

**WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL**

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 5:	Improving Organizational Performance
PROCEDURE 5.4:	Transportation and Assessment of Risk
REVISED:	March 5, 2020, February 2, 2021, March 25, 2024
Governing Body Approval:	March 9, 2020, February 8, 2021, March 27, 2024
Effective Date:	April 5, 2024

PURPOSE: To establish a process of risk assessment and safe transport of patients by WFH staff for on hospital grounds and off hospital grounds transports, including medical-surgical hospital posts.

POLICY: Patients will be provided transportation for the purpose of court appearances (except when transported by Judicial Marshals), medical appointments, recreational activities and temporary leave or temporary visit. All patients have a right to expect a timely and seamless process for transportation on and off hospital grounds. Patients will not be transported on or off grounds in restraints except for purposes outlined in Connecticut General Statute 46a-152.

SCOPE: All WFH Service staff, DMHAS Agency Police

PROCEDURE:

This procedure outlines time frames, risk consideration factors, responsibility for approval and level of supervision during transport.

I. Frequency of Completion:

The Attending Psychiatrist completes the form *Risk Assessment for Transportation Form* (WFH-473) for each patient in the hospital at the following timeframes:

1. Time of the first Interdisciplinary Treatment Plan;
2. Within 48 business hours of a scheduled transport and repeated if clinical or legal status changes within this period for all Whiting patients (for Dutcher, based on levels noted below);
3. For emergency transports and;
4. For the purpose of establishing outside hospital posts.

Whiting Service, D2S and Dutcher Patients Level 2 or below (on and off grounds)

II. Implementation:

1. The Attending Psychiatrist completes the form Risk Assessment for Transportation Form (WFH-473) within 48 business hours of a scheduled transport and obtains necessary approval signatures.
2. Any transport, on or off grounds, requiring the WFH-473, will have a physician's order in the medical record.
3. A DMHAS Agency Police Officer assigned to the WFH co-signs the form (WFH-473) prior to all police escorted trips.
4. All assignments of transportation level are based on an individualized risk assessment by the attending physician with input provided by members of the clinical team and other staff regarding the patient's current clinical status. This assessment will be guided by a weighing of risk and protective factors known to be associated with violence and elopement.
5. The final transport level is documented on WFH-473 and signed off by the CMO or Service Medical Director after review in the morning risk management meeting. The form is then returned to the unit to be filed in the assessment section of the medical record. The document with original signatures must remain in the chart.
6. If the final transport level approved differs from that recommended by the clinical team, the CMO or Service Medical Director will discuss further with the team, including the rationale for the change.
7. In the event that a patient is admitted in the evening and needs to be transported that evening, during a weekend or for an emergency transport at any time of day when the CMO or Service Medical Director is not readily available, the Night-Duty

Physician or Physician on Duty (i.e. MOD) will complete the WFH-473 and review with the CMO, indicating verbal approval by the CMO on the form.

8. On the date of transport, the assigned transporter will complete the WFH-473A (patient's clothing and transport information) and will review/sign acknowledgment of patient's risk factors. The transporter will obtain the Nurse Supervisor's signature immediately prior to leaving and upon return. The completed WFH-473A will be filed in the Nurse Supervisor's office upon return to the facility.
9. Patients should be notified of their designated risk assessment level, unless clinically contradicted.

Whiting Max Group Trips for Activities on WFH/CVH grounds:

The risk for escape/elopement is greater for forensic patients of Whiting Max who are leaving as a group, being escorted by Hospital Staff only. This group setting risk must be factored into the individualized transport risk assessment (WFH-473) and documented under "Group Setting" for each patient in the group. Therefore, each time a Whiting Max patient is scheduled to attend activities on WFH/CVH grounds, the Whiting Service Medical Director (or CMO in their absence), will assess whether the patient may transport with 2 or more other patients. When the group setting causes the overall risk to be significantly elevated, the hospital should reduce the number of patients in the group or have the patients leave one at a time.

III. Level of Escort:

1. The number of staff to accompany a patient will be determined by the Attending Psychiatrist with input from the treatment team, and will be noted on the WFH-473.
2. Staff will maintain unobstructed line of sight supervision of patients at all times while under the custody of WFH staff.
3. Patient Use of Bathroom: When a patient of the opposite gender to staff is using the restroom, staff must ensure no egress exists within the bathroom and staff must remain immediately outside of the door. Depending on risk factors, staff may need to clear the bathroom prior to patient use or same gender staff may be

assigned to transport to accompany the patient into bathroom. If the physician specifically orders “line of sight” supervision in a bathroom or other area, it is understood that the patient will be accompanied by staff member(s) into those areas.

Dutcher Service: Patients on Level 3A or higher (off grounds):

I. Implementation:

1. A Risk Assessment for Transportation Form (WFH-473) is not required based on the clinical assessment resulting in patient obtaining a Level 3A or higher.
2. The Transportation Sheet for TV/TL (WFH-627A) or Community Activity (WFH-627) is completed by the RN, Unit Director, Rehab or Social Worker. A physician’s order is not required for any transportation for which a WFH-627 or WFH-627A form has been completed and signed by all appropriate parties. A physician’s order is required for transportation to the community for which one of these two forms is not completed (e.g. medical appointment, court, etc.). In order for a patient to engage in a TL/TV, s/he must have a level 4.
3. The Attending Psychiatrist writes a standing order for the TL/TV, which is renewed monthly. Patients scheduled for TL/TV are assessed by a psychiatrist within 48 hours of scheduled pass. Patients are assessed by the RN within 8 hours of scheduled pass. If any concerns arise after the RN assessment and up to the departure time, the RN has the discretion to hold the TL/TV until the patient is assessed by the Attending /On Call Physician. The RN will assess the patient upon return from TL/TV.
4. On the date of transport, the assigned transporter will complete side 2 of the WFH-627 or 627A (patient’s clothing) and will review/initial acknowledgment of patient’s risk factors, MOD stipulations, etc. The transporter will obtain Nurse Supervisor/Lead Transporter/Unit Director signature immediately prior to leaving and upon return. The WFH-627 or 627A will be filed in the Nurse Supervisor’s office upon return to the facility.
5. Staff will maintain unobstructed line of sight supervision of patients at all times while under the custody of WFH staff.

6. Patient Use of Bathroom: When a patient of the opposite gender to staff is using the restroom, staff must ensure no egress exists within the bathroom and staff must remain immediately outside of the door. Depending on risk factors, staff may need to clear the bathroom prior to patient use or same gender staff may be assigned to transport to accompany the patient into bathroom. If the physician specifically orders “line of sight” supervision in a bathroom or other area, it is understood that the patient will be accompanied by staff member(s) into those areas.

Dutcher Service (pertains to D2S Level 3 patients only): On-Grounds Treatment Activities (including court and medical)

1. Implementation:

1. Patients will be escorted to on-grounds activities in accordance with privilege level and required supervision.
2. Staff will complete the On-Grounds Treatment Activity form, WFH-466 for all patients, regardless of level. The original copy of the WFH-466 will be placed in the unit log book and copies will be provided to Whiting Agency Police in the Dutcher substation and to the Nurse Supervisor’s Office.

In addition to the On-Grounds Treatment Activity form WFH-466, a Risk Assessment for Transportation Form (WFH-473/WFH-473A) will be completed for patients Level 2 or below (if both the WFH-466 and WFH-473 are completed, the Patient Clothing Description need only be completed on one form).

3. Patients are assessed by the RN within 8 hours of a scheduled activity. If any concerns arise after the RN assessment and up to the departure time, the RN has the discretion to hold the patient back until the patient is assessed by the Attending /On Call Physician. The RN will assess the patient upon return from the activity.
4. Escorting staff will ensure the patient signs out in the unit log and staff will initial. Escorting staff will supervise patients in accordance with level of privilege and supervision, or as ordered by the Attending Psychiatrist. On return to the unit, the escorting staff will ensure patient signs in the unit log and staff will initial.

5. Staff will document the activity, destination, time/duration of the activity, patient's response and behavior in the medical record.

Custody and Supervision of Dutcher Patients:

Dutcher Service patients/acquittees under the jurisdiction of the Psychiatric Security Review Board (PSRB), those civilly committed or those under voluntary status are considered in hospital custody while being transported by WFH staff.

Patients' status does not change to "on temporary leave" until their custody and supervision is handed off per their MOD stipulations. Hand off may occur prior to scheduled time of appointment only as previously agreed upon with provider and noted on the Transportation Sheet (WFH-627A). Staff retains supervision responsibility of the patient until that time (see transfer of custody below).

For patients civilly committed or those under voluntary status, their status does not change to "on temporary visit" until their custody and supervision is handed off to the person responsible for them during the scheduled visit.

To ensure their proper custody and supervision, patients are to be taken directly to their community programs or visit, without any stops or side trips (except as permitted below).

In Transit Stops or Activities:

There may be times during the transport of patients on temporary leave (TL) or temporary visit (TV) destination that a stop may be made for another purpose such as buying lunch or other item for the patient. If this activity is not part of an acquittee's TL as stated in the PSRB's Order of Temporary Leave Conditions, such an activity may occur if and only if this specific activity has been planned and approved via the Transportation Sheet (WFH-627A). This must be reviewed and approved at the weekly risk management (privilege level) meeting by the Consulting Forensic Psychiatrist (CFP), approved and signed by the Dutcher Service Program Manager (in their absence the COO), reviewed by the Forensic Review Committee and approved and signed by the CEO.

Level of Escort:

It is often the case that several patients are transported to the same or different community providers on one trip. In such cases, PSRB patients on TL and civil/voluntary patients on TV may be transported by staff at a ratio no greater than five patients with one staff member. This ratio includes the driver of the vehicle, unless this ratio is contraindicated for clinical or risk management reasons. In such cases, additional staffing will be assigned.

Other than for the acquittee(s) getting off to go to his/her TL agency/program, all PSRB patients must remain in the vehicle at all times with at least one staff member supervising. Even if accompanied by staff, PSRB patients may not leave the vehicle to go into a store, restaurant, other establishment, or to engage in any other activity unless it is part of the acquittee's approved TL or it has been reviewed and approved in advance as described above. During such stops, all other PSRB patients are to remain in the vehicle with at least one staff member supervising at all times.

Transfer of Custody to Community Service Providers:

Regardless of the level of supervision authorized by the PSRB for patients using his/her TL, the treatment team must discuss and develop with the community service providers procedures for the arrival of PSRB patients and the transfer of custody/supervision from WFH staff to the community agency staff, via the MOD process.

It must be discussed and a clear procedure agreed upon for whether direct transfer of custody between WFH and the community provider is required. Discussion should also include where the patients will be taken, what specific community staff will acknowledge the patient's arrival, whether there is a specific sign-in and sign-out procedure, etc. In addition, the MOD must stipulate if the patient may be dropped off prior to the scheduled time of appointment. The transfer of custody requirements will be included in the MOD and noted on the Transportation Sheet (WFH-627A).

For voluntary or civilly committed patients, a risk assessment will be conducted by the treatment team; transfer of custody and drop off procedures will be identified and indicated on the Transportation Sheet (WFH-627A), with attending psychiatrist's approval.

For those patients not requiring direct transfer of custody from WFH staff to community staff, the WFH transporter will call the community provider to notify that the patient has left WFH supervision and is entering the community provider building.

When transporting multiple patients, WFH staff must maintain supervision of all patients, at all times, unless stipulated in their MODs or custody is otherwise transferred to a community provider.

Whiting and Dutcher Hospital Posts:

Regardless of legal status, WFH staff remains with the patient when taken to other hospitals through the time of return to WFH, unless or until the patient is admitted to the outside hospital facility. The determination as to whether the staff remains with the patient during the in-patient stay is then made by WFH staff, including the Unit Director, Program Manager and Attending Physician.

Refer to *Operational Procedure 2.13 Outpatient and Emergency Visits to Acute Care Hospitals, Staff Expectations and Responsibilities* for further clarification.

