incapacities, the hospital petitions the Probate Court for assignment of conservators to serve as decision maker on behalf of the patient.

# Las responsabilidades del paciente

Para asegurarnos de que usted esté recibiendo los mejores cuidados posibles mientras está en el Hospital Whiting Forensic, nosotros necesitaremos su ayuda. Usted es un miembro muy importante de nuestro equipo de tratamiento. Al asumir las siguientes responsabilidades usted contribuirá en una forma positiva en sus cuidados y seguridad.

## **Respetar los derechos de los demás**

Respetaré los derechos, la privacidad, las pertenencias personales, el espacio personal y los derechos civiles básicos de los demás.

## **Comunicar efectivamente**

Proveeré, de la mejor forma posible, información completa acerca de mi condición, mis deseos, metas y sueños. Les diré a los empleados mis preocupaciones, incluyendo los síntomas que me perturban. Le informaré a mi equipo de tratamiento de mis enfermedades pasadas, hospitalizaciones, medicamentos y otros problemas relacionados con mi salud. Reportaré cualquier cambio en mi condición. Si no entiendo mi diagnóstico, mi tratamiento o lo que esperan de mí, pediré al personal del hospital que me lo explique.

## **Seguridad**

Me identificaré a otros. Si el medicamento que me ofrecen es diferente a lo que estoy supuesto a recibir o si no estoy seguro de por qué quieren hacer cualquier análisis, haré preguntas. Si creo que un error se ha hecho en mis cuidados médicos, informaré a la enfermera y/o al doctor. Si veo una situación peligrosa, por ejemplo un piso mojado el cual puede causar que alguien resbale y se haga daño, se lo informaré a un empleado.

## **Seguir las reglas y regulaciones**

Seguiré las reglas y regulaciones concernientes al cuidado y conducta para proveer un ambiente seguro para mí y para los demás.

## **Aceptar resultados y consecuencias**

Participaré activamente en planear mis cuidados. Consideraré cuidadosamente las recomendaciones concerniente a mi plan de tratamiento, hablaré de mis preocupaciones y tomaré responsabilidades para seguir el plan. Tomaré responsabilidad por el resultado si no sigo el plan de tratamiento.



# ***PATIENT RESPONSIBILITIES***

In order to ensure that you receive the best care possible while you are a patient at Whiting Forensic Hospital (WFH) we need your help. You are an important member of our health care team, and by assuming the following responsibilities you can contribute to your care and safety in a positive way.

## **Respecting the Rights of Others**

I will respect the rights, privacy, personal property, personal space and basic civil rights of others.

## **Communicating Effectively**

I will provide, to the best of my ability, accurate and complete information about my condition, wishes, goals and dreams. I will make staff aware of my concerns, including symptoms that are disturbing. I will let staff know of past illnesses, hospitalizations, medications and other matters relating to my health and I will report any changes in my condition. I will ask questions if I do not understand my diagnosis, recommended course of treatment or what is expected of me.

## **Safety**

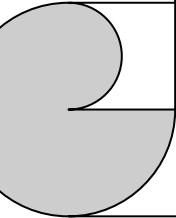
I will clearly identify myself to others. I will ask questions if a medication is different than what I think I should be getting or if I am uncertain as to why a medical test is being done. If I believe an error is being made in my medical care, I will inform the nurse and/or physician. If I see an unsafe situation, such as a spill that could cause someone to fall, I will inform staff.

## ***Following Rules & Regulations***

I will follow the rules and regulations concerning care and conduct to provide a safe environment for myself and others.

## ***Accepting Outcomes and Results***

I will actively participate in the planning of my care. I will carefully consider recommendations made regarding my treatment plan, voice my concerns and take responsibility for following the agreed upon plan. I will take responsibility for the outcome if I do not follow my treatment plan.



## WHITING FORENSIC HOSPITAL OPERATIONAL PROCEDURE MANUAL

<b>SECTION I:</b>	PATIENT FOCUSED FUNCTIONS
<b>CHAPTER 1:</b>	Ethics, Rights and Responsibilities
<b>PROCEDURE 1.2:</b>	<b>Operationalizing the Code of Ethics</b>
<b>Governing Body Approval:</b>	March 8, 2018
<b>REVISED:</b>	

**PURPOSE:** Whiting Forensic Hospital’s (WFH) Code of Organizational Ethics articulates the Hospital’s responsibility to patients, staff, and the community served. It is the responsibility of the Governing Body, hospital leaders, and employees to act in a manner that is consistent with this organizational ethics statement and its supporting policies and procedures. The work of all staff is guided by the general principle that all patients, staff, and visitors deserve to be treated with dignity, respect, and courtesy.

**PROCEDURE:**

1. All staff members are required to follow the Code of Ethics (Appendix A) at all times.
2. Staff members ensure that the Code of Ethics is posted on each unit and is disseminated to each patient upon admission.
3. Selected staff members representing each discipline participate in the hospital’s Ethics Committee.
4. All staff members act with integrity, respect, and courtesy and ensure the dignity and worth of all persons at all times.
5. All staff members shall fairly and accurately represent the hospital and its services to the general public.
6. Clinical staff members provide services to patients based on individual needs of the patient, and provide care to the best of their abilities.
7. Staff members provide a uniform standard of care and conduct to patients throughout the organization, regardless of the individual’s race, sex, age, religion, culture, gender identity or sexual orientation.
8. Staff members consistently follow the relevant standards of care based upon their discipline and the needs of the patient.
9. Staff members seek resolution and/or clarification of ethics questions which may arise in the course of providing care to patients through referrals to the Ethics Committee.

## **Operating Principles of the Organization**

WFH is committed to excellence in the provision of specialty forensic psychiatric services for its patients. The Code of Ethics has been established to acknowledge our responsibility to patients, families, visitors, staff members, trainees, volunteers, and the community. Adherence to the Code is a fundamental responsibility of every member of the organization.

### **1. Admissions**

- a. The Department of Mental Health and Addiction Services (DMHAS), its community networks, and the judicial system are responsible, in conjunction with the hospital, for coordinating all admissions, transfers and discharge activities.
- b. The hospital will provide inpatient services to those patients who meet the criteria for admission and whom we can appropriately treat. No consideration is given to an individual's ability to pay for services.
- c. Patients who present for admission who cannot be adequately treated at WFH will be referred to a more appropriate treatment setting (e.g., an emergency department for acute medical conditions).
- d. The hospital will strive to provide care that is of uniform quality across all its units.

### **2. Discharge/Transfer**

Discharge or transfers occur when the treatment team determines that care can continue safely and appropriately outside the hospital environment and any controlling legal authority (e.g., the Psychiatric Security Review Board) approves of the discharge or transfer. For all patients, continuity of care is facilitated through collaboration among WFH staff, the accepting agency personnel, the patient, and the patient's family members (as permitted by the patient) or Conservator of Person.

### **3. Respect for the Patient**

All patients are treated with dignity, respect, and courtesy. Patients will be involved in decisions regarding the care delivered, including the management of pain. Persons identified by the patient to assist them in decisions about care (e.g., family, advocates, others) will be involved as possible and appropriate. All care planning will take into account the patient's wishes, background, culture, religion and heritage.

### **4. Expression of Spiritual Beliefs and Cultural Practices**

The hospital encourages patients and their families to express their spiritual beliefs and cultural practices.

### **5. Patient/Family Education**

All staff members work to promote clear communication among the patient, family, other advocates, and the treatment team regarding health care decisions. The treatment team makes ongoing assessments of the patient's educational and clinical needs, including assessment and treatment of pain.

Patient education (and family education where appropriate) is provided throughout the hospital stay. Patients and their families are informed about treatment benefits, risks, and alternatives.

## **6. Ethics**

Organizational support for ethical practice and decision making is provided to the medical staff, caregivers, and patient/family. Any staff member, patient, or family member may ask for consultation from the Ethics Committee to help illuminate an ethics concern or question.

## **7. Resolution of Conflicts**

From time to time conflicts arise among those who participate in hospital and patient care decisions. The hospital will seek to resolve all conflicts fairly, objectively and promptly. In cases where mutual satisfaction cannot be achieved, it is the policy of the hospital to involve patient advocates or hospital administrators to oversee resolution of conflicts. Other staff as well as outside consultation will be involved, as needed, to pursue conflict resolution.

## **8. Recognition of Potential Conflicts of Interest**

- a. The potential for conflict of interest exists for decision making at all levels within any facility. The state's policy requires the disclosure of potential conflicts of interest so that appropriate action may be taken to ensure that such conflicts do not inappropriately influence important decisions. Certain hospital leaders are required to submit an annual disclosure form to the state Ethics Commission identifying potential conflicts related to delivery of care in the hospital.
- b. WFH ascribes to ethical and professional relationships with other health care organizations and institutions. Accordingly, all staff members are expected to avoid conflicts of interest in relationships with other health care providers and organizations, payers, and patients. More specifically, all clinical and administrative leadership at WFH must report their involvement in any employment, ownership, or other participation with health care providers and/or contractors with which WFH might or must conduct business. Other members of the staff who are not in policy making and decision making capacities must report to their supervisors any conditions of outside employment so that supervisory staff may assess that no conflict of interest exists.
- c. The hospital's Governing Body and senior management review all potential conflicts and take appropriate corrective action. In the event that a potential conflict of interest has a direct impact on patient care, the hospital may convene an ad hoc group to assist in the resolution of this issue.

## **9. Fair Billing Practices**

- a. WFH provides a uniform standard of care without regard to a patient's financial status. All decisions with regard to admission, transfer and discharge are clinically and/or legally based.
- b. Patient billing for WFH is managed by the Department of Administrative Services, Collection Services, according to state statutes.

## **10. Confidentiality**

The hospital recognizes the importance of maintaining patient and employee confidentiality. As such, patient information will not be shared in an unauthorized manner, and sensitive information concerning personnel and management issues will be maintained in the strictest confidence and utilized only by those individuals legally authorized to review and act upon such information.

## **11. Integrity of Clinical Decision-Making**

Patient care is based on an assessment of the patient's health care needs. The same standard of care is given to all patients who are treated in this hospital.

## **12. Professional Practice**

- a. All WFH employees are bound by the State Code of Ethics for Appointed Officials and State Code Provisions Applicable to Those Leaving State or Quasi-Public Agency Services, as contained in the Connecticut General Statutes (Chapter 10) and further delineated by the Commissioner's Policy Statement Chapter 3.1 and 3.12.
- b. All professional staff members must follow ethics codes as promulgated by their specific disciplines.

## APPENDIX

### Code of Organizational Ethics

#### Whiting Forensic Hospital staff members will strive to:

- **Regard** the health, safety, and dignity of patients as the first consideration and thereby render to each patient the full measure of professional skill, ability, quality care, and experience.
- **Serve** patients in a manner which respects their wishes, dignity, background, culture, religion, spiritual beliefs, age, race, sex, gender identity and sexual orientation.
- **Treat** all patients with dignity, respect, and courtesy.
- **Engage** patients, families, and significant others to participate in care planning to the extent that it is practical and possible.
- **Convey** information to patients regarding services truthfully, accurately, and fully.
- **Inform** all patients of therapeutic alternatives and the risks associated with the care they are seeking.
- **Respect** the unique characteristics of the therapeutic relationship, which demands sound, non-exploitative interpersonal transactions between the caregiver and the patient.
- **Respect** the confidential and personal nature of patient records, always refusing to reveal their contents without proper patient consent or other formal legal-authorization.
- **Resolve** conflicts among and between patients and staff fairly, objectively and as swiftly as possible. In cases where mutual satisfaction is not achieved, to pursue available appeal processes through the grievance mechanism, the Patient Advocate, or the Ethics Committee.
- **Never** knowingly condone the dispensing, promoting or distributing of drugs or medical devices that are not of good quality and that do not meet standards required by law.
- **Uphold** the dignity and honor of one's profession, and accept its ethics principles.
- **Avoid** any activity that brings discredit to one's profession or the hospital.
- **Expose**, without fear or favor, illegal or unethical conduct of others who are providing patient care or services.
- **Respect** the rights, views, and positions of all staff, regardless of their degrees, discipline, status or duties.
- **Evaluate** one's own strengths, limitations, biases, and levels of effectiveness; to strive for self-improvement and development through further education and training.
- **Expand** professional knowledge consistent with best possible judgment and practices, and make this knowledge available to co-workers and patients, as appropriate.
- **Present** the hospital's services and personnel to the community using up-to-date, accurate and valid data and descriptions.
- **Avoid** conflicts of interest in relationships and business practices and report such conflicts to one's supervisor if they arise.
- **Provide** a uniform standard of care without regard to the patient's financial ability to pay. Health care needs are the priority in clinical decisions.
- **Follow** the State Code of Ethics for appointed officials and State Code Provisions applicable to those leaving state or quasi-public agency services as contained in the Connecticut General Statutes Chapter 10 and further delineated by the Commissioner's Policy Statement Chapter 3.1 and 3.12. These codes refer to using one's public position or authority for personal financial benefit.

## WHITING FORENSIC HOSPITAL OPERATIONAL PROCEDURE MANUAL

<b>SECTION I:</b>	<b>PATIENT FOCUSED FUNCTIONS</b>
<b>CHAPTER 1:</b>	<b>Ethics, Rights and Responsibilities</b>
<b>PROCEDURE 1.4</b>	<b>Informed Consent</b>
<b>Governing Body Approval:</b>	March 26, 2018
<b>REVISED:</b>	

**PURPOSE:** To ensure that each patient receives a thorough explanation prior to all treatment or therapeutic procedures and at appropriate times during the delivery of care. By providing information to the patients in their preferred language, the hospital affirms the rights of each patient to information which assists him/her in providing informed consent.

**SCOPE:** All clinical staff

**PROCEDURE:**

1. Informed consent is provided prior to the initiation of any proposed treatment or therapeutic procedure. The physician or primary treater provides a thorough explanation of the nature of the proposed treatment. This discussion should include the following:
  - a. potential benefits, risks and side effects;
  - b. the likelihood of success;
  - c. the likely and possible results of non-treatment; and
  - d. reasonable alternatives and associated potential benefits, risks, and side effects
  
2. The physician or primary treater apprises the patient of the name and professional title of the treater who will have the primary responsibility for the proposed procedures or treatments.
  
3. The physician or primary treater documents his/her opinion of each patient's capacity to consent or withhold consent and understanding of the proposed treatment or procedure and subsequent consent or refusal of consent in one or more of the following documents: the Master Treatment Plan, specific consent forms, a progress note, Advance Directive, DNR consents, or research protocols. Ongoing determination of a patient's capacity to provide consent is made throughout the course of care.
  
4. The physician or primary treater understands that each patient has the right to refuse to consent to or participate in any treatment or procedure. A decision not to participate in a particular proposed treatment or procedure will not compromise the staff's attempts to continue to provide the best possible quality of care for the patient.
  
5. In the event that a patient, in the opinion of the attending psychiatrist, is unable to consent or refuse treatment, the Attending Psychiatrist follows the procedures for appointment of conservator of person by the Probate Court. (please see Procedure 1.17: Conservatorship). In the case of proposed treatment with psychotropic medications, please see *Operational*

*Procedure 3.1 Emergency and Involuntary Medication.*

6. The treating Physician, recognizing that complex legal, ethical, and/or social questions may arise in the care of patients, may seek consultation from the hospital's Ethics Committee. The committee provides a forum to discuss and assist with issues related to informed consent among other issues.

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OPERATIONAL PROCEDURE MANUAL**

<b>SECTION I:</b>	PATIENT FOCUSED FUNCTIONS
<b>CHAPTER 1:</b>	Ethics, Rights and Responsibilities
<b>PROCEDURE 1.5:</b>	<b>Patient’s Request for Treatment by Prayer Alone</b>
<b>Revised:</b>	4/17/24
<b>Governing Body Approval:</b>	6/4/18, 4/30/24
<b>Effective Date:</b>	4/30/24

**PURPOSE:** Any person admitted to an inpatient facility for the treatment of a mental illness who wishes to be treated by prayer alone in accordance with the principles and practices of a church or religious denomination may make application in writing to the hospital in accordance with Connecticut General Statutes (Section 17a-543(i) 1-3). Persons committed for competency restoration, under Section 54-56d, are excluded.

Treatment by prayer alone is affected within the context of a therapeutic milieu, with proper concern for safety, and respect for the rights, needs and dignity of all patients on the unit.

**SCOPE:** Clinical Staff

**PROCEDURE:**

**Application**

- A. Written application must be made to the WFH Chief Medical Officer (CMO) using “Request for Treatment by Prayer Alone” (WFH-472).
- B. This application must indicate that the patient’s sincere religious beliefs require that he or she be treated by prayer alone by an ordained or accredited minister, priest, rabbi or practitioner of the patient’s faith, church or religious denomination, and that such person is available and willing to provide such treatment.
- C. The application must be signed by both the patient and the clergy/practitioner.

D. The application outlines:

1. The nature and frequency of the treatment to be provided;
2. The expected outcome;
3. The expected duration of treatment.

### **Review Procedures**

- A. The CMO or a designated physician meets with the patient to conduct an evaluation that includes past history, current condition and pertinent collateral information. This evaluation is organized into a formal written report that includes a formulation addressing whether or not there is serious risk of harm to the patient or to others if the hospital allows treatment by prayer alone. This report will be submitted to the Chief Executive Officer (CEO) for final determination.
- B. If approved by the CEO, the provision of treatment by prayer alone will be incorporated into the patient's treatment plan. The clergy person/practitioner is expected to work with the treatment team to establish a Master Treatment Plan, and to be available for periodic reviews and updates. Close collaboration is essential and may involve the WFH Chaplaincy Services.
- C. The CEO considers all of the above information and then notifies the patient and clergy person/practitioner in writing of the decision to permit or not permit treatment by prayer alone. A copy of the completed form WFH-472 is provided to the patient and clergy person/practitioner. The original is filed in the patient's medical record in the treatment plan section.

### **Exclusions**

Section 17a-543(i) – 1 through 17a-543(i)-2, inclusive, of the Regulations of the Connecticut State Agencies authorize treatment by prayer alone.

