WHITING FORENSICHOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7	MANAGEMENT OF THE ENVIRONMENT OF CARE
REVISED:	September 09, 2023
Governing Body Approval:	September 26, 2023

POLICY

To provide a safe, functional, and effective environment for patients, staff and visitors in accord with the mission of the Whiting Forensic Hospital (WFH) and the Department of Mental Health and Addiction Services (DMHAS) and standards from TJC, OSHA, Department of Public Health and other regulatory agencies. To instill a sense of responsibility for safety in all employees, at all levels of the organization and to empower staff at the local (unit) level to identify and create solutions to causes of accidents and injuries, reduce and control environmental hazards and risks, and to maintain safe conditions for patients, visitors and staff.

To implement a plan for the Management of the Environment of Care that supports the provision of quality patient care and support services by focusing on injury prevention, maintenance of the environment, and the special needs of the patient population.

I. Introduction

The MEC Program is structured to address the following environmental categories:

- Safety; (including suicide reduction within the physical environment)
- Security
- Hazardous Material & Waste
- Fire Prevention
- Bio-Medical Equipment
- Utility Systems
- Product Evaluation
- Employee Health and Safety
- Emergency Management

Each of these areas is addressed in documented plans. Each plan contains the following elements:

1. Orientation and education components that provide specific information to individuals on the proper processes for integrating with the environment of care;

2. Emergency procedures to be followed when components of the environment of care fail;

3. Performance standards that are used to measure the effectiveness of the program;

II. MEC Program Design

- The design of the MEC outlines the structure and composition of the committees and work groups that carry on the tasks associated with the MEC Program.

- The design of the MEC Program includes provision for three types of committees and seven functional work groups. Each of these entities has specific functions that contribute to an integrated program, which promote the goals of the hospital.

- The Director of Environmental Safety and Emergency Preparedness (DESEP) chairs the MEC Committee, serves as the MEC Director and is responsible for preparing the Safety Management Plan and reviewing the effectiveness of the Program. The Safety Management Plan is approved by the Governing Body.

A. Hospital MEC Committee

1. The Hospital MEC Committee is chaired by the Director of Environmental Services, meets monthly, and includes the following members:

   - Police Lieutenants; or designee
   - Maintenance Supervisor 1
   - Infection Preventionist;
   - Nursing Executive representative
   - Director of Accreditation, Regulatory Compliance and Program Improvement
   - Food Services representative
   - Ambulatory Care staff member
   - Building Superintendent 1
   - Unit Directors

2. The functions of the Hospital MEC Committee include:

   a. Review of status of environmental rounds,
   b. Planning & executing Emergency Preparedness Drills,

c. Approving Utility & Equipment Management Programs,
d. Approving Hazardous Materials Procedures,
e. Approving annual MEC plan;
f. Reviewing equipment and utility failure data,
g. Reporting quarterly to the Governing Body,
h. Approving social environment monitoring tools,
i. Product evaluation;
j. Approving staff education plan;
k. Reviewing incident trends;
l. Reviewing the effectiveness of action plans to reduce incidents;
m. Ensure the proper safety signage within the Division;
n. Schedule, coordinate and perform environmental rounds to all patient care units at a frequency of once every six months and perform annual environmental rounds of all non-patient care areas within their division or building;
o. Complete safety environmental rounds report for hazards that are identified and initiate immediate corrective action;
p. Review EC rounds sheets for trends, repeat items, and provide written reports to the Governing Body;
q. Coordinate with Plant Operations to ensure that all Interim Life Safety Measures (ILSM) are taken when construction is going on within a building;
r. Attend construction meetings as needed to ensure that ILSM are adhered to;
s. Assist in the planning and execution of Disaster Drills; and
t. Assure compliance with all MEC Standards

D. Director of Hospital MEC Program

The DESEP designated by the Chief Executive Officer to coordinate the Hospital's MEC program. Annually, the CEO delegates to this individual as Hospital Safety Director the authority to take immediate action to address issues that present a significant risk to the safety of patients, staff and visitors.

Duties and responsibilities of the Director of the Hospital MEC Program:

a. Chairing the Hospital MEC Committee;
b. Preparing and presenting quarterly reports to the Governing Body;
c. Coordinating communications with Unit Directors and/or Program Managers
d. Acting as Hospital liaison with outside agencies (i.e., State Fire Marshall, OSHA, Health Department, and the Department of Energy & Environmental Protection (DEEP);
e. Overseeing the development and implementation of each of the Management Plans for the functional elements; including Safety, Hazmat and Fire Prevention

f. Completing and submitting annual TJC Periodic Performance Review (PPR)

g. Performing the completion of the Statements of Conditions and coordinating requirements for improvement. (Plan For Improvement (PFI));
h. Developing and implementing performance improvement projects relating to MEC,
i. Drafting policies and procedures as needed.
j. Coordinates in-service education regarding fire drills and provides in-service education regarding the OSHA Haz-Comm Standard; coordinates with MOSD in-services for fire drills, the OSHA Hazardous, Communications Standards, and all other mandatory safety trainings such as CPR, Blood-Borne Pathogens, and Emergency Preparedness;
k. Interfaces with necessary personnel, such as the Infection Control Coordinator, to insure that services and training are provided;
l. Ensures the proper safety signage within the hospital; performs monthly safety inspections;
m. Provides written reports to the Hospital MEC Committee;
n. Completes safety inspection reports for hazards that are identified and initiates immediate corrective action;
o. Monitors safety systems within the building quarterly, including but not limited to, the personal alarms and paging systems on a quarterly basis;
p. Coordinates with the Plant Facilities Engineer to insure that all interim life safety measures are taken when construction is going on within the building;
q. Attends construction meetings as needed to insure that interim life safety measures are adhered to; and
r. Serves as primary contact in the planning and execution of disaster drills

E. Functional Work Teams

1. There are seven Functional Work Teams that are each responsible for a functional element of the MEC standards. Each Team is comprised of representatives of the staff that are responsible for the element. The seven Functional Teams are:

- Safety;
- Security;

- Hazardous Material and Waste;
- Emergency Preparedness;
- Fire Safety;
- Medical Equipment; and
- Utility Systems.

2. General responsibilities of a Functional Work Team include:

    a. developing the Management Plan relating to the respective functional element;
    b. meeting periodically to review goal progress;
    c. reviewing System Failures/Incidents relating to the function;
    d. developing Performance Standards and Indicators; and
    e. reporting quarterly to Hospital MEC Committee on Performance Measures.

   Each plan contains a listing of Team Members, Chairs, and delineates responsibilities.

F. Role of the Functional Work Team Leader:

1. takes responsibility for the development and execution of the MEC Plan for the Work Team. The MEC Plan for the Functional Work Team will include a series of goals related to the critical elements of the functions monitored by that Work Team;
2. conducts monitoring activities that measure the effectiveness of the plan. These monitoring activities take the form of inspections, interviews, records of drills, and review of logs;
3. prepares and presents periodic reports to the Hospital MEC Committee. These reports describe the activities of the committee including educational initiatives and system failures;
4. chairs periodic meetings of the work group as needed, but not less than quarterly; and
5. receives technical supervision from the Hospital MEC director on issues relating to safety.

G. Role of the Program Safety Officer:

1. develops and executes the Safety Plan for his/her unit. The MEC Plan includes a series of goals related to the particular population served by the unit;
2. conducts safety inspections within his/her unit. Inspections include the monitoring of bio-hazardous storage areas, electrical safety, the adequacy of environmental services, and the social environment. These inspections are coordinated with the divisional Infection Control Coordinator and the Environmental Services Team members;
3. assesses and follows up on incidents;
4. reports, administratively, to the Program Manager on issues of safety, and receives technical supervision from the Hospital MEC Director and the MEC Coordinator.

H. Design of the Treatment Environment

1. **Safety**

The Hospital is attentive to the importance of the treatment environment in the recovery process. Of primary importance is adherence to Life Safety Code. To this end, the Hospital utilizes professional architects and engineers in preparing plans for major renovation projects.

Major construction projects are also reviewed by the DMHAS Chief of Engineering and code review specialists from the Office of the State Fire Marshal.

In designing renovation projects, consulting architects and engineers utilize the guidelines for Design and Construction of Hospitals and Health Care Facilities. Design elements are customized to accommodate specific requirements for WFH.

2. **Hazard Surveillance**

The Hospital utilizes several data sources for collecting information relating to hazards in the environment. The following inspections take place at prescribed frequencies:

INSPECTION	CONDUCTED BY	FREQUENCY
Fire Safety	State Fire Marshal	Annually
Grounds Safety	Plant Engineer	Quarterly
M.E.C. Rounds	MEC Director	Monthly
Infection Control	Infection Control Preventionist	Monthly

Reports of inspections are reviewed monthly at the Hospital-Wide meetings. Results and action plans are documented in the respective minutes.

In addition, staff who identify hazards, report them to the Plant Operations unit. These items are addressed and documented through the work order system. (Correction reports are generated monthly and distributed to the MEC Director.)

3. **Privacy, Dignity and the Therapeutic Environment**

   a. The treatment units at Whiting Forensic Hospital are designed and maintained in a fashion that promotes patient privacy, and dignity. An effort is made to enhance the environment with art work and plants. Each patient’s bedroom area includes a wardrobe and bedside table to store his/her belongings. Patients are permitted to keep certain personal electrical items based on an assessment and their level of function, and unit security concerns.

b. Patient rooms are designed to provide maximum privacy. The MEC Committee conducts monthly environmental rounds to review personalization of patient rooms as well as the suitability of storage units.

c. Privacy for patients is maintained through a system designed to prevent the public from associating a patient with a diagnosis through a) securing patient's medical records, b) no identifying signage or other visual cues, and c) through the use of space provided on each unit for private discussions with patients and their families about treatment issues and discharge planning. Visiting rooms are provided for these discussions in some areas.

d. As an integral part of the treatment process, Whiting Forensic Hospital encourages the use of social activities through the construction and maintenance of treatment spaces. Renovations include wiring necessary for data ports for computer use.

e. In the Dutcher Building, a patient "Mall" has been developed to add additional treatment space and program opportunities for those patients that may not have attained a level allowing grounds privileges.

f. The Page Hall Mall is a centralized treatment space that affords patients that have attained the appropriate levels, the opportunity to attend groups outside the residence buildings.

4. Smoking Policy

Whiting Forensic Hospital, as a health care provider, has a smoking policy that prohibits smoking in all buildings and on hospital grounds.

I. Information Collection and Evaluation System (ICES)

The Hospital Safety Management Plan describes the process for the systematic collection and evaluation of information. This incident reporting system yields valuable information, which is used in preventing future accidents and incidents. Aggregated information is analyzed at the Unit, and Hospital-Wide level on a quarterly basis. Conclusions are drawn and recommendations for improvements are made and implemented.

WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7:	Management of the Environment of Care
POLICY 7.1	**FIRE SAFETY MANAGAEMENT** EC.01.01.01 EP7
GOVERNING BODY APPROVAL:	7/27/22
REVISED :	5/1/23

I. SCOPE

The Fire Safety Management Plan describes the methods for minimizing the potential for a fire through the use of building systems, equipment and training. The Fire Safety Management Program is designed to assure appropriate, effective response to fire emergency situations that could affect the safety of patients, staff, and visitors, or the environment, and protect building occupants from fire and the products of combustion. The Program is also designed to assure compliance with applicable codes and regulations, as applied to the buildings and services provided.

The program is applied to Whiting Forensic Hospital

II. FUNDAMENTALS

A. The hospital buildings must be designed and maintained in compliance with law, regulation, and accreditation requirements, including compliance with the *Life Safety Code*®, 2012 Edition.

B. The fire alarm, detection, and suppression systems must be designed, installed, and maintained to ensure reliable performance.

C. Staff training is an essential part of fire safety.

III. OBJECTIVES

The Objectives for the Fire Safety Program are developed from information gathered during routine and special risk assessment activities, annual evaluation of the previous year's program activities, performance measures, reports and environmental tours. The objectives for this plan are as follows:

- Ensure that fire drills conform to the matrix and are at least 1 hour apart from pervious drills.
- Conduct fire drill which includes evacuation of a unit if not on quarantine and

decrease acuity

- Quiz staff of fire safety while completing environmental rounds on the clinical units to enhance knowledge
- Operationalize and integrate a fire barrier penetration plan when trades are working within our buildings

IV. ORGANIZATION & RESPONSIBILITY

A. The Governing Body receives regular reports of the activities of the Fire Safety Program from the multidisciplinary improvement team, the Environment of Care (EOC) Committee, which is responsible for the Physical Environment issues. They review reports and, as appropriate, communicate concerns about identified issues and regulatory compliance. They also provide financial and administrative support to facilitate the ongoing activities of the Fire Safety Program.

B. The Chief Executive Officer (CEO), or other designated leader, collaborates with the EOC Committee Chairperson to establish operating, and capital budgets for the Fire Safety Program.

C. The EC & LS Coordinator in collaboration with the committee, is responsible for monitoring all aspects of the Fire Safety Program. The EC & LS Coordinator advises the EOC Committee regarding fire safety issues which may necessitate changes to policies and procedures, orientation or education, or expenditure of funds.

D. Department heads are responsible for orienting new staff members to the department and, as appropriate, to job and task specific Fire Safety procedures. They are also responsible for the investigation of incidents occurring in their departments. When necessary, the EC & LS Coordinator provides department heads with assistance in developing department Fire Safety programs and/or policies.

E. Individual staff members are responsible for learning, retaining and following job and task-specific procedures for fire safe operations.

V. PERFORMANCE ACTIVITIES

The performance measurement process is one part of the evaluation of the effectiveness of the Fire Safety program. Performance measures have been established to measure at least one important aspects of the fire safety program.

The performance measure for the Fire Safety program is: *staff knowledge including annual education, and fire barrier penetration compliance*

- *95% of staff respond appropriately to fire drills*
- *95% of staff knowledge on the Fire Response Plan (R.A.C.E.)*

- *95% of staff knowledge on the evacuation routes for their Unit*
- *95% of staff knowledge on how to use a fire extinguisher (P.A.S.S)*
- *95% of staff complete the annual fire safety training*

VI. PROCESSES FOR MANAGING FIRE SAFETY RISKS – EC.02.03.01

Minimize Potential for Harm- EC.02.03.01 EP1

The EC & LS Coordinator is responsible for managing the program for minimizing potential harm from fire, smoke, and other products of combustion. The fire protection program includes three phases.

1. The first phase is the design of buildings and spaces to assure compliance with current local, state, and national building and fire codes. Qualified architects and engineers are employed to develop building and fire protection system designs. All designs are reviewed by local or state agencies as a part of the construction and permitting process. A vigorous construction monitoring and building commissioning program round out the design phase.

2. The second phase is testing, inspection, and maintenance of the fire prevention aspects of the facility. EC & LS Coordinator is responsible for setting testing, inspection and maintenance documentation and frequency based on applicable codes, equipment history, and other parameters. Staff and contractors perform the fire system testing and inspection with oversight is by the EC & LS Coordinator The EC & LS Coordinator ensures the end product of all work maintains or improves the level of life safety in each affected area.

3. The third phase is an active training program of fire prevention, fire safety, and fire response. The EC & LS Coordinator manages this phase of the program in collaboration with the education department.

Unobstructed Exits in Business Occupancy- EC.02.03.01 EP4

For those areas designated as Business Occupancy by NFPA 101®– Life Safety Code®, all exits must be maintained free and unobstructed. The status of these areas will be assessed routinely by the staff. Storage will not be allowed in any exit lobby, exit stairwell or exterior anteroom.

Fire Response Plan- EC.02.03.01 EP9

The Fire Response Plan provides clear, specific instructions for staff responding to a fire emergency. The procedures provide information about notifying appropriate staff of the emergency and actions to take to protect patient safety. Each department head is responsible for maintaining copies of emergency procedures in a continuously accessible location.

The EC & LS Coordinator and the department heads are responsible for developing and training staff about department specific emergency fire response procedures. Each department head is responsible for providing departmental and area personnel with an orientation to emergency procedures related to their job. Additional departmental training is provided on an annual basis as part of the LMS continuing education program or on an as-needed basis. Each department head is responsible for reviewing department specific Fire Safety emergency procedures at least every three years.

The roles of all staff and licensed independent practitioners (LIP) are detailed specifically in the Fire Response Plan. The roles of all staff and LIP at and away from a fire's point of are defined. The basic response plan in the hospital is based on the acronym "R.A.C.E.":

- **R**escue anyone in immediate danger from the fire
- **A**larm by activating fire alarm pull station to sound alarm and Report the alarm by dialing 5555 to announce the location of the alarm to the hospital's emergency dispatch
- **C**onfine by closing doors to help contain smoke and the products of combustion
- **E**xtinguish, (P.A.S.S.) and, as needed, prepare to evacuate or relocate patients

The role of all staff and LIP away from the point of fire origin is to close doors and evaluate the situation how to contain smoke and fire, how to use a fire extinguisher and fire blanket, how to assist and relocate patients, how to evacuate to areas of refuge. Staff and LIPs are periodically instructed on and kept informed of their duties under the plan, including cooperation with firefighting authorities.

If the fire is in horizontal, above, adjacent to the fire's origin, or in areas where relocation is planned, the Fire Response Plan emphasizes moving patients to assist and relocate patients to their appropriate area of refuge or evacuation. The Fire Response Plan discusses fire response equipment, and staff response.

Compliance with Chapter 15- EC.02.03.01 EP13

The hospital meets all other Health Care Facilities Code fire protection requirements, as related to NFPA 99-2012 Chapter 15.

Fire Drills- EC.02.03.03 EP1-5

1. Fire drills are a critical tool for maintaining the readiness of staff to respond to a fire emergency and to minimize the likelihood of injury to patients, visitors and staff. Staff participation is necessary to maintain an acceptable level of readiness and to ensure staff knowledge of the equipment and procedures necessary to protect the staff and patients. To evaluate staff knowledge, drill activities are

observed, and staff is questioned about their role and responsibilities during a fire emergency nearby and elsewhere in the building.

2. Fire drills are conducted in all hospital units once per shift per quarter and evaluated on a randomly selected basis. All of the quarterly drills will be unannounced with the exception of those done as corrective training activities. Fire drills are held at unexpected times and under varying conditions. At least once a year a fire drill is conducted in the high-risk areas for fire, such as a Kitchen or electrical room.