Whiting and Dutcher Staff Expectations:

1. Transporters must adhere to the departure and return times, as approved on the Transportation Sheet for TL/TV (WFH- 627A), Community Activity form (WFH-627) or Risk Assessment for Transportation Form (WFH-473). Any unforeseen situation that may prevent adherence with return time must be immediately reported to the Nurse Supervisor/Lead Transporter.
2. Transporters may only go to locations as approved on the WFH 627, WFH 627A or WFH-473. Should a patient on transport need to use a bathroom before reaching an

- approved destination, the transporter should contact the Lead Transporter/Nurse Supervisor to seek direction.
3. Transporters are responsible for patient safety while transporting, including buckling patient's seat belt if patient is unable.
 4. In the course of transporting duties; staff are to either remain onsite for duration of patient appointment, transport additional patient(s), or return to the facility, according to assigned escort/supervision level. If no additional transports are scheduled, the decision to remain on site or return to the facility will depend on the pick- up schedule, distance from the facility and other factors. The assigned transporter should confirm with the Lead Transporter or Nurse Supervisor prior to leaving facility as to which course of action to take based on the transportation schedule for the day.
 5. At no time should the transporter conduct personal business on state time or use the state vehicle for personal use (see General Letter 115).
 6. Transporters will report to their assigned units, notifying the head nurse, during times of no scheduled transports. Transporters will fulfill FTS responsibilities when not functioning in the role of transporter.
 7. Dutcher staff must carry a state issued cell phone when facilitating all on and off grounds activities. The number of the phone being carried by the accompanying staff member must be written on form WFH-466.
 8. Whiting transporters must sign out a cell phone from the Whiting Nurse Supervisor's Office, prior to departing building, for all on and off grounds activities.

Emergency Procedures:

1. Should a patient become dysregulated during transport, the transporter should pull the vehicle over as soon as safely possible, preferably off main highways, and attempt to verbally de-escalate patient.
2. While off campus, if the transporter has reason to believe safety is compromised and there is a potential for imminent risk, the transporter should call 911 for assistance.
3. For emergencies on grounds, staff should call Agency Police at 860-262-5555.
4. If a PSRB acquittee escapes while off campus, staff are to call 911 to report the escape and provide information about the acquittee from the patient's profile sheet. Staff are

to then call Agency Police at 860-262-5555 and lastly call the Dutcher Nursing Supervisor.

5. A copy of emergency procedures is to be carried with staff on all off-grounds patient transports, trips and activities.
6. In medical emergencies requiring transportation to an area general hospital by ambulance, one staff member must accompany the patient in the ambulance while other staff follows the ambulance to the hospital. When there is only one staff member, the staff member will follow the ambulance to the hospital. The Nursing Supervisor will dispatch another staff member to the hospital. The staff member accompanying the patient must secure the patient profile and remain with him/her upon arrival at the hospital until relieved by an oncoming staff member. Other patients may briefly be under supervision of one staff member until the original or a relief staff member arrives.

Refer to WFH Operational Policy and Procedure Manual (OP&P) for procedures to be followed in an emergency, including: WFH Operational Procedure 5.5 Patient and Staff Safety in the Community and Commissioner Policy 6.11 Elopement.

**WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL**

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 5:	Improving Organizational Performance
PROCEDURE 5.5:	Patient and Staff Safety in the Community
REVISED:	September 20, 2022
Governing Body Approval:	May 1, 2018, September 20, 2022

PURPOSE: To provide safe supervised off-grounds activities for individuals and patient groups. This procedure pertains to all activities outside the hospital boundaries including: psychosocial, leisure time/recreational activities, discharge visits, community transitioning, and individual and family interventions. *Note: This procedure does not apply to medical trips.*

SCOPE: All clinical staff involved in psychosocial community integration or potentially involved in community integration.

Definitions: “Visual observation” means general awareness of where the patient is at all times. “Line of sight” means a direct view of the patient at all times.

POLICY:

All patients as they are able have a right to participate in community trips with sufficient staff to provide a safe and productive visit. See *Operational Procedure 5.4 Assessment of Risk for the Purpose of Transport*; and *Operational Procedure 2.17 Patient Privileges*.

PROCEDURE:

I. Standards of Practice:

- A. A physician’s order is required for community visit. The physician’s order clarifies the staff to patient ratio necessary to safely transport the patient into the community, the final destination of the community trip and any planned stops along the way to the final destination. The physician order denotes the escort ratio and is based on current level status, and Risk Assessment (WFH-473).
- B. Patients with the following privileges will be able to be considered for community trips:
 - 1. Level 3b patients with off-grounds privileges with staff;
 - 2. Level 4 patients.

- C. The Community Trip Form (WFH-627) is initiated by staff escorting the patients, and:
 - 1. signed by the Attending Physician and Unit Director within 72 hours; and
 - 2. signed by the Head Nurse or designee at time of departure.

- D. Any significant condition requiring a Focused Treatment Plan Review (FTPR) (See *Operational Procedure 2.6 Integrated Treatment Planning Process*) determines whether the patient attends community trips.

- E. The Physician has the prerogative to increase staff to patient ratio based on clinical need and risk.

- F. Maximum Patient to Staff Ratios
 - 1. Community trips involving one patient, staff/patient ratio is determined by transport risk assessment.

 - 2. Community trips involving two or more patients – 1 staff to 2 patients (staff complement can be adjusted, based on clinical risk assessment).

While the standard patient to staff ratio formula is generally applied, consideration as to the group's destination is factored into the final decision. The final determination as to patient to staff ratio is made collaboratively by the treatment team and physician along with the group leader.

- G. Every community trip has an assigned leader.

- H. All staff involved in community trips are expected to have knowledge of and comply with this procedure.

II. Whiting Forensic Hospital (WFH) Staff Responsibilities

- A. When more than one staff member is assigned to escort patients on a community trip, one staff member is identified as the leader.

- B. Staff may be from any discipline.

- C. WFH staff assigned to participate in community trips are encouraged to take breaks prior to or after a community trip. Conversely, the taking of breaks during a community trip which would compromise patient and staff safety, is not permitted.

- D. In the event that an urgent need for a break is necessary, depending on the level of supervision, the remaining staff will observe the patient in the interim. If the level of

supervision cannot be accommodated by the accompanying staff, the affected employee will contact the Nursing Supervisor for guidance on coverage.

E. Leader responsibilities:

1. Ensure that current physician orders and relevant Risk Assessment Trip forms are in place for outside activity approval which determines staff to patient ratios.
2. Determine how many staff will accompany patients. Consider possible gender issues and specific patient needs including restroom escort. A physician's order may indicate specific gender escort needs.
3. Complete or ensure completion of Community Trip Form (WFH-627) for WFH Police, Head Nurse/Charge Nurse and one for unit which assigns patients with off-grounds privileges to staff, based on escort ratios, patient needs and risk including restroom escort plan if necessary.
4. Complete Property/Clothing Record Form (WFH-23).
5. Distribute copies of all completed forms as indicated by program/division.
6. Ensure that the necessary community trip forms are completed prior to beginning the trip.
8. Schedule vehicle for transportation.
9. Secure an operating cell phone (this phone must be turned on for the duration of the trip).
10. Secure funds for trip if applicable.
11. Assure presence of immediate response card (to be laminated and placed on clipboard for vehicle).
12. Secure and safeguard the Patient Profile and Clothing form in a specially designed locked receptacle. When on the trip, one bag key is kept in Leader's possession. The second key remains in the Head Nurse/Charge Nurse office.

F. All Staff are responsible to:

1. Review patient's clinical status and trip purpose with the nurse and trip leader prior to transport.

2. Continually assess environment for basic safety concerns, such as location of exits, proximity of support services, and restroom access.
3. Maintain staff to patient ratio within various community environments and situations based upon level of escort ascribed in physician order and Risk Assessment documented in the Community Trip form (WFH-627).
 - a. Staff maintains line of sight of patients at all times. For the purposes of this procedure “line of sight” of the patient does not require restroom accompaniment by staff. In areas such as restrooms, dressing rooms; all entrances, windows, exits will be monitored. If the physician specifically orders “line of sight” supervision in the above areas, it is understood that the patient would be accompanied by staff member(s) into the restroom.
4. Follow procedure for emergency situations and assure completion of documentation.
5. Report any unusual non-emergency incidents to the Head Nurse/Charge Nurse and document in medical record upon return to WFH.

III. Emergency Procedures on Community Trips

- A. Major Medical (examples: seizures, broken limbs, head injury, severe bleeding, severe heart, respiratory problems, or allergic bee stings).
 1. Telephone 911
 - a. Identify need for ambulance;
 - b. Define situation;
 - c. State Specific location;
 - d. Provide first aid and closely observe patient (First aid kit located in vehicle).
 2. At first available moment contact Head Nurse/Charge Nurse to report:
 - a. Situation, location, and steps already taken
 - b. Request information about medications, medical history or any current medical/physical problems.
 - c. Give the telephone number for a return call;
 - d. The Head Nurse/Charge Nurse will call the DMHAS Agency Police and the Program Manager (designee).
 3. If patient is transported via ambulance to a general hospital:
 - a. Staff and remaining patients follow with the WFH vehicle. WFH staff must accompany the patient in the ambulance bringing the patient’s profile.
 - b. At the hospital, staff identifies themselves as a WFH employee and gives relevant information.

- c. Staff will call the Head Nurse/Charge Nurse to update the status of the patient. The head nurse will make arrangements for the return other patients and the vehicle to the hospital and to get staff relief. A WFH staff member remains with the injured patient until the relief staff has arrived.
- d. The hospital post designation order will determine ongoing patient supervision requirements which will be staffed and monitored by the Head Nurse/Charge Nurse office (or Agency Police Department if necessary).
- e. If patient being treated at the hospital is or becomes agitated; staff from the general hospital intervenes with the patient while WFH staff provides verbal support.

4. Upon return to WFH staff:

- a. Complete incident report and document in patient's progress notes. and
- b. Updates the Head Nurse/Charge Nurse.

B. Minor Medical Problems (e.g., cuts, bruises, non-allergic bee stings):

- 1. Apply first aid, as indicated; (First aid kit located in vehicle).
- 2. Assess for return or continuation of trip;
- 3. If necessary, escort patient back to WFH and inform Head Nurse/Charge Nurse (or designee) of injury for follow-up treatment.
- 4. Complete incident report and document in progress notes of the medical record.

C. Behavioral Emergencies:

- 1. Assess the emergency;
- 2. Intervene with verbal de-escalation and other Collaborative Safety Strategies (CSS) techniques as appropriate.
- 3. If patient cannot regain control:
 - a. Call 911
 - b. Describe situation and location to dispatcher;
 - c. Keep other patients calm and out of harm's way; and
 - d. Maintain visual sight of all patients and remain on the scene or location until police arrives.
- 4. When time allows, call Head Nurse/Charge Nurse, identify yourself, and give a description of incident and provide information as needed.
- 5. The Head Nurse/Charge Nurse will make other necessary internal notifications.
- 6. Upon return to WFH staff will :
 - a. Update Head Nurse/Charge Nurse; and
 - b. Complete incident report and document in patient's progress notes.

D. Elopement/Escape (See *Operational Procedure 2.10 Elopement, Escape and Unauthorized Absence*)

For all patients who have eloped from a community activity:

1. Call the DMHAS Police at WFH to report the elopement;
2. Follow instructions from DMHAS and WFH Police;
3. Call Head Nurse/Charge Nurse identifying yourself, state purpose of call and give time, location of the elopement, description of patient's attire and patient's mental status at the time of elopement. The Head Nurse/Charge Nurse follows the critical incident notification procedure for elopement;
4. Remain at scene to assist with investigation as directed.
Upon return to WFH, update Head Nurse/Charge Nurse, complete incident report and document the elopement in patient's progress notes in the medical record.