- A. Patients so authorized may not be subject to any involuntary medical, psychological, or psychiatric treatment unless:
  1. Emergency treatment is ordered (under provisions of Section 17a-543(b));
  2. The WFH CMO makes a determination in writing that the clergy person/ practitioner has failed to provide the treatment described in the application; or
  3. The WFH CMO has withdrawn such authorization based on a physician's report that the patient's condition has changed and there now exists a serious risk of harm to the patient or others.

## WHITING FORENSIC HOSPITAL OPERATIONAL PROCEDURE MANUAL

<b>SECTION I:</b>	PATIENT FOCUSED FUNCTIONS
<b>CHAPTER 1:</b>	Ethics, Rights and Responsibilities
<b>PROCEDURE 1.6:</b>	<b>Advance Health Care Directives</b>
<b>Governing Body Approval:</b>	6/4/18
<b>REVISED:</b>	

**PURPOSE:** To screen for and provide all patients and their surrogates/conservators with information about their rights and responsibilities to accept or refuse treatment at Whiting Forensic Hospital(WFH) including the use of an Advance Health Care Directive (AHCD), which includes both medical and psychiatric directives, in accordance with state and federal laws. Certain exceptions apply when patients are admitted to WFH under superior court order. These guidelines are meant to inform, support and protect persons in recovery, rights to participate in health care decision-making and to prevent discrimination based on whether they have executed an AHCD for health care.

Clinical staff will document the patient wishes with regard to every aspect of their AHCD including the patient's wishes or declaration of organ donor status.

Patients admitted to WFH who have Living Wills or other advance directives such as a Health Care Agent or Power of Attorney for Health Care, completed before October 1, 2006 will be considered valid.

Patients admitted to WFH who have advance health care directives from another state will have those directives honored by the state of Connecticut so long as they conform to Connecticut state law. Such matters should be referred to the hospital's Health Information Management (HIM) Office for further review.

**SCOPE:** Registered Nurses; Physicians and Social Workers

**POLICY:**

The policy of WFH is to support our patients' rights to make decisions regarding their health care including their right to make AHCD or to refuse to do so. For the purposes of this policy AHCD refers to both medical and psychiatric directives.

No patient will be denied admission or provided care based on whether they have signed a living will or other type of advance directive. Upon admission to WFH, patients are given written information regarding AHCD:

- a. The patient's rights under state law in relation to health care decisions;
- b. WFH's written practices respecting the implementation of such health care decisions.

WFH will ensure compliance with the requirements of state law regarding AHCD.

WFH will not condition the provision of care or otherwise discriminate against an individual patient who has executed an AHCD.

Patients have the right to have proposed medical interventions explained to their satisfaction and the right to refuse any unwanted care.

If patients do not have decision-making capacity, or if they are unable to speak for themselves, they have the right to have a surrogate/conservator make treatment decisions for them.

WFH informs all patients about the hospital's obligation to inquire about the presence and provide education of an AHCD and to provide patients an opportunity to formulate AHCD.

WFH has an obligation to determine whether or not the patient has formulated an AHCD including Organ Donor Status and document this information in the patient's medical record.

WFH has an obligation to provide education for patients about AHCD including organ donation.

***Definitions:***

*Advance Health Care Directives* - An AHCD is a legal document through which an individual provides direction or expresses their preferences concerning medical or psychiatric care and/or to appoint someone to act on the behalf of the individual should he/she become unable to make or communicate such decisions. Such AHCD may include the individual's wishes concerning organ donation. (For further information, refer *Operational Procedure 1.14 Organ/Tissue Donation*). AHCD are prepared *before* any condition or circumstance occurs that causes them to become unable to make or communicate actively about their medical care. In Connecticut there are two types of AHCD: (a) Advance Directive, also known as the living will or health care instructions; (b) the appointment of a health care representative formally referred to as Health Care Agent.

*Advance Directive/Living Will document* - An Advance Directive/Living Will document is a document in which an individual conveys, in writing, his/her directions regarding any aspect of health care in the event they become unable to make decisions: including but not limited to psychiatric treatment options and specific life-sustaining/support systems, procedures or treatment to be administered should they become in a *terminal condition* or *permanently unconscious*. The Advance Directive/Living Will tells the physician, or other health care providers, whether the individual wishes life support systems administered to keep them alive in these situations or whether they do not want to receive such treatment, even if it results in their death. (For further information, refer to *Operational Procedure 1.8 Do Not Resuscitate Order and Bracelet Protocol*).

A sample form, prepared by the Office of the Attorney General for the DMHAS and the Department of Social Services, in accordance with Connecticut General Statutes, Section 19a-575, is included in the brochure *Your Rights to Make Health Care Decisions 2011* which is given to all patients upon admission.

***Health Care Representative*** - A Health Care Representative, formally known as Health Care Agent is a person whom an individual authorizes in writing to make any and all health care decisions on their behalf including the decision to accept or refuse any treatment, service, or procedure used to diagnose or treat an physical or mental condition, including the decision to provide, withhold or withdraw life support systems. A health care representative does not act unless the individual is unable to make or communicate decisions about their medical care. The health care representative makes decisions on behalf of the individual based on their wishes, as stated in an Advance Directive/Living Will or as otherwise known to the health care representative. In the event the individual's wishes are clear or a situation arises that the individual did not anticipate, the health care representative will make a decision in the individual's best interests, based upon what is known of their wishes. Psychosurgery and Electroconvulsive Therapy (ECT) are specifically excluded from the health care representative's authority. In matters where a patient is committed by the Superior Court, the role of the Health Care Representative is superseded by the role of the Conservator appointed by Probate Court for the purpose of Medication Administration Consent.

***Conservator*** - A conservator of person is someone appointed by the Probate Court when the Court finds that a person is incapable of caring for him/herself including the inability to make decisions about their medical care. The patient may designate the person appointed if the event that a petition is filed on behalf of the patient. A person who is conserved by a court is known as a "ward". The conservator of person has responsibility for the general custody and care of the incapacitated individual and is consulted on all medical care decisions for the conserved person. The conservator is authorized to make all medical care decisions including involuntary medication authority for patients under certain legal categories. If the individual has executed an Advance Directive document, prior to the appointment of a conservator by the court, the conservator's consent is not required to carry out the individuals' wishes as expressed in the Advance Directive document except where involuntary medication has been ordered for certain forensic patients. If a health care representative has been appointed by the individual, the health care representative's decision will take precedent when there is a conflict between the conservator and the representative including medication refusals. A conservator shall comply with a ward's individual health care instructions and other wishes, if any, expressed while the ward had capacity and to the extent known to the conservator, and the conservator may not revoke the ward's advance health care directive unless the appointing court expressly so authorizes.

## **Special Considerations:**

Patients completing the AHCD form must be 18 years of age or older, have decision-making capacity, and be acting upon their own free will.

Certain exceptions apply to patients admitted under superior court orders to WFH as described above.

Copies of written AHCD are treated in the same manner as the original document.

A person with an AHCD can revoke the designation of a Surrogate Decision-Maker or Health Care Representative:

1. By making a new designation, this designation revokes any prior Advanced Medical Directive made.
2. By communicating such wishes orally or in writing when an Advanced Medical Directive/Living Willing is at issue.
3. However, if the person wishes to revoke the appointment of a health care representative, such requests must be made in writing that is observed and signed by two witnesses in order for the revocation to be valid.
4. When the marriage is dissolved or annulled, the person revokes the Advanced Medical Directive/Living Will.
5. AHCD: This revoked form signed by the patient should not be discarded. "Revoked" should be written across the front of the form and either the patient or the physician to whom the patient indicated the intention to revoke should sign it.

The patient should be offered the opportunity to execute a new form.

## **PROCEDURE:**

### *I. On Admission:*

- A. At the time of admission, the admitting nurse or admission screening personnel, provides the patient, family member of their choice or conservator (as appropriate), with written information regarding his/her rights to accept or refuse psychiatric or medical treatment and his/her right to formulate AHCD. The pamphlet given to the patient or representative is entitled, *Your Rights to Make Health Care Decisions*, w prepared by the Office of Attorney General 2011.
- B. Each patient, family member or conservator as appropriate will be asked if they have an AHCD and whether they are an organ donor; their response will be documented in the medical record by the admitting nurse or admission screening personnel.

- C. If the patient and conservator, on behalf of the patient, answer that they have an AHCD or Anatomical Gift document (organ donor card) and provides written documentation at the time of admission then such documents are to be filed in the legal section of the medical record. An approved stick label is to be placed on the outside spine of the binder of the patient's active medical record to alert the appropriate treatment clinicians that the patient has executed an AHCD.
- D. If the patient or conservator affirms that he/she has an AHCD or is an organ donor, the admitting nurse or admission screening personnel will document *this verbal acknowledgement* in the medical record and ask the patient to provide a copy to the physician at his/her earliest convenience.
- E. They will also advise the patient that they have the option of discussing AHCD with the unit social worker so that they can assist them in the process.
  - 1. The patient's, and/or conservator's response is recorded on the Advance Directives Forms (WFH-407 or 407a, respectively).
  - 2. If the patient's Conservator is not present on admission, the pamphlet ***Your Rights to Make Health Care Decisions 2011*** is mailed to him/her by the Social Worker following the admission. Information regarding the patient's AHCD will be obtained by telephone. The conserved patient's medical record documentation reflects any phone calls to the conservator and that the pamphlet was mailed to the conservator.
- F. If the patient wishes to formulate AHCD:
  - 1. The admitting nurse or admission screening personnel will provide the patient with a copy of the State of Connecticut, Office of the Attorney General, pamphlet entitled: ***Your Rights to Make Health Care Decisions 2011*** and review the booklet with them and document such educational interventions in the medical record. The admitting nurse or admission screening personnel will then refer the patient to the unit social worker or physician for further discussions about formulating AHCD and will document such referral in the progress notes of the medical record.
  - 2. The Unit Social Worker or physician will pursue further discussions with the patient or their conservator about their desire to pursue the formulation of an AHCD including formulating an Advance Directive/Living Will; appointing a Health Care Representative; or any wishes to file an Anatomical Donation while in the hospital. As a part of this process the Unit Social Worker will provide the necessary forms (WFH-407 or 407a Rev. 10/06) and provide assistance to the patient about additional assistance, including the possible resources of a CLRP or private attorney or a patient advocate. The patient or conservator is further advised by the Unit Social Worker or physician that any final advance health care directive must include the signing off by witnesses attesting to the legitimacy of the AHCD. All persons in DMHAS facilities

formulating advance directives must obtain two witnesses which will include *one witness who is not affiliated with WFH and one witness who is a physician or licensed clinical psychologist with specialized training in treating mental illness. (sec. 19a-577.)*

G. Additionally, the Unit Social Worker is responsible for:

1. Advising the patient, their families and conservators as appropriate, that an AHCD can be mailed to them.
2. Informing patients, his/her family, or conservators that an AHCD can be mailed to them.
3. Informing patients, their families and conservators (as appropriate) that they ought to mail a copy of or notify their Primary Care providers at the time of discharge that they have an AHCD or any another form of advance directive including Organ Donation designation.
4. Providing social work and counseling as needed.

H. If the patient's condition on admission makes it impossible for WFH to provide the patient with the pamphlet, *Your Rights to Make Health Care Decisions 2011* and/or question the patient regarding his/her advance directive and organ donor status, the Unit Nurse does this *as soon as appropriate* after admission and documents the results in the medical record. The Social Worker will then follow up with patient as they are able.

## II. During the Course of Hospitalization:

During the patient's hospital stay s/he may request information regarding AHCD. The hospital Social Worker will provide information and direct them to the appropriate advocate.

## III. Patient and Family Education:

A. WFH will advise patients, families or other interested parties that AHCD forms are available at a variety of locations, such as health education programs, social services, continuing care, home health, and hospice as well as by reading the State of Connecticut, Office of the Attorney General, pamphlet entitled: *Your Rights to Make Health Care Decisions 2011* and by contacting his/her attorney or their patient advocate. Additionally, patient education interventions are aimed at completion of advance health care directives which:

1. Recommend to patients, their families and conservators (as appropriate) that they discuss any questions regarding their medical condition and prognosis with their physician.

2. Advise patients, their families or conservators (as appropriate) to consider their complex and difficult choices and to discuss their values and wishes with their health care representative and loved ones.
3. Advise patients, their families and conservators (as appropriate) to distribute their completed AHCD forms to their health care representative, alternate representatives, and loved ones. Patients should keep the original documents.
4. Refer patients and their families' questions to their attorneys or a patient advocate.

1.

# WHITING FORENSIC HOSPITAL

## OPERATIONAL PROCEDURE MANUAL

<b>SECTION I:</b>	PATIENT FOCUSED FUNCTIONS
<b>CHAPTER 1:</b>	Ethics, Rights and Responsibilities
<b>PROCEDURE 1.8:</b>	<b>Do Not Resuscitate (DNR) Order and Bracelet Protocol</b>
<b>Governing Body Approved</b>	6/4/18, 2/26/20
<b>Revised</b>	2/10/20

**PURPOSE:** To ensure patients' wishes for a Do Not Resuscitate (DNR) Order are honored and properly communicated to all health care professionals and to ensure this status is maintained during the current hospitalization, transfer and discharge process.

**SCOPE:** RNs, Physicians, APRNs, Clinical Social Workers, Unit Directors

**POLICY:**

It is the policy of Whiting Forensic Hospital (WFH) that a patient's wish for a DNR Order shall be honored and properly communicated to all healthcare professionals treating the patient during the current hospitalization, transfer, and discharge process. DNR bracelets may be worn by the patient in order to communicate the patient's DNR status. If the patient is not wearing a DNR bracelet, the physician or nurse shall ensure that a Transfer of DNR Order form accompanies the patient if transferred or discharged to another healthcare facility.

*Resuscitation* - is initiated for all patients as needed unless there is a *written* DNR order. Verbal DNR orders are not permitted.

*DNR Order* - in the event of cardiac or pulmonary arrest, Cardiopulmonary Resuscitation (CPR) will not be initiated. A DNR order does not imply or allow that any other therapy, supportive treatment, or general level of care should be diminished or compromised.

**PROCEDURE:**

- I. Patients have the right to request a DNR order from the physician at any time. Patients need not be considered *terminally ill* to request a DNR Order.

- II. WFH will honor the DNR orders of patients transferred to WFH from other health care facilities (Connecticut Regulations on the Recognition and Transfer of DNR Orders).
- III. If the patient is not admitted with DNR orders and he/she requests a DNR order, the attending physician must assess the patient's ability to make decisions whenever a DNR order is contemplated. A patient is capable to decide if the patient is able to fulfill *all* of the following criteria:
  - A Comprehend the nature and severity of his/her condition.
  - B Comprehend the relative risks and alternatives to treatment options or lack of treatment.
  - C Make informed and deliberate choices about the treatment of his/her condition.
  - D Communicate such choices with assistance as necessary.
- IV. If the patient makes an informed decision to have a DNR order, the hospital honors the patient's decision. *No DNR order will be written against the patient's wishes.*
- V. When the patient is incapacitated and has not expressed his/her wishes on this matter, a DNR order may be considered if at least one of the following conditions are met:
  - A The patient is in a terminal phase of illness.
  - B The patient is permanently unconscious.
  - C Resuscitation would be medically futile or would impose an extraordinary burden (pain and suffering) on the patient in light of the patient's medical condition and the expected outcome of resuscitation for the patient.
- VI. When a patient lacks decision-making capacity, the Attending Physician must first consider the patient's wishes as expressed in an Advance Medical Directive document, if available, or other oral or written statements by the patient to the Attending Physician, health care agent, next-of-kin, legal guardian, conservator, or any other person.
- VII. If the incapacitated or incapable patient has not expressed his/her wishes regarding CPR, the attending physician may enter a DNR order based on the informed consent of the patient's authorized representative (conservator, legal guardian, next-of-kin, etc.). If there is no authorized representative, the Attending Psychiatrist may use the hospital process for requesting a determination of competency by the Probate Court, and Court appointment of a conservator. The authorized representative would then agree or disagree with the Physician's recommendation to withhold cardiopulmonary resuscitation. If the authorized representative disagrees, no DNR order can be written.

- VIII. If there is no authorized representative, the attending physician may seek consultation from the Chief Executive Officer (CEO) or his/her designee, Chief Medical Officer (CMO), and/or the hospital's Ethics Committee.
- IX. The Physician also includes the patient and family in making the decision for a DNR order. The Attending Physician writes the DNR order on a "Physician Order Sheet" in the patient's medical record. The Attending Physician reviews and renews as necessary all DNR orders every thirty days, and documents the review/renewal on the physician's order sheet and the progress note.
- X. Health care providers who have objections to implementing a DNR order for religious, philosophical or ethical reasons will not be assigned to the patient. They must alert senior staff to objections and request a transfer of care. The DNR order will be followed and staff are obligated to provide such care until a replacement staff member is assigned.
- XI. The Physician writing this order enters a summary statement in the progress note stating the facts and considerations relevant to this decision including:
- A The determination of whether the patient is capable of making an informed decision regarding the withholding of CPR.
  - B The patient's medical condition and prognosis, including whether the patient is in a terminal condition, permanently unconscious, or resuscitation would be medically futile or impose an extraordinary burden on the patient in light of the patient's medical condition and the expected outcome of resuscitation.
  - C Consultations, if any, with other physicians pertaining to the appropriateness of the DNR order.
  - D An explanation of any advance directive (Advance Medical Directive document, previous family discussions, etc.) relied upon are included in the patient's medical record.
  - E Further documentation by the physician will include information about patient and family knowledge of the DNR status.
- XII. DNR Bracelets
- A. The Attending Physician explains to the patient or his/her Authorized Representative that the patient may wear a DNR Bracelet, which communicates to the EMS/paramedics about one's DNR status. This will prevent activation of the EMS system and attempts to resuscitate. These Bracelets are recognized in the community at large and are useful when going into the community.

- B. The patient may wear the bracelet on either his/her wrist or ankle.
- C. The bracelet needs to have both the patient's and physician's name inscribed on it.
- D. Staff is to continue all other appropriate medical/nursing interventions, as the DNR order *will not affect* the provisions of care other than resuscitation.

