WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 6	LEADERSHIP
Governing Body Approval:	6/10/18
REVISED:	

VALUE - In accordance with the Vision and Mission Statements of the Department of Mental Health and Addiction Services Governing Authority and Whiting Forensic Hospital (WFH), the leadership of WFH sets the organizational policy that supports quality patient care.

GOAL - To provide quality care through a hospital structure that:

a. outlines accountabilities and relationships of all major divisions, departments, offices, and committees; and
b. reflects the hospital's vision, mission, policies and by-laws which govern the hospital's operations.

POLICY-

1. By direction of the Governing Authority, WFH has established a Governing Body which is responsible for:
   a. Defining clear lines of authority in relation to strategic planning and organizational management;
   b. Operations;
   c. Establishment of policies and procedures; and
   d. Evaluation at each level of governance as is demonstrated in the Structural and Functional tables of organization.

1. The Governing Body of WFH includes the following members:

WF

- Chief Executive Officer (CEO)
- Chief Medical Officer (CMO);

- Chief Operating Officer (COO);
- Chief Financial Officer (CFO);
- Nurse Executive;
- Chief Quality and Compliance Officer (CQCO);
- Director of Social Services;
- Program Managers
- Service Medical Directors of the Whiting and Dutcher Services;
- Chief of Forensic Services.
- President and President-elect of the Medical Staff.

3. The Governing Body has overall responsibility for the following functions, including but not limited to:

   a. Quality Patient Care;
   b. Strategic Planning;
   c. Performance Improvement;
   d. Safety and Risk Management;
   e. Medical Staff Privileging;
   f. Financial Management;
   g. Compliance; and
   h. HIPAA Compliance

4. The Governing Body develops, reviews, revises and abides by the by-laws which address its legal accountability and responsibility to patients served by the hospital.

5. The Governing Body By-Laws address the following:

   a. Name and Principle Office;
   b. Role and Scope of the Governing Body;
   c. WFH Vision and Mission Statements;
   d. Statutory Authority;
   e. Structure and Composition of the Governing Body;
   f. CEO's Duties and Responsibilities;
   g. Selection and Responsibilities of the Governing Body Members;
   h. Meetings and Committees of the Governing Body;
   i. Organized Medical Staff;
   j. Discipline Chairs and Associate Chairs;
   k. Quality of Patient Care;
   l. Patient Rights and Patient Education;
   m. Conflict of Interest;
   n. Performance, Orientation, and Education of the Governing Body; and

o. Adoption & Amendment of the Governing Body By-Laws.

6. Medical Staff at WFH have representation at the Governing Body meetings to:

   a. Contribute to hospital strategic planning, budget, safety management, and improving organizational performance; and
   b. Make recommendations to the Governing Body for its approval of the following:
      1. structure of the Medical Staff;
      2. the credentialing and privileging procedure;
      3. recommending delineated clinical privileges for eligible Medical Staff members; and
      4. the organization and the process of the Medical Staff's performance improvement activities;
      5. the process for terminating Medical Staff membership; and
      6. the process for fair hearing procedures.

7. The Governing Authority, Commissioner of Mental Health and Addiction Services, establishes a criteria-based process for selecting a qualified and competent Chief Executive Officer.

8. The Governing Body provides for compliance with applicable law and regulations.

9. The Governing Body provides for an Operational Policy and Procedure Committee which develops, reviews, and revises hospital policies and procedures, and submits them to the Clinical Management Committee (CMC) and the Governing Body for final approval. The Governing Body ensures that all discipline, department and division policies and procedures are reviewed, and revised if needed, at least every two (2) years.

10. The Governing Body ensures that procedures address the following key items:
    a. Nursing Policy and Procedures are based on Nursing Standards of Care and Practice; (refer to Nursing Policy and Procedure Manual); and
    b. Medical Staff review its by-laws, rules and regulations consistent with this policy, its own by-laws, and other applicable law or requirement.

11. The Governing Body has a policy for timely conflict resolution as delineated in the Governing Body By-Laws. This policy is designed to resolve conflicts among the leadership of the facility.

WHITING FORENSIC HOSPITAL

OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 6:	Leadership
PROCEDURE 6.3:	**Development/Revision of Operational Procedures**
Governing Body Approval:	6/10/18
REVISED:	

PURPOSE: To describe the process by which hospital-wide procedures are developed and revised.

SCOPE: Individuals charged with the development of operational procedures

Introduction:

Procedures which are applied on a hospital-wide basis are deemed “Operational” Procedures. It is the responsibility of each Division/Department/Discipline Director to ensure consistency with Division/Department/Discipline specific procedures with its own chapters of the operational procedure.