E. Vehicle Breakdown or Motor Vehicle Accident. Do the following:

1. Pull vehicle safely to the side of road if possible and turn on flashers;
2. Assess situation and determine need for patients to exit or remain in vehicle;
3. Call 911 if necessary;
4. Call WFH Campus Police to report breakdown or accident and arrange for return to WFH.
5. As time permits, call Head Nurse/Charge Nurse to report breakdown.

**WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL**

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 5:	Improving Organization Performance
PROCEDURE 5.6:	Risk Management
Governing Body Approval:	6/5/18
REVISED:	

PURPOSE: The purpose of the Hospital’s Risk Management Procedure is to provide a structure that includes performance improvement processes to identify and reduce risk for patients served. In implementing the Risk Management Procedure, the hospital will provide patients with interventions and take corrective actions commensurate with the level of risk to maintain a safe and therapeutic environment. This procedure is supported and supplemented by the Incident Management Procedure.

POLICY:

The hospital will provide a safe, therapeutic environment that utilizes a Risk Management process involving a continuous and direct approach to identifying and analyzing risks and implementing measures to protect patients, staff, and visitors by reducing or eliminating the risk of harm. Staff will ensure that standardized procedures are used when addressing identified behavioral, psychiatric, and medical risk conditions, as well as other high-risk situations.

PROCEDURE:

- I. The Risk Management process will support timely identification of high-risk behaviors, conditions, or situations of an immediate nature, as well as long-term systemic problems that need corrective actions to remedy risks, and timely interventions to prevent or minimize harm to patients, staff, and visitors.
 - A. The Risk Management process includes the following components:

1. Data collection tools and a centralized-database to collect and provide information on various categories of high-risk incidents and behaviors.
 2. Identification of triggers and thresholds that address various levels of risk involving patients and that require timely review by the Interdisciplinary Team.
 3. Formalized mechanisms for notification of Interdisciplinary Teams and disciplines to support timely corrections.
 4. Monitoring systems to support timely implementation of interventions.
 5. Identification and management of long-term trends and patterns.
 6. An oversight mechanism that ensures data are tracked, trended, and analyzed using a performance improvement methodology in an effort to provide ongoing oversight and monitoring of the effectiveness of the hospital's Risk Management process.
- B. The Performance Improvement Department will maintain and utilize risk management data as follows:
1. Ensure that all risk management data (incident reports) are entered into a hospital-wide database;
 2. Sort data by individual, unit, program, and division, as required;
 3. Sort the data by incidents, triggers, and thresholds, as required; and
 4. Utilize the database to analyze risk management data, monitor triggers and thresholds, and identify potential patterns and trends.
- II. The hospital will identify patients at risk for harm as a result of meeting Triggers and Thresholds or other behavioral, psychiatric, and medical conditions. The hospital's triggers and their thresholds are presented in Appendix A. Sample high risk behavioral, psychiatric and medical conditions are presented in Appendix B.
- III. For newly admitted patients, the General Medical Service provider identifies medical risks using information from the Admission History and Physical and the Attending Psychiatrist identifies behavioral and psychiatric risks using information from the Admission Psychiatric Evaluation to ensure risk conditions are reviewed and addressed in the initial treatment plan. Risks are identified throughout the course of hospitalization based on ongoing assessments.
- IV. The hospital will use an established hierarchy of reviews that correspond to the level of risk in order to address the risk and reduce the potential or actual harm to patients involved in any incident, who meet the threshold for a trigger behavior or meet the threshold for high-risk behavioral, psychiatric, and medical conditions.
- A. Each Interdisciplinary Treatment Team will perform the following routine functions:

1. Develop and maintain an updated risk profile for all patients in their care. The risk profile will be documented in the patients' Present Status section of the Case Formulation in the treatment plan;
2. Review all patients who (a) are involved in any incident (b) exhibit a trigger or threshold behavior or exhibit a new behavioral, psychiatric, or medical high risk condition;
3. Identify predisposing factors for behaviors and/or conditions that may occur in the absence of preventative interventions for each high-risk condition identified in the patient's risk profile, focusing on factors that impact the patient's health and wellness.
4. Identify precipitating factors for each high-risk condition identified in the patient's risk profile, focusing on those factors that will precipitate adverse outcomes for the patient.
5. Identify perpetuating factors for each high-risk condition identified in the patient's risk profile, those factors that are maintaining adverse conditions or outcomes for the patient.
6. Incorporate the analysis of the patient's predisposing, precipitating, and perpetuating factors into specific goals, objectives, and treatment interventions to eliminate or reduce the identified behavioral, psychiatric, or medical risk condition.
7. Review all incidents, as well as trigger and threshold behaviors, that involve patients in their care to determine the nature and context of the incident or behavior, contributing (predisposing, precipitating and perpetuating) factors and appropriate behavioral, psychiatric, or medical interventions;
8. Review the current treatment plan in terms of the effectiveness of specific goals, objectives, and treatment interventions already in place in eliminating or reducing the risk associated with involvement in an incident, trigger, or threshold behavior or high-risk behavioral, psychiatric, and medical conditions;
9. Revise the current treatment plan as indicated or document the rationale for continuing with the current goals, objectives, and treatment interventions that are relevant.
10. Continue to update and build upon the individual's treatment plan based on new assessments, consultations, other information and the patient's progress for the first 60 days of admission or the first 60 days from a newly exhibited risk behavior or condition.
11. Incorporate recommendations from the Hospital Review Committee, as applicable, into the individual's treatment plan.
12. The Consulting Forensic Psychiatrist (CFP) participates in weekly Levels meetings with the Dutcher Service interdisciplinary teams to discuss risk issues related to PSRB patients, including privilege increases, trip requests, Temporary Leave (TL) applications, and Conditional Release (CR) applications.

B. *First Level Review:* WFH Daily Morning Report

1. The CEO/designee chairs this meeting.
2. Attendance required:
 - a. Chief Executive Officer

- b. Chief Medical Officer
- c. Chief Operating Officer
- d. Service Medical Director(s)
- e. Nursing Supervisors
- f. Program Director(s)
- g. Unit Directors
- h. Attending Psychiatrists
- i. Performance Improvement Manager

3. Daily review of all WFH patients for psychiatric and medical stability since the last business day.
4. When indicated, recommend further medical consultation with the General Medical Service and/or Specialty Service (for example, Neurology).
5. Review all Incident Reports (IR) since the last business day.
6. Review and approve daily transportation Risk Forms (WFH -473) for appropriate transport level.
7. Review all special observation orders since the last business day.
8. Review daily WFH admissions with respect to psychiatric, medical, and legal issues.

C. *Second Level Review: Hospital Review Committee (HRC)*

1. The CEO /designee will serve as the chair.
2. The HRC will hold regular weekly meetings.
3. Committee Membership:
 - i. CEO
 - ii. COO
 - iii. CMO
 - iv. Service Medical Directors
 - v. Supervising Forensic Psychologist
 - vi. Director of Social Services
 - vii. Nurse Executive
 - viii. Performance Improvement Manager
 - ix. Supervising Psychologist -2
 - x. Chief of Forensic Services
4. Review risk assessment and risk management issues with regard to the readiness of patients to attain increasing levels of freedom and responsibility including:
 - i. Changes in level to 3B or above for PSRB patients;
 - ii. All off-grounds activities;
 - iii. Transfer of civilly committed patients between Whiting Max and Dutcher Service;
 - iv. Periodic review of the clinical status and risk management plans for voluntary or civilly committed patients;

- v. Any patient whom the team feels is “discharge ready”;
 - vi. Level 4/TL proposals for Dutcher 1 North patients;
 - vii. Specialized funding needs;
 - viii. Discharge planning challenges (for civil, PSRB and competency patients);
 - ix. Patients meeting risk factor “thresholds” per Performance Improvement Manager;
 - x. Behavioral Intervention Service updates;
5. Review incident reports of patients who meet defined Trigger and Threshold criteria (see Appendix A).
 6. Review treatment plans of patients meeting Trigger and Threshold criteria. When indicated, recommend intervention to the primary interdisciplinary team to manage various medical or psychiatric risk factors.

D. *Third Level Review: Forensic Review Committee (FRC)*

1. The FRC primarily focuses on risk management issues regarding patients (acquittees) who have been committed by State Superior Courts to the jurisdiction of the Psychiatric Security Review Board (PSRB), but also reviews issues regarding high-risk civil and competency restoration patients in the enhanced security Dutcher Service and the maximum security Whiting Service of the WFH.
2. FRC meets weekly.
3. FRC is chaired by the Chief Executive Officer (CEO)/designee.
4. Members:
 - a. Chief Operating Officer
 - b. Chief Medical Officer
 - c. Service Medical Directors
 - d. Chief of Forensic Services
 - e. Supervising Forensic Psychologist
 - f. Director of Social Services
 - g. Director of Rehab Services
 - h. Consulting Forensic Psychiatrists (CFP), DMHAS
 - i. Other persons may be invited to attend FRC meetings on an ad hoc or ongoing basis at the discretion of the Chair
5. FRC reviews risk assessment and risk management issues including, but not limited to:
 - a. Issues regarding acquittees’ Temporary Leaves, the temporary leave process and procedures, or compliance with PSRB orders or hospital conditions for Temporary Leaves;
 - b. Whiting Service treatment team recommendations for transfers of PSRB acquittees from the maximum security Whiting Service to the enhanced security Dutcher Service;

- c. Whiting Service treatment team recommendations for referrals to the Transition Group or other groups outside of the Whiting Maximum Security service;
- d. Periodic reviews of PSRB patients transferred from Dutcher to Whiting due to increased risk;
- e. Significant incidents involving WFH patients (e.g., assaults, attempted escapes, breeches of security);
- f. Significant changes in the clinical status of Dutcher or Whiting Service patients (including hold/suspension or reduction of patient privileges) that may have risk management implications;
- g. Voluntary or emergency transfers of patients from the Dutcher Service to the maximum security Whiting Service;
- h. Issues regarding the *Roe v. Hogan* Agreement of Settlement, including differences of opinion between an acquittee and his/her treatment team, or between the treatment team and the Forensic Liaison team about an acquittee's privileges or treatment plan;
- i. Upcoming or recently held PSRB and Probate or Superior Court hearings and testimony;
- j. The current status of PSRB acquittees nearing the end of their commitments to the jurisdiction of the PSRB and issues regarding recommitment to the PSRB of these acquittees;
- k. WFH policies and procedures regarding risk assessment and risk management or that are related to or may have implications for risk assessment and risk management; and
- l. Forensic questions regarding competency patients.

V. Review of Transfer Recommendations

Whiting Service Transfers to Less Secure Treatment Settings. Whiting Service treatment team recommendations for transfer of PSRB acquittees from maximum security to the enhanced security Dutcher Service are done as follows:

1. The Whiting Service treatment team first reviews the case with the Chief of Forensic Services, who may confer with the Whiting Service Medical Director about the case.
2. If the Chief of Forensic Services believes it to be appropriate, the treatment team requests a date and time from the Supervising Forensic Psychologist to present their recommendation for transfer at the weekly FRC meeting.
3. If there is consensus in the FRC to proceed further, the CEO requests that one of the Consulting Forensic Psychiatrists (CFP) conduct an evaluation of the acquittee's readiness for transfer. As part of the evaluation, the CFP reviews the acquittee's medical record and other relevant documents, speaks with members of the treatment team, and interviews the acquittee.
4. The CFP presents the results of his/her evaluation and his/her recommendation, after which the FRC discusses the case and arrives at a consensus as to whether or not to concur with the treatment team's recommendation.

5. If the FRC concurs with the team's recommendation, the Supervising Forensic Psychologist (SFP) informs (usually by e-mail) the team's attending psychiatrist and unit director.
6. If the FRC does not concur, or concurs but with specific recommendations for treatment, further evaluation, and/or waiting an additional period of time before proceeding, the SFP sends a memorandum to the treatment team stating the FRC's questions, concerns, or recommendations for the treatment team's follow-up.
7. The Whiting treatment team informs the patient of the outcome regarding the transfer recommendation, and the Unit Director/designee documents this information in the patient's medical record, including the fact that the patient was informed of this information.

**WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL**

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 5:	Improving Organizational Performance
PROCEDURE 5.7:	Management of Patient Allegations
Governing Body Approval:	January 13, 2020, July 22, 2022
REVISED:	December 23, 2019, July 22, 2022

PURPOSE:

To establish requirements of and process for investigations of incidents that involve allegations of patient abuse, neglect, or exploitation and for protecting patients while an investigation is conducted.

SCOPE: All WFH Staff

POLICY:

Incidents that Involve Allegations of Abuse, Neglect or Exploitation: The hospital will take immediate and appropriate action to protect patients involved, including removing alleged perpetrators from direct contact with patients, as specified in this procedure. All incidents that involve allegations of neglect, abuse or exploitation will be investigated according to the requirements outlined in this procedure. The Governing Body will oversee investigations of abuse, neglect, and exploitation through ongoing review of data relative to number of allegations, type of allegation, closure findings, etc.

PROCEDURE:

Critical Incidents that Involve Allegations of Abuse, Neglect or Exploitation (ANE)

All employees must report any evidence of the abuse, neglect, or exploitation of patients to their supervisor immediately. This obligation extends to any employee who is directly involved, witnesses, or is made aware of an alleged incident of abuse, neglect or exploitation.

The employee who observes abuse, neglect, or exploitation (ANE), or has initial knowledge of an allegation is responsible for completing the Incident Report Form (WFH-494) by the end of the shift when the alleged violation occurred or was discovered, in accordance with this procedure.

After ensuring the care and safety of an alleged patient victim, the DN/Manager on Duty immediately reports any potential allegation of ANE to the Chief Quality and Compliance Officer (CQCO), who will report the information to the CEO. In the absence of a DN/Manager on Duty, the Nurse Supervisor will report allegation to the CQCO.

The CEO notifies the Office of the Commissioner of all allegations of abuse, neglect, and exploitation, including the patient's name, alleged violator's name, the type of abuse alleged and the status of the alleged violator.

The CQCO will notify DMHAS Labor Relations of all incidents involving allegations of ANE where there is an identified alleged violator.

PHASE ONE INVESTIGATION

- A. The hospital will take immediate and appropriate action to protect patients involved in allegations of ANE. Alleged perpetrator(s) of physical or sexual abuse, and neglect while assigned to Special Observation of a patient, is/are immediately removed from all patient contact pending the outcome of the investigation.
- B. The alleged perpetrator of other forms of abuse/neglect is reassigned to other patient care areas, at the discretion of the CQCO/CEO based on the allegation and evidence available at the time of initial report.
 - 1) Temporary Reassignment to A Non-Patient Care Area is utilized when the fact pattern does not warrant placing the alleged perpetrator on administrative leave with pay, but where reassigning the employee to a non-direct care area is determined to be in the best interest of both the patient(s) and staff.

Criteria for the use of temporary reassignment to a non-direct care area includes, but is not limited to the following:

- Allegations of physical or sexual abuse where the preliminary investigation is unable to establish a fact-pattern to rule in or rule out the allegation(s)
- The preliminary evidence is such that the abuse could have occurred
- Inattentiveness while assigned to Special Observation

2) Temporary Reassignment to Another Patient Care Area is utilized when the fact pattern does not warrant reassigning the employee to a non-direct care area, and is determined to be in the best interest of both the patient(s) and staff.

Criteria for the use of temporary reassignment of patient care responsibilities for possible reassignment to another patient care unit includes, but is not limited to, the following:

- Allegations of verbal/psychological abuse, exploitation, or neglect (with the exception of inattentiveness while assigned to Special Observation)

3) Administrative Leave with Pay is utilized when there have been serious allegations made against an employee, the employee's presence at work is deemed unsafe or disruptive, and the employee's actions are such that they may lead to termination.

Criteria for the use of administrative leave with pay include, but are not limited to, the following:

- Preliminary investigation determines there is witness confirmation and/or corroboration through physical evidence on the scene of an allegation of physical or sexual patient abuse;
- Employee's presence at work could be harmful to the public, the welfare, health and safety of patients, state employees or state property;
- Physical violence; and
- Suspected staff impairment

The DN/Manager on Duty will verbally notify the affected employee of their reassignment status. The CQCO will notify the affected employee, their manager, the CEO and Labor Relations, in writing.

Reassignment will continue until the investigation is completed, based on additional factual information deeming temporary reassignment no longer necessary.

C. The DN/Manager on Duty must ensure the completion of all necessary documentation including: An Incident Report, the MHAS-20 Work Rule Violation Form, the DMHAS Critical Incident Submission Form (DMHAS 601); and will make immediate notification to the Agency Police (assigned Police Lieutenant or designee) of allegations of physical and/or sexual abuse.

The DN/Manager on duty is responsible to conduct a video review when available/applicable, including the corresponding documentation and request to agency policy for video to be saved.

D. The RN Supervisor immediately collects witness statements from all staff on duty that may have information relevant to or potentially witnessed the alleged violation no later than the end of the shift of report. The RN Supervisor immediately obtains a statement from the alleged violator.

E. The RN supervisor reviews witness statements and ensures they are complete and signed by the witness/involved person.

Staff witness statement may include the following:

- Where staff were specifically at the time of the incident in question
- What staff were doing specifically at the time of the incident in question
- Names of all other individuals present (staff and patients)
- Whether or not staff participated in or witnessed any portion of the incident in question

- A detailed statement of the sequence of the events immediately before, during and after the incident in question

Additional questions may be included specific to the reported allegation.

- F. The DN/Manager on Duty will document any information regarding the chain of events on the Incident Report.
- G. If the incident was captured on videotape, the DN/Manager on Duty will observe the video of the incident as soon as possible following the incident. If an available video recording clearly demonstrates that no ANE was possibly committed by the alleged perpetrator, the DN/Manager on Duty will confer with the CQCO, who may return the staff member to regularly assigned duties (allegations disproved by video, will be managed as a Phase 1A- see below). The DN/ Manger on Duty will request that the Agency Police save all videos reviewed as part of any allegation.
- H. The DN/Manager on Duty will submit the completed ANE packet, including the Incident Report Form (WFH-494), MHAS-20, the DMHAS Critical Incident Submission Form (DMHAS 601), and other relevant documents (witness statements, staffing sheet, assignment sheet, routine or special observation forms, incident report form), to the CQCO by the end of the shift when the allegation was made or was discovered.
- I. Advocacy staff will interview an alleged victim and potential patient witnesses within 1 business day of the allegation being reported. All patients are to be offered the opportunity to speak with advocacy staff. Patient interviews may be conducted jointly by Advocacy staff and DMHAS Labor Relations staff wherever appropriate.
- J. The Advocacy staff will document interviews with involved patient(s) and submit a written report to the CQCO.

Phase 1A Investigations:

This protocol may be initiated under the following circumstances at administration's discretion:

- A report made by a patient with a history of false allegations of 2 or more within a 30-day period
- An allegation that lacks clear merit and can be disproven on the face of it (such as by video review)
- An allegation made that has an identified and documented factor of retribution on the part of the reporting patient
- An allegation that the patient recants and there is no evidence of coercion to do so
- An allegation of abuse that occurred more than 6 months prior to the time of the report, for which there is no reason for not reporting earlier

- If a patient has a history of two or more false allegations, the Treatment Team shall document this in the Integrated Treatment Plan with objectives and interventions to address the issue leading to this behavior.

The alleged violator may or may not be removed from patient care or moved to another unit depending upon the immediate availability of evidence. This decision will be made at the discretion of the CQCO, with consultation with the CEO, and may be made 1) due to circumstances of the report and/or 2) to protect the alleged violator from additional allegations.

If the alleged violator is moved out of patient care or to another unit, they will either be returned or a Phase 1 or 2 will be initiated, no later than 1 business day after the initial report.

The DN/Manager on Duty will obtain information as directed by the CQCO, no later than the end of the shift on which the allegation was made, and may include the following:

- Incident Report
- DMHAS Critical Event Submission Form (DMHAS-601)
- Staff Witness statements
- Video review if available
- Physical exam and/or MSE
- Other documentation that may serve to disprove allegation

The determination to escalate a Phase One or Phase 1A will be based on, among other factors, the following:

1. the fact pattern as presented in the allegation;
2. the physical evidence;
3. the content of witness statements;
4. review of recorded video where available;
5. the feasibility of the circumstances as alleged;
6. the history of allegations attributed to the patient; and
7. the history of allegations directed toward the staff.

Assuming the above provides no supporting evidence, the CQCO will review with Labor Relations and the alleged violator will be returned to their unit/patient care. The evidence upon which all decisions are made regarding an allegation will be documented on Addendum C of the incident report. These cases will also be reviewed at the next IRC meeting.

The employee may be returned to duty prior to discussion with DMHAS Labor Relations during non- business hours, if supported by the available evidence. The decision must ensure an optimum level of patient care, safety, and welfare and to protect the employee from further allegations. In those cases, the CQCO will review with Labor Relations the next business day.

Should there be any reason to believe that a Phase 1/1A allegation may have merit; a full Phase Two investigation will be initiated.

For allegations that proceed to Phase Two, an assessment of possible victimization may be completed and documented for all patients with a similar clinical symptom profile of the alleged victim on the same unit. Actions are taken to protect those patients determined to be at risk.

Phase 2 Investigation:

For any investigations referred to Phase Two, DMHAS Labor Relations will complete the Phase Two investigation within 60 business days, except when material evidence is unavailable. In those cases, the investigation will be completed within 5 business days of its availability.

- A. DMHAS Labor Relations Investigators will use appropriate hospital resources, including clinical management staff, in investigatory interviews to address clinical implications and other risk management issues that are not in their area of expertise.
- B. Incidents that raise systemic issues but do not involve staff misconduct will be referred to the Leadership team for review and response.
- C. The DMHAS Labor Relations investigator will maintain a written record of all investigatory interviews, including the interviewed person's responses to questions and any additional statements provided.
- D. Upon conclusion of each interview, the DMHAS Labor Relations investigator will ask the interviewed person to review the written record of the investigatory interview and to make and initial any changes necessary to ensure that it is accurate and complete. The interviewed person will be asked to sign the record of the interview. If the interviewed person refuses to sign, the participating manager will review for accuracy and sign it, indicating in writing that the interviewed person refused to sign and attesting as to whether it is an accurate record of the interview. In such instances the interviewed person who refused to sign the record of the interview will be required to write and sign his/her own self-written statement which responds to the areas of questioning.
- E. The DMHAS Labor Relations investigator will ask all interviewed persons if they have any concerns related to retaliation or threats as a result of their statements. This is documented in the written record of the investigatory interview.
- F. Investigations are a comprehensive, systemic analysis and must result in a written summary report that clarifies and/or reconciles information submitted at the time of the initial report (i.e., Incident Report Form, MHAS-20 Form, Witness Statements, etc.) with additional information gathered throughout the course of the investigation. Data elements that must be reconciled through the investigation, and included in the written summary report, include the following:
 - 1. the incident/allegation type;
 - 2. staff involved and the type of involvement (alleged violator, witness);
 - 3. patients involved and the type of involvement (alleged victim, witness);

4. the location of the incident/allegation; and
5. the date and time of the incident/allegation.

G. The Investigation Summary Report includes a summary of the investigation and findings, to include the following information:

1. the name of the participating clinical manager and any relevant clinical data or observations provided;
2. Each allegation of wrongdoing investigated;
3. Name(s) of all witnesses, alleged victim(s), and alleged violator(s);
4. Names of all persons interviewed and a summary of each investigatory interview;
5. List of all documents reviewed;
6. All sources of evidence considered, including previous investigations and results that involve the alleged victim(s) and violators(s);
7. A brief synopsis of the alleged violator's employment history with DMHAS, including prior discipline as well as the outcome of previous investigations involving the same alleged victim(s) and alleged violator(s);
8. Cause(s) and contributing factors of the incident/allegation;
9. Findings related to the substantiation of the allegations as well as findings about staff's adherence to hospital policies and procedures;
10. Rationale for the conclusions, including a summary of how potentially conflicting evidence was reconciled; and
11. The outcome of the investigation and any recommendation(s) for follow-up, including a recommendation that the case go forward for disciplinary action when an allegation is substantiated.