### XIII. DNR Determination into WFH from other Facility

- A. When a patient is admitted to WFH from another facility with a DNR bracelet or "Do Not Resuscitate" order form, staff will honor the DNR and it will remain in effect until a physician's order is written (WFH-8).
- B. Once the patient is transferred from another agency, the Attending or on call Physician will transcribe the DNR order onto the Physician's Order Sheet.

### XIV. Discharge or Transfer Out of WFH

- A. If a patient with an active DNR order requires transport by EMS personnel to a health care facility and the patient is not wearing a DNR Bracelet, the physician or nurse completes a "Transfer of 'Do Not Resuscitate' Order" form which accompanies the patient.
- B. The Physician/nurse must ensure that the patient's DNR status is clearly designated in the patient's medical record to facilitate the clear transmission of information at the time of the transfer of the patient to a health care facility.
- C. The patient or his/her authorized representative may withdraw the DNR Order at anytime. The withdrawal can be oral or in writing to any medical care personnel. If the patient withdrawing consent is wearing the orange DNR Bracelet, the DNR Bracelet is removed immediately. The physician documents this rescission on the "Physicians Order Sheet." Additionally, a progress note in the medical record is also written by the physician outlining the specific request.
- D. When a patient is discharged or transferred with an active DNR Order from WFH, the Attending Physician addresses this order in progress notes as well as in the discharge summary. Additionally, such orders are reflected in the transfer form (W-10 referral).
- E. As is required by the Department of Public Health (DPH) regulations and/or upon the patient's request, the Attending Physician will obtain a DNR Bracelet through ACS for the patient.

## XV. Nursing Staff Responsibilities:

- A Nurses and other health care members carry out the Attending Physician's orders and monitor and report to the Attending Physician relevant changes that may indicate a review of the appropriateness of the DNR order.
- B The Registered Nurse will note in the progress note and nursing care plan that a DNR order has been written and communicates the status of this order at each shift report. Other duties include education of personnel who come in contact with the patient, with regard to the meaning of the DNR order and requirements of the hospital policy. Staff other than Attending Physician should not attempt to discuss the DNR subject with the patient or others interested parties on their own. Questions and discussions of this nature are referred to the Attending Physician.
- C If the patient, family member or the patient's authorized representative requests a cancellation of the DNR order at any time, the nurse *immediately* communicates this to the Attending or On-call Physician.

## XVI. Communication among All Clinical Staff and Families

- A Central to the duties of the attending psychiatrist is communication with all members of the health care team as appropriate including nurses, social workers, psychologists, chaplains, and others. Communication should also involve outside professional consultants with regard to diagnosis, prognosis, and management of the patient.
- B The Attending Physician communicates with family members, significant others and the patient's authorized representative, regarding the diagnosis, prognosis, and management of the patient and is available to answer questions about the patient's needs.
- C WFH ensures that all staff is knowledgeable of a patient's DNR order by properly affixing a suitable label or sticker (orange in color) on the front of the medical record. Additionally, any documentation as to the status and location of the DNR Bracelet or DNR transfer forms will be readily visible.

## XVII. Medical Orders for Life Sustaining Treatment (MOLST) Forms

- A. Consistent with Connecticut General Statute Sec. 19a-580h.** "Medical orders for life-sustaining treatment program", WFH patients and/or their conservators who wish to do so may opt to utilize the MOLST form and program to communicate their wishes about live sustaining treatment.

- B.** The Connecticut MOLST is a **voluntary** adjunctive planning tool to an advance health care directive. (Some patients may have already completed a living will and may have both documents). MOLST orders are for patients who are at the end stage of a serious life limiting illness or in a condition of advanced chronic progressive frailty as determined by a physician or advance practice registered nurse. The MOLST form documents patients' decisions in a clear manner that can be quickly understood by all providers, including first responders and emergency medical services (EMS) personnel.
  
- C.** The MOLST form is completed after a conversation or series of conversations have taken place between the patient (and if the patient chooses their loved ones) and the patient's health care provider or providers. The MOLST is an actionable medical order that reflects the patient's goals of care for full medical treatment, limited medical treatment or comfort measures only. It is designed to enable patients to document their preferences for medical treatments as they near life's end, and assists their loved ones and health care providers to better understand the patient's wishes. The form identifies the patient's medical condition as well as their treatment preferences and goals and accompanies the patient across all settings. The documentation makes it easier for health providers at one care setting to know the wishes of a patient previously documented in another care setting.
  
- D.** If preferred by the patient or conservator, a MOLST form may be completed in lieu of Whiting's standard DNR order. The physician writes an order stating that the MOLST form shall be followed if the patient is in need of life-sustaining treatment.
  
- E.** Upon transfer to an acute care medical hospital or other facility, a copy of the patient's MOLST form shall be sent with the patient in order to communicate the patient's wishes to other treatment providers.

**WHITING FORENSIC HOSPITAL  
OPERATIONAL PROCEDURE MANUAL**

<b>SECTION I:</b>	<b>PATIENT FOCUSED FUNCTIONS</b>
<b>CHAPTER 1:</b>	<b>Ethics, Rights and Responsibilities</b>
<b>PROCEDURE 1.9:</b>	<b>Patient Complaints and Grievances</b>
<b>REVISED:</b>	<b>7/22/22, 10/24/23</b>
<b>Governing Body Approval:</b>	<b>6/4/18, 8/8/22, 10/25/23</b>
<b>Effective Date:</b>	<b>10/26/23</b>

**PURPOSE:** To ensure that all Whiting Forensic Hospital (WFH) patients and if applicable, their representatives are afforded the opportunity to voice complaints and have grievances addressed at the lowest possible level in order to exercise their rights regarding care in an effort to respect individual choice, and improve treatment outcomes, without being subject to coercion, discrimination, or reprisal.

**PROCEDURE:**

- I. All patients are encouraged to discuss their complaints with their treatment team so their team can work with the patient to resolve the complaint.
  - A. Patients or their authorized representatives may make an informal verbal complaint or submit a formal written complaint to the Whiting Forensic Hospital Client Rights Officer (WFH CRO) or designee concerning: the care they receive; WFH compliance with applicable federal regulations; or other complaints that are not resolved on the unit level at the time of the complaint.
  - B. The WFH CRO or designee investigates the complaint and submits a written report of their findings and resolutions if applicable to the patient or their authorized representative.
  - C. All complaints are addressed by the CRO or CRO designee in a timely manner not subject to the DMHAS Client Grievance Policy Implementation Procedure timeline.
  - D. If the WFH CRO or their designee reasonably suspects a DMHAS work rule or criminal statute was violated, the CRO or designee will immediately notify the appropriate authority and the WFH Chief Executive Officer (CEO) or designee.
- II. The DMHAS Client Grievance Procedure is available to all patients as provided by the DMHAS Commissioner’s Grievance Policy Implementation Procedure.
  - A. DMHAS Client Grievances are defined as written complaints submitted to the WFH Client Rights Officer or designee by a WFH patient (or their authorized representative)

regarding:

1. Denial, Involuntary Reduction or Involuntary Termination of services except when such decision concerns a matter under the jurisdiction of the Psychiatric Security Review Board.
  2. The patient's belief that WFH or its staff:
    - i. Violated rights provided to patients by statute, regulation, or directive of the DMHAS (*See* "Your Rights as a Client or Patient" – DMHAS Poster);
    - ii. Treated the patient in an arbitrary or unreasonable manner;
    - iii. Failed to provide services authorized by a treatment plan;
    - iv. Used coercion to improperly limit the patient's choice;
    - v. Failed to reasonably intervene when the patient's rights are put at risk by another patient at WFH; or
    - vi. Failed to treat the patient in a humane and dignified manner.
- B. The DMHAS Client Grievance procedure does not apply to:
1. Matters that allege violation of DMHAS Work Rules or violations of criminal statutes, including suspected incidents of abuse, neglect and exploitation. Incidents of those types will be managed via the processes outlined in Procedure 5.7 Managing Patient Allegations and Procedure and 5.8 Patient Safety Event and Incident Management.
  2. Complaints about non-DMHAS operated or funded entities.
  3. Matters under the jurisdiction of the Psychiatric Security Review Board.
  4. Patient against patient complaints. However, patient against patient complaints are addressable as grievances when the patient believes WFH or its staff failed to reasonably protect the rights of the patient when jeopardized by another patient.
- C. WFH Patients may submit grievances within forty-five (45) days of when the complaint incident occurred to the Client Rights Officer, unless:
1. Good cause is shown to the CRO for a late filing (*See* WFH-434, Patient Grievance Form).
  2. The grievance is an Accelerated Grievance under Fair Hearing Regulations (Section 17a-45 (t)-7).
- D. A WFH patient may request any hospital staff to assist the patient in preparing a grievance and submitting it to the WFH Client's Rights Officer (CRO) or designee.
1. WFH Advocates are also available to help patients with writing or submitting a grievance.
- E. Any patient submitting a grievance may appoint, in writing, a representative of his or her choice to assist in pursuing the grievance.
1. WFH may disallow in writing a patient's choice of advocate, for clinical reasons, if the patient's choice is a peer who receives services from the same provider.

2. The patient's authorized representative may appear and advocate with and on behalf of the patient at any proceeding under the DMHAS Client Grievance Implementation Procedure.
  3. The patient may give written permission to their representative to review and access relevant records to the grievance as provided by law to understand the complaint and assist the patient in working with WFH to resolve the grievance.
    - i. All records relating to a grievance are confidential unless disclosure is authorized, in writing, by the person submitting the grievance or by the Office of the Commissioner of the Department of Mental Health and Addiction Services (DMHAS) in accordance with applicable law and policy.
- F. Patients are not required to use forms as long as the written grievance includes the complaint and the patient's suggested remedy.
1. Grievance forms are located in patient accessible areas of WFH units and include copies of the grievance procedure in English and Spanish.
    - i. Grievance forms and copies of the grievance procedure are made available in alternative languages and formats upon request.
    - ii. Completed grievances are considered confidential and therefore not filed in the patient's medical record.
  2. The following are not addressed under the DMHAS Client Grievance Procedure Summary:
    - i. Anonymous petitions and/or complaints; and
    - ii. Petitions and/or complaints made by more than one person.
- G. Grievances are submitted to the WFH CRO or designee.
1. Grievances can be given to a WFH Advocate or Recovery Support Specialist who will deliver the grievance to the CRO.

Patients may also mail them or give to their Unit Director for forwarding to the Advocacy Department.

The patient may withdraw their grievance at any time, unless:

    - The grievance was submitted on the patient's behalf by their conservator or guardian or conservator.
    - The grievance includes a suspected work rule or criminal statute violation or suspected abuse, neglect, or exploitation.
  2. Withdrawal of a grievance will not affect any hospital disciplinary action in progress (See WFH-668, Notice of Proposed Resolution).
- H. The review of a patient's grievance begins when the WFH CRO or designee receives it.
1. The CRO or designee notifies the patient once they receive the grievance within three (3) business days by issuing to the patient or their authorized representative a WFH Grievance Acknowledgement Form (See WFH-668, Grievance Acknowledgement Form) or letter.

- I. Whiting Forensic Hospital has twenty-one (21) calendar days from the date the grievance is received by the WFH CRO or designee to address the grievance.
  1. The CRO or designee works with the patient and their authorized representative to resolve the grievance.
  2. If the CRO believes the grievance can be resolved, a proposed Informal Resolution is written and submitted to the patient and their authorized representative for review.
    - i. The patient or their authorized representative has ten (10) business days to either accept or reject the proposed Informal Resolution.
    - ii. The patient or their authorized representative completes the Patient Proposed Resolution Form and notifies the CRO as soon as possible of their decision.
    - iii. The ten (10) business days does not count towards the twenty-one (21) calendar days WFH has to address the grievance.
    - iv. A grievance is considered withdrawn if the client fails to notify the CRO of their decision within the ten days, unless the CRO determines there is good cause for a delay.
    - v. If the client rejects the proposed Informal Resolution or the CRO cannot propose an Informal Resolution, the CRO submits a written report to the WFH CEO or designee and to the patient or their authorized representative.
- J. The WFH CEO or designee reviews the report and grievance separately, during which time the client or their authorized representative can provide additional information.
  1. The WFH CEO or designee may decide to meet the patient or their authorized representative.
  2. The WFH CEO or designee issues a Formal Decision, which includes information on how the patient or authorized representative can request a Commissioner's Review.
  3. The CEO or designee issues a Formal Decision within twenty-one calendar days after the CRO receives the grievance unless the CEO or designee authorizes an additional fifteen (15) calendar days in writing for good cause.
- K. Patients or their authorized representatives can submit a written request to the DMHAS Commissioner for a Commissioner's Review within fifteen (15) business days after receiving the Formal Decision.
- L. The request for Commissioner's Review should include a copy of the grievance, copy of the Formal Decision and reason why the patient or authorized representative wants a Commissioner's Review.
- M. Patients receiving opioid substitution therapy can submit an accelerated grievance when treatment is involuntarily reduced or terminated.
  1. The grievance is submitted in writing to the WFH CRO within five (5) business days of being notified of the involuntary reduction or termination of opioid substitution therapy.
  2. WFH CEO has five (5) business days to issue a Formal Decision.

- III. Whiting Forensic Hospital has a designated Client Rights Officer whose name and telephone number is posted on every unit.
  - A. The CRO is responsible for making sure the DMHAS Client Grievance Implementation Procedure is followed.
  - B. The CRO may designate a WFH Advocate or other staff to assist in addressing a grievance, however, the CRO is ultimately responsible for making sure the DMHAS Client Grievance Implementation Procedure is followed and for completing any reports regarding the grievance.
  - C. If the CRO reasonably suspects a violation of a DMHAS Work Rule, or Abuse, Neglect or Exploitation of a patient, the suspected violation is immediately reported to the appropriate authority and WFH CEO.
    - 1. The patient and their authorized representative is notified in writing of such referral and if possible the name and phone number of the person(s) the grievance was referred to.
    - 2. The CRO may be directed by the WFH CEO or DMHAS HR to interview patients when there is a suspected violation of a criminal statute or DMHAS work rule or suspected Abuse, Neglect, or Exploitation by DMHAS staff.
- B. The CRO is responsible for:
  - 1. Investigating the grievance to have a thorough understanding of the complaint and how it may be resolved;
  - 2. Reviewing documents pertaining to the grievance;
  - 3. Interviewing parties involved in the grievance;
  - 4. Meeting the patient and their authorized representative to discuss the grievance and how it may be resolved;
  - 5. Working with the patient and their authorized representative to propose a written Informal Resolution;
  - 6. Completing a report to the CEO and patient or their authorized representative if it is impossible to reach an Informal Resolution or the Patient rejects the proposal;
  - 7. Monitoring the progress of how a grievance is addressed and observing the DMHAS Client Grievance Implementation Procedure timeline;
  - 8. Making sure patients with Limited English Proficiency and disabilities have access to effective communication throughout the grievance procedure;
  - 9. Making sure Grievance Procedure and Rights notice is posted where patients can read, and providing copies of the notices, as well as grievance forms, to patients;
  - 10. Encouraging WFH staff and patients to be familiar with the rights and grievance procedure notices;
  - 11. Having a working understanding of client rights and the DMHAS Client Grievance Procedure as evidenced by completing LMS and OOC trainings; and
  - 12. Making sure WFH Advocates and RSS have a working understanding of client rights and the DMHAS Client grievance procedure.

**WHITING FORENSIC HOSPITAL  
OPERATIONAL PROCEDURE MANUAL**

<b>SECTION I:</b>	<b>PATIENT FOCUSED FUNCTIONS</b>
<b>CHAPTER 1:</b>	Ethics, Rights and Responsibilities
<b>PROCEDURE 1.10:</b>	<b>Visitation</b> RI 01.07.05
<b>REVISED:</b>	January 31, 2022, May 29, 2024
<b>Governing Body Approval:</b>	January 31, 2022, June 5, 2024

**PURPOSE:** To provide an opportunity for patients to visit with friends, relatives, and conservators while protecting the confidentiality of the patients and the security of the facility.

**SCOPE:** All staff involved in the patient visitation process.

**POLICY:**

It is the policy of Whiting Forensic Hospital (WFH) that the hospital provides patients with the opportunity to visit family, friends and/or conservators while protecting the confidentiality of all patients and security of the hospital. Visitation may be restricted, suspended, or denied as clinically indicated. Professional visits involving the provision of clinical treatment are not permitted, with the exception of court mandated assessments.

**PROCEDURE:**

I. Whiting and Dutcher:

- A. Patients are allowed to have visits.
- B. Patients may refuse to see visitors.
- C. WFH has regular visiting hours throughout the week. Patients can arrange visits during this time and can expect to visit for at least two hours during that time as mutually agreed upon. However, reasonable accommodations will be made, if alternative times are necessary if visitors are unable to visit during the regularly scheduled times.
- D. Visitors are informed of visiting policies and rules, including visiting hours, items not permitted, and how to contact staff.

- E. Each visitor is provided a list of permitted and prohibited items prior to or at the time of the first visit.

Each building within the hospital will have a detailed list of unapproved items not specifically covered by this policy.

- F. A patient's clergy, lawyer, advocate, or conservator may visit the patient at any time although visits during daytime and early evening are preferred. In addition, visits that do not conflict with treatment activities or mealtimes are also preferred. In any case, if the patient wishes to visit with their clergy, lawyer, advocate or, conservator and these times cannot be accommodated, such visits will be arranged when they are available. Privacy will be provided for these professional visits as requested. "Phone visits" with attorneys, clergy or conservators are an option for patients, which can be arranged. (See Operational Procedure 1.16 Privileged Conversation for Patients on One-to-One Observation Status).
- G. Special visits outside of visiting hours are usually pre-arranged. When visitors arrive unexpectedly, given the nature of safety and security, clinical staff will need to speak with the patient to determine whether the visitor is someone, with whom the patient wishes to visit and special paperwork may need to be completed. Generally, treatment activities are not to be interrupted in order to accommodate an unscheduled visitor unless there are extenuating circumstances.
- H. Visits take place in designated locations on the units or off the unit to protect patients' confidentiality or as much as possible. Privacy of visits is afforded to the greatest extent possible. Visits are not permitted beyond patient privilege limits.
- I. Visitors will be expected to sign in and out and to wear visitor badges. They are expected to pass through a metal detector and to have belongings they bring in X-rayed and/or searched. Visits may also be supervised and/or observed. Individual patients may have unique restrictions based on their particular case.
- J. *Restrictions* of visitors to WFH are implemented in response to a variety of circumstances (as described in detail in Operational Procedure 1.18 Patient Communication and Restriction of Communication) where patient care may be compromised for security reasons.