3. All staff who work in the buildings where patients are house or treated will participate in drills, according to the fire response plan. This includes all hospital staff and all hospital staff in buildings where space is shared with others. <u>Fire drill during the shift hours of 9:00pm-6:00am will have fire alarms activated but bells and horns will be silenced quickly to not disturb patients.</u>

4. Fire drills are observed and critiqued to evaluate fire safety equipment, fire safety building features and staff response. In addition, fire response knowledge is evaluated during fire drills and environmental rounds.

5. The results of the critique and evaluation of drills and evaluation of staff knowledge are used to identify improvements needed in training programs, fire protection equipment, and compliance issues. Such improvements are evaluated during monitoring activities and the results are to identify the effectiveness of the activities.

Maintaining fire safety equipment and building features- EC.02.03.05 EP1-27

The EC & LS Coordinator is responsible for maintenance of the fire alarm and related systems. Troubleshooting fire alarm systems and performing corrective and preventive testing, inspection and maintenance is performed by staff and contractors as appropriate. All testing, maintenance, inspection, and repairs are documented and reviewed by the EC & LS Coordinator. Any fire protection feature that is not operating properly will be evaluated for the appropriate Interim Life Safety Measure (ILSM).

The systems inspected, maintained, tested and documented on the landlord's inventory are: *fire alarm systems, sprinkler systems, fire extinguishers, fire blankets, standpipes, fire department connections and fire suppression systems.*

1. Supervisory signal devices (except valve tamper switches) are tested at least quarterly.

2. Vane-type and pressure-type water-flow devices and the valve tamper switches are tested every 6 months. Mechanical water-flow devices (including, but not limited to, water motor gongs) should be tested quarterly.

3. Duct detectors, heat detectors, manual fire alarm boxes, and smoke detectors are tested every 12 months.

4. Visual and audible fire alarms, including speakers and door-releasing devices, horns, and strobes are tested every 12 months.

5. Main drain tests at system low point or at all system risers are conducted every 12 months.

6. Each fire department water supply connection is inspected every quarter.

7. Hydrostatic and water-flow test for the standpipe system every 5 years.

8. Kitchen automatic fire-extinguishing systems are inspected for proper operation every 6 months.

9. Carbon dioxide and other gaseous automatic fire-extinguishing systems are tested for proper operation every 12 months.

10. Each portable fire extinguisher is inspected at least monthly using check marks on a tag, and using an inventory. Inspections involve a visual check to determine correct type of and clear and-unobstructed access to a fire extinguisher, in addition to a check for broken parts and-full charge.

11. Each portable fire extinguisher is maintained every 12 months including recharging. Individuals performing annual maintenance on extinguishers are certified.

12. Each fire and smoke damper is operated one year after installation and then at least every 6 years (with fusible links removed where applicable) to verify that they fully close.

13. Each automatic smoke-detection shutdown devices for air-handling equipment is tested to document shut-down (i. e., operationally activated) every 12 months.

14. Inspection and testing of fire door assemblies annually by individuals who can demonstrate knowledge and understanding of the operating components of the door being tested. Testing begins with a pre-test visual inspection; testing includes both sides of the opening.

When appropriate, competent contractors are used to test, inspect, maintain, and repair the fire protection features, when appropriate to assure the special skills and equipment

they have are available. Documentation is maintained as part of the database to assure activities are conducted in a timely fashion.

Documentation – EC.02.03.05 EP28

The documentation for maintenance, testing and inspection activities for fire alarm and water-based fire protection systems will include, the date, test frequency, required frequency of the activity, inventory of devices, equipment, or other items, name and contact information of person performing the activity, NFPA standard(s) including year referenced for the activity, and the results of the activity. The documentation will be maintained for three years after the next inspection, test or maintenance required by the standard.

Evaluating the Management Plan- EC.04.01.03 EP15

Every 12 months, the EC & LS Coordinator evaluates the scope, objectives, performance, and effectiveness of the Plan to manage the fire safety risks to the staff, visitors, and patients.

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CHAPTER 7:	Management of the Environment of Care
PROCEDURE 7.1a	**Fire Watch** LS.01.02.01 EP2
Governing Body Approval:	7/27/22
REVISED :	7/19/22
REVIEWED	09/29/2023

POLICY

A Fire Watch is required when the fire alarm system is out of service more than four hours out of 24 hours or a sprinkler system is out of service for any 10 hours in a 24-hour period in an occupied building. The assigned facilities staff will conduct the Fire Watch tour at least hourly

PURPOSE

The purpose of the Fire Watch is to supplement the existing fire detection and response systems and to provide additional compensatory activity to assure the safety of patients, visitors, and staff. The Fire Watch will identify and report hazards and corrective action and will document their findings and activity. Regular reports of the activity and findings will be provided to the Environment of Care (EOC) Committee and to appropriate governmental agencies on a periodic basis.

PROCEDURES

1. The South Fire District, State Fire Marshall and DPH Fire Marshall is notified, and the time of this notification is documented by the Facilities Services Engineer.

2. A Fire Watch inspection tour will be made hourly throughout the affected areas and documented including times on the Fire Watch checklist (Attachment I).

3. Each item identified will be documented on the inspection form as exceptions, and the appropriate responsible party will be informed for correction.

4. Items identified will be corrected as quickly as possible by notifying the appropriate individual to correct.

5. Open items will be reviewed by the WFH EC & LS Coordinator in conjunction with the Facilities Services Engineer to allow ongoing evaluation of the problems and documentation of the corrective activity completed.

6. Items that are not corrected or cleared in a timely fashion will be assessed for Interim Life Safety Measures and brought to the attention of the appropriate individual or administrative management for further action.

DOCUMENTATION

1. The status of items identified in the Fire Watch Checklist will be documented on the Follow-Up to Identified Issues form (Attachment I). An additional instruction and Fire Watch Log is available in Attachment II.

2. The name of the person contacted during the "Follow-up" will be documented on the inspection form.

3. The Fire Watch Checklist and Follow-up form will become part of the record of the project.

4. On a periodic basis, open issues will be printed and provided to the WFH EC & LS Coordinator for evaluation.

5. The completed issues will be identified by date, person responsible and action taken on the Follow-Up to Identified Issues form (Attachment I).

6. Additionally, open issues will be sorted by responsible departments, and lists of the open issues for which that department or person is responsible will be sent to them. They are then requested to provide status reports for those open items.

Checklist
The Fire Watch checklist will be evaluated at least every three years to assure that the appropriate elements are on the list.

Training

1. Staff who conducts a Fire Watch the training will include:
   a. Purpose of the Fire Watch
   b. The key elements on the checklist to be observed
   c. The documentation process, including notification and recording the data
   d. The areas including routes to be taken and the specific elements to be included in the observations
   e. The person(s) who will be notified of identified problems and deficiencies
   f. The person(s) who will be responsible for the fire watch process and with whom to check if there are questions

2. Staff in the affected areas will be trained on their fire response procedures during the duration of the fire watch upon the areas being affected. Annual training will be conducted for staff on fire response procedures.

(For full text and any exceptions, refer to NFPA 101-2012: 9.6.1.6; 9.7.6; NFPA 25-2011:15.5.2)

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SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7:	Management of the Environment of Care
PROCEDURE 7.1:	**Fire and Smoke Barrier Penetrations**
Governing Body Approval:	7/27/22
REVISED :	7/19/22
Reviewed:	09/29/2023

PURPOSE: To provide a fire-safe environment of care and to protect patients, personnel, visitors, and property from fire, smoke and other products of combustion by maintaining the integrity of smoke and fire barriers.

SCOPE: Plant Operations Staff, Contractors, Maintenance Personnel, and other personnel

Authority:

2005 Connecticut State Fire Safety Code, 2009 Amendments

National Fire Protection Association (NFPA) 101, Life Safety Code 2003

POLICY:

1. WFH Staff and Contractors, shall obtain a permit from Plant Operations before beginning work that requires penetration of smoke and fire barriers.
2. Work permits will not be issued on a blanket basis, except as related to multiple penetrations in a single job (e.g., cable and electrical conduit penetrating several fire walls).
3. Holes and spaces in fire or smoke barriers shall be repaired in an approved manner as soon as feasible after work is completed.

Responsibilities:

1. CVH Plant Operations, **in their role as part of our landlord organization**, will:

    a. Administer the Fire and Smoke Barrier Penetration Policy and Permit Program.
    b. Conduct final inspections of work areas before closing out permits and forward completed permits to WFH EOC Committee Chairperson monthly.

c. Conduct biannual inspections, in all buildings which are not fully sprinkled, of smoke and fire barriers, ceilings, and floors to verify continuity and report needed repairs to the Plant Facility Engineer, who will coordinate the repairs as necessary.
d. Conduct biannual inspections of door assemblies and other protective devices (e.g., rolling doors) installed within smoke and fire barriers to verify proper operation and report needed repairs to the Plant Facility Engineer, who will coordinate the repairs as necessary.

2. Contractors and **WFH and CVH** facility personnel will:

   a. Obtain a Smoke and Fire Barrier Permit before beginning work, and maintain a copy of the permit in the work area at all times.
   b. Repair holes and spaces created during the completion of projects and those identified by Fire Service inspection.
   c. Contact the **CVH** Plant Facility Engineer during work if there are questions regarding repairs.
   d. Notify the **CVH** Plant Operations (860-262-5720) after repairs are completed to schedule a final inspection.

PROCEDURE:

1. Permits will be obtained from CVH Plant Operations – Routine permits should be obtained between the hours of 8:00 AM and 9:00 AM.

   Contact Numbers: CVH Plant Operations 860-262-5720

   CVH Dispatcher 860-262-5555

2. All holes and spaces in fire and smoke barriers will be protected as follows:

   a. Filled in per Underwriter Laboratories' approved methodology which is described in the Specified Technologies Incorporated (STI) Manual using STI fire-stopping products capable of maintaining the fire resistance of the smoke or fire barrier.
   b. Sleeves, where required, shall be solidly set in the smoke or fire barrier and the space between the items shall be filled with an approved material capable of maintaining the fire resistance of the smoke or fire barrier.
   c. Insulation covering pipes and ducts passing through smoke and fire barriers shall be capable of maintaining the fire resistance of the barrier.
   d. White silicone caulking shall be used to seal ceiling tile penetrations.

WHITING FORENSIC HOSPITAL

FIRE AND SMOKE BARRIER PENETRATION PERMIT

Permit Number:	Issue Date:
Approved By (Plant Operations Representative):	Estimated Completion Date:
Permit issued to (Department/Contractor name, individual's name, phone number)	
Location of barrier(s) to be penetrated (building number, wing, floor, room number) (Attach sketch if applicable)	

Location of ceiling tile(s) to be removed (building number, wing, floor, room number) (Attach sketch if applicable)	
Reason for penetration:	
Final Inspection by Department/Contractor Representative Date:	Plant Operations Representative: Date:

INSTRUCTIONS:

1. Maintain a copy of this permit at the work area at all times.
2. Promptly repair penetrations in an approved manner. Contact **CVH** Plant Facility Engineer if there are any questions regarding the repairs.
3. Notify **CVH** Plant Operations when repairs are completed to schedule final inspection.

WHITING FORENSIC HOSPITAL
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SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7:	Management of the Environment of Care
PROCEDURE 7.1c:	**Fire and Evacuation Response Plan**
Governing Body Approval:	7/27/22
REVISED :	5/1/23

PURPOSE: To reduce the probability of injury and /or loss of life of patients, staff and visitors from the effects of a fire.

First responders – The South Fire District Fire department is the primary responder to this campus. The signal of fire alarms in all patient care buildings is transmitted to the Shew Hall dispatch center. Fire alarm notifications are then forwarded to the local municipal City dispatch center.

I. ANNOUNCEMENT OF LOCATION OF FIRE ALARM

A. When a FIRE ALARM is activated in the building, the system will transmit an announcement over the FIRE SPEAKERS system. This will continue until fire personnel arrives and silence or reset the fire alarm system.

1. Command Center Location

   The Command Center will be located at the Nurses' station of the unit that will be accepting evacuated staff/patients/visitors.

2. The Operations Group is notified via alpha/numeric pager of all fire alarm activations in patient care buildings and whenever there is an actual fire.

B. The code phrase "**Code Red Fire Emergency**" shall be used under the following conditions:

1. When an individual discovers a fire and immediately goes to the aid of any endangered persons, they shall call out "Code Red Fire Emergency."
2. When someone hears the phrase "Code Red Fire Emergency," they will activate the nearest fire alarm pull station.
3. During a malfunction of the building fire alarm system.
4. During an actual fire and/or smoke condition to alert building staff of the emergency.

In the event of a fire alarm malfunction and the alarm does not activate automatically, the person discovering a fire will dial 5555 to notify dispatch and request them to announce the code red fire emergency including the alarm location over the overhead announcement system. This shall be announced three times.

II. PROCEDURE: The basis of this fire plan is a four step procedure:

1. Rescue
2. Alarm
3. Contain
4. Extinguish/Evacuate

Rescue

1. Rescue any patient/staff/visitor by removing them from immediate danger while calling aloud for others in the immediate area to sound the fire alarm. Staff person should take those individuals in immediate danger to the closest area of safe refuge.
   a. If smoke or flames are blocking the primary evacuation you evacuate into the secondary evacuation (area of refuge) call 5555 give your location and evacuate vertically down stairwell to unit below or specified location.
2. Technique: Use fire blanket, fire extinguisher and walk with assistance: blanket drag: two rescuer hand carry, etc.

Alarm

1. Pull/activate the nearest fire alarm pull station, or if unable to do so, instruct a fellow staff member to activate the fire alarm. Remember that some pull stations have alarmed protective covers. These covers do not activate the fire alarm. The pull station must be pulled.

Contain

1. Contain the fire, such as closing the door to the affected room or area, or in the case of a partition dormitory, close the corridor door to contain smoke. If at all possible, prevent smoke from infiltrating into the egress corridor.

Extinguish / Evacuate

1. If you are unable to extinguish a small fire, the primary evacuation route is horizontally to an adjacent unit. Ensure all corridor clutter has been removed from the hallway prior to evacuation, such as: chairs used for observation, laundry carts, and food carts. These should be placed in the closest available empty room. Listen to the overhead announcement or follow the instructions from the nurse in charge.

2. **Primary Evacuation** – laterally across the hall into an adjacent unit and/or through a smoke barrier into another smoke compartment.
3. **Secondary Evacuation** – vertically down the stairwell to the unit below or a specified area.
4. **Defend In Place** - if smoke or fire infiltrate the corridor and impede your ability to evacuate, defend in place by placing staff / patients/visitors behind closed doors, such as patient bedrooms, areas of refuge, offices or unaffected dormitories and wait for the arrival of fire personnel.

III. USE OF FIRE EXTINGUISHERS

Staff may attempt to extinguish small fires with the use of fire extinguishers. To use a fire extinguisher correctly, remember the acronym: **P.A.S.S.**

P: Pull the Pin

A: Aim at the base of the fire

S: Squeeze the handle

S: Sweep side to side

Note: If a fire extinguisher is unable to fully extinguish a small fire, cease attempts to extinguish the fire and proceed with the evacuation or defend in place procedures. Portable fire extinguishers are best used for extinguishing a small fire or getting safely away from a large fire.

IV. STAFF ROLES AND RESPONSIBILITIES

A. "Affected" Unit (Alarm Location)

1. **Charge nurse or designee** will be responsible for proceeding as follows:

   a. Initiate the R.A.C.E. Procedures (RN in charge or designee will determine either evacuation or defend in place procedures will be implemented and notify the telecommunications dispatchers at Shew Hall).
   b. RN in charge (or designee) retrieves "Override Keys" and directs response activities.
   c. Assemble all patients, visitors and staff.
   d. Check and inspect all rooms to ensure that all patient/staff/visitors are accounted for, closing all doors after inspection. Doors to patient bedrooms and common areas are to remain closed and unlocked.
   e. Take Census Sheet and Medication Kardex, Patient Sign In/Out Book, Visitor's Book.
   f. Call 5555 upon arrival to your new location to report all pertinent information (i.e. unit status, problems identified, etc.) relating to the fire alarm situation.

2. **All Staff including Licensed Practitioners**

   a. Definition - All other staff includes clinical and non-clinical, including licensed independent practitioners present on the affected unit during an alarm situation
   b. Report to the RN in charge (or designee) to receive instructions to assist in the evacuation of patients.

B. **“Unaffected” Units**

1. **Nurse in charge** will be responsible for proceeding as follows:

   a. Assemble all clients, visitors, and staff, in case further evacuations become necessary.

   b. Ensure clients, visitors, and staff remain in the assembly area until further instruction is received.

   c. Take census.

   d. Assign a staff member to assure the safe evacuation of clients in restraint and/or seclusion

   e. <u>Do Not Use</u> Any of the Following (Except in a medical and/or psychiatric emergency)

      1. **The P.A. system**
      2. **Telephones**
      3. **Pagers/beepers, etc**.

   f. Call 5555 only:
      a. If abnormal condition(s), i.e. smoke, relating to the fire alarm situation exists and/or develops,

      b. If situations exist and/or develop requiring additional assistance.

   g. An individual from each unaffected unit, as designated on the daily Nursing Assignment Sheet, will report to the Nurse supervisor on the unit that will be accepting evacuated staff/patients/visitors.

   h. Remain in place and be on alert for further instructions.

2. **All others** (Clinical staff, non-clinical staff, independent licensed practitioners and visitors):
   i. Remain on the unit
   ii. Report to and follow the direction of the RN in charge
   iii. Be on alert for further instructions

A. **<u>Nurse Supervisor Responsibilities</u>**

1. Report to the primary unit that will be accepting evacuated staff/patients/visitors. Determine if evacuation or defend in place procedures have been implemented.

2. Receive all information pertaining to patient status from the site/unit with the fire alarm and any other site(s)/unit(s) which develop any abnormal condition(s) relating to the fire alarm situation.

3. Assess needs and makes assignments to aid in the movement/ evacuation/management of patients, as the situation dictates.

   (a) NO staff member will be deployed to the affected site/unit to assist in movement/evacuation/management of patients if the fire is NOT CONTAINED.

C. "Unaffected" Areas Other Than Units

A. Staff will be responsible for proceeding as follows:

(1) Remain in place and be alert for further instructions.

(2) **Discontinue / do not initiate use of the P.A**. system, pagers / beepers, etc., except in situations involving medical and/or psychiatric emergencies.

(3) Call 5555 only if abnormal condition(s), i.e. smoke, relating to the fire alarm situation exists and/or develops or in situations requiring additional assistance.