H. A Clinical Manager Analysis will be completed for all Phase Two investigations to document analysis and corrective action for any administrative and/or clinical issues identified during the course of the investigation. Consideration is given to:

1. Staff supervision or education needs;
2. Policy and/or procedure issues;
3. Unit rules or practices;
4. Interpersonal environment;
5. Physical environment;
6. Equipment or related procedures;
7. Patient's clinical condition; and
8. Other causal and/or contributory factors.

The Manager ensures that recommended follow-up action occurs and is documented.

I. Records Management System

1. DMHAS Labor Relations will use a standardized records management system to maintain records of all allegations, investigations, and findings, providing record retention commensurate with the State of Connecticut Record Retention Schedule.

2. The Director of DMHAS Labor Relations will train staff and monitor adherence to the investigation manual.

Conclusion of Investigations

Unsubstantiated:

Return to Duty is utilized after the evidence gathered during the Phase 1 or 2 investigation has indicated that the alleged ANE did not occur.

In these instances, the investigation is completed, and all records are retained by the CEO and/or Labor Relations Office. The supervisor will inform the employee verbally that the investigation is complete, there were no findings of the allegation against the employee, and that he/she is being returned to duty. The CEO will notify the affected employee in writing, as soon as possible after such a finding.

Substantiated:

Should there be findings upon completion of the Phase 2 investigation, the employee's return to duty will be based on recommended/approved disciplinary action. Depending on the severity of the findings and discipline recommendations, Labor Relations may place the employee on Administrative Leave with Pay according to the following guidelines:

Administrative Leave with Pay is utilized when there have been serious allegations made against an employee, the employee's presence at work is deemed unsafe or disruptive, and the employee's actions are such that they may lead to termination.

Criteria for the use of administrative leave with pay include, but are not limited to, the following:

- Preliminary investigation determines there is witness confirmation and/or corroboration through physical evidence on the scene of an allegation of physical or sexual patient abuse;
- Employee's presence at work could be harmful to the public, the welfare, health and safety of patients, state employees or state property;
- Physical violence; and
- Suspected staff impairment.

Investigatory Review Committee (IRC)

The IRC will oversee investigations of incidents of abuse, neglect and exploitation that allegedly involve staff misconduct. The IRC membership shall consist of: the CEO, COO, Facility Labor Relations Representative, Quality and Compliance, the Director of Advocacy, Program Managers and the Service Medical Directors (SMD). At least one clinical staff (e.g., SMD), a representative from Quality Improvement, and two additional members of the IRC will be present for all IRC meetings. The IRC will review ANE investigations as often as needed. The

IRC will maintain minutes, including conclusions and recommendations, following each meeting, and make them available to the Governing Body.

In performing this function, the IRC will:

- a. Review all investigations to determine if they were conducted according to relevant policy and procedures, and that appropriate corrective actions were taken in response to investigation findings;
- b. Monitor corrective actions recommended by investigators and/or clinical managers (including but not limited to, supervision, training, and discipline) to ensure timely implementation;
- c. Ensure documentation of corrective actions;
- d. Identify and track programmatic corrective actions to ensure effective and timely implementation; and
- e. Review and analyze data and trends related to ANE.

The CEO is responsible for overseeing the implementation of the Clinical Manager's Corrective Action Plan and the submission of all required documentation.

INCIDENT REPORT

The purpose of this form is to ensure prompt and accurate reporting and evaluation. Effective reporting provides the hospital with the data to identify problems areas and implement corrective/remedial actions and preventive measures.

SECTION 1 BASIC DATA

Whiting Maximum Security Dutcher Service Dept/Other Incident Date: _____ Time: _____ AM / PM

SECTION 2 TYPE OF INCIDENT (Circle only one):

<u>AGGRESSIVE ACTS</u>		<u>ALLEGED PATIENT ABUSE</u>		<u>INJURIES</u>		<u>MEDICAL CONDITIONS</u>	
Aggressive Act to Self	100	Physical	200	Restraint Related Injury	300	Choking:	
Aggressive Act to Other Physical	101	Psychological	201	Injury of Unknown Origin	301	Self-Cleared Airway	500
Aggressive Act to Other Verbal	102	Verbal	202	Infection Control Exposure	302	Heimlich	501
Sexual Assault	103	Sexual	203	Other Accidental Injuries	303	Cardiac	502
Sexual Contact	104	Neglect	204	FALL	400	Respiratory	503
Exploitation of Peer	105	Exploitation by Staff	205			Seizure	504
Murder Attempt	106	Violation of Patient Rights	206			Trauma	505
						Other Medical Condition	506
<u>DEATH</u>		<u>PROPERTY DESTRUCTION</u>		<u>LOST OR STOLEN PROPERTY</u>			
Expected	600	Patient Property	700	Patient Property	000		
Unexpected	601	Staff Property	701	Staff Property	001		
Suicide	602	State Property	702	State Property	002		
Murder	603	Other Property	703	Other Property	003		

ELOPEMENT

1. Elopement Attempt	800
2. Elopement from unit/remained in building	801
3. Elopement from building/remained on campus	802
Elopement from campus or authorized off-campus activity with no return at time Incident Report completed	xxx
4a. Elopement from campus; returned to hospital within 24-hours	803
4b. Elopement from campus; did not return within 24-hours	804
4c. Elopement from authorized off-campus activity; returned to hospital within 24-hours	805
4d. Elopement from authorized off-campus activity; did not return within 24-hours	806
5a. Elopement from campus during admission process, discharged after inquiry	807
5b. Elopement discharged ACA/AMA/NCR after inquiry	808
5c. Elopement discharged after inquiry	809

OTHER INCIDENTS

Alleged Criminal Act	900	Missing Keys/Key Card	905	SUICIDE ATTEMPT	910
Confidentiality - Unauthorized Disclosure	901	Missing Sharps	906	SUICIDE THREAT	911
Contraband	902	Security Breach	907	Other Incident	912
Fire Setting	903	Serious Threat/Threatening Behavior	908	TLP Unauthorized Leave	913
Medical Device Failure/Malfunction	904	Smoking Violation	909	Equipment Failure/Malfunction, non-medical	914

SECTION 3 PERSON(S) INVOLVED

<i>Check One</i>			Last Name	First Name	MPI/Employee #	<i>Check One</i>				
Patient	Staff	Visitor				Aggressor	Victim	Primary Involved	Other Involved	Witness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

An Aggressive Act must have occurred for there to be an aggressor or a victim. Primary Involved – Patient, staff or visitor who is the primary focus of the incident (Incident Types in Italics) (excluding aggressive acts).

SECTION 4 LOCATION OF INCIDENT (Circle appropriate codes)

<u>UNITS</u>						<u>BUILDING (if applicable)</u>		<u>OTHER LOCATIONS</u>			
Dutcher	D1N	D1S	D2N	D2S	D3N	D3S	Dutcher	Cotter	Restroom	Hallway	Public Restroom
Whiting	WH1	WH2	WH3	WH4	WH5	WH6	Whiting	Chapel	Bedroom	Lobby	Recreation Area
							Page	Other	Courtyard	Nurse's Station	Stairwell
							Haviland		Dayroom	Parking Lot	Other Outside
									Dining Room	Visitor's Room	Other
									Elevator	Shower Area	Off Campus.

SECTION 5 SUMMARY DESCRIPTION OF INCIDENT:

Print Name and Title _____ Signature _____ Date _____ Time _____ AM / PM

(Over)

SECTION 6 IMMEDIATE CORRECTIVE ACTION(S) TAKEN:

Unit Nurse:

Nurse Supervisor's Office:

PERSON(S) NOTIFIED	DATE	TIME	PERSON(S) NOTIFIED	DATE	TIME
_____	_____	_____	_____	_____	_____
Print Name and Title	Signature	Date	Time	AM/PM	

SECTION 7 PHYSICIAN REPORT: Exam is required for all significant patient injuries (necessitating care beyond first aid). If more than two patients examined, use Addendum A

Patient #1	INJURY TYPE (Circle all that apply)					SEVERITY OF INJURY (Circle one)		
Abrasion	Bruise	Puncture Wound	Laceration	Sprain	No Injury	956	Death Occurred	955
Bite	Burn	Dislocation	Multiple Injuries	Swelling	No Treatment	951	Refused Examination	957
Blood Loss	Contusion	Fracture	Pain	Other:	Minor First Aid	952	Hospitalization Required	954
					Medical Intervention Required	953		

Patient Name _____ Date of Exam _____ Time of Exam _____ AM/PM

Summary and Treatment Ordered: _____

 Print Name and Title (Physician) _____ Signature _____ Date _____ Time _____ AM/PM

Patient #2	INJURY TYPE (Circle all that apply)					SEVERITY OF INJURY (Circle one)		
Abrasion	Bruise	Puncture Wound	Laceration	Sprain	No Injury	956	Death Occurred	955
Bite	Burn	Dislocation	Multiple Injuries	Swelling	No Treatment	951	Refused Examination	957
Blood Loss	Contusion	Fracture	Pain	Other:	Minor First Aid	952	Hospitalization Required	954
					Medical Intervention Required	953		

Patient Name _____ Date of Exam _____ Time of Exam _____ AM/PM

Summary and Treatment Ordered: _____

 Print Name and Title (Physician) _____ Signature _____ Date _____ Time _____ AM/PM

SECTION 8 FINDINGS/FOLLOW UP BY DIRECTOR OF NURSING/MANAGER ON DUTY: Include: Precipitating events, unit acuity, staff issues, milieu/environmental factors, corrective action taken and recommendations. To be completed by end of shift of occurrence

Suspected Patient to Patient Abuse Yes No (if yes, forward Incident Report to Program Manager by end of shift of occurrence)

PERSON(S) NOTIFIED	DATE	TIME	PERSON(S) NOTIFIED	DATE	TIME
_____	_____	_____	_____	_____	_____
Print Name and Title	Signature	Date	Time	AM/PM	

FINDINGS/FOLLOW UP BY UNIT DIRECTOR: To be completed within 3 business days of incident

 Print Name and Title _____ Signature _____ Date _____ Time _____ AM/PM

QA Review: Incident Code Correct: Yes No Referred For: CIR Admin Review N/A DPH Adverse Event Report: Yes No

 Print Name and Title _____ Signature _____ Date _____

WHITING FORENSIC HOSPITAL OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 5:	Improving Organizational Performance
PROCEDURE 5.8:	Patient Safety Event and Incident Management LD.03.09.01
REVISED:	July 22, 2022, May 1, 2023, February 29, 2024
Governing Body Approval:	July 22, 2022, May 1, 2023, March 1, 2024
Effective Date:	February 1, 2024, March 1, 2024

PURPOSE: To establish a system to identify, manage, classify, document, report, track, and trend events with the potential for adverse effects on the safety, care, treatment, and recovery of patients served by Whiting Forensic Hospital (WFH). The system will include a multi-level review process to ensure that safety events are reviewed, appropriate corrective actions are implemented, and the effectiveness of actions in preventing recurrence is monitored.