Restrictions to visits will be implemented in accordance with the existence of a court restraining order, protective order, or other official court order limiting or prohibiting personal contacts.

Whatever the circumstance, the patient is notified of the possible restriction and is provided an opportunity to participate in the decision making process. However, the attending psychiatrist makes the final decision (unless court ordered). The patient is advised of their right to an advocate if such restrictions are implemented and such restrictions are documented in the medical record. Where legally permitted by federal or state statute, the visitor is advised of the restriction of visits.

### **Whiting:**

Visitors that are under the age of 16, need prior written authorization from their parents/guardian and the WFH Administrations for visiting privileges. After receiving these authorizations, they will be allowed in the children visiting area only. Any visitors under the age of 16 must be in the company of an authorized adult visitor 18 years or older.

Visitors that are 16 and 17 years of age, need prior written authorization from their parents/guardian and the WFH Administrations for visiting privileges. After receiving these authorizations, they are permitted to visit in the adult or children visitation areas, based on family preference, unless contraindicated as determined by treatment team. Sixteen and 17 year olds must be in the company of an authorized adult visitor 18 years or older during children visitation.

Children's visits outside of regular visiting hours can be arranged through the treatment team.

### **Dutcher:**

1. All visitors must enter the Dutcher building through the front door (the door facing Holmes Drive) and must register in the Dutcher Service Police Substation. (In the event that a WFH police officer is unavailable, CVH agency police will be in the Dutcher Police Substation.)

Handicapped accessibility through the rear entrance of the building is available but requires the advance notification and assistance of unit staff.

All visitors 18 years-of-age and older must provide the WFD police with valid picture identification (e.g., driver license, passport, State photo ID card). If an unknown visitor fails to present valid picture identification, the visit may be restricted or prohibited. Upon showing proper identification, the police officer will sign-in the person legibly on the Visitor Log and issue the visitor a "Visitor" badge. The Visitor badge must be worn on their person and be visible at all times.

The treatment team shall notify the Dutcher Police Substation, in writing, of any prohibited visitors on a "Visitor Authorization Form."

The treatment team shall notify the Dutcher Police Substation in advance on a "Visitor Authorization Form" of any planned exceptions to the usual visiting hours or procedure.

The police will inform visitors what items are not permitted in the building and on the treatment units and will provide visitors with a copy of the handout, "Information for Visitors of Patients in Dutcher Hall," which describes visiting rules.

Visitors must leave all their own personal items (e.g., coats, cell phones, pocketbooks, etc.) in one of the lockers available in the Substation for that purpose; visitors will be given the key to the locker to secure their possessions. The key will be signed in and out in at the Substation.

All visitors and packages for patients must pass through the walk-through metal detector and/or be screened with a hand-held metal detector and may be subject to physical examination of the item, as some prohibited items may not show up on the X-ray machine. After being brought to the treatment unit, all items/packages shall be opened by a member of the nursing staff in the presence of the patient before the item(s) is given to the patient.

The police will notify unit staff that the patient has a visitor(s). Unit staff will verify that the visitor is not on the "restricted visitor list" and that the patient is willing to see the visitor. After being cleared by police and unit staff, all visitors must go directly to the treatment unit and sign-in on the unit visitor log before the visit takes place. If the patient has Level 4 privileges with sufficient grounds pass times, then the patient may sign out on his/her on grounds pass and meet with the visitors in the Dutcher lobby or outside on grounds. If, however, the patient does not have Level 4 and the necessary grounds pass, the visit must take place on the unit, in a common area, observable by staff. All Dutcher 2 South visits take place on the unit, in the patient visiting room, under observation by a security officer.

NOTE: Patients are *prohibited* from meeting any visitors on grounds while using their grounds passes without the visitor(s) first having completed the sign-in at the substation and unit, and screening procedure as described in this procedure. When visiting outside on grounds, patients are prohibited from entering any of the parking lots and may not enter a visitor's car or any other type of vehicle.

Patients are required to inform their treatment team in advance, if they wish to have visitors for an event, outside of typical visiting practice (see Patient Requests to Hold Events on Campus below).

**All Children:** All minors (children *under* 18 years of age) must be supervised at all times by a parent, legal guardian, or other responsible adult, but this supervision *may not* be provided by the Dutcher patient him- or herself, even if the child is the patient's child. A "Release of Responsibility for Minor Children" waiver form must be completed at the time of visitor registration in the Dutcher Police Substation and will be retained by the treatment team on the treatment unit (not in the patient's medical record) for **one year**.

**Children Under 14:** Children *under* the age of fourteen (14) are **not** allowed to visit on the treatment units; however, they may visit in the Dutcher Activity room (only upon review and approval of the treatment team, and with staff supervision), or, if the patient has the appropriate privilege level to allow doing so, they may visit on grounds or on the first floor of Page Hall (when it is open for patient use) with the child's parent/guardian present and at all times directly supervising the child. Visitors who plan on bringing children under 14 years-of-age to visit a patient **must** give the treatment unit at least 24 hours advance notice to ensure appropriate staffing levels if during the visit unit staff would be required to supervise the patient elsewhere in the Dutcher building or on hospital grounds. If visitors arrive with children under 14 years-of-age without having informed the treatment team in advance, the treatment unit may accommodate supervising the visit off the treatment unit if staffing levels allow.

**Infants.** In addition, the treatment team **must** be informed of, review, and approve visitors bringing newborn babies (infants less than six months old) into the Dutcher building or onto the grounds.

**Dutcher 2 South:** Children under 14 are not generally permitted to visit, however, a patient may make a request in advance, to their treatment team, and when possible, arrangements may be made to accommodate a visit.

### **Inpatient Visitors**

Dutcher patients may receive visits from (or go to visit) persons who are inpatients on other units in Dutcher or in CVH. Upon patient request, the treatment team will determine clinical appropriateness, including discussing with and obtaining approval from other patient's treatment team. In order for sharing of protected health information (PHI), both patients must sign *Releases of Information*.

### **Number of Visitors**

Up to three (3) visitors may visit with a patient at any one time. More than three persons may visit at one time **only with the prior approval** of the treatment team. The treatment team shall notify the Dutcher Police Substation of this approval **in advance** on a "Visitor Authorization Form" (see Appendix 3.8.7.c). If the friends or family members arrive with more than three visitors and **have not** received prior approval of the treatment team, the additional visitors may not be able to visit at that time or, may wait and visit after the first three visitors have left.

**Supervision of Visits.** Visits by friends/family may be supervised by Dutcher staff if determined by the treatment team to be clinically indicated. An explanation of the clinical and/or risk management rationale for the supervised visits shall be documented in the patient's medical record.

## Visiting Hours

The regular hours for visiting patients in the Dutcher Service are as follows.

<i>Monday through Friday</i>	<i>Weekends and Holidays</i>
1:00 p.m. – 2:45 p.m.	1:00 p.m. – 7:45 p.m.
6:00 p.m. – 7:45 p.m.	

- Unit staff must document in the patient's medical record all visits including documenting (a) who visited, (b) the relation of the visitor(s) to the patient, (c) how the visit went, and (d) any other information that may be relevant, important, or potentially useful for the treatment team to know (e.g., additional information about the patient's history, background information about the family). It is especially important to document any problems that occurred during the visit or any negative reactions the patient had during or after the visit.
- Signing Out.** After visiting with a patient, visitors **must** sign out with WFH police at the Dutcher Police Substation, return the Visitor badge, retrieve any personal items they had in a visitor locker, return the locker key to the police officer, have the police officer sign out the visitor on the Dutcher Service Substation Visitor Log, and then, *and only then*, may the visitor(s) leave the Dutcher building.

## Gifts, Food, or Other Items Brought by Visitors

Visitors may bring small gifts or other items for the personal use of the patient. All items brought into the Dutcher building must be carefully screened by the police officer on duty. In addition, items must be screened on the treatment unit, added to the patient's property list (as appropriate). As a general rule, visitors may not just drop off items for a patient at the Dutcher Police Substation. Items may be dropped off at the substation only after obtaining the prior approval of the treatment team. The treatment team shall notify the Dutcher Police Substation of this approval in advance on a "Visitor Authorization Form." When the visitor arrives to drop off the item, he/she will sign in at the Dutcher Police Substation as described above (i.e., show picture identification, have his/her name recorded by the officer on duty). The person must remain in the substation while the officer on duty inspects and scans the item(s) through the X-ray machine. If the item(s) is cleared, the person may then leave, the officer on duty will notify the treatment unit, and unit staff will pick up the item to give to the patient.

It is prohibited for visitors to bring home-cooked foods or open/unsealed foods or beverages from stores or restaurants. Only foods or beverages that are store-bought and factory/hermetically sealed in the original manufacturer's packaging may be brought by visitors into the Dutcher building and given to patients. All foods or beverages in glass containers are prohibited. All foods in cans must be opened by staff or opened by the patient under direct staff supervision, and staff are responsible for ensuring that the empty cans and lids are not available to patients and are properly disposed of in locked trash containers.

### **Dutcher Family Night Events**

**Patient Notification:** Patients' friends and family members should be encouraged to attend the monthly Family Night events held in Page Hall as is clinically appropriate for the patient. Patients who are planning to attend a Family Night event **must** notify unit staff no later than the day before the event and inform staff of the expected guest(s) including the number of guests, their names, and their relation to the patient. Guests must sign in at the event.

**Cell Phones:** While visitors may have cell phones with them when they come to Family Night, it is prohibited for any friend or family member to give his/her cell phone to the patient and to allow the patient to use the cell phone. Further, friends/family taking pictures of the patient or anyone/anything else is strictly prohibited.

**Food, Gifts:** Gifts, food, packages, or patient clothes/personal items brought by family members from the family's home for use by the patient must be brought directly to the Dutcher Police Substation, be cleared through the screening protocol described above, and then taken by unit staff to the patient's treatment unit. Such items **are not** to be brought to the Family Night event. Homemade foods, unsealed foods from stores or restaurants, or any other foods or beverages as described above, are not to be brought to Family Night events.

**Children:** Minors must be closely supervised at all times **during** the Family Night event. The accompanying adult must agree to this and must sign the "Release of Responsibility for Minor Children" waiver form upon arrival at the Family Night event. Unruly children or children who are not being appropriately supervised by the family may be asked to leave the Family Night event.

### **Patient Requests to Hold Events on Campus**

A patient request to hold an event on campus (e.g., wedding, memorial service) must be scheduled in advance and requires prior approval from the treatment team and CEO. Requests must include purpose of event, date, time, length, location, and attendees' names and relationship to patient. Requests may require FRC review and approval based on patient's legal status, with final approval at the discretion of the CEO.

## **Patient Requests for Special Community Trips to Visit Family**

There are times that a member of a patient's immediate family is unable to visit because, for example, the family member is in the hospital or does not have transportation. Staff-supervised family trips also may be considered for a significant, one-time (or very rare) special life/family event that would be very important and therapeutic for the patient to be able to attend

In such circumstances, patients may request to go on a special, individual trip into the community with staff supervision to visit the family member. Generally, these trips are limited to visiting an immediate family member of the patient.

In determining whether to take a patient on a special individual trip to visit family or to attend a special event, the following factors are to be considered:

- the nature of the trip
- the patient's current clinical status and possible negative effect the visit may have on the patient
- the location of the crime, victim, and victim's family
- risk factors for the trip such as patient's history of violence and AWOL, the potential presence of and access to prohibited items (e.g., weapons, illegal drugs, prescription or over-the-counter medications); and
- availability of and impact on hospital resources.

### **Review Process for Patient Family Trip Visits**

Following patient request and review / approval by the treatment team, the team then proposes the special trip to the Risk Management Committee and the CFP for PSRB acquittes. If the Risk Management Committee and CFP concur with recommending this trip to the FRC, the Service Medical Director signs the WFH-121 Patient Community Trip/Family Visit Recommendation form and the Program Manager signs the WFH-627 Community Trip/Activity form. The Program Manager holds both forms until the next FRC meeting and the Program Manager requests the review be added to the next FRC agenda.

At the FRC meeting, a member of the Risk Management Committee provides a brief summary of the clinical and risk management issues regarding the patient and his or her request.

The FRC discusses the team's recommendation for the special trip. The Committee's concurrence and/or questions or recommendations to the treatment team are written on the WFH-121 Patient Community Trip/Family Visit Recommendations form, and the form is signed by the CEO or designee.

After review by the FRC, the forms are returned to the Program Manager, who returns the forms (in the envelope with all other treatment unit recommendations) to the Unit Director.

The treatment team informs the patient of the disposition of the request and, if denied, the rationale for the denial. Notification of the patient is documented in the progress notes of the patient's medical record and the Attending Psychiatrist writes the appropriate order.

In the event that a patient requests a special trip, but there is not sufficient time (e.g., due to the sudden death and funeral of an immediate family member) to go through the above process, the following procedure will be followed:

1. The treatment team shall discuss the request with the Service Medical Director and Program Manager (and CFP if applicable)
2. If approval is recommended, the Program Manager shall contact the CEO/designee to discuss the patient's request and obtain approval
3. If the CEO approves the special trip, the Program Manager ensures that the WFH-121 Patient Community Trip/Family Visit Recommendation and the WFH-627 *Community Trip/Activity* forms are completed and contain all necessary approval signatures. The Attending Psychiatrist writes the appropriate order, and the treatment team proceeds with making arrangements for the patient's trip

**WHITING FORENSIC HOSPITAL  
OPERATIONAL PROCEDURE MANUAL**

<b>SECTION I:</b>	PATIENT FOCUSED FUNCTIONS
<b>CHAPTER 1:</b>	Ethics, Rights and Responsibilities
<b>PROCEDURE 1.11:</b>	Patient Searches
<b>Governing Body Approval:</b>	5/17/21, 9/28/21
<b>REVISED:</b>	4/30/21, 9/20/21

**PURPOSE:** To maintain a safe environment for all individuals served by Whiting Forensic Hospital (WFH) without unduly interfering with treatment, creating security risks, infringing on individual rights (as provided for in Connecticut General Statutes, Section 17a-548), or causing harm to the patient or others.

**SCOPE:** All Clinical Staff

**POLICY:**

It is the policy of WFH that the hospital maintains a safe, therapeutic environment for its patients and families. Having a safe environment for all is accomplished through periodic searches of the patient, his/her belongings, and/or the hospital environment. Searches are conducted to minimize or eliminate the presence of dangerous objects in the environment. Any exceptions to this policy must be approved by the Chief Executive Officer (CEO)/designee or Chief Medical Officer (CMO)/designee and documented in the patient’s medical record, including the approval and rationale for the exception.

***Definitions:***

*Emergency* – A search may be conducted immediately only when there is a serious concern for patient or staff welfare and safety, or facility security. The object or item being sought has life-threatening potential and/or poses a significant security risk

*Non-Emergency* – A search that is conducted when there is no immediate threat to life or safety by the object or item being sought. *Examples:* money or personal property of another patient or staff member.

*Individual Property Search* – A search of personal items belonging to the patient.

*Non-Emergency Search of Common Living Areas and Furniture* – Applies to situations where

there is no immediate threat to life and safety by the object or item being sought. The hospital's property is generally defined as those items integral to structure and décor, and/or intended for common use. Examples include, but are not limited to: lockers, wardrobes, bedside stands, furniture, and trash cans. A patient's personal property may be stored in and on some items of hospital property; such searches may be conducted on a routine or random basis depending on location and/or level of urgency.

*Individual Body Searches* – A physical examination of an individual body, from a simple “pat down” to a strip search (removal of clothing, examination of clothing contents, and visual inspection of the patient's body, including the bottoms of the feet, buttocks, genital area, and interior of the mouth) to a “body cavity search”. Each of these increasing levels of inspection is rigorously reviewed and authorized and is to be conducted with full respect for personal dignity and the right to privacy of the patient involved.

*Medically Harmful* - Items which are capable of inflicting serious mental or physical injury on the patient, or producing in the patient a disturbed mental state or impaired judgment which may be grossly detrimental to his physical or mental well-being.

*Non-Permissible/Prohibited Items* - Items not permitted on in-patient units which pose significant risk or are prohibited by hospital or Commissioner Policy. Such items may be returned to the sender or visitor or, where not otherwise disposed of, placed in the patient's “do not issue” storage area. Also included are items which may be illegal, including drugs, medications (prescribed or not prescribed), alcohol, weapons and sharps found on a patient, in a patient area or other unsecured location.

## **PROCEDURE:**

### **Searches upon Admission, Transfer and Re-Admission**

- I. Dutcher Service: Upon arrival on the unit, unit staff will ask patients to empty their pockets and remove their shoes and outer clothing (coat, hat, etc.) for screening.

It is the responsibility of the unit staff to conduct a search of the patient's property. Patients' belongings are to be stored in a secure area upon arrival and remain in said area until such time as unit staff can thoroughly complete the search. Search of property may include shaking out all clothing items, opening any containers, smelling any liquid/lotions bottles, flipping through books/magazines, examining footwear, etc. This list is not exhaustive and staff must use their judgment in completing a thorough search of patient belongings given the particular items accompanying the patient and the patient's particular risk factors.

The search should occur in a timely manner as to not cause the patient distress. Unit staff should explain the process and rationale for the search, including reviewing a list of prohibited items. The patient should be present while their belongings are searched. Should a prohibited item be found, it should be discarded or inventoried and stored until the patient

is discharged from the hospital. Should an item of an illegal nature be found, agency police and the manager on duty are to be notified immediately. The manager on duty should notify the Nurse Executive and CEO (or designee(s)).

Body searches are not routinely conducted at the time of admission to the Dutcher Service. If there is concern that the patient has contraband on their person at the time of admission, the patient should be brought to the police sub-station and screened via the metal detector and wand. If there is further concern regarding contraband hidden on their body, the patient should be continuously monitored until such time as a decision can be made regarding a body search, following the patient search procedure noted below.