The need for a new or a revised procedure may arise from a variety of sources, including DMHAS Commissioner’s Policies, federal regulations, accreditation requirements, safety quality initiatives, critical incident reviews, and staff/committee recommendations.

The Whiting Forensic Hospital (WFH) Operational Procedure (OP&P) Committee is chaired by the Director of Accreditation and Regulatory Compliance and consists of representatives from divisions, departments, and disciplines. As needed, content experts may be invited as ad hoc members to Operational Procedures (OP&P) Committee meetings.

POLICY:

Operational Policies and Procedures are those which apply hospital-wide. Members of the OP&P Committee represent Divisions, Departments, and Disciplines across the hospital. The mechanism for developing and revising OP&P is detailed within the procedure.

Definitions:

Policy

- provides foundation for codifying behavior;
- formal, high level statement;
- statement of believe, value or position regarding mission;
- contains rules or standards;
- defines responsibilities;
- clarifies expectations;
- helps manage risk; and
- describes consequences of non-compliance.

Procedure

- defines a process for implementation;
- describes mandatory course of action for compliance;
- provides guidelines for specific behavior
- outlines sanctions;
- identifies responsibilities;
- makes policies practical; and
- may define exceptions.

PROCEDURE:

1. When the need for a procedure is identified, the chairperson of the OP&P Committee will work with the Division/Department Director to assign it to the manager/ designee with the greatest expertise and/or greatest responsibility for the content involved. This individual may or may not be a committee member. If the author is not a committee member, an individual from the committee will be assigned to assist the writer with both clarity of content and correct formatting.
2. All procedures must be reviewed and presented to the OP&P Committee at least triennially, and whenever a practice or regulatory requirement changes the procedure. All triennial reviews must occur within the month set by the last approval date.

3. Those who write Operational Procedures will use the format guidelines, which can be found on Pages 3 and 4 of this procedure.

3\. The assigned manager/designee is responsible for the presentation of the draft procedure
to the OP&P Committee for review.

4. Procedures ready for review by the OP&P Committee are distributed prior to the committee's next scheduled meeting to allow adequate time for review.

5. The OP&P Committee reviews and edits as needed, and prepares the final draft of all new or revised procedures.

6. The OP&P Committee recommends the nature of training indicated based on the content of the procedure and whether new or revised information is contained within. Generally, training will be ascribed to one of four categories:
    a. *Memorandum* – for basic sharing of information. This memorandum with the accompanying procedure is distributed electronically.
    b. *Read and Sign* – for information sharing in which a higher level of staff awareness and accountability is indicated. The procedure being disseminated accompanies a sign-in sheet in this case to verify staff receipt/review of the procedure.
    c. *Electronic Learning (E-Learning)* – for computer-based training.
    d. *In-Person Training* – the most intensive information sharing method is reserved for procedures which are deemed critical and/or complex and likely to require discussion. This method also involves hard copies of the Operational Procedures as well as use of the WFH-288, Read and Sign Form.

7. The chairperson of the OP&P Committee submits a final draft of all new or revised procedures to the Clinical Management Committee (CMC) and/or Governing Body for their review and approval.

8. Upon approval by the Governing Body, the Operational Procedure will be:
    a. added to the next quarterly training cycle;
    b. placed on the T: Drive in the Operational Procedure folder; and
    c. distributed in hard copy for placement in designated Operational Procedure Manuals.

The Operational Procedure Format Guidelines

Format for Operational Procedures

WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL
(All Caps, Centered, Bold, Times New Roman 14pt. Font)

SECTION: **PATIENT FOCUSED FUNCTIONS** *(Example)*
(All Caps, Bold Times New Roman 14pt font)

POLICY: **Patient Rights and Organizational Ethics** *(Example)*

(Bold Times New Roman 14pt font,

Policy Name in Title Case, Bold, Times New Roman 14pt font)

PROCEDURE*:* **Patient Grievance Policy** *(Example)*

(Bold Times New Roman 14pt font,

Procedure Name in Title Case, Bold, Times New Roman 14pt font)

PURPOSE: (bold Times New Roman 14pt font)

(text paragraph - Times New Roman 12pt font)

State the reasons for the procedure clearly and concisely. If applicable, include operational objectives or standards of care – clearly define all items utilized in the Operational Procedure.