SCOPE: All WFH Staff

POLICY:

1. **Categories and Definitions of Incidents:** The hospital will use the categories and definitions of incidents to be investigated listed in Appendix A.
2. **Initial Documentation on the Incident Report Form (WFH-494):** The hospital will use a standardized form to document and classify incidents as well as to document review findings. The hospital will use the Risk Management and Notification System (RMANS) and other electronic systems to provide information and data on categories of incidents, as well as patient specific incidents, to support timely intervention by interdisciplinary treatment teams and committee(s).
3. **Multilevel Review Process:** The hospital will implement a multi-level review process to ensure the appropriateness and effectiveness of follow-up actions and safety of patients. This includes mechanisms for oversight of critical incident reviews.
4. **Performance Improvement:** The hospital will track, trend, and analyze data to evaluate the effectiveness of the Incident Management System and to identify and manage systemic patterns and trends. De-identified data will be maintained and available through RMANS and other electronic systems for review of aggregate patterns and trends.
5. **Notifications and Reporting:** Adverse Events (as defined by the Department of Public Health) and other Critical Incidents (as defined by the Department of Mental Health and Addiction Services) will be reported to the DMHAS Office of Health Care Systems as outlined in this procedure. These incidents will be reported to external agencies, as appropriate and required by law, as outlined in this procedure.

6. **Retention of Incident Reports:** Incident Report Forms will be retained for a minimum of 10 years and require permission from the Public Record Administrator to destroy, coordinated by the HIM Supervisor.

PROCEDURE:

Definitions:

Incident: An occurrence or attending circumstance, which adversely affects or has the potential of adversely affecting an individual's health, safety, and wellbeing and/or the operation of the hospital. An incident may, or may not, be patient related.

Patient Safety Event: An event, incident, or condition that could have resulted or did result in harm to a patient.

Adverse Event (DPH): A discrete, auditable, and clearly defined occurrence with a consequence that results in an undesired outcome that was due to the course of care, and which indicates further investigation and/or root cause analysis of the unplanned event to confirm or refute the presumed relationship between the care and undesired outcome.

Critical Incident: An incident that creates a significant health hazard, puts an individual's health and safety in immediate jeopardy, or may have a serious adverse impact on the hospital and the patients, staff, facilities, funded agencies, or the public or incidents that may bring about adverse publicity. The incident must have involved a hospital/DMHAS patient, or an on-duty staff member or visitor, and must have occurred within a DMHAS-operated or DMHAS-funded agency or program. (A listing of critical incidents reportable to the DMHAS Office of Health Care Systems is located at the end of this procedure - Appendix A)

I. Initial Documentation of Incidents

A. Responsibility for initial documentation

1. Any occurrence meeting the definition of an incident will be documented on the Incident Report Form (WFH-494) prior to the end of the shift by the person who observes and/or has initial knowledge of the incident.
2. Unit staff will be responsible for documenting occurrences any time information is reported by advocacy and grievance staff, volunteers, contractors, or visitors to the hospital.

B. Documentation requirements

1. Initial documentation will include a synopsis of the incident, incident details, incident category, who the incident was reported by, related incidents, patient data relating to an incident, staff/other involvement, initial response, notifications, and contributing factors.

2. All incidents will be reviewed, and relevant findings, interventions and follow-up documented by the Nurse Supervisor, DN/Manager on Duty and the appropriate administrator.
3. All pertinent information relative to incidents involving patients must be documented in the Progress Notes section of the Medical Record, including the Registered Nurse and Physician assessment as indicated. Assessment of injury and potential trauma related to any incident should be documented per hospital procedure.
4. The Incident Report Form is an administrative form only, does not substitute for the necessary clinical documentation in the Medical Record and will be filed in the CEO's office following data entry into RMANS.

C. Accuracy of documentation

1. All staff are to be aware of and use the correct incident definitions and codes.
2. As part of the second level review described in this procedure, the COO/CNO or designee will review all incidents. It is their responsibility to ensure that the incident report is complete and accurate.
3. The Performance Improvement Department will review all incident reports for accuracy and completeness and make coding corrections as indicated.
4. COO will ensure that all Incident Report Forms are entered in RMANS as soon as possible, but no later than the 10th day of the month following the date of the incident.
5. New employees will receive training in the documentation and reporting of incidents as part of their new hire orientation.

II. **Initial Documentation on the Incident Report Form (WFH-494)**

A. Basic Data

1. ***Incident Date and Time:*** Enter the date and time on which the incident occurred. (This date may or may not be the same date on which the incident becomes known and is entered in the system.). If the exact time is unknown, use the best estimate available (and note that the time is estimated in the description of the incident).

B. Type of Incident

Select only one incident type that most closely reflects the factual account of the incident.

C. Summary Description of Incident

Enter a detailed, factual account of the incident, including who, what, where, when, and how. This summary should include contributing factors, any identifiable triggers, actions taken by staff, and how the incident concluded. Note all immediate actions taken to care for the patient and/or manage the situation following the incident.

F. Physician Report

The physician will complete this section for each patient involved in an incident if an exam was required and performed. An exam is required for all patient injuries.

1. **Note Injury Type and Severity:** Select the appropriate severity using the following definitions:

- a) No Injury.
- b) No Treatment Required.
- c) *First Aid Required:* The injury received is of minor severity and requires the administration of minor first aid. This is meant to include treatments such as the application of small adhesive bandages (Band-Aids), cleaning of abrasion, application of ice packs for minor bruises, and use of over-the-counter medications such as antibiotic creams, aspirin, and acetaminophen. *This is to be selected whether the nurse or physician administers the first aid.*
- d) *Medical Treatment Required:* The injury received is severe enough to require the medical treatment of the individual by a licensed medical doctor osteopath, podiatrist, dentist, physician's assistant, or nurse practitioner, but the treatment required is not serious enough to warrant or require hospitalization; further, the treatment received may be provided within the facility or provided outside the facility where it may range from treatment at a doctor's private office through treatment at the emergency room of a general acute care hospital. This medical treatment goes beyond first aid and involves more than diagnostic assessment. Examples include sutures, setting broken bones, and prescriptions beyond over-the-counter medication.
- e) *Hospitalization Required:* The injury received is so severe that it requires medical intervention and treatment as well as care of the injured individual at a general acute care hospital; regardless of the length of stay, this severity level requires that the injured individual be formally admitted as an individual to the hospital and assigned to a bed on a unit outside of the emergency room.
- f) *Death:* The injury received was so severe that it resulted in – or complications from the injury lead to – the termination of the life of the injured individual.
- g) *Refused Examination/Treatment:* The individual refused assessment and/or treatment for an identified or suspected injury.

The assigned severity rating is based on the information known by the physician at the time of the assessment. The severity of injury rating should be changed as appropriate based on subsequent information as it becomes available. This is addressed in the hospital leadership review process.

3. *Physician Summary and Treatment Ordered:* the physician briefly summarizes findings of the physical exam and treatment ordered for the patient.

The physician prints his/her name, signs, and dates and times the Incident Report Form.

III. Critical Incident Reporting and Notification

A. Initial Report

The staff person who observes, is involved in, or becomes aware of any critical incident immediately notifies the supervisor on duty (Unit Director/Nurse Supervisor). The supervisor on duty notifies the DN and Attending Psychiatrist/On-Call Physician and initiates the verbal internal notification process.

B. Special Notification Procedures

Special notification procedures are required for certain types of critical incidents as delineated below.

1. Elopement: Unauthorized Absence or Escape

Any staff person discovering that a patient has eloped will immediately notify the Nurse Supervisor/DN on duty. The Nurse Supervisor/DN on duty immediately notifies the DMHAS Police via Dispatch at X5555 and makes internal notification to the CEO. When reporting to the DMHAS Police and CEO, the following information will be provided: client's legal status, mental status, level of dangerousness and circumstances surrounding the elopement.

This information is necessary for the CEO to make a determination as to whether or not DMHAS Police will send an online law enforcement communication to other Law Enforcement Agencies to aid in locating the missing patient or escapee.

Refer to Operational Procedure 2.10 Elopement/Escape and Unauthorized Absence for more detailed, specific information including the definition of elopement including escape and unauthorized absence.

The CEO notifies the DMHAS Medical Director and/or any other manager as indicated by the incident.

2. Unexpected Death, Sexual Assault, or Other Major Offense

The Nurse Supervisor/DN on duty immediately notifies the DMHAS Police if the incident involves an unexpected death, sexual assault, or other major crime on hospital grounds. The DMHAS Police follow internal policy and procedures for investigation, preservation of evidence, and any required notification of external law enforcement agencies.

C. Internal Verbal Notification for all Critical Incidents

1. The DN/Manager on Duty immediately notifies the CEO, CMO, CNO, and/or CQCO depending on the type of critical incident.

The immediate notification includes as much of the following information as possible:

- a) A brief summary of what occurred, the date, time, place of the incident, and the assigned unit(s) of the persons involved;
- b) The names of the person(s) involved and their relationship to the hospital (e.g., patient, staff, visitor, other);
- c) The age, gender, legal status, privilege level, diagnosis, clinical status, and the current level of dangerousness as determined by the Attending Psychiatrist/On-Call Physician at the time of the incident of the person(s) involved;
- d) External notifications that may be needed (identified through consultation with the Attending Psychiatrist/On-Call Physician), such as next of kin, conservator, probation officer, significant others, other agencies, etc.; and
- e) Immediate actions taken, follow-up steps in process, and current location of the person(s) involved if they have been moved.

2. The CEO reviews all (potential critical incidents in daily Morning Report.

E. Written Notification/Reporting

In addition to an Incident Report, the Manager overseeing the department in which the Critical Incident occurred will complete the DMHAS-601 form and forward to the Quality Assurance and Program Improvement Manager (QAPI). The QAPI Manager will ensure accuracy and completeness, identify if a Critical Incident Review (CIR) or Administrative Review (AR) is indicated and forward to the administrative assistant for entering into DDAP at closure. The QAPI Manager will make external notifications to DPH and DRCT, as necessary.

The CEO forwards a copy of the Incident Report Form ([WFH-494](#)) and the Critical Incident Verbal and Written Notice Form ([DMHAS--601](#)) to the office of the Medical Director at the Office of the Commissioner within one (1) business day.

D. External Verbal Notification of Critical Incidents

1. The CEO/designee notifies:
 - a) The DMHAS Office of The Medical Director (860-418-6879). When an incident occurs after hours, the CEO or designee calls the OOC Administrator On Call. If the CEO is not available, the COO will initiate the report.
 - b) The Psychiatric Security Review Board for all patients under the jurisdiction of the Psychiatric Security Review Board.
 - c) The DMHAS Evaluation, Quality Management and Improvement Division (EQMI) and the designated Protection and Advocacy (DRCT) for notification for all inpatient deaths (expected and unexpected).
 - d) CONN_OSHA for any incident which results in a work-related staff death or hospitalization of three or more staff from a work-related incident. This reporting process must be completed within 8 hours of the incident.
 - e) Critical incidents that meet the threshold for DPH Adverse Events are submitted online via the FLIS portal. For those incidents requiring immediate verbal notification, DPH is notified by calling 860-509-7400.
2. The Unit Director/Nurse Supervisor/DN consults with the Attending Psychiatrist/On-Call Physician to determine the need for any external patient-related notifications that may be needed such as next of kin, conservator, probation or parole officer, Tarasoff warnings, significant others, other agencies, etc.
3. If the patient goes to the Emergency Department due to a serious (life-threatening) injury or illness after normal business hours, the On-Call Physician will notify the CMO.
4. If a patient dies at an acute care hospital, the Director of ACS contacts the hospital, confirms what notifications have occurred and whether an autopsy has been requested. The CMO calls the family to offer condolences, answers questions, and requests an autopsy if one is not already being performed.

IV. Multilevel review of incidents

After unit staff documents an incident, it is subject to two levels of review. There is a third level of review adverse events that are determined to be critical incidents.

1. First Level Review: The Nurse Supervisor, Unit Director, and Director of Nursing (DN) complete a detailed summary of findings of the incident and document any

additional measures taken to manage the immediate situation and any further notifications that are made.