4. Fire Alarm activations in areas other than patient care units

(1) Staff will be responsible for proceeding as follows:

a. Initiate R.A.C.E. Plan.

b. Evacuate to designated area.

c. Remain on alert for possible further instructions.

d. Do not initiate use of the P.A. system, telephones, pagers / beepers, etc., except in situations involving medical and/or psychiatric emergencies.

e. Call 5555 to report any abnormal condition(s), i.e., smoke, relating to the fire alarm situation which exists and/or develops or in situations requiring additional assistance.

V. TERMINATION OF EMERGENCY PLAN

Upon receipt of direction from South Fire District the "ALL CLEAR" announcement will be made over the public address system; until that time, all occupants of the building are required to remain in an "emergency mode".

TOTAL BUILDING EVACUATION:

Only the South Fire District Incident Commander can determine if a full building evacuation is necessary.

- In the event that a full evacuation has been deemed necessary, an overhead announcement will be made throughout the building directing staff to follow evacuation procedures. Additionally, the Incident Commander will notify the Telecommunications Dispatcher who in turn will notify WFH leadership that a full building evacuation has been ordered.

VI. Evacuation / Relocation Procedures

Short Term (1 - 3 hours) and/or Long Term

1. Arrangements will be made through the CEO/designee or the Connecticut Valley Hospital Emergency Operations Center (when activated) to relocate / evacuate patients.

WHITING BUILDING: FIRE EVACUATION PROCEDURE

PURPOSE: To reduce the probability of injury and /or loss of life of patients, staff and visitors from the effects of a fire.

PROCEDURE:

PHASE I: LIMITED BUILDING EVACUATION

I. ALERTING PROCEDURE

A. Fire Alarm System

1. **Heat and Smoke Detectors**
Installed throughout the building that will automatically sound when there is a fire emergency.

2. **Manual Pull Stations**
Installed throughout the building. In the event any individual detects a burning odor, or observes smoke or other signs of burning in the building, and a fire alarm has not sounded, **a fire alarm pull station should immediately be activated in the location the burning odor or smoke is detected**.

3. When activated:

(a) Emits an audible signal which exceeds the level of operational noise in any area.

(b) Automatically transmits an alarm to the DMHAS Police Communication/Dispatch Center and DMHAS Police - Whiting Unit Control Center.

(c) Middletown Dispatch and DMHAS Fire Services personnel (when on duty) alerted.

C. Announcement of Location of Fire Alarm Situation

1. When a FIRE ALARM is activated in the Whiting Forensic building, the FIRE CONTROL PANEL located in the Police Unit Control Center will transmit an announcement over the FIRE SPEAKER system. This announcement will continue until fire personnel arrive and silence or reset the fire alarm system.

D. Command Center Location

1. **Primary:**
DMHAS Police Control Center, Main Gates
(Ext. 5400)
Secondary:
Main Conference Room #802
(Ext. 5412)

2. **Staffing**

(a) Days

(1) CEO
(2) COO
(3) Medical Director
(4) Police Lieutenant
(5) CNO/Director of Nursing
(6) Nurse Supervisor

(b) Evenings / Nights / Weekends / Holidays

(1) CNO / Director of Nursing
(2) On-Call Physician
(3) Nurse Supervisor

E. Notifications
To be made by the Police Supervisor or designee (Officer in Charge) during evening / night / weekend / holiday shifts

(a) Police Lieutenant
(b) CEO
(c) Plant Ops. / Maintenance Supervisor
(d) Safety Director / Environment of Care coordinator

II. RESPONSE / RELOCATION / EVACUATION PROCEDURE

A. General

1. **R-A-C-E**

a. In fire emergencies, remember the acronym **R.A.C.E** –

RESCUE
ALERT / ALARM
CONTAIN
EVACUATE

Rescue

(1) While calling aloud for others in the immediate area to sound the fire alarm, a person should take those individuals in immediate danger to the closest area of safe refuge.

(a) Technique: Walk with assistance; blanket drag; two rescuer hand carry, etc.

2

Alert / **A**larm

(1) If a person(s) is not endangered by the fire, the individual discovering the fire or upon receiving notification of a fire in progress shall activate the nearest fire alarm pull station to alert all facility personnel of the problem, and initiate response of Fire Department.

Contain

(1) Upon hearing the fire alarm, all personnel shall immediately execute the duties outlined in the Fire Evacuation Procedures and close all doors to restrict the travel of smoke and heat to the room or area of origin.

Evacuate

(1) Evacuation Procedure: report to the Nursing Station. Follow the directions of the RN in charge. Listen to the paging system. Evacuate the fire area first and then the rest of the unit working from the fire area.

2. P-A-S-S

Staff should not attempt to extinguish fires by themselves; some cases may need to use a fire extinguisher or fire blanket to secure a safe exit route. To use a fire extinguisher correctly, remember the acronym P.A.S.S.

P: Pull the Pin
A: Aim at the base of the fire
S: Squeeze the handle
S: Sweep side to side

B. Specific

1. Whiting Police Unit Personnel

(a) The Police Supervisor or designee (Officer in Charge) on duty is in command of all fire alarm situations until such time DMHAS Fire Services personnel and/or South Fire District arrives at the scene.

(b) The Police Supervisor or designee will be responsible for:

(1) Coordinating the necessary evacuations with nursing staff. Officers arriving to a fire alarm situation will ensure that all staff and patients are (have been) evacuated from the affected area. Responding officers shall evacuate with staff and patients, radioing to the Control Center that the affected area has been cleared, and that all personnel are standing by for further instructions.

(2) Ensuring no individuals enter the secured area of the building during a fire alarm. Nonessential personnel will not be allowed access through the main gates or sally port during any fire alarm situation. Only after the ALL CLEAR has been given by fire personnel can traffic resume into the building.

(3) Evaluating the fire alarm situation, and relaying to fire personnel reporting to the scene all pertinent information concerning the incident and directing their response to the appropriate location.

(4) Coordinating all access into, and throughout the building for responding fire personnel.

(c) If further evacuation becomes necessary after initial response to the fire alarm situation, it will be done under the supervision/direction of fire personnel, in collaboration with the Police Supervisor (Officer In Charge) on duty.

2. Maintenance Personnel

(a) May be called to Command Center to support response.

3. Chief Nursing Officer/Director of Nursing/ Nursing Supervisor

(a) Will be responsible for:

(1) Reporting to the Command Center.

(2) Receiving all calls pertaining to patient status from the area with the fire alarm situation and any other area(s) which develop any abnormal condition(s) relating to the fire alarm situation.

(3) Keeping the Police Lieutenant (in his/her absence the Senior Police Officer) advised of any abnormal condition(s) relating to the fire alarm situation; updating as needed.

(4) Sending additional staff to units / areas which may and / or do require assistance resulting from the fire alarm situation.

4. All Available Nursing Staff Off The Unit During An Alarm Situation

(a) Will be responsible for returning to their unit, when not assigned to and / or accompanying a patient(s), unless that unit is the specified alarm location; in which case they will report to the Command Center and await further instructions.

5. **Unaffected Units**

(a) Nursing staff will be responsible for proceeding as follows:

(1) Remain in place and be on alert for further instructions.

(a) Assemble all patients, visitors and staff, in case evacuation becomes necessary.

* <u>Note</u>: Patients in restraint and / or seclusion- a staff member will be assigned to assure the evacuation of the patient if necessary.

** <u>Note</u>: During courtyard hours, patients are to remain in courtyard until further instructions.

(b) Take census.

(2) Discontinue / do not initiate use of the P.A. system, telephones, pages / beepers, etc., except in situations involving medical and / or psychiatric emergencies, or as stated in subsection.

a. Call Control Center, Ext. 5400 only if abnormal condition(s), i.e. smoke, relating to the fire alarm situation

exists and / or develops or in situations requiring additional assistance.

(a) When applicable, call designated alternate Command Center.

(b) All other clinical staff, non-clinical staff and visitors should remain on unit; reporting to and following the direction of the R.N. in charge and be on alert for further instructions.

6. **Affected Unit (Specified Alarm Location)**

(a) Nursing staff will be responsible for proceeding as follows:

(1) Initiate the R.A.C.E. Plan

(2) Assemble all patients, visitors and staff, and follow evacuation procedures.

(3) Turn on all lights when checking all rooms on units; then turn off same. Doors to patient bedrooms and common areas are to remain closed and unlocked.

(4) Take Census Sheet and Medication Kardex.

(5) Do not initiate use of the P.A. system, telephones, pagers / beepers, etc., except in situations involving medical and / or psychiatric emergencies, or as stated in subsection.

(6) Call Control Center, Ext. 5400 to report all pertinent information (i.e. unit status, problem identified which has not necessitated evacuation of unit, etc.) relating to the fire alarm situation.

(a) When applicable, call designated alternate Command Center.

(b) All other clinical staff present on the unit during an alarm situation will present themselves to the RN in charge who will assess the need for assistance from clinical staff present and make assignments to aid in the movement / evacuation of patients.

(c) Non-clinical staff present on the unit during an alarm situation will report to and follow the direction of the RN in charge.

7. **Discovering a Fire on a Unit**

(a) Nursing staff will be responsible for proceeding as follows:

(1) Initiate the R.A.C.E. Plan

(2) Evacuate horizontally to another unit, assembling in the hallway. Receiving unit will assemble their patients to the T.V. Room, Dining Room, Day Hall, etc. and take census.

(3) While leaving fire area, the taking of the census is initiated. Upon arrival of designated area, census is to be completed by calling and/or checking the following areas to verify the correct census: Activity Center, Visiting Room, Gym, Courtyard, etc. Any discrepancies in the census are to be reported to the Control Center, Ext. 5400.

(4) Call Control Center, Ext. 5400 upon your arrival to your new location.

(a) When applicable, call designated alternate Command Center.

8. **Unaffected Areas Other Than Units**

(a) Staff will be responsible for proceeding as follows:

(1) Remain in place and be alert for further instructions.

(2) Discontinue / do not initiate use of the P.A. system, pagers / beepers, etc., except in situations involving medical and/or psychiatric emergencies, or as stated in subsection.

(3) Call Control Center, Ext. 5400 only if abnormal condition(s), i.e. smoke, relating to the fire alarm situation exists and/or develops or in situations requiring additional assistance.
(a) When applicable, call designated alternate Command Center.

9. **Affected Areas (specified alarm location) Other Than Units**

(a) Staff will be responsible for proceeding as follows:

(1) initiate R.A.C.E. Plan.

(2) evacuate to designated area.

(a) Administration Area - Use front and/or back door to exit building; assembling in Physician's parking lot.

(b) * Main Corridor - Use most direct route to exit building; assembling in Courtyard.

(c) * Basement - Use most direct route to exit building; assembling in Courtyard
* Upon arrival in Courtyard, courtyard will be closed and patients will be escorted back to their respective units by unit staff member(s).

(3) Remain on alert for possible further instructions.

(4) Do not initiate use of the P.A. system, telephones, pagers / beepers, etc., except in situations involving medical and/or psychiatric emergencies or as stated in subsection.

(5) Call the Control Center, Ext. 5400 to report any abnormal condition(s), i.e., smoke, relating to the fire alarm situation which exists and/or develops or in situations requiring additional assistance.

(a) When applicable, call designated alternate Command Center.

III. TERMINATION OF EMERGENCY PLAN

A. Upon receipt of direction from South Fire District the "ALL CLEAR" announcement will be made over the public address system; until that time, all occupants of the building are required to remain in "Emergency mode".

1. For fire drills, the DMHAS Fire Services personnel will determine when the drill will be terminated; and the "ALL CLEAR" announced over the public address system.

2. Once the "ALL CLEAR" has been given, normal traffic into and out of the building will resume.

PHASE II: TOTAL BUILDING EVACUATION

I. ALERTING PROCEDURE

A. DMHAS Police/Fire Services personnel and the Command Center, in collaboration with the South Fire District, will determine the notification procedure to be used (i.e. P.A. announcement, telephone, runner(s), etc.).

II. EVACUATION / RELOCATION PROCEDURES

A. Short Term (1 - 3 hours) and/or Long Term

1. Arrangements will be made through the Office of the Chief Executive Officer of Whiting Forensic Hospital, the Office of the Commissioner of the Department of Mental Health and Addiction Services, Governor's Office, Department of Correction, and/or Psychiatric Security Review Board, to relocate / evacuate patients.

WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7:	Management of the Environment of Care
PROCEDURE 7.2:	**Environmental Services**
Governing Body Approval:	6/10/18
REVISED :	09/29/2023

PURPOSE: To provide and maintain a clean environment for staff, patients and visitors.

PROCEDURE:

The Environmental Units at WFH are cleaned by staff housekeeping staff.

Environmental Services Department (Housekeeping) has a procedure manual which contains the following:

1. Daily cleaning schedules;
2. Cleaning procedures;
3. Staff training; and
4. Environmental monitoring procedures.

The Environmental Procedure Manual is located on the T: Drive as well as with:

1. The Building Superintendent 1

WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7:	Management of the Environment of Care
PROCEDURE 7.4:	**Requesting Use of State Pool Vehicles**
Governing Body Approval:	6/10/18
REVISED :	
Reviewed:	10/02/2023

POLICY:

To establish a centralized reservation system for **pooled vehicles provided per an established Memorandum of Understanding by our landlord organization, Connecticut Valley Hospital.**

Employees using state vehicles must comply with Department of Administration Services (DAS) Fleet General Letter 115, Motor Vehicle Usage Policy which can be found on the web at http://das.ct.gov/Fleet/GL115rev2012.pdf (especially the policy language of "possessing the ability, knowledge, skill, experience and appropriate license to operate the type of vehicle assigned

Vehicles will be available for patient programming and official state business.

PROCEDURE:

Vehicles are assigned to each hospital based on need for programming. Additional vehicles needed on a daily basis will be requested from the supervisor of transportation from an inventory of vehicles kept at the Transportation Office. Those requests will be filled on a programming needs (and availability) basis as determined by the Hospital CEO.

Out of State Travel:

A. Authorization must come from the Hospital CEO to the supervisor of transportation.

B. Staff signing out the vehicle is responsible for checking the vehicle for safety equipment, fuel, and other normal safety points. Staff is responsible for completing and submitting to the Director of Fiscal Services monthly mileage sheets (in accordance with DAS Vehicle Policy GL-115).

Reserving Vehicles:

A. To reserve a vehicle, staff will e-mail or call the following in the order listed:
- Secretary 2 (860-262-5082/primary)
- Chief of Fiscal Services (860-262-5099/2nd alternate)
- CVH Garage (860-262-5727/3rd alternate)

B. When reserving a vehicle, staff will provide the following:
- Name;
- Hospital;
- Phone Number;
- Reason for use (Patient Medical Appointment, Court, Staff Meeting, etc.);
- Time period being requested; and
- Destination

Staff will pick up the reserved vehicle and gas keys at the CVH garage, unless otherwise directed.

Staff will secure vehicle whenever they leave it (i.e., remove keys from ignition, turn off lights, lock doors, close windows, place confidential/valuable items out of sight).

Staff will legibly and accurately complete the Vehicle Mileage form housed in the vehicle *(for each and every trip use)*

Staff will top off the tank with fuel after use if the tank is ½ full or less.

Staff will remove all trash and personal items from the vehicle after use.

Cancellations: Staff will provide a minimum of prompt, ideally 24-hour notice should usage differ from the original reservation.

After Hours Usage: Upon return of a vehicle after hours, staff will return the vehicle to the location retrieved and place the keys in the drop box in the CVH garage. Only in special circumstances, ***pre-approved*** by the Agency Transportation Administrator, are vehicles to be kept overnight. (*See* Page 10 of DAS GL115)

Failure to follow this policy and procedure may result in suspension of reservation rights.

Please Note: The CVH garage operates: Monday through Friday from 6:00 AM to 3:00 PM.

WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7:	Management of the Environment of Care
PROCEDURE 7.5:	**Safety Hazards**
Governing Body Approval:	6/10/18, 3/1/19
REVISED :	3/1/19
Reviewed:	09/29/2023

PURPOSE: All staff members of Whiting Forensic Hospital (WFH) play a role in the safe operation of the facility. The identification and timely reporting of safety hazards in the environment is critical.

SCOPE: All WFH staff

PROCEDURE:

The hospital identifies safety hazards through a number of surveillance activities which include:

1. Fire Marshall Inspections;
2. Building Inspections by WFH and CVH Maintenance personnel;
3. Environmental Rounds conducted by the Management of the Environment of Care (MEC) Committees;
4. Daily observations by employees and Agency Police;
5. Vehicle inspections by garage personnel;
6. Incident Report reviews; and
7. Worker's Compensation reviews;
8. Grounds Surveillance Report

If a safety hazard is identified in a patient care area, the Head Nurse will assess the hazard and determine if it must be monitored by staff until it is repaired or removed from the area. These hazards include but are not limited to: door locks that are not functioning properly; broken or exposed metal or other sharps; and any material that could be harmful to patients or staff.

When a safety hazard is identified as part of the above surveillance activities, the reviewer reports the safety hazard to the facility Safety Officer.

If the Safety Officer is unable to fix the hazard with internal resources, he will contact the CVH Director of Plant Operations, in his role as facility manager for our landlord organization, to assign the appropriate staff to correct the hazard or eliminate access to the hazard until the repair is made. Employees who come upon a safety hazard should report the hazard immediately to the facility Safety Officer or the Building Maintenance Supervisor.

When reporting the safety hazard, the caller includes:

1. the nature of the hazard, e.g., broken outlet;
2. the location of the hazard, e.g., Dutcher North 3, Room 326; and
3. any other helpful information, e.g., behind the counter.

Any adaptive/medical equipment must be ordered by a physician and noted on the physician's order sheet. If such equipment poses a safety or security risk, the request for such equipment must be reviewed and approved by the respective Service Medical Director, Agency Police and Safety Officer prior to implementation. If approved, the equipment may be added to the unit's sharps count or other safety checklist such as the Environmental Rounds or Medical Equipment Form in order to ensure a safe environment.

WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7:	Management of the Environment of Care
PROCEDURE 7.6	**Management of Patient Personal Property**
REVISED:	1/30/22, 2/29/24
Governing Body Approval	1/31/22, 3/1/24
Effective Date:	3/4/24

PURPOSE: These guidelines have been developed to ensure the patients' right to their personal property, to retain and access seasonal and intermittently used personal property separate from their rooms, provide off-unit storage for a limited quantity of items and establish a process for patients to access their personal property.

SCOPE: Clinical staff and patients

POLICY:

1. Each patient will be permitted to store a maximum number of items in the off-unit storage area; Patients will be provided access to their personal belongings.
2. Whiting Forensic Hospital shall collaborate with outside agencies to receive property from DOC facilities and other community-based residential agencies.