- II. Whiting Service: Property and body searches are conducted by DMHAS Police. All belongings are screened via x-ray and an agency officer goes through all items before the items are sent to the unit. All patients will be strip/body searched during the admission process to ensure the safety and security of the facility. These searches will be conducted by two same gender DMHAS Police. Patients who identify as transgender will be asked their preference regarding the gender of the officers to be present during the search.

If same or preferred gender officers are not available, campus wide, to conduct a body search, a physician's order will be obtained and two same gender (or preferred gender for transgender person) nurses will conduct the search. An officer will be present in the room, behind a partition. A Director of Nursing/designee will also be present to assist, as needed.

For patients who are unwilling at the time of admission to participate in an individual strip/body search, DMHAS Police will notify the attending physician, Nurse Supervisor, Director of Nursing/Manager on Duty, CNO, CMO and CEO or designee(s). In such circumstances, an individual strip/body search may still be conducted against the patient's wishes by DMHAS Police when there is grave concern for the health and welfare of the patient, other patients, staff or facility security. In order to ensure such a search can be conducted safely for all involved, DMHAS Police may use appropriate, approved physical hold techniques to conduct the search. Such individual body searches require the authorization and approval in *advance* by the CEO, CMO or their designee and *require a physician's order prior to any examination*.

### **Searches upon Return from Temporary Leave, Activities or Appointments/Court Appearances (on and off campus)**

- I. Dutcher Service: Patients enter the Dutcher building via the Dutcher police sub-station and pass through the metal detector. If the metal detector sounds, the patient is wanded. Unit staff will ask the patient to empty their pockets and remove their shoes and outer clothing (coat, hat, etc.) for screening.

All bags are screened via the x-ray by agency police.

Any contraband found is held in the sub-station until such time as it can be discarded or stored. Should concern arise regarding the patient having contraband on their

person, the patient is held in the sub-station until such time as a decision can be made regarding a body search (see patient search procedure below).

Upon arrival to the unit, staff conducts a second screening of bags before the property is permitted in community areas or the patient's bedroom.

If the patient is returning from non-staff escorted privileges off the unit, nursing staff will ask patients to empty their pockets, and remove their shoes and outer clothing (coat, hat, etc.) for screening prior to entering their bedrooms or a community area.

Enhanced screening at the police sub-station, including wandings, emptying pockets, removing shoes, etc. may be conducted on a specific patient, based on the treatment team's recommendation due to assessed risk, under the following conditions:

- The treatment team presents the patient to and obtains approval from FRC
- The treatment plan is modified to note the enhanced search intervention. The intervention must be re-evaluated at each treatment plan review and documented in the patient's treatment plan
- A physician's order must be written which includes the rationale and specific risk necessitating enhanced screening
- The patient is notified of the enhanced screening by the treatment team
- The Unit Director notifies the Police Lieutenant, including the reason necessitating enhanced screening

Whiting Service: Strip/Body searches are always conducted upon return to the Whiting building unless patient has been under the custody of agency police during the entirety of the trip out of the building. Searches will be conducted by two same gender DMHAS Police. Patients who identify as transgender will be asked their preference regarding the gender of the officers to be present during the search.

If same or preferred gender officers are not available, campus wide, to conduct a body search, a physician's order will be obtained and two same gender (or preferred gender for transgender person) nurses will conduct the search. An officer will be present in the room, behind a partition. A Director of Nursing/designee will also be present to assist, as needed.

### **Property Searches: Whiting and Dutcher Services (routine and emergent)**

- I. Property searches may occur on a random schedule or when there is reason to believe that a particular patient's property contains non-permissible/prohibited material and/or items that may threaten the health and safety of the patient, other patients or staff and/or building security.

Some searches are announced and some are unannounced if there is reason to believe that there are prohibited items in the area. These searches are conducted in common areas or patient occupied areas. Examples of such hazards include perishable food items that could cause illness if ingested after improper storage; food items or debris that would attract vermin; trash that may create a fire threat or contraband items like aerosol cans, matches, lighters, tiles or missing sharps.

Routine random searches will occur in Whiting and D2S a minimum of one time weekly for each patient. Routine random searches will occur at least monthly for patients in all other Dutcher units. More frequent searches may be ordered by the attending physician for specific patients based on identified risk factors and/or if contraband has been found in a patient's bedroom. Routine random searches will include patients' entire bedroom, including tills, and all patient areas including community rooms.

The Nurse Supervisor's Office in both Whiting and Dutcher is responsible for scheduling and initiating routine random searches to ensure compliance with above noted frequency.

The Nurse Supervisor's Office in each building will maintain the completed documentation of all searches (routine and emergent), via the unit specific Unit Room Search form.

Under certain emergency circumstances, patient property may need to be searched in the patient's absence if they are not on hospital grounds at the time an emergency search is conducted.

- II. Searches for suspected contraband are typically conducted by nursing staff, and may include assistance from other disciplines, as requested. The Unit Director, Nurse Supervisor or Director of Nursing may request agency police assistance depending on the nature of the suspected contraband and the area to be searched. If the assistance of the agency police is requested, they will be present to maintain safety while unit staff conducts the search.

Agency police must be notified if there is a suspicion of a weapon or sharp in the patient's property and in such cases the agency police will conduct the search. Agency police may conduct a random search of a patient's property and/or body (with Chief Executive Officer or Chief Medical Officer approval) if there is sufficient reason to believe that there is a situation that presents an imminent and acute risk of safety to patients, staff or the security of the hospital.

- III. Unit searches: Prior to conducting a search, a community room on the unit is first searched to ensure no contraband is present. Patients are then notified of the search and situated in that room. The bathroom is then searched to ensure no contraband is present so that patients can access the bathroom as needed during the full unit search. At this point, nursing staff and/or agency police will take individual patients to their bedroom and conduct a search of the bedroom in the presence of the patient. There are certain situations in which a patient may not be allowed to be present during his/her room search (see below). Following a full unit search, a community meeting must be conducted to discuss why the search was necessary, allow patients the opportunity to process the event and to reinforce the importance of maintaining a safe environment for patients and staff.

Bedroom search: The patient is notified of the reason for the search and is immediately taken to his/her bedroom by staff and/or agency police to ensure the patient does not have the opportunity to move suspected contraband.

Bedroom searches should include the following: remove and shake out linens, remove and examine mattress and pillow, shake out all clothing items, open any containers, smell any liquid/lotions bottles, flip through books/magazines, examine footwear, etc. This is not all-inclusive and staff must use their judgment in completing a thorough search of the room and patient belongings given the particular situation.

- IV. Patients are permitted to be present during such searches *as provided for in the Connecticut General Statutes Section 17a-548.*

The right of a patient to be present during a search shall be denied only if the CEO or CMO, or their authorized representative determines that it is medically harmful to the patient to exercise such rights. An explanation of such denial shall be placed in the patients' medical record.

- V. Whenever any search results in discovery of significant prohibited items or a situation that would be deemed a critical incident, the CEO, CMO or their designee will be notified of the results of the search as soon as is reasonable.

Unless contra-indicated, the patient should be interviewed by the manager on duty, by end of shift, in order to ascertain how the item entered the building in order to prevent future occurrence.

### **Patient Searches: Whiting and Dutcher Services (emergent/non-routine)**

- I. Individual body searches are conducted only when there is grave concern for the health and welfare of the patient, other patients, staff or facility security. Such body searches *require a physician order prior to any examination.*
- II. When such conditions exist, unit nursing staff will alert the attending physician, Nurse Supervisor, Unit Director/Director of Nursing, and senior DMHAS Police Officer that an object or item being sought has life-threatening potential and/or poses a significant security risk if it is not found by the clinical staff, or if it were to be found by non-staff.
- III. Authorization and approval in *advance* by the CEO, CMO or their designee is required, with a doctor's order, unless an extreme, immediate or emergency situation exists. Where such a situation exists, these searches must be authorized by the Attending Psychiatrist or On-Call Physician, with immediate notification to hospital leadership (CEO and CMO or their designee(s)) as soon as the emergency has been reasonably resolved.
- IV. Individual body searches are permitted and are conducted for only the most serious of circumstances, and with careful and thoughtful consideration for full personal dignity and rights to privacy. Therefore, gender considerations regarding who will be present during searches are decided upon before the search is conducted, unless an extreme emergency precludes such consideration. Only in an extreme emergency, and with prior authorization by the CEO or their designee, will a patient be strip/body searched without a person of the same or preferred gender being present. Such searches are conducted by the RNs. In the case of body cavity searches; the physician will write an order to transport the patient to the ED for this purpose and will communicate with the ED staff the reasoning for the request for a cavity search.
- V. An observing nursing staff will be present, with agency policy stationed behind a screen should intervention be necessary. Any staff observing a body search must be of the same gender as the patient being searched (or the expressly preferred gender of a patient who identifies as transgender).

## **Mail and Packages**

- I. Whiting Service: All packages are screened via x-ray. Upon clearance, patients are called to the agency police office and given their package, to open in the presence of agency police. Mail is delivered to the patient on their unit by DMHAS police. Mail is opened, in the presence of the patient, by police, to ensure there is no contraband. Mail is not read by agency police.

Dutcher Service (with the exception of D2S): All mail and packages are screened via x-ray by agency police. Mail and packages are then sorted, and brought to the

mailroom in the Dutcher treatment mall for retrieval by the respective units. Letters are placed in patient mailboxes or hand delivered. Packages will be opened by the patient, in front of nursing staff. If nursing staff have concern as to the contents of the package, they are to hold the package and notify a supervisor immediately.

Dutcher Service D2S: All mail and packages are screened via x-ray by agency police. Mail and packages are then sorted, and brought to the mailroom in the Dutcher treatment mall for retrieval by the respective units. Letters are given to patients directly by staff. Patients may be asked to open their mail in the presence of staff if mail appears irregular or suspicious. Packages are opened by staff in front of the patient. If there is contraband found, patients are advised that the package must either be returned to sender or stored until discharge. If nursing staff have concern as to the contents of the package, they are to hold the package and notify a supervisor immediately.

Exceptions to the above may be considered when clinically indicated or due to safety concerns. In such cases, a physician's order must be written, including the rationale for the exception.

- II. Non-permissible mail or packages will be returned to sender. Should the patient refuse to open the package, it will be returned to sender in its entirety. When a package is returned to the sender, a letter explaining the reason for the return along with the hospital's procedure on permitted and non-permissible items will be provided.
- III. In the event that there is suspicion that an item of mail or package may contain illegal substances or dangerous weapons, the package will be held by DMHAS Police. The unit team and patient will be notified that this package is subject to consideration of a search warrant and hospital leadership will be notified. Should a search warrant be obtained, the DMHAS Police at the Whiting Forensic Hospital will search the package and all non-permissible items will be confiscated and legal action taken in cases where federal or state law has been violated. Hospital leadership will be immediately notified.
- IV. DMHAS Police and/or staff will inform all visitors of hospital's procedure regarding bringing packages into the hospital as well as specific guidelines hospital staff must follow in allowing certain items into the hospital including permissible items and the need to screen or x-ray all packages before they are allowed onto the patient units. Visitors are also advised that all permitted items will be inventoried and listed in the patient's medical record.

- V. When non-permissible/prohibited items have been found, the visitor will be asked to remove such items from the hospital building or, if not possible, have them stored in the reception area until the visit has ended. A copy of the hospital's list of permissible and non-permissible items will be provided to the visitor. If visitors decline to show the contents of the packages, they will be advised to remove such items from the hospital building or have them stored in the reception area for them until they leave.
  
- VI. DMHAS Police will assist the staff member assigned to visitation duty, with any problems regarding packages from visitors.

### **Smoking-related Contraband (Dutcher only)**

In an effort to curtail patients bringing smoking/tobacco related contraband onto hospital units, nursing staff will ask all patients returning from non-staff escorted privileges off the unit to empty their pockets, and remove their shoes and outer clothing (coat, hat, etc.) for screening prior to entering their bedroom or community area.

Any cigarettes, tobacco, matches, lighters or other smoking related contraband discovered as a result of this process will be confiscated and discarded by the staff. If the patient refuses to cooperate with the staff check for contraband, the FTS will inform the unit RN, who will in turn consult with the attending or on-call physician to determine necessary follow-up actions. The need for any additional interventions will be determined by the clinical team engaged in treating the patient.

For patients who are granted temporary leave (TL/TV) to a residential or family setting that permits smoking, the treatment team shall consider counseling regarding the risks and benefits of exposure to nicotine in the community setting. The treatment team shall review this policy regarding smoking contraband with the patient prior to the TL and document this discussion in the progress notes section of the medical record.

All smoking/tobacco related products will be confiscated by nursing staff upon admission and will be disposed of.

**WHITING FORENSIC HOSPITAL  
OPERATIONAL PROCEDURE MANUAL**

<b>SECTION I:</b>	PATIENT FOCUSED FUNCTIONS
<b>CHAPTER 1:</b>	Ethics, Rights, and Responsibilities
<b>PROCEDURE 1.12:</b>	<b>Access to Advocates for Recovery/ Treatment Planning</b>
<b>Governing Body Approval:</b>	6/4/18
<b>REVISED:</b>	

**PURPOSE:** This procedure establishes standards and processes to ensure access to advocates and the related rights of persons in recovery.

**SCOPE:** All clinical nursing staff and hospital leadership

**POLICY:**

In accordance with statutory, regulatory requirements as well as Department of Mental Health and Addiction Services (DMHAS) policy, and Agreements of Settlement, the patients of Whiting Forensic Hospital (WFH) as persons in recovery, are entitled to active and meaningful participation in the development and implementation of an individualized, multidisciplinary recovery/treatment plans. They may be assisted in this process with advocates of their choice. It is the policy of WFH, to support the patient’s desire to have an advocate participate in their treatment planning and facilitate easy access to advocates by providing information about advocacy.

***Definitions:***

*Advocate* - Is an individual chosen by a person in recovery to act on their behalf and assure that the patient’s individual rights are protected and respected. Advocates may be friends, family members, clinical and legal professionals. They may be affiliated with (but not limited to) an advocacy service such as: DMHAS Human Services Advocates; Peer Advocates from Advocacy Unlimited; Connecticut Community for Addiction Recovery (CCAR); Connecticut Legal Rights (CLRP) paralegals and attorneys; Advocates from the Connecticut Office of Protection and Advocacy for Persons with Disabilities (OP&A). While a person in recovery can count on and have many individuals who advocate on their behalf, they need to choose *one individual who will* take the lead role in working with the treatment team.

*Legal Advocate* - Is an individual who is an attorney or works under the supervision of an attorney. Under these circumstances attorney/client privilege applies. Legal advocates are obligated to vigorously represent their clients expressed preferences. If the person in recovery chooses a legal advocate, this advocate takes the lead in working with the treatment team.

*Recovery* - A process of restoring or developing a positive and meaningful sense of identity apart from one's condition and then rebuilding one's life despite, or within the limitations imposed by that condition.

*Individual Recovery/Treatment Plan* - The multi-disciplinary, individualized recovery plan incorporates treatment, service, or care plans and will include a comprehensive and culturally sensitive assessment of the person's hopes, assets, interests, goals, and preferences in addition to a holistic understanding of his or her behavioral health conditions and other social, legal or medical concerns within the context of his or her ongoing life.

*Treatment Team* - As defined by the Centers for Medicare/Medicaid Services (CMS), treatment teams minimally comprise of clinical providers directly involved in the treatment of a patient and typically include: a psychiatrist, primary nurse, clinical social worker, and rehabilitation therapies professional. As indicated by clinical need a psychologist and unit director may also participate.

## **PROCEDURE:**

Upon admission and when requested, WFH nursing staff will inform each patient of their rights, including the right to an advocate. Each patient will be provided (1) a summary page of patient's rights, (2) a copy of the DMHAS Patients' Rights Poster (see attached pages in this section) and, upon request, shall be provided a copy of a WFH Patients' Rights Handbook. Written confirmation of this notice will be documented in the medical record by nursing with confirmation of receipt by patient (signed by patient) on Form WFH-606.

Information about patient's rights and available advocacy services will be posted on each unit in English and Spanish. Patients' rights and advocacy information will be translated to other languages as needed.

The Unit Director or designee will obtain a Release of Information (WFH-184) from the patient before a staff member speaks with an advocate if they are not employed by WFH. The form will be filed in the medical record.

WFH staff will provide or arrange for privacy for meetings or telephone conversations between persons in recovery and their advocates.

An advocate designated by the patient will be invited (Form WFH-287 (rev. 12/05) Invitation to Team Meeting) to treatment planning meetings. Every attempt will be made to schedule meetings at a time convenient for the advocate and to give reasonable notice of the scheduled meeting, typically a minimum of two business days. CLRP Advocates require three business days notice. When accommodations cannot be made, the reason will be documented in the medical record.

Patient Advocates meets with the treatment team as a part of formal treatment planning and also participate in other meetings that the patient has the right to attend with and/or on behalf of the patient.

In an effort to keep individuals informed when CLRP paralegals or attorneys are the designated advocates for a WFH patient, a label indicating CLRP involvement is affixed to the spine of the patient's medical record. These labels are available from Medical Records on each unit and the task of affixing them is responsibility of each unit designee.

Shorter notice of treatment meetings may be provided to the patient and advocate when extenuating circumstances require more immediate action. Treatment teams will document in the patient's medical record notice provided and the extenuating circumstances.

The Unit Director or designee notifies both the patient and advocates of treatment and discharge decisions that affect the patient. This notification will be documented in the medical record.

As in all treatment planning, when a Patient Advocate attends a formal treatment planning meeting or other meeting of the patient and treatment team, the outcome of formal meetings should be documented as part of the patient's medical record.

Advocates are encouraged to discuss treatment issues, questions about programs or concerns regarding policies with the treatment teams or other hospital staff. Division and hospital leaders may also be helpful in addressing issues.

When CLRP paralegals or attorneys are the designated advocates for a WFH patient, a label provided by CLRP will be affixed to the spine of the patient's medical record.