The first level of review is to be documented on the Incident Report Form by the Nurse Supervisor and DN by end of shift of occurrence and by the Unit Director within three working days. This review includes at minimum the following information:

- a) Precipitating events, known early warning signs, history affecting the incident, behavior of the individual days prior to the incident, and where the incident occurred;
 - b) Actions taken to protect victim, e.g., staff movement, patient movement;
 - c) Unit acuity, staffing ratio and mix, location of staff and staff changes;
 - d) If applicable, reaction of patient's conservator;
 - e) Staff actions related to incident (different from medical/nursing interventions);
 - f) Therapeutic milieu factors; and
 - g) Environmental factors and any equipment concerns.
2. Second Level Review: The second level of review is to be completed by the COO/CNO and documented on the Incident Report Form (Addendum C) within five business days and includes at minimum the following information:
- a) Additional information to Level I Review by the Unit Director;
 - b) Analysis of contributing factors, including staff actions, actions by other individuals, staffing ratio/mix, and therapeutic milieu factors;
 - c) Actions to prevent recurrence; and
 - d) Recommendations and referrals for CIR/ARs.

Incidents will remain "open" in RMANS until the second level review is completed.

3. Third Level Review: The third level of review is to be completed via the Critical Incident Review (CIR) or Administrative Review (AR) process, which is completed within 30 days and includes all events defined as a DPH Adverse Event. CIRs typically involve patient related incidents and ARs focus on operational/systems issues. CIRs and ARs are reviewed in Governing Body, including a summary of the RCA and CAP.

A. Critical Incidents and Adverse Events are investigated and examined through a comprehensive systematic analysis via a root cause analysis (RCA). The comprehensive systematic analysis results in the development of a corrective action plan (CAP) to reduce the potential recurrence of a similar event.

CIRs that involve patients (or have the potential for a significant impact on the clinical care of patients) are conducted by the Service Medical Director under the auspices of the Peer Review Committee of the Medical Staff, and, as such, are entitled to the protections granted to medical review committees under Title 19, "Public Health and Safety," Chapter 368a, Section 19a-17b of the Connecticut General Statutes.

The Manager overseeing the department in which the incident occurred conducts the AR.

- B. A comprehensive systematic analysis is the methodology by which an in-depth investigation is conducted, focusing on systems and processes to identify causal and contributing factors that underlie the event (any incidental findings may be noted for action). The comprehensive systematic analysis is documented and maintained in the critical incident file.
- C. A Corrective Action Plan is developed to eliminate or control system hazards or vulnerabilities that have been identified by the comprehensive systematic analysis. The plan must identify corrective actions directly related to causal and contributory factors, assign responsibility for implementation, include timelines for completion, and identify strategies for evaluating the effectiveness of the actions and strategies for sustaining the changes.

Critical Incident Reviews

- A. The Service Medical Director (SMD) and QAPI Manager will direct all aspects of CIRs. An interdisciplinary review team, to include the CNO, will be charged by the CEO to facilitate the root cause analysis. The process should be completed as described below, unless access to information or staff is restricted as part of a criminal investigation or Labor Relations investigation. Under those circumstances, the review team should complete as many of the tasks as feasible and complete the remainder of the process as permitted and / or until the investigatory hold is lifted.
- B. The SMD and QAPI Manager are responsible for ensuring the following in relation to CIRs:
 - 1. The planning meeting is convened within 3 business days. Participants in this meeting are given assignments to include additional investigatory interviews to be conducted, review of the medical record and other relevant documents and forms, review of relevant procedures, visiting the involved unit/location, and other activities as appropriate.
 - 1. The Clinical Case Summary (which provides relevant patient-specific data and clinical background, describes the course of events leading up to the event, and summarizes any other relevant information) is prepared by the Attending Psychiatrist and submitted prior to the RCA.
 - 2. The Clinical Case Summary, incident report and critical incident report paperwork, and other relevant documentation will be gathered by the QAPI Manager and reviewed by the SMD and CNO.
 - 3. Participants will be given assignments, to include investigatory interviews, review of the medical record and other relevant documents and forms, review of relevant procedures, visiting the involved unit/location, and other activities as appropriate.
 - 4. The goal of the investigation is to establish the facts and a timeline relevant to the incident under review.

5. The SMD will facilitate the RCA within 10 business days of the event in order to complete the comprehensive systematic analysis. The goal of the investigation is to establish the facts and a timeline and review investigation findings, identify any discrepancies, and identify additional information needed to complete the comprehensive systematic analysis.
 6. Within 14 days of the RCA, the team will develop a Corrective Action Plan identifying actions already implemented as well as those to be implemented that directly relate to the identified causal and contributory factors, assigning responsibility and timelines for implementation, and identifying strategies for evaluating effectiveness and sustaining changes. For those events defined as a DPH Adverse Event, the QAPI Manager will submit the CAP via the FLIS portal.
- C. Participants in the RCA process include, as appropriate: Staff involved in, or witnessing, the incident; the Attending Psychiatrist; the Ambulatory Care Clinician as indicated; the Unit Director and/or Program Manager; the CNO; the Supervising Pharmacist, as indicated; the Chair of the Falls Committee and/or a Physical Therapist for fall related injuries; and Plant Operations staff as indicated.
- F. The QAPI Manager is responsible for the following:
1. Scheduling the planning meeting, RCA, and CAP meetings;
 2. Facilitating the planning meeting and obtaining all relevant documentation; video review, policies, etc.;
 3. Maintaining RCA and CAP documentation of outcome measures related to implementing Corrective Action Plan items necessary for the closure of the CIR file;
 4. Submitting Section C of the DMHAS Critical Incident Review Closure Form to the DMHAS Office of Health Care Systems within 45 days of the Critical Incident; and
 5. Ongoing monitoring of the implementation of the corrective actions approved by the CIR as reviewed in Quality Risk and Safety Committee.
- I. The Manager assigned to corrective action items is responsible for ensuring that the corrective actions identified on the plan are implemented and any related auditing occurs and forwards any necessary data or supporting documentation to the QAPI Manager/CQCO. The Manager will report monthly in QRS until the CAP item and related auditing is satisfied.

V. Administrative Review

An *Administrative Review* may be conducted to ensure a comprehensive review of non-patient related incidents that do not rise to the level of a critical incident, or for an incident involving staff members or procedural/systems issues only and having no significant impact on the clinical care of patients.

The CIR process and timelines noted above are followed for ARs, with the assigned department Manager responsible for conducting the review in collaboration with the QAPI Manager.

Administrative Incident Review proceedings are not peer-protected unless they involve patient-related information/issues.

VI. Performance Improvement

- A. The hospital will track and trend data to evaluate the effectiveness of the Incident Management System (e.g., timeliness of documentation and corrective actions) and to identify and manage individual and systemic patterns and trends (e.g., changes in frequency, location, or severity of incidents).
- B. The Quality, Risk and Safety Committee is responsible for analyzing data and making recommendations for corrective action. Data is presented to the Governing Body on a quarterly basis.
- C. Quarterly Reports:
 - 1. The Quality Assurance department and department heads will prepare summary reports on quality indicators quarterly for presentation to the Quality, Risk and Safety Committee and Governing Body. Quality indicators may be added based on trends identified through the CIR and AR process.
 - 2. Trends will be noted and further drill down analysis will be conducted as indicated, with a summary provided and corrective action identified as needed.
 - 3. The Quality Assurance department will prepare a semiannual report for presentation to QRS and Governing Body to include the number and types of critical incidents and trends identified.

1. Critical Incidents/DPH Adverse Events

- a. Any serious or significant injury, or death, that occurred during or due to the use of seclusion or restraint. The determination of “serious or significant” for injuries requiring medical intervention, but not hospitalization, is made by the CEO/CMO in conjunction with the CQCO.
- b. Any serious suicide attempt, including suicide attempts that occur up to 30 days after discharge, if known.
- c. A medication event that resulted in the need for admission to an acute care hospital but was not life threatening and resulted in no permanent or severe temporary patient harm.
- d. Any serious or significant injury requiring medical intervention outside the hospital to a patient, on-duty staff member, or visitor, resulting from an accident, unexplained/suspicious circumstances, or possible criminal activity. The determination of “serious or significant” for injuries requiring medical intervention, but not hospitalization, is made by the CEO in conjunction with the CQCO.
- e. The death of an on-duty staff member or visitor to the hospital related to accident, unexplained circumstances or suicide.
- f. The unexpected death of a patient, including death that occurs up to 30 days after discharge, if known.
- g. Escape or elopement of a patient under the jurisdiction of the Psychiatric Security Review Board (PSRB), a patient admitted under a Physician’s Emergency Certificate (PEC), a patient legally deemed incompetent, or a voluntary patient deemed dangerous to self or others or gravely disabled.
- h. Serious behavior committed or allegedly committed on or by a patient, or a staff member, or a visitor to the facility that resulted in or may result in a felony arrest, such as arson, assault, armed robbery, bomb threat, hostage taking, or sale of illegal substances or sexual assault/rape of a staff member or visitor while on the grounds of the hospital.
- i. Rape, defined as coerced sexual contact involving a patient and another patient, staff member or other perpetrator while being treated or on the premises of the grounds of the hospital.
- j. Alleged or suspected patient abuse or neglect, non-accidental injury, or patient rights violation, including confidentiality breaches having serious consequences or potentially serious consequences for the patient.
- k. Threats by a patient who has been assessed by the Attending Psychiatrist to represent a serious risk to staff, other patients, or others.
- l. An incident involving a patient or staff member in which it appears reasonable that media coverage or adverse publicity will be or is likely to occur.

- m. Major environmental event that requires emergency evacuation or relocation of patients (other than for the purpose of a drill) for a duration of at least two (2) hours, such as a fire or flood.
- n. Significant loss or allegation of theft of property or property damage that compromises or could compromise staff or patient safety.
- o. Significant (\$1,000 or greater) loss or theft of state property or property damage; and emergency situations that result in the notification of any government agency (e.g., FBI, U.S. Secret Service, Board of Examiners, Protection and Advocacy, etc.), in conformance with the incident reporting requirements of the respective agency.
- p. Any other incident determined by the CEO and CQCO as needing to be reported.

WHITING FORENSIC HOSPITAL OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 5:	Improving Organizational Performance
PROCEDURE 5.9:	Assessment and Reporting of Victims of Abuse, Neglect or Exploitation
Governing Body Approval:	November 19, 2020, July 21, 2021
REVISED:	November 15, 2020, July 6, 2021

PURPOSE: To delineate staff responsibility for reporting verbal, physical, sexual or emotional patient abuse and the process to meet that responsibility.

SCOPE: All WFH Staff

POLICY:

The Connecticut Department of Mental Health and Addiction Services (DMHAS) and Whiting Forensic Hospital (WFH) have a zero tolerance policy for the abuse, neglect or exploitation of patients. Every patient has a right to be free from verbal, physical, sexual, and emotional abuse, neglect and exploitation. WFH, in collaboration with DMHAS Human Resources and DMHAS Public Safety, work collaboratively to ensure that every allegation of abuse, neglect or exploitation (ANE) is immediately reported and thoroughly investigated. All WFH employees involved in, witness to or made aware of alleged abuse, neglect, or exploitation of patients must report this immediately to their supervisor and complete an incident report by the end of the shift when the alleged violation occurred or was discovered. Immediate reporting ensures the protection of our patients, and the immediate initiation of the investigation of events leading to the report. Failure to report incidents of ANE in accordance with this policy may result in disciplinary action. Licensed or certified individuals who fail to report ANE may also be subject to State of Connecticut regulatory sanctions or penalty. WFH also has an obligation to report ANE of special populations (e.g. children, elderly, and persons with developmental disabilities) to other agencies.

Definitions:

Abuse: Intentional maltreatment of an individual that may cause physical or psychological injury.

Physical Abuse - includes hitting, slapping, pinching, or kicking. Also includes controlling behavioral through punishment.

Sexual Abuse - includes sexual harassment, coercion, and assault.

Verbal Abuse - refers to any oral, written, or gestured language that includes disparaging derogatory terms towards patients or to describe patients.

Neglect - includes failure to provide proper care to an individual who is unable to care for him/herself. Neglect may exist in one or more of the following five functions: physical, nutritional, medical, emotional, and safety.

Exploitation - An unjust or improper advantage or use of another person or their property for one's own advantage (e.g., using a victim's financial means for another's gain).