Definitions:

Authorized representative: (1) a representative from a group home or agency to where the patient is being released; (2) a family, friend, or other party who the patient identified in a signed document as being permitted to receive property and the staff have confirmed are willing to receive patient property.

Contraband: "Contraband" means any property, the possession of which is prohibited by any provision of the general statutes, which includes (*but is not limited to*) alcohol, weapons, explosives, mace, illicit or other unauthorized/unidentified substances/ items.

Depreciation Value: "Depreciation" is the loss in value from all causes, including age, wear and tear. The "normal" contents claim process is: the claimant (with help from an adjuster) prepares a

detailed list of every single damaged or destroyed item noting approximate age, value, and replacement cost.

Do Not Issue: Items that are not currently permitted for patient use; as determined by the DMHAS Police, the Treatment Team, or WFH administration.

Electronic Devices: As identified in Operational Procedure 7.15 Allowable Patient Personal Property – Electronic Items.

Legal Materials: Patients shall be allowed to maintain legal materials in their bedroom within the parameters noted below for amount of belongings permitted. Additional short-term storage will be available in the Whiting and Dutcher storage areas to store excess material. Patients (with staff escort or assistance) shall be allowed supervised access to the storage area. All legal materials retained in a patient's bedroom shall be considered patient property and shall be subject to search for contraband; however, the content of such material shall not be read.

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

PROCEDURE:

Hospital-Wide:

A. The Hospital has the authority to examine and inspect all envelopes, parcels and packages brought into the Hospital.

B. All patients have identification and other important documents (e.g., birth certificates, social security cards, EBT cards, State issued identification cards, passports, etc.) locked up, unless required for transitional activities.

C. All patients must keep valuables (jewelry, etc.) locked up when not in use; or to send to family or outside parties for safe keeping

D. Given the potential for imbalances in patient-patient relationships, patients are discouraged from exchanging money and gifts with one another. In the event a patient intends to exchange money or a gift (with monetary value greater than $20), both the patient giving and the patient receiving must report the exchange to their treatment teams. The treatment teams will then determine what, if any, intervention is indicated, i.e. to prevent exploitation.

Responsibilities of the Hospital:

A. The Hospital must maintain a reasonable balance between permitting patients access to personal property while also meeting statutory and regulatory compliance requirements governing Fire Safety, Personal Safety and Infection Prevention, all critical areas that could be impacted by excessive accumulation of personal property in patient rooms.

B. When possible, store the remainder of the patients' personal property in an area where patients can access it in a timely manner.

Responsibilities of Staff:

DMHAS Police:

Whiting Building- Police shall process property upon admission and when received from outside agencies; will maintain valuables in safe such as identification and jewelry until discharge; work with the Storekeeper to facilitate the transfer of property to storage area; release property to discharged patient or authorized representative.

Dutcher Building- Screen new property being brought by visitors; notify unit staff when new items arrive, scan/inspect incoming parcels

Each patient in Dutcher will be provided an individual locked storage area for storage of personal property and belongings permitted on patient units. Upon admission to the unit, staff will assign patients a locker and a key for the secure storage of valuable belongings permitted on units. Patients will maintain possession of their locker key, unless clinically contraindicated. In the event that a key is lost, stolen or broken, patients must inform staff immediately. Staff will then contact the lock shop for a replacement key. Staff shall perform searches of each patient's locker when the patient's room search is conducted, in accordance with WFH's Patient Search Policy (Procedure 1.11).

All personal property, clothing and valuables will be searched by unit staff on admission, including those items on person (Refer to OP&P Section 1:11). All clothing and valuables, which are placed in the hospital storage area, will be recorded by unit staff on the Property Clothing Record WFH-454. Items permitted for use only with staff supervision will be labeled and locked in a secure, designated area.

Items brought in after admission will be searched before they are distributed to the patient.

Social Work:

Social workers serve as liaison with outside agencies and families to inform them of the Hospital's storage space limits and of any items that are not permitted at WFH. Notification can be via printed handout or by emailing standardized information to any interested party.
As part of the discharge planning process, social workers will inform the storekeeper of upcoming discharges to ensure that belongings are released to the patient upon discharge. If a

patient is unable to take belongings with them upon discharge from WFH, the social worker will with the patient, identify a plan for belongings to be picked up from WFH within 60 days of discharge. If items are not picked up within 60 days of discharge, they will be discarded.

Transfers from Department of Corrections: The social worker shall meet with all patients newly admitted from the DOC and complete the WFH-DOC property transfer form (WFH-118) with the patient. The unit social worker or designee will send the property transfer form WFH-118 to the designated DOC contact. The WFH Stores will collaborate with DOC facility property officers to coordinate the transfer of the requested property via mail or correctional transport unit.

NOTE: DOC facilities will not accept return of property from Whiting, *except for legal papers and identification documents*. Property is not permitted to be sent back to DOC. Any patient property remaining at WFH must be picked up by family members, conservators or a designated agency working with the former patient.

Storekeeper:

- Works with DMHAS Police, Unit directors, patients and others on patient property maintained in the storage areas.
- Retrieves all patient property from the patient storage area prior to patient discharge. The storekeeper will place property in a designated area so that it can be taken with the patient upon discharge or picked up by the patient's designee upon appointment.
- Storekeeper may work with light duty personnel when assigned to assist with storage area inventory of patient belongings and 'Do Not Issue' property.

Unit Directors:

Unit Directors are authorized to access patient property in the storage areas. Unit Directors will contact the storekeeper, or designee, to relay any information necessary before acquiring/removing any patient property from the storage areas.

Responsibilities of Patients:

A. Property in personal possession: *The patient assumes responsibility for all personal items kept on their own person, in the till, in their room or at the bedside.*
B. Do not use the space behind doors for storage, doors to patient rooms need to open fully.
C. Limit the amount of wall covering to the size of a standard bulletin board
D. Provide a clear path of travel to and around one's bedside to provide emergency care (medical personnel, emergency cart and stretcher access). Keep floor clear of obstacles and trip hazards. Ensure that the room surfaces (floors, windows, vents, radiators) are accessible for thorough cleaning.

E. Prior to purchasing (or asking someone to purchase) any item, patients will seek review by Treatment Team to ensure item is not on the prohibited list or therapeutically contraindicated.

Permitted Personal Property

Dutcher Services

NOTE: Changes in the patient's risk status may, at times, temporarily affect what property the individual may have or use, such as belts, shoelaces, eyeglasses, jewelry (chain longer than 14 inches), or electronic devices. Any changes from previous allowable property items must be documented in the physician's order sheet in the patient's individual medical record.

A. **Items which may be kept by Patient/Client:** Personal Clothing, Eyeglasses, Contact Lenses, Hearing Aids, Dentures, Jewelry*, Reading Materials, Up to $30 cash on one's person.

B. **Items which may be kept by the Patient per Policies/Treatment Team Discretion**

1. Privilege Level Cards
2. Wallets/Purses
3. Identification Cards
4. Bankbooks
5. Checks & Checkbooks
6. ATM Cards
7. Insurance Cards
8. Birth Certificates
9. EBT ("Food Stamp" Cards)
10. Orthopedic Aides and Prostheses
11. Stuffed Animals
12. Small Pillows
13. Pens/Pencils
14. Personal Linens
15. Musical Instruments
16. Pocket Radios
17. Tape Players
18. Hand-Held Games
19. Permitted Pornography (see below)
20. Electric toothbrushes (with no metal)

C. **Items Secured by Nursing per Policies/Treatment Team Discretion**

The following items on this list, if permitted, shall be kept on Sharps Count:

1. Razors
2. Beard Trimmers
3. Razor Blades
4. Scissors
5. Nail Clippers
6. Keys
7. Glass objects or containers
8. Frames with glass
9. Mirrors
10. Knitting Needles, Crochet Hooks/Craft Sharps
11. Tweezers
12. Cosmetics, lotions, colognes
13. Electrical appliances with cords, such as IPod, CD Players, Boom Boxes, Ear Buds, hair dryers, curling irons, electric beard trimmers, etc.

D. **Food Items Permitted in Dutcher Units**

Food and beverage are not permitted in patient bedrooms.

Snacks and food from outside vendors:

1. Foods purchased from designated Vendors approved by Unit Personnel on a Unit "Order Out" event will be permitted on to the unit. It is assumed that quantity of food ordered in these circumstances is meant for eating in a single sitting.
2. Home-cooked foods or open/unsealed foods or beverages from stores or restaurants that are brought by visitors or other outside persons for a patient are prohibited.
3. Only foods or beverages that are store-bought and factory/hermetically sealed in the original manufacturer's packaging may be brought by visitors and given to patients.
4. All foods or beverages in glass containers are prohibited. Beverages in metal cans (e.g., soda, soft drinks) are prohibited.
5. Foods in metal cans (soup, beans, fruit, chili, canned fish/meats, and so forth) are permitted to be brought into the above identified patient occupied buildings. All foods in metal cans must be secured by staff in the patient personal items cabinets on the treatment unit.
6. All foods in cans must be opened by staff or opened by the patient under direct staff supervision, and staff is responsible for ensuring that the empty cans and lids are not available to patients and are properly disposed of in locked trash containers.

7. Items that are in the original manufacturer's packaging but have been opened or, in the judgment of the WFH police officer on duty, appear to have been opened and resealed will not be permitted in the building.

E. Electronic Items – See Operational Procedure 7.15 Allowable Patient Personal Property- Electronic Items

Whiting Maximum Security building

Snack food items may only be brought by someone on a patient's approved visitor list or it will not be accepted by Agency Police. Snack food items must be identified on their individual wrappers as "single serving" packages.

Hospital-Wide: Items That Are Not Permitted

1. Aerosol Containers
2. Large belt buckles
3. Flammables (lighters, matches, aerosol cans)
4. Dental Instruments
5. Wire Hangers
6. Perishable Food Items
7. Gang-Related Materials
8. Tobacco Products: This includes cigarettes, cigars, pipe tobacco, chewing tobacco, electronic cigarettes ("Vapes") as well as mechanisms and devices (pipes, cigarette papers) that would be used to ingest tobacco.
9. Exception: Small amounts of tobacco used in traditional, ceremonial Native American religious practices may be permitted with prior clinical/administrative approval.
10. Over the Counter Medications: Non-prescription meds, vitamins, herbal remedies, nutritional supplements.
11. Except for permitted pornography," materials that contain sexually explicit and/or violent content.
12. Gang-related, racially offensive or sexually provocative images on clothing, wall hangings, posters, or other materials.
13. Materials which promote (or appear to promote) the use of alcohol or illicit substances.
14. Contraband: includes (but is not limited to) Alcohol, Guns, knives or other weapons, Explosives, Mace, Unauthorized/unidentified substances, Illicit/illegal Substances, All Tobacco Products

15. Whiting Secure Services: Any battery powered devices, shoe laces, belts, gang-related clothing or markers
16. Dutcher Restoration Program: Steel-toed boots - skull caps with long ties, turbans, belts, shoelaces, scarves, suspenders, pantyhose, long socks, ties; Batteries (except one set allowed for Walkman) pedestal fans.
17. Prescription Medications: Any medications prescribed by outside physicians are to be inventoried by nursing staff upon admission and surrendered to WFH Pharmacy staff until such point when the patient is to be discharged from WFH. If it is determined by the patient's assigned physician and the treatment team that a prescribed medication should be destroyed, must notify WFH Pharmacy documenting which medication(s) and the clinical rationale for this decision. WFH Pharmacy shall, in turn, destroy medications per Pharmacy protocols.
18. **Toiletries:** Toiletries are provided by the hospital. Exceptions can be made at the discretion of the Unit Director due to:

    a. unique client needs or sensitivities
    b. items not provided by the hospital, (e.g., contact lens solution) or
    c. Clinical rationale (e.g., makeup to improve one's self-esteem).
    d. All items not supplied by the hospital must arrive sealed.

With patient consent, the Unit Director can assign a FTS to contact family members/friends, to arrange to have permitted items dropped off or to allow such items to be made available on the unit.

Pornography

Patients are **only** permitted to have sexually explicit materials where the participants appear to be consenting adults and that are on **printed media** such as in books, magazines, posters, calendars, printed photographs, and so forth.

"Sexually explicit" (or "pornographic") content includes – but is not limited to – media or materials that show or portray nudity, partial nudity, or actual or simulated sexual acts/activity regardless of whether the portrayals are of living persons, drawings or paintings, or computer generated images.

Patients are not permitted to have sexually explicit material in other mediums, *i.e.* video. Patients must ensure that the allowed printed materials remain in their bedroom and that roommates are not subjected to that material. Failure to adhere to these expectations may result in the treatment team's decision to prohibit the material, by physician order.

Admission Protocols and Inventory:

The Hospital must maintain a reasonable balance between permitting patients access to personal property while also meeting statutory and regulatory compliance requirements governing Fire Safety, Personal Safety, Infection Prevention, and all critical areas which could be impacted by excessive accumulation of personal property in patient rooms.

Patient Property Storage Protocols:

The Hospital has the authority to examine and inspect all envelopes, parcels and packages brought into the Hospital.

All patients may have identification and other important documents (e.g., birth certificates, social security cards, EBT cards, State issued identification cards, passports, etc.) locked up, unless required for transitional activities or legitimate purposes.

Whiting - The DMHAS police secure valuables such as identification, jewelry and cell phones in a safe. Patients in the Whiting building are not permitted to have these items in their possession. These items are placed in a safe upon admission and released to the patient upon discharge or transfer to Dutcher.

Dutcher – All patients are responsible for any jewelry in their possession. Any patient that elects to hold on to their valuable property will be responsible for that property. Patients are encouraged to send valuable jewelry items to a family member, conservator or other patient identified designee, for safe keeping.

Items Not Permitted in storage

Contraband as defined by the state statute; food items of any kind; old newspapers and magazines; tobacco products; combustible items; soiled clothing; furniture; household or automobile items.

Upon Admission and Receipt of Property- Upon admission, patient and property will be searched per policy (See: Operational Procedure 1.11 Patient Searches).

Prescription Medications

Prescription and over the counter (OTC) medications will be taken from a newly admitted patient and forwarded to the Pharmacy for inventory and storage. They will be recorded on a Log of Confiscated Patient Medications form (WFH-454C). Medications will be returned to a patient upon discharge. Medications that belong to someone else or are unlabeled or non-uniform in appearance will be confiscated and noted on a WFH 319.Contraband articles will be confiscated, turned over to Security, and destroyed per WFH procedures (WFH-319)

Dutcher Services

All items brought for patients must be screened through the Dutcher Substation, passed through the X-ray machine, and inspected/searched by hand as determined to be necessary by the DMHAS Police Officer on duty.

Whiting Building

During patient admission, the DMHAS Police will list all incoming patient property through a "Patient's Personal Property List form" (PPP). Issuable property (property appropriate to go into the secured area) will be placed in "banker boxes" to be distributed on the units with a copy of the PPP. Unit staff will work with the Police to ensure all of the issuable property is present by going through the issuable property and "signing off" on the PPP before the patient receives the property.

Any mail order parcels or other packages from outside businesses/individuals are inspected by the DMHAS Police before distribution during "package call". All property received through the mail (excluding approved consumable items) will be listed on a PPP. Unit staff will work with the Police to ensure all of the issuable property (excluding approved consumable items) is present by going through the issuable property and "signing off" on the PPP.

Approved Patient's Visitors may drop off personal items to the DMHAS Police during visitation. All property received through visitation (excluding approved consumable items) will be listed on a PPP. Unit staff will work with the Police to ensure all of the issuable property (excluding approved consumable items) is present by going through the issuable property and "signing off" on the PPP.

Items received either via mail order or visitation that need to be forwarded to a Unit Director to determine appropriateness should be documented on a PPP (excluding consumable items) and both the item(s) and a copy of the PPP should be given to Unit Director.

Any patient property that is received through admission, mail order or visitation that is not appropriate for inside the building will be documented on a PPP as "Do Not Issue" and forwarded to the storeroom for safekeeping.

Patient valuables, identification documents shall be documented on a PPP and secured in the DMHAS Police safe until release from Whiting Max or if patient authorizes in writing release of said items to an outside party.

Copies of PPPs shall be forwarded to Medical Records and Patient's Assigned Unit to be added to the patient's chart.

Dutcher Restoration Services (D2S)

1. All patient property entering the **Dutcher** Restoration Services (D2S) shall be inventoried by designated Unit Personnel. Items permitted for use only with staff supervision will be labeled and locked in a secure, designated area.
2. Packages brought by visitors to the unit are to be shown to Nursing staff immediately when entering the unit. Items that are not allowed on the unit should be left in the visitor's vehicle.
3. A completed inventory sheet (WFH-23) shall be added into the patient's Medical Record chart.
4. Patients may be provided copies of inventory lists upon request
5. Items given to visitors for their use or to be sent home must be logged out by staff.

During Transfers Within Facility

Patient Property Transfers Between Buildings

When a patient is transferred with notice, the patient's property will be transferred along with the patient to his/her new unit. Patients are encouraged to take a primary role in packing their own belongings to ensure that all items are transported with the patient to their new unit. Staff will assist patients with packing, as needed. Items which are designated for placement in off-unit storage will be inventoried on the WFH-454.

When a patient is transferred without prior notice, the patient's property will be packed and inventoried by nursing staff prior to being sent to the new unit. Items which are released for patient use will be placed in a separate bag/box and inventoried on the WFH-454. Items, which are designated for off-unit storage, will be inventoried on the WFH-454. The unit director from the patient's former unit is responsible for transporting allowable patient property to the patient's new unit by the end of the next business day and contacting the storekeeper for the transport of property to an off-unit storage area.

In all cases of transfers from Dutcher to Whiting, the patient's property must be screened and approved by the police, before property is permitted on the unit or placed in the storeroom area.

Copies of the WFH-454 will be provided to the patient upon request.

Patient Property Discharge Protocols

Prior to discharge from WFH

1. **Funds in Patient Accounts**

   Social Work will notify Fiscal Services via completion of a WFH-15, Patient Accounts Disbursement form, in advance of discharge, identifying how funds are to be disbursed or transferred once released from WFH.

2. **Patient Valuables in Safe**

   Social Work will contact the DMHAS Police and coordinate the release and/or transfer of any property that the patient has in the Patient Safe.