Persons in recovery for whom a conservator has been appointed may still designate an advocate to participate in the treatment planning process and to access the patient's medical record (consistent with state and federal confidentiality laws) and participate at treatment planning meetings unless the Probate Court has made a finding that the patient is incapable of exercising the right to participate in treatment planning.

## WHAT RIGHTS DO CLIENTS HAVE?

### **Basic Human Rights:**

- To be treated in an humane and dignified manner at all times with respect to:
  - Personal Dignity, Civil Rights, Privacy, the Right to Vote and to Sell or own personal property
- The right to not be discriminated against due to race, gender, sexual orientation, physical disability, age, etcetera;
- Freedom from all forms of abuse or harm
- Freedom from seclusion or restraints of any form unless medically necessary or where there is imminent danger to self or others AND a physician's order of such procedures;
- The greatest degree of freedom possible, limited only by dangerousness to self or others, potential elopement (AWOL) risk, or due to Probate or Superior Court ordered commitment or other Court placement (e.g. CGS 54-56d – Court evaluation for competency to stand trial).

### **Treatment or Service Rights:**

- To have a written, individualized treatment/recovery plan that is developed with you and suited to your own goals, desires, aspirations and needs
- To be present in meetings or formal discussions involving your care, the ability to participate in decision-making processes; provide input about desired outcomes; request to review medical records and participate in discharge planning;
- To decline treatment or medication; ask for changes in treatment, services or medications\*
- To obtain medical treatment for other illnesses, injuries or disabilities

### **Communication Rights:**

- To visit and have private conversations with clergy, attorneys or paralegals at any reasonable hour, and to include anyone who you feel may be helpful in your recovery
- To communicate with others by telephone, send and receive sealed correspondence, and receive visitors during scheduled visiting hours. Exceptions may be made for family when scheduling or other extenuating circumstances exist\*

### **Personhood or the Right to Maintain Self Identity:**

- To wear your own clothing and maintain your own personal belongings
- Have access to and spend your own money for personal purchases\*

### **Confidentiality Rights:**

- All records or any information that identifies you as a client, type of treatment or diagnosis cannot be provided to any unauthorized person without your explicit written consent
- Exceptions: Duty to warn, or when evidence of neglect or abuse to children, the elderly, or any other protected class of citizens

### **Grievance Rights:**

- You have the right to be informed of your rights and responsibilities and the DMHAS Grievance Process
- To file grievances with the hospital and with the Clients Rights Officer
- To be heard concerning any other complaint
- To be free from coercion, intimidation, discipline or any form of retaliation by staff or other clients resulting from filing a grievance or complaint
- Have the written grievance be investigated in a timely manner
- Have mediation available in order to resolve a dispute
- Have the ability to request a CEO and/or Commissioner level review of a proposed resolution, if necessary

### **Probate Court Hearings and Appeal Rights:**

- To be able to request hearings from the Court and file appeals

\*Statutory exceptions may be made to certain rights. Documentation of the reasons for any such exceptions, must be authorized by the Chief Executive Officer of WFH (or Designee) and a copy of the reasons for such exceptions be entered into a person's medical record.

### **(2) The DMHAS Patients' Rights Poster:**



# Your Rights as a Client or Patient

of the Connecticut Department of Mental Health & Addiction Services



You are entitled to be treated in a humane and dignified way at all times, and with full respect to:

## ❖ Personal Dignity ❖ Right to Privacy ❖ Right to Personal Property ❖ Civil Rights

You have the right to freedom from physical or mental abuse or harm. You have the right to a written treatment plan that is developed with your input and suited to your own personal needs, goals and aspirations. You should be informed of your rights by the institution, agency or program. In addition, a list of your rights must be posted on each ward of a hospital.

### Other rights you have include:

**Humane and Dignified Treatment:** You have the right to receive humane and dignified treatment at all times and with full respect to your personal dignity and privacy. A specialized treatment plan shall be developed in accordance with your needs. Any treatment plan shall include, but not be limited to, reasonable notice of discharge, your active participation in and planning for appropriate aftercare. (See CGS 17a-542)

**Personal Dignity:** While in an inpatient facility, you have the right to wear your own clothing, to maintain your own personal belongings (given reasonable space limitations) and to be able to have access to and spend your own money for personal purchases.\* Except for patients in Whiting Forensic Division, you have the right to be present during any search of your personal belongings. Any exception to these rights must be explained in writing and made a part of your clinical record. (See CGS 17a-548)

**Privacy & Confidentiality:** You have the right to privacy & confidentiality. Records that would identify your person, manner of treatment or your diagnosis cannot be given to any other person or agency without your written consent. All records maintained by the courts [as they relate to a recipient's treatment] shall be sealed and available only to respondent or counsel.\* No person, hospital, treatment facility nor DMHAS may disclose or permit the disclosure of the identity, diagnosis, prognosis or treatment of any service recipient that would constitute a violation of state or federal statutes concerning confidentiality.\* If an arrest warrant has been issued or a police complaint filed, some information – such as the fact of your presence in the facility and the basis for the complaint – will be released to the criminal justice authorities.

(See CGS 17a-500, 17a-688, 52-146f and 42 CFR part 2)

**Physician's Emergency Certificate & Commitment:** You, your advocate or counsel, can find out more about what Commitment procedures apply by reviewing the appropriate statutes. All persons admitted through a Physician's Emergency Certificate have the right, upon request, to a probable cause hearing within three business days from admission. All voluntarily admitted patients shall be informed, upon admission, of their ability to leave after three days notice. Any voluntarily confined patient shall not be denied his or her request to leave within three days notice in writing unless an application for commitment has been filed in a court of competent jurisdiction. Different statutes apply depending on your placement in addiction treatment or for a psychiatric disorder. See CGS 17a-495 et seq.; 17a-502; 17a-506; 17a-682 to 17a-685, 54-56d)

**Visiting and Communication Rights:** You may receive visitors during scheduled visiting hours. You have the right to visit with and may have private conversations with clergy, attorneys or paralegals of your choice at any reasonable hour. Facilities may reasonably maintain rules regulating visitors. Mail or other communications to or from a service recipient in any treatment facility may not be intercepted, read or censored.\* Any exceptions to rights regarding communications must be explained in writing, signed by the head of the facility (or designee) and made a part of your clinical record. (See CGS 17a-546, 17a-688)

**Access to Your Medical Record:** You or your attorney may have the right, upon written request, to inspect your hospital records. Unless your request is made in connection with litigation, a facility may refuse to disclose any portion of the record which the mental health facility has determined would create a substantial risk that you would inflict a life threatening injury to self or others, experience a severe deterioration in mental state,\* or would constitute an invasion of privacy of another. (See CGS 17a-548, 52-146f)

**Restraint & Seclusion:** If conditions are such that you are restrained or placed in seclusion, you must be treated in a humane and dignified manner. The use of involuntary seclusion or mechanical restraints is allowed only when there is an imminent danger to yourself or others. Documentation of reasons for these interventions must be placed in your clinical records within 24 hours. Medications cannot be used as a substitute for a more appropriate treatment. (See CGS 17a-544)

**Remedies of Aggrieved Persons:** If you have been aggrieved by a violation of sections 17a-540 to 17a-549 you may petition the Superior Court within whose jurisdiction you reside for appropriate relief. (See CGS 17a-550)

**Medication, Treatment, Informed Consent & Surgical Procedures:** You, your advocate or counsel, can find out more about what procedures apply by reviewing the appropriate statutes (See CGS 17a-543a-j). If you have been hospitalized under any sections of 17a-540 to 550, you shall receive a physical examination within 5 days of admission and at least once every year thereafter. Reports of such exams must be entered into your clinical record (See CGS 17a-545). No medical or surgical procedures, no psychosurgery or shock therapy shall be administered to any patient without such patient's written informed consent, except as provided by statute.\* A facility may establish a procedure that governs involuntary medication treatments but any such decision shall be made by someone not employed by the treating facility and not until the patient's advocate has had reasonable opportunity to discuss such with the facility.\* If a facility had determined to administer involuntary medication pursuant to statute, the patient may petition the Probate Court to hold a hearing to decide whether to allow this intervention. Notwithstanding the provisions of this section (17a-540 to 550) if obtaining consent would cause a medically harmful delay, emergency treatment may be provided without consent. (See CGS 17a-543a-f)

**Treatment by Prayer:** You have the right to ask the hospital to be treated by prayer alone in accordance with the principals and practices of your church or religious denomination.\* (See CGS 17a-543i)

**Freedom of Movement:** You are entitled to the greatest degree of freedom possible, limited only by: dangerousness to self or others or potential elopement ["AWOL"] risk. (See CGS 17a-541, 178-542)

**Denial of Employment, Housing, Etcetera:** You cannot be denied employment, housing, civil service rank any license or permit (including a professional license) or any other civil or legal right, solely because of a present or past history of a mental disorder, unless otherwise provided.\* (See CGS 17a-549)

**Filing of Grievances:** Recipients of DMHAS facilities or programs have the right to file a grievance if any staff or facility has: 1) violated a right provided by statute, regulation or policy; 2) if you have been treated in an arbitrary or unreasonable manner; 3) denied services authorized by a treatment plan due to negligence, discrimination ...or other improper reasons; 4) engaged in coercion to improperly limit your treatment choices; 5) unreasonably failed to intervene when your rights have been jeopardized in a setting controlled by the facility or DMHAS; or 6) failed to treat you in a humane or dignified manner. (See CGS 17a-451-t(1-6))

**Disclosure of Your Rights:** A copy of your rights shall be prominently posted in each ward where mental health services are provided. (See CGS 17a-548)

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Other Rights may be guaranteed by state or federal statute, regulation or policies, which have not been identified in this list. You are encouraged to seek counsel to

**WHITING FORENSIC HOSPITAL  
OPERATIONAL PROCEDURE MANUAL**

<b>SECTION I:</b>	<b>PATIENT FOCUSED FUNCTIONS</b>
<b>CHAPTER 1:</b>	Ethics, Rights and Responsibilities
<b>PROCEDURE 1.14:</b>	<b>Organ/Tissue Donation</b>
<b>Governing Body Approval:</b>	6/4/18
<b>REVISED:</b>	

**PURPOSE:** To ensure that the patient’s wishes concerning organ/tissue donation are honored and that patient’s family are provided an opportunity to donate organs/tissues in the absence of the patient’s self determination.

**PROCEDURE:**

- I. The opportunity for organ/tissue donation must be made with the legal next-of-kin unless:
  - A. the deceased has already consented to donate through the Connecticut Donor Registry (such that consent from the next-of-kin is not required);
  - B. the deceased has already expressed his/her intention *not* to make a donation; or
  - C. a determination is made in collaboration with LifeChoice Donor Services, the Organ Procurement Organization (OPO), that the donation would not yield suitable organs/tissues for transplantation (*See below for specific contact information*).
  
- II. In all cases, sensitivity and discretion to the circumstances, views, and beliefs of the family are to be kept in mind.
  
- III. In the State of Connecticut, next-of-kin (in order of priority) is as follows:
  - A. Spouse;
  - B. Person designated as a decision-maker under CGS 1-56r;
  - C. Adult son or daughter;
  - D. Parent;
  - E. Adult brother or sister;
  - F. Grandparent;
  - G. Guardian of the person at the time of death;
  - H. Any person legally authorized to make health care decisions, including, but not limited to, a health care agent appointed under Connecticut General Statutes (CGS) Section 19a-576; or
  - I. Conservator of Person as defined in: CGS Section 45a-644.

IV. Any Time a Patient Requests Information about Organ/Tissue Donation:

- A. He/she is provided information about organ/tissue donation.
- B. His/her wishes regarding donation are entered on WFH-407, for those without a conservator of person, or WFH-407b, for those with a conservator of person.
- C. If he/she wishes to be noted as an organ/tissue donor, he/she will need to provide WFH with documentation of previous organ/tissue donor status, such as a driver's license indicating organ donor status. If he/she wishes to initiate organ/tissue donor status for the first time, and is not conserved, the attending psychiatrist and service medical director will evaluate the patient for competence to become an organ/tissue donor and document their findings in the medical record. If the patient is determined to be competent, his/her wishes are entered on WFH-407 as above.
- D. WFH-407 or WFH-407b and (*when applicable*) documentation of organ donor status are filed in the legal section of the medical record.

V. When death is imminent or when the patient has died:

If the patient is transferred to an acute care hospital as an already established donor, this information is shared with the EMS/paramedics as well as documented on the W-10 accompanying the patient to the hospital. If the patient is to be transferred to an acute care hospital and had already been determined not to be a potential donor, (either by choice or lack of suitability) the acute care hospital physicians will be responsible for any further action taken.

VI. For patients pronounced at WFH:

- A. If the patient is pronounced at WFH, the pronouncing physician will inform the family of WFH's responsibility to comply with federal regulations for organ/tissue donation by notifying LifeChoice, the OPO.
- B. The pronouncing physician will notify the OPO within one hour following a patient death (*contact information follows*).
- C. The pronouncing physician documents the phone call to the OPO in the Organ Donation portion of the Report of Death form (WFH-595).
- D. The OPO is responsible for determining whether the patient is a suitable donor.
- E. If no obvious contraindications exist, the OPO will contact the family to secure appropriate informed consent or provide disclosure from the legal next-of-kin. As part of the process for determining medical suitability, a medical and social history questionnaire will be completed.
- F. Either the eye bank or the OPO will coordinate the administrative tasks required for organ/tissue procurement.

G. The involvement of the Medical Examiner's Office (required in certain deaths) does *not* preclude donation. The OPO or eye bank will facilitate contact with the Medical Examiner's Office to secure approval for donation.

VII. Performance Improvement

- A. The Peer Review Committee will monitor the pronouncing physician's documented call to the OPO to ensure that the patient's or family's wishes regarding organ/tissue donation were honored.
- B. The CMO will be the Organ Donation contact person. He/She will maintain a record of potential donors whose names were submitted to the OPO, including the date the OPO was contacted and the name of the physician who made contact.
- C. LifeChoice will provide an annual report to the CMO of the effectiveness of organ/tissue procurement.

**Administrative Contact Information For:**

*LifeChoice Donor Services  
340 West Newberry Road, Suite A  
Bloomfield, CT 06002*

www.lifechoiceopo.org

**Phone: (860) 286-3120**

**or**

**Parent Organization:**

**New England Donor Services  
60 1<sup>st</sup> Avenue  
Waltham, MA 02451**

**Phone: (800) 446-6362  
[nedsonline@neds.org](mailto:nedsonline@neds.org).**

WHITING FORENSIC HOSPITAL  
OPERATIONAL PROCEDURE MANUAL

<b>SECTION I:</b>	PATIENT FOCUSED FUNCTIONS
<b>CHAPTER 1:</b>	Ethics, Rights and Responsibilities
<b>PROCEDURE 1.15:</b>	<b>Arrest of Patients at Whiting Forensic Hospital</b>
<b>Governing Body Approval:</b>	6/4/18
<b>REVISED:</b>	
<b>REFERENCE:</b>	<b>DMHAS Commissioner's Policy 6.23</b>

**PURPOSE:** This procedure is intended as a WFH specific addendum to the *DMHAS Commissioner's Policy 6.23 Arrest of Clients*.

**SCOPE:** All clinical staff involved in direct care of the patient.

**POLICY:**

It is the policy of Whiting Forensic Hospital (WFH) that hospital leadership and staff shall follow *DMHAS Commissioner's Policy 6.23 Arrest of Clients* when considering arresting a patient. Arrest is a criminal justice response to illegal behavior. Arrest is not a clinical tool, and must not be regarded as such. The hospital staff shall employ strategies and interventions in order to prevent patient violence and/or illegal behavior.

**PROCEDURE:**

**I. Timeline for Reporting to WFH Police**

All events which may lead to the arrest of a patient must be reported to the WFH Agency Police as soon as possible, but no later than the end of the shift when a staff member is first aware of the potentially criminal act. The Agency Police will notify the CEO, or designee. The Agency Police will conduct an investigation to determine whether probable cause exist to arrest or seek an arrest warrant.

The Chief or designee will discuss individual case reviews with the CEO prior to filing an arrest warrant application, and will report aggregate review findings to the CEO and to the Office of the Commissioner.

## II. Procedure for Reporting to WFH Police

- A. For any patient in the Whiting Building the Whiting Agency Police contact number for reporting potentially criminal acts is Extension 5400.
- B. **For all other patient areas at Dutcher the WFH Agency Police contact number for reporting potentially criminal acts is Extension 5555.**

## III. Prevention Strategies

Statements and actions made by clients in the course of investigation, even before an arrest, could have serious consequences. Treating clinicians must be aware that once clients are engaged in the criminal justice system, they become defendants with specific legal rights, as well as significant stressors and risks.

- A. Recognizing that a minority of patients with psychiatric disabilities engage in violent or, illegal behavior, WFH provides a broad range of preventative and responsive interventions to limit such behavior. The following types of interventions are the primary response to problematic patient behavior.
  - 1. full array of clinical treatment interventions;
  - 2. full use of the therapeutic milieu;
  - 3. adherence to safety and security procedures;
  - 4. staff training;
  - 5. consultation; and
  - 6. Use of quality improvement data to assess and revise the treatment plan and therapeutic milieu.
- B. Give all patients written notice of patient's rights and responsibilities. Responsibilities include the expectation that patients will respect the rights of others (patients, staff, and visitors) and exhibit lawful behavior. Notice also includes a clear statement that the hospital or any individual may request arrest when patients violate the law.
- C. Inform all patients that if a complaint is filed, some information such as the fact of their presence in the hospital and the basis for the complaint will be released to the criminal justice authorities. **[CGS 52-146f (1-2)]**
- D. Clinical staff shall be responsible for informing the client that police have been contacted and reminding the client of the availability of advocacy services to help

protect his/her legal rights and the right to wait for an attorney to before speaking to the DMHAS Public Safety Division (PSD).

- E. Arrest shall be used to address violent acts or other illegal behaviors that represent a serious threat to clients, staff and visitors, or significantly interfere with the therapeutic work of the facility or its safety or security, such as injury to a victim, sexual assault, distribution or sale of controlled substances, or repeated antisocial acts of a violent nature.