Elder - Any patient sixty years of age or older.

Precursors of Abuse – Factors which place patients at increased risk.

- Impaired Communication (Inability to verbalize effectively or alternate language)
- Debilitating Physical Condition(s)
- Social Isolation
- Poor Mental Health
- History of Domestic Violence
- Staff feeling unable to cope with care demands.

PROCEDURE:

I. Staff Vigilance and Reporting (All Staff):

Staff vigilance is essential to ensuring WFH's commitment to the protection of patients. Staff must be familiar with the precursors, the signs, and the symptoms of abuse, neglect and exploitation to fulfill their responsibility as patient advocates and designated reporters. The chart below provides specific examples of signs and symptoms of abuse.

Signs and Symptoms of Specific Types of Abuse, Neglect, and Exploitation

Physical Abuse	<ul style="list-style-type: none"> • Unexplained injuries such as burns, bruises, cuts, dislocations, fractures, lacerations, punctures, scars, sprains, or welts • Injury patterns-i.e. symmetrical on body, multiple surface areas, size/shape of familiar objects (i.e. hand/fingers, cord, or belt) • Injuries in various stages of healing • Broken eyeglasses or frames
Verbal & Emotional Abuse	<ul style="list-style-type: none"> • Disparaging, derogatory, insulting, demeaning or vulgar comments directed at a patient • Harassment of patient • Threats of punishment • Threats of deprivation • Intimidation through yelling, swearing • Habitual blaming or scapegoating
Sexual Abuse	<ul style="list-style-type: none"> • Sexual contact regardless of consent • Showing pornographic material or other sexual harassment • Bruises around breasts or genitals, and unexplained vaginal or anal bleeding may be indicative of sexual assault. • Unexplained venereal disease or genital infections • Eliciting sex
Neglect by Caregivers or Self-Neglect	<ul style="list-style-type: none"> ▪ Failing to assist in personal hygiene ▪ Failing to take the patient to the toilet when required ▪ Untreated physical problems, such as bed sores ▪ Being left in soiled bedding or clothing

	<ul style="list-style-type: none"> ▪ Unsuitable clothing or covering for the weather
Financial Exploitation	<ul style="list-style-type: none"> • Withdrawals from the patient’s accounts for personal gain • Items or cash missing from the patient’s living area • Financial activity the patient couldn’t have done • Unnecessary services, goods, or subscriptions

While the above signs/symptoms are not conclusive evidence of ANE, a staff member noticing them should consider them in the context of all available information. If this evaluation creates a reasonable cause to suspect ANE is occurring, the staff member must immediately report it to his/her supervisor and complete an Incident Report Form (WFH 494) by the end of the shift when the alleged violation occurred or was discovered. The procedures involved in reporting, reviewing and investigating allegations of ANE are addressed in Policy 5.8 Patient Safety Event and Incident Management.

II. Immediate Care of the Patient(s) (Completed by Registered Nurses and Physicians):

1. The patient should be moved to a physically safe location. This may require the removal of another patient, visitor, or staff suspected of involvement in abuse, neglect, or exploitation.
2. A registered nurse and physician must complete a thorough physical assessment of the patient, including evaluation of the presence of any psychological effects, such as trauma. Any history of previous trauma should be considered in this assessment. The assessments results should be clearly documented in a progress note. In addition, the Registered Nurse should complete the Injury Assessment/Reassessment form WFH-635 for any reported physical abuse.
3. If the patient requires emergency medical care, the physician arranges transfer to an acute care medical-surgical hospital’s emergency department. If a forensic medical examination is required, the examining physician will arrange this evaluation with the acute care medical-surgical hospital’s emergency department.
4. For allegations of physical or sexual abuse that result in temporary reassignment to a non-patient care area (see OP&P 5.8 Patient Safety Event and Incident Management), an assessment of possible victimization should be completed and documented for all patients with a similar clinical symptom profile of the alleged victim on the same unit. The purpose of this assessment is based on reasoning that a certain clinical presentation can increase the likelihood of victimization by other members of the unit community. This assessment is intended to ensure the absence of victimization and the sustained overall safety of the milieu.

III. Reporting to External Agencies (Social Workers/other designated Licensed Professionals):

- 1) The team social worker is the designated reporter to external agencies for the three special populations, to which the facility has reporting obligation. The special populations are:
 - a. a child under the age of 18

- b. an individual 60 years of age or older
 - c. clients of the Department of Developmental Services
- 2) In the absence of the social worker, the team will designate another licensed professional to complete the reporting process.
- 3) The COO/CEO reports incidents to the Office of the Commissioner (OOC) as necessary.

SPECIAL POPULATION	REPORTED TO	REPORTED BY	VERBAL WRITTEN REPORTS	TIME REQUIREMENT
Suspected child abuse, neglect or imminent risk or abuse (<18 years old)	Department of Children & Families	Team Social Worker	Verbal 1-800-842-2288 ===== Written – DCF Form-136 http://www.ct.gov/def/lib/def/policy/pdf/def-136-Fillable.pdf	Written within 48 hours of call to Careline
Suspected elderly abuse (≥ 60 years old)	Department of Social Service	Team Social Worker	Verbal 1-888-385-4225 ===== Written – DSS Form W-675 https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Common-Applications/W-675.pdf	Verbal within 5 calendar days followed by written report.
Suspected abuse or neglect of an adult with intellectual disability	Department of Developmental Services	Team Social Worker	Verbal 1-844-878-8923	Verbal immediately A written report within five (5) calendar days of oral report

Reporting Suspected Child Abuse

While WFH does not directly serve children, reporting is required when we suspect that a child under the age of 18 has been abused, neglected, or exploited or is at imminent risk.

- A. The designated reporter contacts the Department of Children and Families (DCF) hotline in consultation with the CEO, COO, CMO, and/or Director of Social Services. Designated reporters are under no legal obligation to inform parents or alleged perpetrators of a DCF report, and in cases of abuse, should not talk with parents before DCF investigates the allegations as this may place the child(ren) at greater risk.

- B. The social worker/designated reporter should have the following information available to report:
 - 1. Name and Address of Child(ren) and Parents/Caregivers
 - 2. Age and Gender of Child(ren)
 - 3. Nature and Extent of Injury/Maltreatment/Neglect
 - 4. Approximate Date and Time of Event
 - 5. Circumstances which led to knowledge of event
 - 6. Previous Abuse History (if known)
 - 7. Name of Suspected Perpetrator
 - 8. Actions taken to protect child

- C. Within 48 hours of the initial call to the DCF hotline, the reporter completes a DCF Form-136 and mails it to DCF at: ***505 Hudson Street, Hartford, Connecticut 06106.***

The form can be obtained at:

http://www.ct.gov/DCF/lib/DCF/policy/forms/DCF-136_Rev_05_2015.pdf

- D. The DCF abuse unit determines whether there is probable cause to investigate the allegation based on information gathered,

Reporting Suspected Abuse of the Elderly

Suspected abuse, neglect or exploitation involving an individual 60 years of age or older is reported to the Department of Social Services (DSS).

- A. The designated reporter contacts the DSS Central Office, Elderly Protective Services in consultation with the CEO, COO, CMO, and/or Director of Social Services within 5 calendar days of learning of the suspected abuse.

- B. The reporter sends a subsequent written report on DSS Form W-675 to the State of Connecticut, DSS, ***Elderly Protective Services Unit, 25 Sigourney Street, Hartford, Connecticut 06106-5033.***

The form can be obtained at:

www.ct.gov/dss/lib/dss/pdfs/W675rev1206pt.pdf

Reporting Alleged Abuse or Neglect of an Adult with Intellectual Disability

- A. Suspected abuse, neglect or exploitation involving individuals with intellectual disabilities is reported to the Department of Developmental Services (DDS) at **1-844-878-8923**. An oral report should be made immediately to the abuse investigation division. The designated reporter contacts DDS in consultation with the CEO, COO, CMO and/or CQCO.
- B. The designated reporter should have the following information available to report:
 - 1. Name and Address of Alleged Victim
 - 2. Evidence Supporting Diagnosis of Intellectual Disability
 - 3. Nature and Extent of Injury/Maltreatment/Neglect
- C. A written report using form PA-6 must be submitted to DDS within five (5) calendar days of the oral report. The completed PA-6 should include the name, date of birth, address and telephone number of the alleged victim of abuse or neglect. The form should also include the reasons the reporter believes the victim to have an intellectual disability, information supporting the victim's inability to protect themselves from abuse or neglect, information regarding the extent of the suspected abuse or neglect and any supporting information. Lastly, the name and address of the person reporting should be included as well as a number where they can be reached.

Confidentiality and Immunity from Prosecution

Designated reporters identify themselves when making a report to DCF, but may request anonymity from the alleged perpetrator. Under these circumstances DCF will only release the reporter's identity if required by law and to parties involved in the investigation process (i.e. law enforcement, state attorney).

Immunity from civil or criminal liability is granted to people who make good faith reports. Immunity is also granted to people who in good faith have not reported. However, failure to report could result in fines and potential lawsuits for damages if further injury is caused to the child because of failure to act. The identity of any person who fails to report may be disclosed to the appropriate law enforcement agency and to the perpetrator of the alleged abuse.

Intentional false reporting of abuse or neglect is a criminal offense, and if DCF suspects or knows that a reporter has made a false report both law enforcement and the alleged perpetrator will be notified.

Employers may not discharge, discriminate or retaliate against an employee for making a good faith report or testifying in an abuse or neglect proceeding.

There is also statutory protection for good faith reporting of elderly abuse. Any person who makes any report, or who testifies in any administrative or judicial proceeding arising from such report shall be immune from any civil or criminal liability on account of such report or testimony. A reporter is exempt from liability for perjury, unless such person acted in bad faith or with malicious purpose.

Suspected Patient to Patient Abuse

Patient to patient abuse is defined as physical abuse or exploitation of a vulnerable individual by another patient, including but not limited to those protected groups where the hospital is statutorily required to report to outside agencies when they incur physical harm (e.g. the elderly or intellectually disabled). In addition, all reports of patient to patient sexual contact will be managed as potential abuse. Acts of physical aggression directed from one patient toward another patient who is not identified as representing a statutorily protected/vulnerable class will be assessed by the Program Manager and Service Medical Director to determine if the incident rises to the level of patient to patient abuse.

All potential patient to patient abuse must be immediately reported to the DN/Manager on duty. During regular business hours, the DN/Manager on duty will immediately notify the Program Manager and Service Medical Director. After hours, the DN/Manager on duty will immediately notify the On Call Physician.

Immediate steps will be taken to ensure the safety and wellbeing of the alleged victim, which may include a room change, transport to and assessment at the ED, special observation, etc.

The DN/Manager on duty will obtain and document (on the Incident Report) information regarding the suspected abuse, including when it occurred, location, staff and/or patient witnesses, etc. This includes review and documentation of video, if available. In cases where video exists, the DN/Manager on duty will request the video is saved.

If evidence suggests that a serious assault of a vulnerable patient occurred or if evidence suggests there has been a patient to patient sexual assault, agency police must be notified immediately. In cases of physical or sexual assault resulting in need for outside medical care, the CMO and CEO must be notified.

If reported after hours, by the end of shift of occurrence, the DN/Manager on duty and On Call Physician will document on the Incident Report, what steps were taken to address the suspected abuse. The DN/Manager on duty will email the Program Manager to expect the incident report and will forward the completed report to the Program Manager/Service Medical Director for follow up to occur the next business day.

The Program Manager and Service Medical Director will obtain and review relevant information, make a determination of finding and document the findings and action taken on addendum C on the Incident Report.

Any substantiated findings of abuse of the elderly or intellectually disabled will be reported to DDS or DSS as required above. Additional reporting to DPH may be required as an adverse event.

Depending on the circumstances of the incident and findings, a Critical Incident Review may be initiated. The PI Manager will collect, aggregate and trend data relative to patient to patient abuse. Data will be reported at least quarterly in QRS and Governing Body.