3. **Property in Patient Possession**

   a- Prior to discharge patients shall be encouraged to assist in packing up all belongings to ensure property can move with them upon discharge or be transferred to a secure storage area if the property is not being taken by the patient the day they are discharged.
   b- Unit staff must initiate an inventory of Patient Property using Form WFH-454 before the transfer or storage of this patient property. This Patient Property Inventory Form shall be completed and affixed to the storage container(s) before the transfer or storage of patient property occurs Patients and/or their designated representative are encouraged to make a timely effort to retrieve any property that they did not take with them at the time of discharge.

4. **Medications in Storage**

   a. Nursing staff on the units will arrange for return of the medications to the patient upon discharge.
   b. Up to two days prior to discharge, the unit will notify the pharmacy of the discharge so that the medications can be returned to the patient. The WFH 454c form will be reviewed and disposition codes will be determined by the physician.
   c. The medications will be dropped off to the Nursing Office before 9:30am on the day of discharge.
   d. In the event the patient leaves when the pharmacy is closed, the medications will be stored by the pharmacy for seven days. Patients will be informed of this and to call the discharging unit's Nursing Station to set up an appointment to retrieve their meds.
   e. The patient or the patient's representative (e.g. Community Program Case Manager) can go to the Pharmacy to retrieve a person's medications.
   f. Medications that are not returned to, or retrieved by the patient will be destroyed by the pharmacy.

5. **Preparing to Release Property in Secured Storage Areas**

Social Work, to ensure follow-up and a smooth transition of property from WFH to the client's new place of residence is responsible to obtain from the client/patient (and document in the patient's medical record):

a. a verifiable current forwarding address
b. phone number
c. active email account address (if available)
d. any like information for an authorized party (e.g. family, outpatient DMHAS program, staff from a treatment program identified in discharge plan or other authorized parties

e. A signed release of information form authorizing WFH personnel to contact and speak with outside agencies, family members or other authorized persons. The scope and purpose of this release would be limited to information related to how patient/client property is to be transferred from WFH, to whom it is to be released, and (if necessary) where to send remaining patient property items. This authorization shall automatically expire after ninety (90) days.

6. **Property in Secured Storage Areas**

a. The Hospital shall make every reasonable effort to make certain a discharged patient's property is returned to its owner.
b. Sixty (60) days after the date of discharge, and after making good faith efforts to communicate with and/or locate the owner, if WFH has not heard from the former patient or their representative, a final notice shall be sent to the last known address stating that the property (*except for valuables and identification documents*) shall be disposed of in 30 days if not claimed.
c. Sixty (60) days after final notification, unclaimed belongings may be disposed of by: (1) Donation it to the WFH "Styles for Smiles" boutique; (2) Donation to a charitable organization such as Goodwill or Savers; (3) Sell the items and deposit the proceeds in the Patient Welfare Fund; or (4) dispose of any items that cannot otherwise be disposed of.
d. **Unclaimed article of jewelry or valuables** in the custody of WFH shall be retained for a period of 3 years, during which time every reasonable effort shall be made to return such articles to their owner. At the end of three years, WFH may sell or otherwise dispose of unclaimed valuables with the approval of the governing body. Any revenue derived from the sale of such valuables shall be credited to the Patient Welfare Fund of WFH.
e. **Unclaimed identification**, such as birth certificates, driver's licenses, and etcetera shall be placed in the patient's medical records archive files after 30 days.

Storage of Patient Property

Property Inventory

ALL property brought into Whiting Forensic Hospital (WFH) must be inventoried upon admission.

In Whiting, DMHAS Police inventory all property brought upon admission and all property transferred from DOC. Any excess or Do Not Issue patient property will be sent to the storage area. A copy of the inventoried items will be placed inside the storage container.

The Storekeeper, or designee, shall maintain an inventory list of any patient property in the storage area.

Storage and/or Possession of Valuables

Whiting Forensic Hospital discourages patients from keeping valuables on their person, in their rooms or in storage.

Patients are strongly advised to release to family, conservators, or representatives from an agency named as having supervision/care authority with the patient, any valuables they currently have in their possession, for safe keeping.

Patient Property on Units / Personal Possession

***Responsibilities of Patients/Clients*:**

Property in personal possession: The patient assumes responsibility for all personal items and money kept on their own person, in their assigned locker, in their room or at the bedside. Such property is retained at the person's own risk. The Hospital shall not be responsible for any property personally retained by a patient which is lost, stolen, damaged, consumed or discarded while in the patient's possession (e.g., living quarters or on person).

A patient shall not loan, trade, sell, give or transfer property to another patient, unless approved by the Treatment Team via a request with their respective Treatment Team and filling out a 'Buy-Sell-Trade' form

Valuables: Each patient/client is responsible for all items in their possession in their rooms and lockers.

Wall Coverings: Limit the amount of wall covering to 18"x24".

Free access to room: Keep the doors to the patient rooms open fully.
Do not use the space behind doors for storage. Property and furniture must not obstruct line of sight into the patient room nor block ready access to the room.

Provide a clear path of travel to and around one's bedside to provide emergency care (medical personnel, emergency cart and stretcher access). Keep floor clear of obstacles and trip hazards. Ensure that the room surfaces (floors, windows, vents, radiators) are accessible for thorough cleaning.

Quantity Limits:
On Unit- Personal property is limited to that which can be stored INSIDE the Till (wardrobe), the bedside stand and locker. In addition, each patient may have space in the room (approximately a volume of 3'x3'x3' or2 hospital approved bins) to place allowable property. In some rooms, space may be more limited than others.
Secured Off Unit Storage Areas- Patients are permitted to store, limited excess or Do Not Issue, allowable property off the unit. Property storage will be limited to 10 banker boxes (or the equivalent of 3 plastic storage bins) in the storage areas.

Personal Electronic Devices: Dutcher patients are permitted up to three Hospital approved electronic devices (e.g. computer, television, audio play equipment, printers, etc.). Additionally, all corded devices must be loomed before being placed in any patient room. (See: Operational Procedure 7.15 Allowable Patient Personal Property – Electronic Items.)

Storage of Patient Property

Storage of Patient Property – General Rules

Patient property in all storage areas is arranged by alphabetical order.

Valuables: Patients are discouraged from keeping Valuables either in storage or on the units in their room. Valuables should be sent to family, conservators or an authorized community agency.

Contraband: Any property, the possession of which is prohibited by any provision of the law, which includes (but is not limited to) alcohol, tobacco, weapons, explosives, mace, illicit substances or other unauthorized/unidentified substances

The Hospital cannot store boxes of newspapers and magazines, these are fire hazards and will be discarded.

The Hospital cannot store food items in the patient storage area. Any unopened food products sent to storage shall be returned to the patient, if permitted to have on the unit. If the food products are not allowed on the unit they will be discarded.

In collaboration with the Program Managers, the Patient Property Storekeeper will determine the most suitable location (Dutcher/Whiting) for any individual patient's property as to when or if property would be transferred between buildings or remain in location.

Access to the storage areas is restricted. Scheduled times will be established by the Storekeeper, or designee, for when the storage areas are open for specific units. Whiting unit directors are permitted to sign out the storeroom key, Dutcher Unit Directors may contact the Storekeeper or designed to arrange access.

Patient property being placed or removed from the storage area will be processed (drop off/pick up) in a specific location. Whiting will be located at the entering port with the gate. Dutcher will be located in the designated processing room.

All staff placing or removing patient property from the storage areas will need to document any item changes on a WFH – 454 that will be located at the entrance port for Whiting and the processing room for in the Dutcher storage area.

Whiting Storage Area

The storekeeper does not have authority to release any Do Not Issue items to a patient. The DMHAS Police and Unit Treatment Teams determine what a patient is permitted to have while on the units.

Staff access to the Whiting storage area will be during posted hours during regular business days. Special exceptions may be made – in advance by appointment – with the WFH Patient Property Storekeeper. Patients do not have access to the Whiting Storage area.

The Whiting long term storage area is located underneath Whiting Unit 2. It is divided into "Issuable" and "Do Not Issue" sections.

Dutcher Storage Area

Staff and patients will not be allowed access into the actual storage area/rooms unless accompanied by the Storekeeper or previously approved and/or arranged with the Storekeeper.

Access to the Dutcher storage area will be during posted hours during regular business days. Special exceptions may be made – in advance by appointment – with the WFH Patient Property Storekeeper.

The Dutcher patient property storage area is in the Warehouse building. Patient property is kept in rooms of alphabetical sequence on shelves.

Lost or Damaged Personal Property in Patient's Possession

Property that was lost or damaged but in patient's possession (including items stored in the patient's secure locker) is deemed in custody of the owner and the Hospital is not obliged to replace or reimburse for those items

Personal Property that is Lost or Damaged while in the Institution's Custody

The Hospital is liable for personal property that is lost or damaged only if the property is cataloged on the patient's property list (WFH-454). If a patient claims that the Hospital has caused an item to become lost or damaged, the Unit Director must alert the Storekeeper. The Storekeeper will conduct a review of the patient's property list to determine if the item in question has been cataloged on the WFH-454. If the item is listed on the patient's property list, and the item has been lost or damaged, WFH will provide reimbursement for the lost or damaged item. Any reimbursement value of lost or damaged property that is in the Hospital's custody will be determined by insurance industry standard reimbursement value tables and not according to what a purchase price was.

Depreciation of value: Refer to the Depreciation Rate Guide to determine property value depreciation. Reimbursement for the lost or damaged patient property will be determined by the following:

A. Actual Cash Value (-) Replacement Cash Value divided by the depreciation rate of the item
B. The date the item was first entered on to the patient's 454
C. The replacement value (cost to purchase the time it was discovered lost or damaged)
D. Divided by the estimated depreciation value rate of the item at the time it was discovered lost or damaged.

Release of Patient Property

Prior to discharge, patients are encouraged to take a primary role in packing up all of their belongings. Staff will be available to assist, if needed. On the day of discharge, patient property will accompany the patient upon discharge or be transferred to a secure storage area if the patient is unable to take the property with them.

Unit staff must complete an inventory of Patient Property using Form WFH-454 before the patient property is transferred to a secure storage area. This Patient Property Inventory Form WFH-454 shall be completed and affixed to the storage container(s) before the transfer of patient property occurs.

Patients and/or their designated representatives are encouraged to retrieve all property that they are unable to take with them at the time of discharge within 60 days of discharge.

Upon discharge, patient property can be:

1. Surrendered to the patient personally
2. Released to an authorized third party (any authorized* party [DMHAS or DMHAS contracted agency staff, family member, authorized friend)
3. All parties, except for the patient, will be required to show a photo ID with current address, to Storekeeper or WFH APO's before release of property
4. The CT Department of Corrections does not permit patient property to be returned to a DOC facility

Unclaimed property still in Whiting or Dutcher Storage after discharge from Whiting Forensic Hospital

1. The Hospital is responsible for doing due diligence to notify and assure the return of former patient property not retrieved from Whiting Forensic Hospital by a patient before disbursing unclaimed patient property.
2. Unclaimed property remaining at WFH after 60 calendar days (except for valuables and identification) must be disbursed according to protocols established by CGS Sec. 4-58.
3. *Disposition of unclaimed property in the custody of heads of state institutions*. "*…and … any unclaimed article of jewelry or any accumulation of such articles or valuables in the custody of the administrative head of any state institution shall be retained by such administrative head for a period of three years, during which period he shall make every reasonable effort to return each such article to its owner*."
4. Identification documents (birth certificates, passports, drivers' licenses etc.) must be surrendered to medical records to be retained in the documents indefinitely.

Alternative storage options

Patients with excessive boxes are permitted to make arrangements with commercial storage vendors. The Whiting Patient Property Storekeeper shall schedule a time convenient to all parties for patient property to be released to the patient, their social worker and/or unit staff, and authorized patient representatives to remove and release property to them.

The number of boxes, bins and bags released, the date of release, and to whom such items have been released shall be recorded in the Patient Property inventory logs as being removed from the area.

Neither Whiting Forensic Hospital nor any of its staff or shall be held responsible to pay or reimburse anyone for rental of an outside storage site. Any and all rentals of outside storage sites shall be paid for by the owner of the property or their authorized representative.

Whiting personnel may be assigned, if staffing, and sufficient time, is available, to escort a patient to a local commercial storage facility.

Any and all containers of property retrieved from an outside rental site, must be surrendered to staff escort until the contents of the property has been examined, and added to a patient's property inventory.

References:

State Statutes
CGS Sec. 4-58. Disposition of unclaimed property in custody of heads of state institutions.
CGS Sec. 17a-54X.

DMHAS Policies / Commissioner's Directives
DMHAS Commissioner's Policy Statement # 13; Patient's Property Rights

Whiting Forensic Hospital Policies

Procedure 7.12	Use of Extension Cords and Surge Protectors
Procedure 7.15	Allowable Patient Personal Property – Electronic Items
Procedure 1.11	Patient Searches

WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7:	Management of the Environment of Care
PROCEDURE 7.7:	**Firearms and Deadly Weapons**
Governing Body Approval:	6/10/18
REVISED :	
Reviewed :	09/29/2023

POLICY:

To provide and maintain a safe campus through the prohibition and control of firearms, deadly weapons and dangerous instruments, as promulgated through the General Work Rules of the Department of Mental Health and Addictions Services (DMHAS) and the Connecticut General Statutes 53a-174 section (2), Conveying of Unauthorized Items into a Correctional or Humane Institution.

SCOPE: All WFH Staff

PROCEDURE:

The possession of firearms or dangerous weapons of any kind are strictly prohibited on the campus of the Whiting Forensic Hospital (WFH), which includes but not limited to all work sites on the campus as well as vehicles both private and State owned. Deadly weapons include, but are not limited to any firearm, whether loaded or unloaded, from which a shot may be discharged, or a switchblade knife, gravity knife, billy club, blackjack or metal knuckles, axes, hatchets, hunting knives, etc., per CGS; 53a3(6), as well as dangerous instruments as defined in the CGS, 53a-3(7).

Staff members should report any individuals with firearms or dangerous weapons immediately to the DMHAS Police Dispatch Center at x5555.

This policy shall not apply to employees of the DMHAS Division of Safety Services carrying department agency weapons in the performance of their official duties.

Outside law enforcement personnel are requested to secure firearms in their vehicles on a voluntary basis.

WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7:	Management of the Environment of Care
PROCEDURE 7.8:	**Bomb Threats**
Governing Body Approval:	6/10/18
REVISED :	09/29/2023

PURPOSE: To provide staff with adequate procedures to deal effectively in the event of a bomb threat.

SCOPE: All WFH

PROCEDURE:

All Whiting Forensic Hospital (WFH) employees receiving telephone bomb threats will implement the following procedures:

1. Remain calm;
2. Allow the caller to speak his/her mind;
3. Attempt to gather specific information such as:
    a. time the bomb is scheduled to explode;
    b. location of the bomb;
    c. reasons the bomb was planted; and
    d. type of materials used to make the bomb.

4. Express a desire to save lives by informing the caller that many innocent people may be injured if the bomb explodes;

5. Listen closely to the caller's voice and note the following:

    a. gender of the caller (male/female);
    b. voice quality (calm/excited);
    c. accents or speech impediments;
    d. background noises which may give a clue as to location of the caller; and
    e. the phone number of caller if received on a display phone.

6. Immediately after the caller hangs up, dial the DMHAS Police Dispatch Center x5555 from a hospital telephone, and inform the Dispatcher of your name, your location, and that you have received a call which was a bomb threat (use the exact words used by the caller).

7. Notify the Nursing Supervisor of the situation and your actions taken thus far.

8. Talk to no one other than your immediate supervisor.

9. The Dispatch Center institutes procedures to activate the emergency response.

10. If a bomb threat is made, the Dispatch Center immediately notifies the DMHAS Police and Middletown Police Communications for assistance from the South District Fire Department.

11. Should staff find any suspicious object they:

    a. are not to touch it or move it; and
    b. are to notify the command post by calling the Telecommunications Dispatcher.

12. The Dispatch Center, after receiving word from the DMHAS Police that the bomb threat is over, announces the “all clear” over the Public Address System.

WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7:	Management of the Environment of Care
PROCEDURE 7.9 :	**Employee FIT Testing**
Governing Body Approval:	March 19, 2021
New:	March 1, 2021
Reviewed :	09/29/2023

POLICY: All staff in positions classified as Health Care Workers (HCWs), as well as other support staff, will have initial and annual mandatory respiratory protection training and fit-testing for respirator use in accordance with Occupational Safety Health Administration (OSHA) regulations 29 CFR 1910.134. The Ambulatory Care Services (ACS) department will coordinate testing and maintain on-going records thereof.

SCOPE: All direct service and support staff

PROCEDURES:

1. The ACS department will track the new hire and annual fit-testing of HCWs and other support staff such as housekeeping and maintenance, utilizing the fit-testing database. The database will include name, employee number, title, division, medical evaluation confirmation, date fit-tested, PAPR or respirator model, number and size; and whether the test was passed or failed.

2. The ACS department will send out a notice to staff and their supervisor one month prior and two weeks prior to when staff are due for repeat annual fit-testing.

3. FIT testing schedules will be coordinated and announced by ACS staff weekly via hospital wide e-mail.

4. FIT testing will proceed per Whiting Forensic Hospital's Respiratory Protection Program guidelines.

5. Employees will be provided with either a sticker (to be adhered to his/her ID badge) or a wallet card indicating PAPR requirement or the make, model, and size of the N95 found to be effective.

6. HR will update the ACS Service Medical Director when there are new hires to ensure that all staff that need fit testing are provided testing as soon as possible after hire.

WHITING FORENSIC HOSPITAL

OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7:	Management of the Environment of Care
PROCEDURE 7.10:	**Traffic Control and Designated Parking**
Governing Body Approval:	6/10/18
REVISED :	
Reviewed :	09/29/2023

PURPOSE: To maintain a safe campus through effective vehicular traffic management.

SCOPE: All WFH Staff

PROCEDURE:

Staff is aware that vehicles parked on the grounds of Whiting Forensic Hospital (WFH) are parked at their own risk. This includes property left in personal vehicles.

Staff are required to ensure that their vehicles which are driven on the grounds of the hospital are properly registered, insured and in running condition.

Staff is required to park in a legal parking space in any one of twenty-three (23) designated parking areas on the campus.

Staff may park in handicapped parking spaces with appropriate state issued handicapped parking permits.

Staff is not permitted to park in designated visitor parking spaces, fire lanes, loading zones, or parking areas designated for special event parking.

WFH Police enforce motor vehicle laws through Connecticut Infraction Complaints, Misdemeanor Summons, Warning tickets or Middletown Parking Authority parking tickets.

The WFH Police provide vehicle traffic control for ambulance, fire, and other emergency vehicles.