SCOPE:Identified Target Audience

POLICY STATEMENT: Definitions (as needed), supporting dates, regulation, legal requirements (as needed)

PROCEDURE: (bold Times New Roman 14pt font)

(text paragraph - Times New Roman 12pt font)

1. Outline the specific action steps in the performance of a particular procedure in order to accomplish the desired result(s) by using the following format:
   - I. Roman Numeral (usually major section headings)
     - A. Capital Letter
       - 1. Arabic Number
         - a. Lowercase letter
           - i. Lowercase Roman Numeral

2. Include who is responsible for each step as indicated, who is responsible for complying.
3. Equipment required.

4. Reference other sections in the Operational Procedure within their text if needed by referring to:
   - a. The name of Chapter, Section X, Policy Y, Procedure Z, Page 1;
   - b. The appendix of the Hospital-wide Operational Procedure Manual which contain the names of all other Hospital Procedure Manuals; and

5. Paginate each individual procedure (example 1 of 9). Footer on each page to contain:
   - Operational Procedure Manual;
   - Chapter Number, Policy Number, Procedure Number; and
   - Date Approved, Reviewed, Revised, etc.

6. Insert attachments, if any, at the end of the procedure, paginating.

7. Who is responsible for monitoring compliance?

8. Where is procedure originating from?

WHITING FORENSIC HOSPITAL

OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 6:	Leadership
PROCEDURE 6.4:	Management of Critical Staffing Levels
Revised:	January 18, 2022, December 21, 2022
Governing Body Approval:	February 22, 2022, January 9, 2023

POLICY:

Whiting Forensic Hospital is committed to providing the necessary staffing to ensure a safe care environment for patients and employees. Staffing shortages created by Covid-19, extreme conditions, or other emergencies require analysis and modification of normal staffing pattern in order to ensure safe allocation of resources and quality care.

SCOPE: All hospital staff

PROCEDURE:

For all COVID related staffing issues, the facility should refer to the CDC *Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2** for guidance on managing critical staffing levels related, at least in part, to SARS-CoV-2 (covid-19) (https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html). The facility should also consult with the DMHAS medical director for guidance around returning employees to work.

Hospital wide staffing levels will be reviewed regularly in ongoing management meetings led by the CEO and CMO.

Nursing Staffing Analysis:

1. review of available nurse and FTS personnel compared to the normal Nursing Staffing Plan
2. review of acuity including:
    a. patients presenting with risk of injury to self or others, intentional and non-intentional
    b. patients requiring special observation
    c. review of unit census and staffing needs

Potential Critical Nursing Staffing Levels

The staffing analysis may result in a determination of critical staffing levels. Criteria for critical staffing levels may include the following:

1. Less than one nurse per unit
2. Inability to maintain the desired staffing patterns as noted in the Hospital Plan for Providing Nursing Care

Critical Nursing Staffing Response Plan

There is a variety of potential strategies available to mitigate critical staffing levels. The Chief Nursing Officer will be consulted for support and guidance any time staffing patterns are projected or go below staffing minimums. The Chief Nursing Officer should identify and implement those strategies in response to the critical staffing levels, with consultation from the CEO / CMO.

Strategies to be considered when critical nursing staffing levels exist:

1. Seek voluntary and mandatory overtime consistent with the /WFH-1199 overtime agreement
2. Redeploy nursing personnel (with necessary competencies) from non-direct care roles into direct care (e.g. nursing leaders/managers, Nurse Instructors, etc.)
3. Redeploy non–nursing personnel (with necessary competencies) into direct care
4. Dutcher Building

Assign one nurse to provide RN coverage responsibility for a maximum of two units that are on the same floor. When this option is used, there should be an LPN on each of the units for which the RN is responsible. The RN assigned to the units serves as the first line of supervision and support for each LPN. The RN and LPN duties will be maintained consistent with the roles and framework of the Nurse Practice Act, Connecticut General Statue20-87a Definitions. Scope of practice.

5.Whiting Building

Whiting building does not currently employ LPN's. Whiting RN's critical staffing patient assignment is not to exceed 30 patients per RN. Consultation with CNO/CMO/CEO regarding patient acuity/unit needs shall occur prior to implementing this critical staffing plan.

(https://www.cga.ct.gov/current/pub/Chap_378.htm#sec_20-87a)

a) Duties maintained by the RN include but are not limited to:
    - RN is ultimately responsible for all delegated tasks
    - RN is responsible for all RN assessment and assessment documentation
    - RN should have balanced presence on both covered units
    - Both units should have a means of contacting the nurse at all times

b) Duties maintained by the LPN, under the delegation of the RN, include but are not limited to:
    - Medication and treatment administration
    - Clinical data collection and documentation

- Vital signs data collection

5. Temporarily collapse units based on building census and patient treatment needs

Non-Nursing Staffing Analysis:

Each department head will continually monitor staffing in order to identify and plan for potential critical staffing levels. Department heads will consult with their hospital administrator to identify and deploy mitigation strategies.