#### **IV. Managing Patient Confidentiality**

- A. Confidentiality is maintained. Medical Records (paper or electronic) and other privileged information may only be shared when:
  - 1. The patient has provided a written release of information; *or*
  - 2. Upon receipt of an appropriate court order. The Director of Health Information Management (HIM) (Medical Records) contacts the Attorney General's Office if there is any question about the propriety of a subpoena or other request for information.

#### **V. Managing the Ongoing Treatment Responsibility**

- A. Any serious incident, whether or not it results in an arrest, must trigger an automatic treatment plan review, and pending allegations that might interfere with the client's community integration must be addressed by staff in a timely manner during discharge planning.
- B. The facility should seek to promote and assist the clients' recovery, and therefore, to continue its therapeutic work with the client.
- C. The treatment team aspires to maintain a clinically appropriate relationship with the patient and is cognizant of the potential for a multiplicity of emotional responses from the patient and the staff related to the incident.
- D. The treatment team may counsel the client about personal responsibility, societal expectations and the negative consequences to the client of violent or illegal behaviors.

If an incident is currently under investigation by DMHAS Public Safety Division (PSD), clinical staff should be respectful of the patient's legal right to remain silent regarding discussion of the matter.

## **VI. Protocols Regarding Arrest and Conviction**

- A. The treatment team ensures continuity of care for the patient. After arrest or conviction, the court may transfer the patient to a jail or prison facility. In this event, treatment staff informs the sheriff or other transport personnel, and the receiving facility of:
1. any concerns about the patient's well being;
  2. potential for self injury;
  3. clinical status; and
  4. current treatment regimen, especially medications.

# WHITING FORENSIC HOSPITAL OPERATIONAL PROCEDURE MANUAL

<b>SECTION I:</b>	PATIENT FOCUSED FUNCTIONS
<b>CHAPTER 1:</b>	Ethics, Rights and Responsibilities
<b>PROCEDURE 1.16:</b>	<b>Privileged Conversation for Patients on Continuous or More Restrictive Levels of Observation Status</b>
<b>Governing Body Approval</b>	6/4/18
<b>REVISED:</b>	

**PURPOSE:** To provide the opportunity for privileged or confidential conversations with patients who are on continuous observation status or a more restrictive level of special observation, while ensuring the safety of all involved. A patient, the patient’s attorney, legal representative, patient advocate, or clergy may request a privileged or confidential conversation.

**SCOPE:** All Clinical Staff

**PROCEDURE:**

The Unit Director, upon receipt of a request for a confidential meeting with a patient who is on one-to-one observation, will assess the patient’s current status with the attending psychiatrist and treatment team.

If the clinical assessment permits change in the special observation status:

1. the Attending Psychiatrist/designee provides a Physician’s Order which temporarily changes the order from continuous observation or a more restrictive level of special observation to a modification of the current observation status to allow staff to continuously observe the patient through a window of a closed door. This modification is in effect while the patient meets with his/her attorney, legal representative, patient advocate, or clergy member and the modification is automatically terminated at the end of the meeting.
  
2. The staff member assigned to the patient observation provides the patient and visitor a room with a window which allows visual contact to continue.

3. The staff member assigned to the patient remains outside the room behind the closed door maintaining continuous observation of the patient, until the meeting is completed.

If the patient is assessed as being too *acutely* suicidal or dangerously assaultive:

1. the Attending Psychiatrist/designee will document the reason for restricting such a meeting in the progress note. (*Restriction should be extremely rare*).
2. A non-privileged conversation may still occur with the staff member remaining in the room.
3. If the patient is restricted in having confidential meetings, the Attending Psychiatrist/designee immediately notifies the designated WFH Medical Director.
4. The WFH Medical Director consults with the Attending Psychiatrist regarding the request and may evaluate the patient face-to-face in order to ascertain whether the restriction is warranted. The WFH Medical Director documents the results of his/her evaluation in the patient's progress note.

WHITING FORENSIC HOSPITAL  
OPERATIONAL PROCEDURE MANUAL

<b>SECTION I:</b>	PATIENT FOCUSED FUNCTIONS
<b>CHAPTER 1:</b>	Ethics, Rights and Responsibilities
<b>PROCEDURE 1.17:</b>	<b>Conservatorship</b>
<b>Governing Body Approval:</b>	6/4/18
<b>REVISED:</b>	

**PURPOSE:** To ensure that a patient who is incapable of caring for him/herself or managing his/his affairs is assigned a conservator. (The Connecticut General Statutes Section 17a-506; 45a-242 and 45a – 644 through 45a – 663 were referenced in this procedure and should be referred to for more information.)

**SCOPE:** All Clinical Staff

**POLICY:**

A patient who is incapable of caring for him/herself or managing his/her affairs is assisted by Whiting Forensic Hospital (WFH) staff and the Probate Court in the process of applying for a conservator. The Social Worker is responsible for maintaining current contact information for the assigned conservator of patient's in his/her care.

***Definitions:***

*Conservator of Estate:* a person, official or corporation appointed by the Probate Court when an individual is found to be incapable of managing his/her own financial affairs.

*Conservator of Person:* a person, official or corporation appointed by the Probate Court when an individual is found incapable of caring for him/herself.

*Incapable of Caring for One's Self:* when a mental, emotional or physical condition results in an individual's inability to provide medical care, nutritious meals, clothing, safe and adequately heated and ventilated shelter, personal hygiene and protection from physical abuse or harm resulting in endangerment to the individual's health.

*Incapable of Managing One's Affairs:* when a mental, emotional or physical condition prevents an individual from performing the functions required to manage his/her affairs, and the individual has property that will be wasted or dissipated unless properly managed, or an individual is unable to obtain/provide funds needed for the welfare of his/herself or those entitled to be supported by the individual.

*Involuntary Representation:* the appointment of a conservator of person, estate, or both, after a Probate Court finds the individual incapable of managing his/her affairs or incapable of caring for him/herself.

## **PROCEDURE:**

### **I. Applying for conservatorship**

- A. When the treatment teams assess that a patient does not appear to have the capacity to manage his/her own affairs and/or to care for him/herself, the process for applying for conservatorship is initiated. As part of this process, the Social Worker completes the Probate Court Form "Application for Appointment of Conservator" (PC-300). Additionally, the Attending Psychiatrist completes the Probate Court Form "Physician's Evaluation: Conservator" (PC-370). The Social Worker is responsible for ensuring that the forms are sent to the Probate Court and for sending copies to Health Information Management (HIM).
- B. When the Probate Court receives the application for involuntary representation, it sends hearing date notification to all interested parties.. The patient has the right to attend the hearing and has the right to representation by an attorney (the court may appoint an attorney).
- C. At the hearing, evidence of the patient's condition is presented, including a written report or testimony, by at least one physician who has examined the patient within the past 30 days. The court may consider other relevant available information at this time.
- D. If the court finds by "clear and convincing evidence" that the patient is incapable of managing his/her affairs, then a Conservator of Estate will be appointed by the court. If, likewise, the court finds by "clear and convincing evidence" that the patient is incapable of caring for him/herself, then a Conservator of Person will be appointed.
- E. HIM coordinates and attends the Probate Court hearings at WFH. It is the responsibility of the HIM employee to follow through with obtaining a copy of the official Court decree for inclusion in the Medical Record. It is the responsibility of each Social Worker to know which of his/her assigned patients are conserved, to

retain contact information for that conservator, and to note this information on the inside cover of the conserved patient's medical record (HIM Policy 21) with affixed sticker.

*Note:* Regardless of whether a patient is conserved or not, he/she maintains the right to refuse psychotropic medications. If administration of psychotropic medications is indicated, the patient may be involuntarily medicated per *Operational Procedure 3.1 Emergency and Involuntary Medication*. Such action requires Probate Court intervention by appointment of a conservator with the unique right of decision over administration of psychotropic medications to the patient.

## II. Duties of Conservators

A. Duties of Conservators of Estate: The Conservator manages the estate and acts to support the conserved with all financial matters..

B. Duties of Conservators of Person:

1. The conservator is responsible for the general custody and belongings of the patient, including the power to consent for medical or other care and treatment;
  2. At least annually, the conservator is to report to the appointing Probate Court as to the condition of the conserved; and
  3. The Conservator of Person does not have the power to commit the individual "to any institution for the treatment of the mentally ill..." (Refer to CGS 45a – 656 for references for exceptions to this statement.)
- C. Given the duties of Conservators, it is essential for him/her/them to be as involved in the care of the patient as possible. Any document requiring the signature of the patient and any procedure requiring the informed consent of the patient must involve the Conservator. Documented involvement and/or documented attempts to invite, involve and inform the Conservator should be found in the patient's medical record. When the signature of the conservator is required, attempts to obtain the signature are to be noted either in the progress note entries of the Social Worker relevant to the patient's treatment plan or on copy of the unsigned Authorization form (placed in the appropriate section of the medical record) on which the attempt is noted.

### III. Review of Conservatorship

- A. The Probate Court will review all of conservatorship appointments one year following appointment, then *at least every three years*. At that time the Presiding Judge will either: continue, modify, or terminate the order for conservatorship.
- B. To conduct this process, the Court reviews written evidence on the condition of the patient. In response to the court's request, the conservator, the patient's attorney (one may be appointed by the court), and a physician must each submit a written report to the Court within 45 days of notice of the review. The physician must examine the patient within 45 days of submission of the report to the Court.
- C. Based on the written reports, if the court determines that no change is indicated, a hearing does not have to occur. If the attorney, physician, or conservator requests a hearing, however, one will be scheduled.

### IV. Replacement of Fiduciary and Appointment of Successor Fiduciary

If the conservator fails to fulfill his/her duties, the Probate Court with jurisdiction may remove him/her upon the application and complaint of any interested party. The Probate Court may then appoint a suitable person to fill the vacancy. When a conservator fails to respond to the efforts of the treatment team, the treatment team will document these failures in the medical record and will continue to operate on behalf of the best interests of the patient.

### V. Admission or Transfer to WFH of a Conserved Patient

- A. The Social Worker assigned an admission or transfer of a new patient contacts the Probate Court from which the appointment of the conservator originated to verify the conservatorship decree and to request, as appropriate, for the file of the conserved person. Once received, this document is then copied, certified, and sent to the Middletown Probate Court. With these documents in hand, the Middletown Probate Court will then take over jurisdictional oversight of the conserved person. If the Probate Court originating the decree is unknown, the Social Worker contacts the Office of the Probate Court Administration, West Hartford, Connecticut. The status of the patient is forwarded to HIM.
- B. If a conserved patient requests and is granted voluntary admission to WFH, the Hospital will notify the conservator and the Probate Court which appointed the conservator within five (5) business days. Within ten (10) business days of

notification, the Probate Court will appoint a psychiatrist from a panel provided by the Commissioner of DMHAS to examine the patient within ten (10) business days of his/her appointment, to determine whether the patient gave informed consent to his/her hospitalization. The psychiatrist reports his/her findings to the court. The court will then act based on its conclusions.

## VI. Termination of Conservatorship

- A. The Court may terminate the Conservatorship of Person if it finds the person capable of caring for him/herself. Likewise, the Court may terminate a Conservatorship of Estate if it finds the person capable of managing his/her own affairs.
  
- B. The patient, his/her Psychiatrist, or conservator may petition the Probate Court for removal of conservatorship status. As appropriate the Judge will schedule a hearing in Probate Court to determine if the patient is capable of caring for him/herself and/or is capable of managing his/her own affairs.

WHITING FORENSIC HOSPITAL  
OPERATIONAL PROCEDURE MANUAL

<b>SECTION I:</b>	PATIENT FOCUSED FUNCTIONS
<b>CHAPTER 1:</b>	Ethics, Rights and Responsibilities
<b>PROCEDURE 1.18:</b>	<b>Patient Communication and Restriction of Communication</b>
<b>Governing Body Approval:</b>	6/4/18, 4/27/22
<b>REVISED:</b>	4/22/22

**PURPOSE:** To allow patient communication by mail, telephone, fax and with visitors to the greatest extent possible without interfering with treatment, creating security risks, infringing on individual rights, or causing harm to the patient or others. Connecticut General Statutes, Sections 17a-546 and 17a-547 govern this procedure.

**SCOPE:** All clinical staff and nursing staff

**PROCEDURE:**

I. Communication via Mail (mail includes items in envelopes or packages sent and delivered by the United States Postal Service and private carriers)

A. Outgoing mail

1. Patients are allowed to send mail.
2. When requested, patients will be provided writing materials. Postage for regular first class mail is provided. Costs beyond regular first class postage may be the responsibility of the patient. The cost of mailing packages is the responsibility of the patient and is typically handled through Patients' Accounts.

Note: Any incoming/outgoing package is subject to search for security purposes.

B. Incoming Mail

1. Patients have the right to receive sealed mail.
2. Staff may request, and require, that mail received by patients be opened in their presence to check for prohibited or restricted items, however, staff are not to read patient mail without permission.

### C. Restrictions on outgoing/incoming mail

1. Restrictions to outgoing mail are implemented in response to a complaint of threatening or harassing mail being received and/or the existence of a restraining or other official court order restricting communication.
2. Restrictions to outgoing or incoming mail may be implemented if:
  - a. the patient's treatment is being compromised by sending/receiving mail;
  - b. sending/receiving mail is judged to be medically harmful to the patient;
  - c. the patient requests not to receive mail from an identified party; or
  - d. an extraordinary volume of mail is being sent.
3. If patient mail needs to be restricted on an emergency basis the doctor imposing the restriction will write a medical order describing the limitation, and a progress note describing the circumstances that prompted the emergency restriction. The restriction will be reviewed by the treatment team on the next business day. Whenever restrictions are placed on the patient's mail the treatment team meets with the patient to discuss these restrictions and the reason(s) why. The patient will be provided a reasonable opportunity to discuss the restriction.
4. This treatment team meeting is documented in the medical record. Whenever restrictions on mail are instituted, the Restriction of Communication form (WFH-596) is completed and reviewed with the patient by the WFH Chief Medical Officer (CMO)/designee. The form is filed in the Legal Section of the medical record and a copy is provided to the patient.

*Note: If the restriction on mail is in response to a concern that the mail is medically harmful to the patient, a copy of the Restriction of Communication form is sent to the patient's family and any known relevant parties who send mail to, or receive mail from the patient. The patient's written consent is required.*

5. Restrictions on mail are to be reviewed monthly and as part of each treatment plan/review. The Attending Psychiatrist/designated team member is to document this review and its continued justification or reason for discontinuation.
6. For patients under a restraining or other official court order restricting communication, the expiration date established by the court will be honored by the WFH .

## II. Communication via phone (including internal hospital phones, and pay phones)

### A. Outgoing calls

1. Patients are permitted to make phone calls.
2. Patients are provided access to telephones.

3. If the patient has phone restrictions (See Section C below) the staff may request to speak with the recipient of the phone call to verify his/her identity.

#### B. Incoming phone calls

1. Patients have the right to receive incoming phone calls.
2. If the patient has phone restrictions (See Section C below) the staff may request to speak with the caller for the purpose of identifying the caller.

#### C. Restrictions on outgoing/incoming phone calls

1. Restrictions on patients making telephone calls may be implemented when it is determined that a patients use of the phone has become obscene, harassing, or threatening calls and/or there is a restraining or other official court order restricting communication.
2. Restrictions to phone calls may be implemented if making/receiving phone calls are judged to be medically harmful to the patient.
3. If patient phone use needs to be restricted on an emergency basis the doctor imposing the restriction will write a medical order describing the limitation, and a progress note describing the circumstances that prompted the emergency restriction. The restriction will be reviewed by the treatment team on the next business day. Whenever restrictions are placed on the patient's telephone calls the treatment team meets with the patient to discuss these restrictions and the reason(s) why. The patient will be provided a reasonable opportunity to discuss the restriction.
4. This treatment team meeting is documented in the medical record. Whenever restrictions on phone use are instituted, the Restriction of Communication form (WFH-596) is completed and reviewed with the patient by the WFS CMO/designee. The form is filed in the Legal Section of the medical record and a copy is provided to the patient.

*Note: if the restriction on phone calls is in response to a concern that the phone calls are medically harmful to the patient, a copy of the Restriction of Communication form is sent to the patient's family and any known relevant parties who make calls to, or receive calls from, the patient. The patient's consent is required.*

5. Restrictions on phone calls are to be reviewed monthly as part of each treatment plan/review meeting. The Attending Psychiatrist/designated team member documents this review and its continued justification or reason for discontinuation.
6. For patients under a restraining or other official court order restricting communication, the expiration date established by the court will be honored by WFH staff.

7. See Procedure 2.48 Use of Hospital Cell Phones (for patient use)

### III. Communication by fax:

Patients may request that material be faxed by a member of the clinical team or advocacy. Approval is at the discretion of the staff member of whom the request was made, taking into consideration the reason for and frequency of the patient's requests. If restrictions to faxing are necessary, this will be documented in the patient chart, including the rationale.

Staff are not required to read the material however if there is concern as to the recipient or nature of the material to be faxed, the staff member will review with the clinical team prior to proceeding.

The patient must complete the fax cover sheet available for patient use, which includes acknowledgement that material (which may include PHI) is being faxed at patient's request and with their approval. The faxing staff should ensure the cover sheet does not identify the patient as residing in WFH.

Upon completion of the fax, the staff member will staple the fax confirmation to the patient cover sheet and have filed in the patient's chart in the "Miscellaneous" section. The material faxed will be returned to the patient.

### IV. Restrictions on visitors to WFH

- A. Restrictions to visits are implemented in response to the existence of a restraining or other official court order restricting visits.
- B. Restricting visits may be considered if:
  - 1. receiving visitors is judged to be harmful to the patient;
  - 2. visitors are suspected of being under the influence of alcohol and/or drugs;
  - 3. visitors create a disturbance or annoyance;
  - 4. visitors engage in offensive behavior;
  - 5. visitors disrupt the therapeutic milieu.
- C. Based on the circumstances of the situation, it may be appropriate for staff to contact DMHAS WFH Police and have the visitor(s) escorted from the premises. Consultation with supervisory staff is indicated under such circumstances. If a patient's visitation needs to be restricted on an emergency basis the doctor imposing the restriction will write a medical order describing the limitation, and a progress note describing the circumstances that prompted the emergency restriction. The restriction will be reviewed by the treatment team on the next business day. Whenever restrictions are placed on the patient's visitation the treatment team meets with the patient to discuss these restrictions and the reason(s) why. The patient will be provided a reasonable opportunity to discuss the restriction.