Staff can expect that the hospital provides for appropriate signage and traffic lights, as needed.

Staff is expected to obey all Connecticut traffic laws while on the WFH **and landlord hospital CVH** grounds, including but not limited to a 15 mph speed limit.

WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7:	Management of the Environment of Care
PROCEDURE 7.11:	**Interim Life Safety Measures** LS.01.02.01EP1
Governing Body Approval:	7/27/22
REVISED :	7/19/22
Reviewed :	09/29/2023

POLICY

It is the policy of Whiting Forensic Hospital to assure the safety of all building occupants during periods of construction or when deficiencies compromise the level of life safety protection provided by the building by implementing the appropriate Interim Life Safety Measures (ILSM).

PURPOSE

Interim Life Safety Measures (ILSM) is administrative actions taken to temporarily compensate for the hazards posed by construction activities or any time the fire protection features of the facility are compromised. ILSM's are intended to provide a level of fire safety comparable to that described in the 2021 edition of NFPA 101 Life Safety Code·

ILSMs may be required to temporarily compensate for the hazards posed by, but not limited to:

1. Construction projects.
2. Interruption of fire suppression systems.
3. Interruption of fire alarm and notification systems.
4. Full or partial obstruction of exit passageways.
5. Penetration of fire and smoke walls.

REQUIREMENTS

1. The Interim Life Safety Measures (ILSM) will be implemented when Life Safety Code deficiencies cannot be immediately corrected or during periods of construction.

2. Life Safety Code deficiency, whether identified during a Statement of Conditions assessment, through environmental tours or any other source, will be evaluated to determine if any ILSM should be implemented (Attachment I- Life Safety Deficiency Assessment).

3. The potential project, whether construction, renovation, and/or remodeling, will be assessed at least one week before the project begins. The ILSM Assessment Tool will be utilized (Attachment II- ILSM Assessment Tool).

4. When the fire alarm is out of service for more than 4 hours in a 24-hour period or sprinkler system is out of service more than 10 hours in a 24-hour period in an occupied building, a fire watch is initiated and documented, and the local fire department is notified per ILSM a Policy for a Fire Watch and the local fire department or emergency services is notified.

5. Signs will be posted to identify the location of alternate exits to everyone affected, in periods when their exits are blocked due to construction or other reasons (See Attachment III and IV for signage).

ILSM Assessment Tool Instructions

1. Evaluate the project or deficiency for impact on exiting, compartmentation, fire detection and response systems, ignition sources, storage, debris, and other potential concerns identified the criteria.

2. Determine if the impact is significant. An activity which takes place in a room with an intact door and which does not penetrate walls generally does not require an ILSM. Activity that affects doors or walls for less than one shift generally does not require an ILSM. Activities that block or compromise exit stairs, required exit corridors, or exit discharge areas for more than one shift, generally require an ILSM.

3. If it is determined that an ILSM is warranted, monitor and document that the ILSM is in-place and functioning as required. If the ILSM is not functioning as required, adjust the ILSM or re-assess the situation.

4. Document and submit findings to the Environment of Care (EOC) Committee

5. Document enforcement of each required ILSM when appropriate on the ILSM Monitoring Form

ASSESSMENT CRITERIA

1. Conditions that may lead to the implementation of Interim Life Safety Measures may include but are not necessarily limited to the following evaluation criteria:
    a. Emergency exits are obstructed.
    b. Fire detection or alarm systems are inoperable or impaired
    c. Current firefighting equipment is insufficient.
    d. Temporary construction partitions are not smoke-tight or made of non-combustible or limited combustible materials or barriers extend into the egress pathway.
    e. Increased risks of fire are present in buildings, on grounds, and with equipment,

giving special attention to construction and storage areas, excavation activities, and field offices requiring increased surveillance.

f. Increase in the building's flammability and combustible fire load.

g. The situation requires additional fire safety training for individuals on the use of firefighting equipment.

h. Life Safety Code deficiency that cannot be repaired within the shift or after 45 days after being placed on a maintenance work order.

i. Any "other" ILSM that is needed that is not noted above.

PROCEDURES

1. If any one of the above conditions applies, the appropriate measure(s) should be selected from the list below that applies to the life safety deficiency or during the project that inhibits Life Safety. These measures will be implemented once identified using the ILSM Assessment Tool:
   a. Inspects exits in affected areas on a daily basis.
   b. Provides temporary but equivalent fire alarm and detection systems for use when a fire system is impaired.
   c. Provides additional firefighting equipment.
   d. Uses temporary construction partitions that are smoke-tight, or made of non-combustible material, or made of limited combustible material that will not contribute to the development or spread of fire.
   e. Increases surveillance of buildings, grounds, and equipment, giving special attention to construction areas and storage, excavation, and field offices.
   f. Enforces storage, housekeeping, and debris removal practices that reduce the building's flammable and combustible fire load to the lowest feasible level.
   g. Provides additional training to those who work in the hospital on the use of firefighting equipment
   h. Conducts one additional fire drill per shift per quarter.
   i. Inspects and tests temporary systems monthly. The completion date of the tests is documented.
   j. Conducts education to promote awareness of building deficiencies, construction hazards, and temporary measures implemented to maintain fire safety
   k. The hospital trains those who work in the hospital to compensate for impaired structural or compartmental fire safety features

2. When a project is under ILSM, the criteria identified will also have the responsibilities identified:

B. Construction and Renovation Planning

1. During the planning phase for construction or renovation projects, Construction and Design and/or Facilities Services will conduct a risk assessment to determine what hazards may be encountered during the project.
2. During the construction risk assessment meeting, the Environmental Health and Safety Interim Life Safety Measures Assessment form, found in Appendix A, will be used and filled out by the Hospital Safety Director, Project Manager/Facilities Services Manager. A determination will be made on whether or not possible life safety hazards would be encountered during the construction project that would require ILSMs be initiated.
3. When the need for ILSMs is recognized, the person initiating the ILSM will determine which ILSM process will need to be implemented during the construction or renovation project.

C. Fire Protection System Failure Interim Life Safety Measures

1. It is recognized system failures occur even when proper maintenance procedures are performed. Because of the need for immediate action in the event of a fire protection system failure, some initial changes are required in the procedures of setting up ILSMs.
2. When a fire alarm or sprinkler system failure occurs unexpectedly the following procedures will be followed:
   a) When the emergency requires the need to develop ILSMs, the Plant Facilities Engineer will be notified by calling (860) 262-5720 The Plant Facilities Engineer will determine what ILSMs will need to be implemented and will verify that the following is performed:
      (1) Notification to the on duty supervisor of the affected area that ILSMs are being implemented in that area.
      (2) Posting updated fire evacuation plans of the affected area, showing alternate exits as needed.
      (3) Providing additional fire protection equipment in the affected area if needed.
      (4) Initiate a fire watch as needed.
      (5) Notify the fire department and other agencies of the impaired system as needed.
   b) Systems failure related to the fire alarm system or sprinkler system are considered a priority and are to be repaired and corrected as quickly as possible.

D. Interim Life Safety Measures Implementation

1. When the determination has been made that ILSMs need to be implemented, the following procedures will be completed and documented on ILSM forms:
   a) Prior to start of construction, the ILSMs initiation form, found in Appendix B, will be completed by the person initiating the ILSMs and sent to the

department management of the areas affected and the other department noted at the bottom of the form. Upon implementation of ILSMs the person initiating the ILSMs will:

(1) Notify department management in all the areas being placed under ILSMs.
(2) Ensure updated fire evacuation plans of the affected areas show alternate exit(s) as needed.
(3) Indicate the estimated time frame of the ILSMs on the initiation form.
(4) Ensure that additional fire protection safety equipment will be available as needed.
(5) Staff training will be provided for the following:
   (a) Location and operation of additional fire protection equipment as needed.
   (b) Alternate exits and travel routes identified in and around the construction area.
   (c) Additional steps and requirements needed to compensate for impaired structural or smoke/fire compartmentalization features for fire safety.
(6) Information is shared with all staff in the department as soon as possible and without delay.

2. In addition to the above, Construction and Design and/or Facilities Services staff or their designee will perform the following.
   a) Perform daily inspections of the affected areas and complete the ILSM Daily Survey document to ensure that all ILSMs are in place and being properly maintained. The daily inspection will be documented on the daily inspection form in Appendix E of this policy.
3. Any deficiencies noted during the inspection will be corrected as soon as possible. All corrective actions will be documented on the same inspection document that the issue was noted.
4. A minimum of two fire drills per shift per quarter will be conducted and documented by Environmental Health and Safety.
5. Upon completion of the construction project and termination of ILSMs:
   a) The ILSM Termination document found in Appendix C will be completed and sent to all departments that were affected by the project.
   b) Permanent fire evacuation plans will replace temporary plans, showing any new and/or reopened exits.

E. Training
   1. Construction Project Managers, Facilities Services Engineers, Emergency Response Team Members, Environmental Health and Safety Officers and any other staff member who is authorized to initiate, perform daily surveys and/or terminate ILSMs, will be trained in the policies, procedures and documentation.
   2. Staff members will be knowledgeable of the ILSMs procedures. This training is included in the annual Learning Leak training.

F. Documentation

1. **<u>All</u>** daily and weekly ILSMs documentation will be forwarded to Plant Operations located in the Cotter building who will forward to the WFH EOC Committee Chair.
2. Plant Operations will maintain all ILSMs documentation for a period of three years.

3. The ILSM will be established, implemented, documented, and monitored during construction by the Contractor and Facilities Director or designee for feedback to the EOC Committee.

Appendix A

Environmental Health and Safety
Interim Life Safety Measures Assessment

Please Note: After performing the ILSM assessment, permit must be brought to Fire Services for final approval before the project can start.

Project Name:	Date of Construction Risk Assessment:
Project Manager:	Construction Contractor:
Fire Services: **Approved** ☐	**Denied** ☐

Assessment Questions

Life Safety Questions	Yes	No	If yes, what is involved?
1. Will the project compromise any of the following? • Reduce the required number of exits. • Restrict the required width of exit access, exits, or exit discharge locations.			
2. Will the project penetrate or impair any fire/smoke barriers (walls, doors, windows, deck slabs, etc.)			
3. Will the project obstruct access to emergency services and for emergency responders (Police, Fire, or EMS)?			
4. Will the fire alarm or suppression system be impaired at any time during the project?			
5. Will the project involve any hot work? (Cutting, welding, brazing, or other open flame devices)			
6. Will the project involve the presence of large quantities of combustible storage or debris?			

☐ Interim Life Safety Measures ***are not*** required. *****Note: This must be determined by the Plant Facilities Engineer*****

☐ Interim Life Safety Measures ***are*** required. (Check below all that apply)

	1.	Ensure free and unobstructed exits. Staff receives additional information/communications when alternative exits are designated. Building or areas under construction must maintain escape routes for construction workers at all times and the means of exiting construction areas are inspected daily.
	2.	Ensure free and unobstructed access to emergency services and for fire, police, and other emergency forces.
	3.	Ensuring that fire alarm, detection, and suppression systems are in good working order. A temporary but equivalent system must be provided when any system is impaired. Temporary systems must be inspected and tested monthly.
	4.	Ensuring that temporary construction partitions are smoke-tight and built of non-combustible or limited combustible materials that will not contribute to the development of spread of fire.
	5.	Providing additional firefighting equipment and training staff in its use.
	6.	Prohibiting smoking throughout the hospital's buildings and in and near construction areas. * Note: This is not applicable as it is automatically cover by a hospital-wide no smoking policy in any of the hospital buildings.

	7.	Developing and enforcing storage, housekeeping, and debris removal practices that reduce the buildings flammable and combustible fire load to the lowest feasible level.
	8.	Conducting a minimum of two fire drills per shift per quarter.

Assessment Questions Cont'd

	9.	Increasing surveillance of buildings, grounds, and equipment, with special attention to excavations, construction areas, construction storage, and field offices.
	10.	Training staff to compensate for impaired structural or compartmentalization features of fire safety.
	11.	Conducting hospital-wide safety building deficiencies, construction hazards, and ILSMs.

Additional Comments:

Other Potential Risks

Issues	Risk?		Action / Comments
	Yes	No	
Construction Access Route			
Noise			
Vibration			
Air Quality			
Utility Disruptions			
Operational Disruptions			
Equipment Danger /Risk			

Additional Comments / Requirements:

Appendix B

INITIATION of

Interim Life Safety Measures

Environmental Health and Safety

Date ILSM Initiated:		**Time:**		**Person Initiating ILSM:**	
Approximate Duration of ILSM's:				**Name:**	
				Title:	

Areas/Units affected:	**1**	
	2	
	3	

Nature of Deficiency(s):	**Describe:**
Plan for Equivalent Protection:	**Describe:**
What special requirement or information is needed for staff in affected areas:	**Note Requirements**:
Notification: (All departments checked are to be notified of ILSM initiation. Add additional departments if required.)	☒ **Management of Affected Area** ☒ **Environment Health and Safety** ☒ **Campus Police & Public Safety** ☒ **Infection Control** ☒ **Facility Services** ☒ **Construction and Design** ☒ **WFH EOC Chair** ☐ ☐ ☐

Appendix C

TERMINATION of

Interim Life Safety Measures

Environmental Health and Safety

Date ILSM Terminated:		Time:		Person Terminating ILSMs:
				Name:
				Title:

Areas/Units affected:		
	1	
	2	
	3	

Due to completion of the construction and/or repair of the affected Life Safety systems, you are hereby notified that the Interim Life Safety Measures initiated for your work area are no longer necessary. Standard policy and procedures should now apply.

Notification: (All departments checked are to be notified of ILSM terminated). Additional department identified on the initiation sheet will need to be notified.				
	☒	Management of Affected Area	☒	Construction and Design
	☒	Environmental Health and Safety	☒	WFH EOC Chair
	☒	Campus Police & Public Safety	☐	
	☒	Facility Services	☐	
	☒	Infection Control	☐	

Appendix D

Fire Watch Documentation Form

Project Name / Location:

This form shall be used to document the Fire Watch requirements for Interim Life Safety Measures. The person responsible for conducting the Fire Watch shall perform a surveillance of the area hourly and document the survey on this form. Please comment on any abnormal situations. If an actual emergency is noted, follow the necessary procedures.

Rescue, Alarm, Contain, and Extinguish (R.A.C.E.)

Date	Time	Person Conducting Fire Watch	Comments

Appendix E

Interim Life Safety Measures Daily Survey Document

Area Surveyed:	Inspector:	Date of Survey:

	A. ILSM Documentation	**Yes**	**No**	**N/A**
1.	ILSMs initiation documents have been completed and forward to required departments?			
B. Exits				
1.	Exits are easily accessible, are clear and unobstructed for areas affected by ILSM?			
2.	Staff in affected area received training for alternative routes?			
4.	Exit signage and directional signage is clear and understandable for patients, visitors, staff, and construction staff?			
C. Emergency Services Access				
1.	Entrance to Emergency Services is unobstructed and easily accessible?			
2.	Free and unobstructed access for Police, Fire, and other Emergency Services?			
D. Fire Detection and Suppression Equipment				
1.	Fire alarms and suppression systems are operational and functioning properly?			
2.	Temporary fire alarms and suppression systems have been tested monthly?			
3.	Additional firefighting equipment (e.g. fire extinguishers) and training has provided for personnel in the affected areas?			
E. Additional Safety				
1.	"No Smoking" Policy is enforced throughout and around the construction area?			
2.	Temporary construction partitions are smoke tight and built of non-combustible or limited combustible material (flame retardant plastic)?			
3.	Storage of flammable and combustible materials in the construction area is kept to the minimum?			
4.	Construction debris, food, and food waste is removed daily?			
5.	Conducting a minimum of two fire drills per shift per quarter during the ILSM?			
6.	Staff in the area of the ILSMs have been notified, and have received training for impaired structural or compartmentalization features of fire safety?			
7.	Is power properly secured at the end of each workday?			
F. Infection Control				
1.	Barriers are airtight and prohibit airflow between clean and dirty areas?			
2.	Ceiling tiles in areas adjacent to the construction areas are in place at all times?			
3.	Proper traffic routing signage is present in and around the construction area and is appropriate as agreed upon with Infection Prevention and Control?			
4.	HEPA filters are used to prevent airborne particles from migrating to patient care areas and helps maintain negative pressure in the construction area?			
5.	All doors and windows in the area are kept closed to prevent circulation of debris and dust?			
6.	Areas adjacent to the construction area are kept clean of dust and debris at all times?			
7.	There is no evidence of water leaks or mold?			
8.	No evidence of standing water in containers, sinks, or toilets in the construction area?			

Appendix E
Interim Life Safety Measures Daily Survey Document Cont'd

If "No" is answered for any questions above, indicate the issue in the comments section below and what steps were taken to correct the issues. Add additional comments using the back of this sheet for additional space if needed.

Comments:

Risk is considered manageable	Location: Department: Assessed By: Date:		Fire Dept. notification	Initiate fire watch	Ensuring Egress	Post signage to identify alternative	Inspects exits on a daily basis	Ensuring operational life safety	Temporary construction barriers are	Additional firefighting equipment	Prohibiting smoking	Controlling combustible loading	Conducting 2 fire drills per shift in all	Conducting additional fire drills in	Provide temporary equivalent fire alarm and detection system and test monthly	Enforce storage, debris removal and	Increase hazard surveillance	Compartmentation training of	Conducting organizational training on	Conducting additional training of	Appropriate personnel trained to
	Code Deficiencies																				
	1	Lacking a code complying smoke barrier																			
	2	Exit stairs discharge improperly																			
	3	Excessive travel distance to an approved exit																			
	4	Lack of two remote exits																			
	5	Nonconforming building construction type																			
	6	Improperly protected vertical opening																			
	7	Large penetrations in fire barriers																			
	8	Hazardous areas not properly protected																			
	9	Minor Life Safety Code Deficiency																			
	Construction Related Issues																				
	10	Blocking off an approved exit/closing an egress																			
	11	Temporary alternate exit provided																			
	12	Major / Minor renovation of an occupied area																			
	13	Replacing the fire alarm system (out of service long-term)																			
	14	Installing sprinkler system (out of service)																			
	15	Taking a portion of sprinkler or standpipe																			
	16	Adding an addition to an existing structure																			
	17	Hot Work																			
	18	Significantly modifying smoke or fire barrier walls																			
	Maintenance and Testing Impairments																				
	19	Taking a fire alarm system off-line																			
	20	Impaired fire pump																			
	21	Generator failure																			
	22	Taking a sprinkler system, fire alarm system or standpipe out of service																			
	23	Disconnecting alarm devices long-term (8 hrs or more)																			
	24	Disconnecting alarm devices short-term (less than 8																			

ILSM Notification

This construction project is under Interim Life Safety Measures (ILSM).