- D. The treatment team meets with the patient to discuss any restrictions to the patient's visits as part of a treatment planning process.
- E. This treatment team meeting is documented in the medical record. Whenever restriction on visitors is instituted, the Restriction of Communication form (WFH-596) is completed and reviewed with the patient by the WFH CMO/ designee. The form is filed in the medical record and a copy is provided to the patient.

*Note: If the restriction on visits is in response to a concern that the visits are medically harmful to the patient, a copy of the Restriction of Communication form is sent to the patient's family and any relevant parties who had been visiting the patient. The patient's written consent is required.*

- F. Restrictions on visits are to be medically reviewed monthly and as part of each treatment plan/review meeting. The Attending Psychiatrist/designated team member is to document this review and its continued justification or reason for discontinuation.
- G. For patients under a restraining or other official court order restricting communication, the expiration date established by the court will be honored by WFH staff.

WHITING FORENSIC HOSPITAL  
OPERATIONAL PROCEDURE MANUAL

<b>SECTION I:</b>	PATIENT FOCUSED FUNCTIONS
<b>CHAPTER 1:</b>	Ethics, Rights and Responsibilities
<b>PROCEDURE 1.19:</b>	<b>Patient-to-Patient Sexual Harassment</b>
<b>Governing Body Approval:</b>	6/4/18
<b>REVISED:</b>	

**PURPOSE:** Sexual harassment is a form of discrimination and abuse of power. All patients have the right to live in an environment free from all forms of discrimination and where it is safe to report incidents of sexual harassment.

**SCOPE:** Clinical Staff and Patients

**Definition:** Sexual harassment is defined as:

- a. Any unwanted and unwelcome sexual advances, requests for sexual favors, and other unwanted verbal, visual, or physical conduct of a sexual nature; or
- b. Deliberate or repeated offensive comments, gestures, or physical contact of a sexual nature; or
- c. Sexually oriented conduct that is offensive or objectionable to the recipient.

**Prevention:**

Creation of an environment in which sexual harassment is recognized, not tolerated, and is reported and corrected will help prevent occurrences of sexual harassment. Retaliation against anyone who brings a complaint of sexual harassment or speaks as a witness in the investigation is not permitted and will not be tolerated.

Sexual harassment may occur as a spectrum of behaviors, and it is important to recognize that there are individual differences reflecting personal and cultural variations about acceptable expressions of sexuality. Additionally in a patient population, there are variations in the ability to consent to requests. Even when sexual contact is consensual, if a patient is not competent, the behavior may nonetheless meet the standard for harassment. Furthermore it is important to recognize that we have treatment responsibilities to both victims and offenders.

**PROCEDURE:**

1. Any patient who is the recipient of unwanted sexual advances of any nature should report the behavior to a member of the treatment team, the Unit Director, the Attending Psychiatrist, or administrative staff. If the victim prefers, he/she may report harassment to the patient rights officer.
2. The complaint should then be immediately reported to the Unit Director and documented in the complaining patient's chart. All allegations of sexual harassment will be taken seriously.
3. The Unit Director will promptly investigate and intervene where indicated to facilitate resolution of the concerns so that people are living in a safe environment without fear of retaliation. If the complaint is not substantiated, the Unit Director will make appropriate notations in the patient's chart documenting the steps taken and the outcome of the investigation.
4. If the complaint is substantiated, the Unit Director will complete an Incident Report for the victim and offender and will report the incident to administrative supervisors and the Attending Psychiatrist. The hospital CEO will review and address any Incident Report involving patient to patient sexual harassment. The confidentiality and treatment concerns of both the complaining patient and the offender must be respected. The specific interventions would depend upon and relate to the clinical situation. Interventions might include, but not be limited to, counseling the victim, counseling the offender, assertiveness training and personal empowerment for the victim, education about appropriate behavior for the offender and responses to inappropriate behavior for the victim, strategies for coping, separating the patients while on the unit, and possibly changing units.
5. If a staff member observes behaviors that he/she has concerns about being possible sexual harassment, the staff member will discuss the situation with the possible victim. If any concern remains, the staff member will discuss the issue with the Unit Director. The Unit Director will investigate as appropriate.
6. Once the investigation is completed and interventions instituted, the complainant will be informed of the outcome. If he/she is unsatisfied, he/she may contact the patient rights officer to initiate a grievance or other action.

WHITING FORENSIC HOSPITAL

OPERATIONAL PROCEDURE MANUAL

<b>SECTION I:</b>	PATIENT FOCUSED FUNCTIONS
<b>CHAPTER 1:</b>	Ethics, Rights and Responsibilities
<b>PROCEDURE 1.20:</b>	<b>Recording and Filming of Patients</b>
<b>Governing Body Approval:</b>	6/4/18
<b>REVISED:</b>	

**PURPOSE:** To clarify the circumstances in which a patient may and may not be recorded or filmed.

**SCOPE:** All Whiting Forensic Hospital (WFH) staff and all contracted staff

**POLICY:**

The hospital is committed to protecting the privacy of patients through adherence to statutory state and federal confidentiality protections.

*Definitions:*

Patient Care Areas are defined as any area where patients are present.

**PROCEDURE:**

- A. Generally, patients are not to be recorded or filmed other than for the following purposes:
  - 1. Photographs taken for identification purposes (typically done at admission);
  - 2. When patients access areas surveyed by security cameras;
  - 3. When patients attend public hearings held on the WFH or CVH campus (See *Operational Procedure 1.21 Videotaping of Public Hearings held on WFH Campus*);
  - 4. With patient consent (and after consultation with their attorney) as part of a forensic evaluation; and
  - 5. With patient consent, portraits may be taken (typically at special events) by authorized WFH staff that would then be given to the patients directly for their personal use and distribution will be conducted periodically;

6. With patient consent as part of a police investigation

- B. For situations in which recording or filming are to be conducted for external purposes (in which the public will see and/or hear them) separate specific written consent is required from each patient involved. This includes therapeutic activities with patients in which other patients are photographed. Form WFH-612 *Consent to Photograph/Videotaping* must be completed in its entirety to be valid, including the intended use of the recording or filming. The completed form is filed in the legal section of the patient's medical record.
- C. Patient's family members and visitors who wish to take photographs of the patient for personal use must check with staff so that arrangements can be made, while at the same time assuring that no other patient's confidentiality is jeopardized. Hospital staff may assist patients who request having photographs taken for their own personal use.
- D. Cell phones, cameras and other technology capable of recording or filming are not to be used in patient care areas, and are not permitted in the maximum security building.
- E. Although the use of cell phones is permissible in non-patient care areas, the use of the camera function of any electronic device is strictly prohibited on WFH grounds.

# WHITING FORENSIC HOSPITAL

## OPERATIONAL PROCEDURE MANUAL

<b>SECTION I:</b>	PATIENT FOCUSED FUNCTIONS
<b>CHAPTER 1:</b>	Ethics, Rights and Responsibilities
<b>PROCEDURE 1.21:</b>	<b>Videotaping of Public Hearings Held on WFH or CVH Campus</b>
<b>Governing Body Approval:</b>	6/4/18
<b>REVISED:</b>	

**PURPOSE:** To clarify the circumstances and rules governing videotaping of a public meeting as defined in CGS 1-225 and 1-226.

**SCOPE:** *All WFH staff, all contracted staff, any attendees at public meetings as defined in CGS 1-225 and 1-226*

**POLICY:**

The hospital is committed to adhering to the Freedom of Information Act (FOIA) while protecting the privacy of patients afforded to them through statutory state and federal confidentiality laws. The hospital will work with TV-media personnel and other individuals to ensure mutual cooperation

***Definitions:***

*Patient Care Areas* – are defined as any area where patients reside or receive treatment.

**PROCEDURE:**

Generally public meetings as defined in CGS 1-225 and 1-226 will not be held on the campus of WFH but may occur on the campus of Connecticut Valley Hospital (CVH).

Public meetings as defined in CGS 1-225 and 1-226 that take place on the WFH or CVH campus will be held in non-patient care areas.

When patients residing on the WFH campus, including patients under the jurisdiction of the Psychiatric Security Review Board (PSRB) attend public meetings as defined in CGS 1-225 and 1-226, and it has been

determined that the meeting will be videotaped, the patient will be informed of their right to refuse to attend the meeting.

TV-Media outlets and other individuals who wish to videotape a public meeting as defined in CGS 1-225 and 1-226 are encouraged to adhere to the following guidelines to balance statutory state and federal confidentiality protections for the individuals served by the hospital with the Connecticut FOIA.

TV-Media outlets and other individuals who wish to videotape a public meeting as defined in CGS 1-225 and 1-226 may contact the CEO of WFH seventy-two (72) hours prior to the scheduled meeting to inform him/her of the intent to film the public meeting. This will allow time for the hospital to give adequate notice to patients so that they can decide on whether they wish to waive their right to attend the meeting. For PSRB hearings held in Page Hall, this media contact may be made to the CEO of CVH, who will notify the CEO of WFH.

Although failure to give notice does not forfeit TV-Media's or any other individuals right to tape a public meeting as defined in CGS 1-225 and 1-226, the hospital is committed to meeting state and federal confidentiality mandates and will work with TV-Media outlets and other individuals in an effort to gain their cooperation.

TV-Media outlets and other individuals who wish to videotape a public meeting as defined in CGS 1-225 and 1-226 shall report to Shew Hall on the hospital campus on the day of the scheduled meeting and make contact with the DMHAS Police-WFH Unit. Videotaping shall be restricted solely to the permissible portions of the public meeting.

TV-Media outlets and other individuals who wish to videotape a public meeting as defined in CGS 1-225 and 1-226 shall not turn on any camera or other recording equipment until they are within the assigned meeting room and the public meeting has been called to order.

TV-Media outlets and other individuals who wish to videotape public meetings as defined in CGS 1-225 and 1-226 shall not be permitted to film the interior or exterior of the building in which the meeting is being held.

The DMHAS Police Officers shall monitor all TV-Media outlets and other individuals who wish to videotape public meetings as to the use of their cameras so that the confidentiality of DMHAS patients and patient care areas are protected in accordance with state and federal law.

## WHITING FORENSIC HOSPITAL OPERATIONAL PROCEDURE MANUAL

<b>SECTION I:</b>	PATIENT FOCUSED FUNCTIONS
<b>CHAPTER 1:</b>	Ethics, Rights and Responsibilities
<b>PROCEDURE: 1.22</b>	<b>Registration of Sexual Offenders</b>
<b>Governing Body Approval:</b>	7/10/19
<b>New:</b>	7/3/19

**PURPOSE:** To define the procedure used by Whiting Forensic Hospital (WFH) staff for registering patients who have been committed to the Psychiatric Security Review Board (PSRB) with the Connecticut Sex Offender Registry.

**SCOPE:** Hospital-wide

**POLICY:** Whiting Forensic Hospital will comply with state statutes related to registration of sexual offenders.

All relevant WFH PSRB acquittees must register with the Department of Emergency Services and Public Protection (DESPP) Sex Offender Registry *before* they can be placed on Overnight Temporary Leave and/or discharged from WFH to Conditional Release in the community.

In accordance with C.G.S. Section 54-256, the responsibility for registering PSRB acquittees lies with the PSRB. In practice, however, when PSRB acquittees are in the hospital, the hospital and the acquittee's treatment team fulfill these responsibilities as described below.

### Introduction

**Sex Offender Registration:** In accordance with C.G.S. Sections 54-250 through 54-261, certain persons are required to register with the Connecticut Sex Offender Registry. These persons are:

- (a) any person who has been convicted or found Not Guilty by Reason of Mental Disease or Defect of a nonviolent criminal offense against a minor, and is released into the community on or after October 1, 1998;
- (b) any person who has been convicted or found Not Guilty by Reason of Mental Disease or Defect of a nonviolent criminal sexual offense, and is released into the community on or after October 1, 1998; or
- (c) any person who has been convicted or found Not Guilty by Reason of Mental Disease or Defect of a sexually violent criminal offense, and is released into the community on or after October 1, 1988.

C.G.S. Section 54-250 (10)(C) states, in relevant part, that acquittees must register prior to “temporary leave to an approved residence by the Psychiatric Security Review Board pursuant to section 17a-587, conditional release from a hospital for mental illness or a facility for persons with intellectual disability by the Psychiatric Security Review Board pursuant to section 17a-588, or release upon termination of commitment to the Psychiatric Security Review Board.”

For sexually violent offenses, individuals must register for life. For persons who have committed a criminal offense against a victim who is a minor or a nonviolent sexual offense, registration shall be for 10 years, except that any person who has one or more prior convictions of any such offense or who is convicted of a violation of subdivision (2) of subsection (a) of C.G.S. Section 53a-70 shall maintain such registration for life.

## **PROCEDURE**

The acquittee’s treatment team is responsible for educating acquittees about the Sex Offender registration requirements and in assisting with the registration process. If the treatment team is unsure whether a PSRB acquittee falls under the jurisdiction of Connecticut’s sex offender registration statutes, the social worker should contact the Chief of Forensic Services, who, if necessary, will check with the Executive Director of the PSRB and/or Department of Emergency Services and Public Protection (DESPP). In addition, prior to discharge or overnight Temporary Leaves, the treatment team is responsible for transporting the patient/acquittee to the DESPP for registration.

### **Educating Acquittees**

The treatment team is to ensure that the patient/acquittee is aware that the above laws apply to him/her and that the he/she understands his or her responsibilities prior to beginning *overnight* Temporary Leaves and/or prior to being discharged from the hospital on Conditional Release.

In particular, as the acquittee approaches beginning Temporary Leaves or Conditional Release from the hospital, the unit social worker will meet with and educate the acquittee of the specific requirements of Sex Offender registration as the patient progresses in the process of transition to the community. The requirements for persons required to register as Sex Offenders include the following:

- (a) Completing the registration process before beginning *overnight* Temporary Leaves, Conditional Release (CR), or discharge.
- (b) Signing the Sex Offender Advisement of Registration Requirements form before beginning overnight Temporary Leaves, Conditional Release.
- (c) Once in the community on overnight Temporary Leave or Conditional Release, completing a change of address form and submitting it to the Department of Emergency Services and Public Protection within five (5) business days of any change in the acquittee’s address.

- (d) Complying with the DESPP's address verification procedure that involves signing and returning to the DESPP an address verification card/form verifying one's current, correct address. When the acquittee is living in the community, this address verification procedure will be required every ninety (90) days. Failure to verify one's address can result in the issuance of an arrest warrant.
- (e) At least once every five (5) years, having a new digital photograph of him/herself taken by the DESPP.

The treatment team must ensure that the acquittee understands that in the future he/she still must register even if his or her commitment to the PSRB expires or if he/she obtains an early discharge from the jurisdiction of the PSRB by the Superior Court.

### **Assisting with the Registration Process**

In addition to educating acquittees, treatment teams are responsible for taking acquittees to the DESPP office to register.

Approximately **two weeks** prior to the person's release (i.e., beginning overnight TLs or being discharged on CR), the unit Social Worker or other designated treatment team staff will call the DESPP Sexual Offender Registry Unit at 860-685-8060 to arrange a time (usually between 9:00 a.m. and 3:00 p.m.) to bring the patient to register in person. The Social Worker or nursing staff will escort the patient/acquittee to the DESPP offices at 111 Colony Road in Middletown.

Note that for PSRB acquittees, before taking the acquittee to register, escorting staff must obtain the date that the acquittee provided a DNA sample in accordance with C.G.S. Section 54-102g, as this information will be required when the acquittee registers. (This date can be found on the WFH computer network "T: drive" in the "PSRB\_Data" folder > "DNA Data" sub- folder.) DESPP will also need to know the exact date that the acquittee will be beginning overnight TLs or will be discharged on Conditional Release. When at the DESPP offices, the patient will register, which includes being fingerprinted, having a photograph taken and completing other required paperwork. The registration process will take about 30 to 45 minutes.

### **Readmission to the Hospital from Temporary Leave or Conditional Release**

In the event that an acquittee who is on the Connecticut Sex Offender Registry is returned to the hospital from overnight Temporary Leave or Conditional Release, the PSRB must be notified so that the Executive Director can take necessary steps to inform DESPP of the acquittee's change of address. The unit Social Worker or designee shall call the PSRB **within two business days** to inform the Board of the patient's readmission and document the call in the medical chart.

Once notified by the hospital, the Executive Director of the PSRB shall email a letter to DESPP (copied to the WFH Chief of Forensic Services, Social Work Supervising Clinician, and unit social worker) informing them of the acquittee's hospital admission. The social worker or designee will ensure that a copy of the Board's letter is placed in the patient's medical chart. DESPP will then place the acquittee in an "inactive" status with the Sex Offender Registry until

he/she is once again released from the hospital on overnight Temporary Leave, Conditional Release, or Discharge. The patient will not be required to verify his/her address with the Sex Offender Registry while on inactive status.

At least *one business day* before the patient resumes his/her Temporary Leave, Conditional Release, or Discharge status, the unit social worker shall call the PSRB to notify them of the patient's anticipated date of release from the hospital and new address in the community (if applicable). The unit social worker shall document this call in the patient's medical chart. The PSRB Executive Director shall then email a letter to DESPP (copied to the WFH Chief of Forensic Services, Social Work Supervising Clinician, and unit social worker) informing them of the patient's release and new address. The social worker or designee will ensure that a copy of the Board's letter is placed in the patient's medical chart. The patient will then be placed on "active" status with the Sex Offender Registry and be required to comply with the conditions delineated in *Educating Acquittees* section above.

### **Individuals Who Refuse to Register**

When a treatment team learns that a patient is required to register as a sex offender but refuses to do so, the case should be referred for discussion at the hospital's Forensic Review Committee (FRC). The social worker or designee will request that the issue be added to the FRC agenda, and the attending psychiatrist or designee will give a brief presentation of the relevant history during the FRC meeting at which the patient's case is discussed and course of action identified.