If you have any questions or comments that pertain to these measures please do not hesitate to call the Facility Services Engineer, (860) 262-5720.

In the event of an emergency, please have Gregory Cross paged through the operator.

WHITING FORENSIC HOSPITAL

OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7:	Management of the Environment of Care
PROCEDURE 7.12:	**Use of Extension Cords and Surge Protectors**
Governing Body Approval:	6/10/18
REVISED :	
Reviewed :	09/29/2023

PURPOSE:

It is the policy of Whiting forensic hospital (WFH) that Extension Cords will not be utilized.

SCOPE: All WFH Staff

PROCEDURE:

A. Extension Cords present an unnecessary risk to the environment.

1. Extension Cords may only be utilized in temporary situations i.e. when using a power tool.

B. Surge Protectors:

1. Surge protectors may be utilized for computers and low voltage electronic equipment only.
2. Surge protectors utilized at WFH must be UL Approved (UL 6601-1 for patient care areas, and UL 1449 for administrative areas).

WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7:	Management of the Environment of Care
PROCEDURE 7.13:	**Social Environment**
Governing Body Approved:	6/10/18
REVISED :	
Reviewed :	09/29/23

PURPOSE: Whiting Forensic Hospital (WFH) recognizes the importance of a positive social environment in the recovery process.

PROCEDURE:

The WFH is responsible for maintaining a therapeutic environment that supports the treatment process. Based on the length of stay of our patients, staff is asked to make every attempt to create a "home-like" environment in both the living and activity spaces.

Clinical and support staff maintain living spaces in a manner that maximizes privacy.

Clinical and support staff maintain clean and hazard free living spaces.

WFH conducts Environmental Rounds to assess and improve the quality of patient living spaces. Each division may requisition funds from the Director of Fiscal Services to purchase enhancements to the environment such as pictures, plants, and area lighting.

Staff from Whiting Forensic Hospital may be assigned to provide patients with treatment services in the Page Hall Treatment Mall of CVH through an established Memorandum of Understanding. Designed to assist patients in their recovery, the treatment mall contains Physical Therapy, a Unisex Hair Salon, a bank, Art Therapy, a radio station, library, and gift shops. Additional evening activities such as dances and movies are also available.

WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7:	Management of the Environment of Care
PROCEDURE 7.14:	**Space Planning**
Governing Body Approval:	6/10/18
REVISED :	
Reviewed :	09/29/23

PURPOSE: It is the policy of Whiting forensic hospital (WFH) that all programs have adequate space to carry out the functions of the unit.

SCOPE:

Chief of Fiscal Services, Department Director(s); Discipline Supervisor; Supervisor of the Service Unit; Infection Prevention, and Plant Facilities Engineer

PROCEDURE:

At the time of renovations or relocation, a review of the space under consideration should include a discussion about current and potential space utilization and needs both within and between departments and disciplines as follows:

a. Chief of Fiscal Services
b. Department Director(s);
c. Discipline Supervisor for areas dedicated to or under consideration for a particular discipline's activities;
d. Supervisor of the Service Unit;
e. Infection Prevention; and
f. Plant Facilities Engineer **– representing our landlord organization, Connecticut Valley Hospital**

WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7:	Management of the Environment of Care
PROCEDURE 7.15:	**Allowable Patient Personal Property - Electronic Items**
REVISED:	March 19, 2021, July 17, 2024
Reviewed:	September 29, 2023
Governing Body Approval:	April 19, 2021, August 22, 2024

PURPOSE: The hospital is required to maintain patient privacy and confidentiality. In order to (a) protect patient privacy and Protected Health Information (PHI), (b) ensure a safe patient environment, and (c) protect hospital security and telecommunication systems, it is necessary to restrict access to some forms of personal electronic devices. This procedure is designed to assist staff and patients in reviewing and managing patient possession and use of such devices.

SCOPE: Dutcher and Whiting Services

Dutcher Building Electrical Devices (with the exception of D2S)

General Guidelines

Patients are allowed a maximum of three loomed electrical devices (e.g., television, stereo, alarm clock). All items must be approved for patient possession by the treatment team and there must be specific attending psychiatrist orders. All items must conform to the photography/recording and Internet access guidelines described in this procedure or other relevant hospital procedures. Any violation of this procedure may result in removing the item from the patient's possession and hospital grounds.

All corded electrical items must be inspected for electrical safety and be properly secured or "loomed" by the maintenance department prior to patient possession. All electrical cords over 18" must be loomed; those under 18" can remain in bedroom unloomed. Electrical cords that are longer than 18" that cannot be loomed, such as charging cords, must be maintained by staff and cannot remain in patient possession.

Nursing staff will conduct daily checks to verify the integrity of the corded devices and loomed cords. Unit Directors are responsible for ensuring that all devices and related materials, such as video games and DVDs, comply with this policy.

Inspection of Electronic Devices:

All patient electronic devices (corded or battery operated) must be inspected by the Unit Director and EOC designee for compliance with this procedure prior to being given to the patient to have and use on his or her treatment unit. This inspection must occur when the device is initially purchased, delivered, or brought to the patient by friends or family or whenever the electronic device is returned to hospital grounds. Any other electronic device about which there are questions regarding its electronic, recording, network, wireless, or communication capabilities must be inspected. Certain device functions (e.g., Wi-Fi, recording components), must be disabled and/or parental controls installed. In those cases, those functions will be enabled or re-installed at the patient's time of discharge.

Regarding this examination and possible disabling or removal of electronic device components, the treatment team, members of the IT department who examine the electronic device, as well as Whiting Forensic Hospital will not be responsible for any accidental or coincidental damage done to the device during the process of examining, approving, or disabling or enabling functions/components of the device.

If the patient is unwilling to allow the disabling and/or parental controls on the device, he/she should not acquire the electronic device or, if already acquired, return it to the retailer or the person who gave it to him/her, or give/send it to a friend or family member in the community for safekeeping.

After the patient has been informed of the limits of liability, the Attending Psychiatrist, Unit Director, or designee shall document in the patient's medical record:

(a) that the patient was informed of his/her responsibility regarding the device;
(b) that the patient was informed of the limits of liability of staff and WFH;
(c) whether the patient accepted the responsibility and limits of liability noted above.
(d) whether the device was not approved and why

If a patient's electronic device is sent out for repair, when it returns to WFH, it must be brought to Whiting Forensic Hospital (WFH) Police (either at the Dutcher Service or Whiting Service locations) to be passed through the X-ray unit to detect contraband, weapons, or any other non-compliant devices. After it has been cleared by WFH Police, the WFH Mail Department will then deliver it back to the patient unit, which will coordinate a compliance inspection prior to returning to the patient/patient's room.

Computers:

Patient use of personal computers is not allowed in either building of Whiting Forensic Hospital.

Video Game Consoles and Video Games:

Whiting Building and D2S

Patients are not permitted to have personal consoles. Consoles are provided by the hospital in community areas.

Video games that contain graphic, violent, or sexual content are prohibited. Software and games must be rated "E" (Everyone) or "E-10+" by the Entertainment Software Rating Board. "T" rated video games may

be permitted following the determination of appropriateness by the Unit Director prior to patient use. An MD order is required for each patient approved for the use of any T-rated game. Video games will be secured and accounted for as a sharp.

Patient-owned games are permitted; however, they are not allowed to be held in patients' possession. Patient-owned games will be maintained on the sharps count and inventoried and marked to avoid confusion about ownership. Patients may allow unit use of a personal video game provided it conforms to the above guidelines. "M" rated games are prohibited.

<u>Dutcher Building (with the exception of D2S)</u>

Patients must agree to allow WFH to place parental controls on all video game consoles. Those parental controls must comport with the ratings noted below. Should a patient not agree to parental controls, the video game console will be placed in patient storage until the patient is discharged. The Unit Director will request that the EOC designee place the parental controls on the console and add the device to the Environment of Care Rounds for continued monitoring. Parental control passwords will be random, not duplicated, and only shared with the Unit Director and Program Manager.

Video games that contain graphic, violent, or sexual content are prohibited. Software and games may be rated "T", "E" (Everyone) or "E-10+" by the Entertainment Software Rating Board.

"T" rated games must be reviewed by the treatment team for appropriateness. Upon approval, the patient must allow Unit Director to mark the game with "A" in permanent marker. "T" rated games not approved will be noted in the patient's record, including justification. "M" rated games are prohibited. Patients are permitted to keep approved video games in their possession.

Networks:

Wireless (Wi-Fi) devices, including "hotspots" and mobile broadband modems (i.e., air/data/connect cards, phones) or any other type of device that could permit access to the Internet, e-mail, or any other computer or telecommunication device or network are prohibited. The hospital reserves the right to periodically inspect or assess for any network or wireless activity.

Cell Phones:

Cell phones are not permitted unless specifically identified as necessary for a treatment need. Cell phones must be maintained in a secure area of the treatment unit. Cell phones must be signed out when leaving WFH grounds and turned into the Nurse's Station when patients return to WFH and enter their treatment units. Using a cell phone's camera, e-mail, or Internet capability on WFH or CVH property is prohibited under any circumstances. Patients are prohibited from possessing, handling, or using the cell phone of a visiting friend, family member, or employee, including using it to make phone calls as well as using the cell phone's camera, e-mail, or Internet capabilities.

Digital Cameras:

Cameras of any kind are prohibited on the WFH and CVH campus.

Digital Recorders:

Digital video or audio recording devices or software are prohibited on WFH grounds. Voice and video recording for treatment purposes, such as speech therapy, must take place in accordance with Operational Procedure 1.20 Recording and Filming of Patients.

Digital Pagers:

Any type of Digital pagers ("beepers") is prohibited.

Items Generally Allowed: Dutcher (with the exception of D2S Competency Unit):

The following electronic items are considered generally allowable for patients to have in the Dutcher Building unless contraindicated based on an individualized clinical and/or risk assessment by the treatment team. In such cases, documentation will be included in the patient's medical record indicating the reason the item was not permitted.

- Any DVD rated by the Motion Picture Association of America (MPAA), with the exception of NC-17
- Bluetooth speakers and headphones
- TV's up to 24" (larger TVs in use as of 2/11/19 are permitted until patient discharges unless contraindicated based on clinical and/or risk assessment)

Items Generally Allowed: Whiting/D2S:

The following electronic items are considered generally allowable for patients to have in the Whiting Service Building unless contraindicated based on an individualized clinical and/or risk assessment by the treatment team. In such cases, documentation will be included in the patient's medical record indicating the reason the item was not permitted.

- DVDs with MPAA ratings up to PG-13. Pornography is not permitted. DVDs remain in staff possession and are included in the sharps count

Items Generally Prohibited for All Patients:

The following electronic items are generally considered prohibited for patients to have and use, including while on pass, on and off hospital grounds:

- Personal computers
- Computer printers or "multifunction centers" that have scanning, faxing, or photocopying capabilities.
- Devices that provide Internet access or have Wi-Fi/wireless capability (with the exception of hospital patient computers, monitored by staff, such as those in the library or Dutcher Classroom A computer lab)
- USB/thumb/flash drives, or other external storage devices (e.g., memory cards/sticks, external hard drives), with the exception of MP3 players and iPods.
- Computer software/programs/applications that:

    - enable wireless/Wi-Fi or telecommunication capability
    - circumvent blocks or filters that prevent access to the Internet or to Internet sites that contain certain prohibited content
    - enable access to social media accounts (e.g. Facebook, Twitter, etc.) and email
    - enable computer or computer network "hacking" or that enable the ability to access or interfere with telephone/telecommunication systems, computer network, or electronic security systems
    - Duplicate (i.e., "pirate") music, movies, videos, or other copyrighted material on CDs, DVDs, USB/flash memory, gaming console hard drives etc.
- Recordable CDs or DVDs.
- Digital or film cameras or any other camera/photographic device.
- Tape recorders or any other recording device, including MP3 with recording capability.
- Cell phones (except under the circumstances described above).
- Digital pagers/beepers.
- Blackberries, Palm Pilots, Personal Digital Assistants (PDA), or similar devices.
- Surveillance, motion detectors, GPS (global positioning system), or similar devices to monitor areas and persons' movements.
- Police scanners
- The copying or "burning" of CDs/DVDs is prohibited due to possible violation of U.S. or international copyright laws

New or Updated Electronic Items:

Technology is changing at dramatic speeds, and it is understood that there may be situations that a new or a newly updated electronic device comes into WFH with Internet, recording, e-mail, wireless, photographic, or other capabilities that IT and other staff are either unaware of or that cannot be disabled. Patients having and using any new electronic items with or possibly with any of these capabilities is prohibited until the item has been fully evaluated by IT staff, hospital administration, and/or other relevant parties within WFH or DMHAS and has been approved for patients to have and use. Use of any electronic devices with these or similar features may result in confiscating and removing the device from WFH grounds.

Changes in Patient's Clinical Status:

All items on the above lists, and any items not specifically addressed elsewhere in this procedure are subject to review and approval/or denial based on clinical and/or risk management necessity and appropriateness.

Whenever there is a noteworthy change in the patient's clinical and/or risk status, the nurse shall contact the attending psychiatrist or on-call physician to review what if any electronic items will be permitted for the patient to have. Any changes from the previously approved list of allowed electronic items for the patient and the rationale for the change must be documented in the patient's medical record and be accompanied by a new order by the attending psychiatrist on the Physician Order Sheet.

Exceptions:

In the event that there is a clinical need that supersedes this policy, exceptions may be made to accommodate the clinical need with permission of the CEO, Director of IT or designee and the Attending Psychiatrist.

Pilot programs, involving use of electronics outside of the scope of this policy, may be initiated with Governing Body and the Director of IT/designee approval.

WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7:	Management of the Environment of Care
PROCEDURE 7.16:	**Security Alert: Active Shooter**
Governing Body Approval	6/10/18
REVISED::	
Reviewed :	09/29/23

PURPOSE: To protect and preserve the life and safety of all WFH patients, staff and visitors in the event of an active shooter situation.

Definition: An Active Shooter scenario posing an imminent threat of violence or loss of life on or around campus where an individual is actively engaged in the random or systematic killing of people in a confined space or populated area.

SCOPE: All WFH staff

PROCEDURE:

Principles of Protection

Alert the DMHAS Police Department and provide as much factual information about the situation as is known.

Minimize the number of potential targets by securing staff, patients and visitors behind locked doors and out of sight of main hallways until the **"All Clear"** announcement.

WFH Campus – Security Alert-Active Shooter Plan

When a person becomes aware of an active shooter situation and is capable of safely alerting others, this person will

1. **REPORT:** Call 5555 via landline, or (860) 262-2333 from a cell phone, and provide the exact address, location and all facts known about the emergency to the DMHAS Police Dispatch Center. The

DMHAS Police will be immediately dispatched to the location of the emergency. The Dispatch Center will notify the Middletown Police and provide all available information to support their emergency response.

2. **NOTIFICATION:** The DMHAS Police Dispatch Center will begin notification **of WFH and the entire surrounding CVH campus.**

   a. A ***WFH-ALERT*** emergency notification message will be sent to the WFH Disaster Group, and all *WFH-ALERT* registered staff members will receive the following message: **Security Alert – Active Shooter-incident location**, and any vital information and instructions regarding the incident.

      b. Announce the alert via all applicable building overhead paging systems 3 times (**Security Alert-Active Shooter-Location, Security Alert-Active Shooter-Location, Security Alert-Active Shooter-Location**). Buildings include

         - Dutcher Building
         - Whiting Building

3. **INDIVIDUAL RESPONSE:**

   a. Assess the Situation

      i. Determine what type of situation you are in. Review your surroundings for where you are, what's around you, where you think the threat is coming from. Determine your best course of action based on situation.

   b. Act/React

      i. Choose course of action, understanding that circumstances may change drastically as the situation evolves.

         (1) Evacuate – if an escape route is accessible

         - Have an escape route and plan in mind
         - Leave belongings behind
         - Keep hands visible to law enforcement
         - Remain calm and do exactly as the officers tell you.

         (2) Hide Out/Shelter in Place – if evacuation/escape is not possible, find a place to hide where the active shooter is less likely to find you. If you are responsible for patients, afford them the best protection that you can, depending on their mobility.

- Be out of shooter's line of sight or view
- Lock all doors; stay away from windows
- Barricade the door if possible with available items
- Silence cell phones, pagers, radios, etc.
- Conceal yourself behind large objects, inside closets, etc.
- Remain in place until law enforcement officials arrive.

(3) Take Action – as a last resort, only when your life is in immediate danger, attempt to disrupt and/or incapacitate the active shooter.

- Act aggressively towards the shooter, engaging in physical attack
- Throw items or use improvised weapons

4. WHAT TO EXPECT FROM LAW ENFORCEMENT AND HOW TO REACT

a. Arriving police officers' first priority is to engage and stop the active shooter. The first officers on scene will not stop to aid the injured.

b. Officers may be armed with rifles, shotguns or other weapons. Their appearance may seem threatening, but their equipment is critical to your survival.

c. Immediately raise hands, keeping them visible at all times.

d. Do exactly as officers tell you. Do not ask questions. Their verbal commands will be loud and authoritative; do not be frightened or offended.

5. FACILITY ACTIONS:

a. Nursing Supervision will maintain contact with their assigned units to insure that all staff have received notification of the active shooter, and are taking the appropriate actions. Unit census will be confirmed, and all off site staff and patients will be informed whether or not to return to their unit / campus.

b. The DMHAS Police Department – WFH Unit will respond to the location of the emergency, and take charge of an active shooter situation. The DMHAS Police Supervisor/or Officer in Charge (OIC) on duty will immediately contact the DMHAS Police Lieutenant and advise him/her of the emergency.

c. The DMHAS Police Chief and Captain will be notified by the DMHAS Police Communications/Dispatch Center.

d. The DMHAS Police Lieutenant will contact the Whiting Forensic Hospital (WFH) Chief Executive Officer (CEO) or designee and inform him/her of the emergency.

e. The CEO or designee will notify the Office of the Commissioner.

f. Upon the completion of a Security Alert-Active Shooter emergency, an *"**All-Clear**"* will be announced via all overhead paging systems, and through the ***WFH-ALERT*** emergency notification system. At this time, all campus activity will return to normal, and a debriefing will occur at a designated location.

WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7:	Management of the Environment of Care
PROCEDURE 7.17	**Environmental Hot Spot Rounds**
Governing Body Approval	3/15/19, 5/20/22
REVISED:	3/11/19, 5/5/22
Reviewed :	09/29/23

PURPOSE: To provide a standardized process for the assessment of the physical environment to minimize the risk of patient or staff injury due to environmental factors.

SCOPE: All hospital Staff

POLICY:

In order to foster a safe physical environment for patients, the hospital conducts weekly environmental "Hot Spots" rounds, on all Clinical Care Units, to identify potential safety hazards.

PROCEDURE:

As a result of hospital wide environmental rounds, regulatory findings, morning risk management meeting discussions, patient and staff observations, and/or changes in the physical environment, items identified as potential risks are submitted to the Environment of Care Committee for inclusion on the weekly Hot Spots Rounds. The results are reported to the Hospital-wide EOC Committee on a monthly basis, and included as appropriate in reporting to the Quality, Risk and Safety (QRS) Committee and Governing body.

I. **Risk Identification**

A. Hot Spot rounds are conducted on each Clinical Care unit on a weekly basis as follows:

1. Rounds for the 1st week of the month are completed by 1st shift Nursing Staff.
2. Rounds for the 2nd week of the month are completed by 2nd shift Nursing Staff.
3. Rounds for the 3rd week of the month are completed by 3rd shift Nursing Staff.
4. Rounds for the 4th week of the month are completed by the Unit Director (or designee in their absence).

B. The completed rounds are documented on the Environmental Hot Spots form as follows:

1. The unit, including building (i.e. DS2, WH1) is entered in the unit block.
2. The date of the rounds is entered in the date block.
3. The name of the person completing the rounds signs and prints their name.
4. The week of the month the rounds are completed for is circled.
5. The items reviewed are checked as yes/no/ or N/A as appropriate depending on condition noted on the unit.
6. The "notes" field should be used document issues identified and corrective actions (i.e. submission of a work order).
7. The completed Hot Spot logs must be faxed weekly to the EOC Coordinator/designee to facilitate hospital wide tracking of issues, aggregation and analysis of data, for presentation at monthly EOC meetings.

II. **Risk Reduction Tracking**

A. The Governing Body By-Laws charge the Environment of Care Committee with several tasks related to the maintenance of a Culture of Safety at WFH. The Environmental Hot Spots Rounds plays a key part in ensuring a safe environment. .

1. The results of Hot Spot rounds are collected and analyzed on a monthly basis for the following issues:
    a) Trends
    b) Patterns
    c) Correction of Deficiencies
2. A report on the analysis results is presented at the monthly EOC meeting.
3. The committee will recommend any necessary follow-up actions based on their review of the report.
4. The committee will attempt to limit the Hot Spots Rounds to high priority/high risk items to facilitate reliable completion of the survey process and corresponding corrective action.
5. The committee may add items to the Hot Spot form based on input from environmental rounds, regulatory findings, morning risk management meeting discussions, patient and staff observations, and/or changes in the physical environment environmental survey.
6. The committee may choose to drop items from the Hot Spot form based on evidence of sustained compliance or to move facility focus to new priority items.

B. Reporting Linkage

1. Any significant trends, patterns, or actions related to the Environmental Hot Spots Rounds should be included in the quarterly report to the Governing Body.
2. The compliance rates for items on the Environmental Hot Spot rounds and actions taken to address identified issues should be included in the quarterly Environment of Care report to Governing Body.

WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7:	Management of the Environment of Care
PROCEDURE 7.19:	**Portable Heaters**
Governing Body Approval:	6/10/18
REVISED :	
Reviewed :	09/29/23

PURPOSE: To provide heat to a non-patient area as a temporary measure until the heat is restored.

SCOPE: All WFH Staff

PROCEDURE:

1. If a portable heater is needed in a non-patient area, staff is to request them through the Plant Facilities Engineer of our landlord organization, Connecticut Valley Hospital.

2. The Plant Facilities Engineer ensures that the portable heater is an approved type and Underwriters Laboratory (UL) approved.

3. The use of portable heaters within patient care units (Smoke compartments) is forbidden.

WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7:	Management of the Environment of Care
PROCEDURE 7.20:	**Activity/Welfare Funds**
Governing Body Approval:	6/10/18
REVISED :	

POLICY:

WFH Activity Fund is a fund operated by the hospital for the benefit of the employees or clients. The benefits may include but not be limited to recreational activities, holiday festivities, business enterprises, vending operations, monthly grants etc. Revenue is derived from the operation of canteens, vending machines, greenhouse, café's, boutiques or any other legal source compatible with the good government of the hospital.

Management of Activity Fund:

The Chief Fiscal Officer is responsible for authorizing the annual budget and expenditures from the Activity Fund. The Supervisor of Valley Finances is the Treasurer of the Activity Fund and is responsible for the day to day operation of the fund. That includes purchases, expenditures, financial reports, cash management, requests to Comptroller for account activity, establish internal controls etc.

PROCEDURE:

Cash Receipts

a. All cash belonging to the fund will be deposited within 24 hours after receipt, except if otherwise authorized by the State Treasurer, or the total amount is less than $500. Total daily receipts of less than $500 may be held until the total receipts to date amount to $500, but not for a period of more than 7 calendar days. The receipts are to be deposited in the Valley Finances Office located in Page Hall. There is a drop box at this location for off hour deposits.
b. A pre-numbered cash receipt form is prepared by Valley Finance staff for all Activity Fund deposits and given to depositor. A Bank of America deposit ticket is prepared and logged for Dunbar Armored Car Service pick up, Monday – Friday (except holidays).
c. All deposits are posted to the Quickbooks EDP accounting system using specific coding that charts the specific source of said receipts.

Expenditures (Comptroller's A.P.M. for Activity and Welfare Fund, September 2000):

Purchases are to be done according to State Procedures as defined in the State Comptroller's Accounting Procedures Manual revised 9/2000

Special Approval:

Prior approval of the State Comptroller-Accounting System Division must be obtained for (1) any single expenditure from the Institution Activity or Welfare Fund in excess of $1,000 or (2) any combination of expenditures in excess of $1,000 for any single project, contract or event within a 12-month period. Form CO-1052, Activity or Welfare Fund Request Form, must be completed for this request.

A waiver from the approval process may be granted to agencies that submit detailed annual budgets for expenditures from their Activity Fund. Requests for such waivers should be made to the Director of the Policy Services Division, Comptroller.

Purchasing Regulations:

Purchases should be made at the best prices obtainable. Before making a purchase the Treasurer of the Activity Fund should obtain information about special rates available on State contracts. Competitive bids should be obtained for major purchases. A purchase order/requisition system should be used.

Unauthorized Expenditures:

The following are some unauthorized uses of the Funds:

1. Routine expenditures for State use;

2. Loans to State Employees;

3. Expenditures that would directly benefit the employees; such as testimonial dinners, holiday parties, or travel expenses.

4. Gifts, services, or donations to State Employee, citizens, or organizations

Disbursement Procedures:

The following procedure should be followed when making expenditures for Activity Fund

1. Payments for goods are initiated by preparing a Payment Voucher (Quickbooks Voucher)

2. The Payment Voucher is signed by an authorized person and co-signed by persons designated by the head of the facility.

3. All payments for goods and services should be substantiated by Vendor's Invoices or by receipts from individuals. Payments should also be supported by a purchase order/requisition or contract when applicable.

4. The signed Payment Voucher (Quickbooks Voucher), along with supporting documentation attached is then processed for payment.

5. Valley Finances (Patients Accounts) uses EDP accounting software package Quickbooks Pro. When expenditures are processed staff using Quickbooks will assign the proper accounts for the expenditure while Quickbooks processes automatically the payment voucher and journal entries for the transaction.

WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7:	Management of the Environment of Care
PROCEDURE 7.21:	**Dietary Services**
Governing Body Approval	6/10/18
REVISED::	
Reviewed :	09/29/23

POLICY:

The Dietary Services Unit, which is managed by our landlord organization, Connecticut Valley Hospital, per an established Memorandum of Understanding will provide nutritional care to all WFH patients according to the accepted Nutritional and Food Service standards of care.

SCOPE: All WFH direct care and Dietary staff

PROCEDURE:

A. Dietary Services prepares and maintains, Policy and Procedure Manuals addressing the standards for Clinical and Administrative Services within the framework of the Governing Body of Whiting Forensic Hospital (WFH), as follows:

1. The Dietary Service Administrative Manual is located in the Manuals folder on the T: Drive. The manual is prepared and updated as necessary by the Food Service Director. The manual addresses leadership, administrative functions, personnel, food production, storage, delivery and service, sanitation, safety, quality improvement activities and disaster plan.

2. The Clinical Dietary Services Manual is located in the Manuals folder on the T: Drive. The manual is prepared and updated as necessary by the Supervising Dietitian. It addresses all clinical issues related to Food Services, such as nutritional screening and assessment, diet orders, charting, computerized system, and food and drug interactions.

3. The Nutrition Care Manual is an internet-based resource available to aid the Medical Staff in the ordering of therapeutic diets. This manual outlines the procedures for ordering special diets, and the diets that are available. The diet manual subscription, with all revisions, is approved by

the Pharmacy Nutrition and Therapeutics Committee and renewed annually by the Supervising Dietitian. The manual is accessible to all clinical and dietary services staff at WFH via the following website: www.nutritioncaremanual.org.

WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7:	Management of the Environment of Care
PROCEDURE 7.22:	**Signs**
Governing Body Approval	6/10/18
REVISED::	
Reviewed	09/29/23

PURPOSE: All interior signs are produced in the Paint Shop of our landlord organization, Connecticut Valley Hospital, per an established Memorandum of Understanding. Signs are standard sizes and meet American Disability Act (ADA) guidelines.

SCOPE: All WFH Staff

PROCEDURE:

1. Requests for internal signs will be submitted on an electronic work requisition form and sent to the e-mail address "MHA WFH-Work Order". Standard sizes are 2" x 8" for patient name; 4"x 8" and 8" x 8" for informational signs and room identification. Non-standard sizes are for outdoor usage. Include color requests on the standard work request form.

a. No staff names allowed
b. Position or Function is allowed (example: Business Office)
c. Date the request.
d. The color of the sign is based on the location.
e. The sign must be authorized by the CEO or designee.

WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7:	Management of the Environment of Care
PROCEDURE 7.23:	**Patient Clothing and Linen Requests**
Governing Body Approval:	6/10/18
REVISED :	
Reviewed :	09/29/2023

PURPOSE: All patients at Whiting Forensic Hospital (WFH), should have individualized clothing and footwear. WFH will provide clothing and footwear for any patient that does not have personal clothing. Linen is supplied to all patients. **Our landlord organization, Connecticut Valley Hospital (CVH), as part of an established Memorandum of Understanding oversees a State of Connecticut contract with Unitex to launder and distribute bath towels, wash cloths, sheets, pillowcases, bed pads, blankets and clothing for Whiting Forensic Hospital.**

PROCEDURE:

Linen counts are taken daily, Monday through Friday, by the Housekeeping Services Supervising /Lead Custodian, or their assigned designee. Once the count is taken for each area, if needed, the corresponding Housekeeping Supervising/ Lead Custodian, or their assigned designee, will contact Unitex to request an adjustment in the count for their building(s). When deliveries are received the Housekeeping Supervising /Lead Custodian, or their assigned designee, will sign off on the delivery ticket and then forward WFH delivery tickets to the Building Superintendent 1 in the Dutcher building. At times, due to extenuating circumstances, Supervising/Lead Custodians may need to conduct a count to cover for an emergency situation, such as extreme cold.

Scheduled Linen Deliveries

Monday = Whiting Building

Tuesday = Dutcher Building,

Thursday = Dutcher Building

Friday = Whiting Building

Saturday = No linen deliveries are scheduled for Saturday

Sunday = No linen deliveries

Nursing recommendations and/or complaints about goods or services received from Housekeeping must be in writing and signed. They should be sent to the Building Superintendent 1 for Housekeeping Services, whose office is located in the Dutcher

WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7.24	Environment of Care
Policy	Safety Management EC.02.01,01
REVISED:	8/23/2023
Governing Body Approval:	8/24/2023

Whiting Forensic Hospital
Environment of Care
2023 Safety Management Plan

Scope

Connecticut Valley Hospital (CVH) as the landlord agency of WFH has collaborated in establishing "The Safety Management Plan" to encompass all Safety Management in all patient care areas, business areas, and hospital grounds for the Middletown campus while providing some safety management support functions.
The WFH Director of Environmental Safety & Emergency Preparedness serves as the Director of Safety working closely with the campus Director of Plant Operations on services that include consultation, evaluation, worksite risk analysis, and prioritization of correcting identified deficiencies.
There is definitive executive leadership and management commitment and employee participation in this Safety Management Plan with input and review from the following committees: The Governing Body, the Environment of Care (EOC) Committee, the Workplace Violence Prevention Committee, and the Quality Risk and Safety Committees.

Objective

The objective of the Safety Management Plan is three-fold:
1. Provide a safe, functional, and therapeutic environment for patients, staff, and visitors, in accordance with the mission of Whiting Forensic Hospital (WFH), the Department of Mental Health and Addiction Services (DMHAS), standards from The Connecticut Department of Public Health), the Occupational Safety and Health Administration (OSHA), and other regulatory agencies.
2. Instill a sense of responsibility for safety in all employees at all levels of the organization and empower staff at the local (unit) level to identify and create solutions to causes of

accidents and injuries, with the effect of reducing and controlling environmental hazards and risks, and to maintain safe conditions for patients, visitors, and staff.

3. Implement a plan for the EOC that supports the provision of quality patient care and support services by focusing on injury and illness prevention, maintenance of the environment, product evaluation, and the special needs of the patient population.

Goals For 2023

- Hospital-wide evaluation and installation of camaras in areas where it is determined there is a need.
- Analyze the data from the Culture of Safety Survey and identify and plan the implementation of the top 3 concerns as determined by the workplace violence committee.
- Implement new patient area risk assessments to track the elimination of ligature risks.

Performance

I. Introduction

The WFH plan for the EOC includes a decentralized process that is focused at the unit level. All staff, from unit-based staff to Program Managers, and staff of centralized services (i.e., Plant Engineers and trades staff), play a vital role in maintaining a safe environment.

The EOC Program is structured to address the following environmental categories:

- Safety; (including suicide risk reduction within the physical environment)
- Security
- Hazardous Material & Waste
- Fire Prevention
- Bio-Medical Equipment
- Utility Systems
- Product Evaluation
- Employee Health and Safety
- Emergency Management

Each of these areas is addressed in documented plans. Each plan contains the following elements:

1. Orientation and education components that provide specific information to individuals on the proper processes for integrating with the environment of care.
2. Emergency procedures to be followed when components of the environment of care fail.
3. Performance standards that are used to measure the effectiveness of the Program.

II. EOC Program Design

- The design of the EOC outlines the structure and composition of the committees and work groups that carry on the tasks associated with the EOC Program.

- The design of the EOC Program includes the primary EOC committee and various other committees. Each of these entities has specific functions that contribute to an integrated program, which promotes the goals of the Hospital, and supports the flow of information to key leadership committees.

- The Hospital Chairman of the EOC committee is responsible for preparing the Safety Management Plan and reviewing the Program's effectiveness. The Governing Body approves the Safety Management Plan.

A. Hospital EC Committee

1. The Hospital EOC Committee is chaired by the Director of Environmental Safety & Emergency Preparedness (as appointed by the facility CEO) and includes the following members:
   - CEO; COO
   - Police Lieutenants; or designees
   - Landlord Plant Facilities Engineer 1
   - Infection Prevention
   - Staff Development Representative.
   - Nursing Executive representative
   - Director of Accreditation and Regulatory Compliance
   - Director of Compliance and Performance Improvement
   - Director of Food Services
   - Human Resources Representative
   - Director of Fiscal Services
   - Ambulatory Care staff member
   - Environmental Services Director
   - Directors of Nursing
   - Unit Directors

2. The functions of the Hospital EOC Committee include:

   a. Review of the status of environmental rounds,
   b. Planning & and reviewing Emergency Preparedness Drills,
   c. Approving Interim Life Safety Plans,
   d. Approving Utility & Equipment Management Programs,
   e. Approving Hazardous Materials Procedures,
   f. Reviewing equipment and utility failure data,

g. Developing hospital-wide indicators for the seven (7) Functional Elements of the Safety Plan.
h. Reporting quarterly to the Governing Body,
i. Approving social environment monitoring tools (Fire Drills, testing data, and product evaluation).

Unit Directors

Duties and responsibilities of Unit Directors:

a. Attend environmental rounds
b. Attend environment of care meetings
c. Initiates corrective actions of rounds (submits work orders)
d. Review environment of care database
e. Ensure completion of Hot Spot Rounds, including issue follow-up and reporting

B. Chairman of Hospital-wide EOC Program

The Director of Environmental Safety & Emergency Preparedness is designated by the Chief Executive Officer to coordinate the Hospital's EOC program. Annually, the CEO delegates to this individual as Hospital Safety Director the authority to take immediate action to address issues that present a significant risk to the safety of patients, staff and visitors.

Duties and responsibilities of the Chair of the Hospital-wide EOC Program:

a. Chairing the Hospital-wide EOC Committee;
b. Preparing and presenting quarterly reports to the Governing Body;
c. Coordinating communications with the Hillwide MEC Committee Chair
d. Acting as Hospital liaison with outside agencies (i.e., State Fire Marshall, OSHA, Health Department, and the Department of Energy & Environmental Protection (DEEP));
e. Overseeing the development and implementation of each of the Management Plans for the functional elements;
f. Completing and submitting the annual TJC Environmental Periodic Performance Review (PPR)
g. Performing the completion of the Statements of Conditions and coordinating requirements for improvement. (Plan for Improvement (PFI));
h. Developing and implementing performance improvement projects relating to EOC, and;
i. Drafting policies and procedures as needed.

Design of the Treatment Environment

1. Safety

The Hospital is attentive to the importance of the treatment environment in the recovery process. Of primary importance is adherence to the Life Safety Code. To this end, the Hospital utilizes professional architects and engineers in preparing plans for major renovation projects.

Major construction projects are also reviewed by the DMHAS Chief of Engineering Services and Code Review Specialists from the Office of the State Fire Marshal and/or the Department of Construction Services.

In designing renovation projects, consulting architects and engineers utilize the Design and Construction of Hospitals and Health Care Facilities manual guidelines. Design elements are customized to accommodate specific requirements for the treatment units within the Hospital.

Risk analyses will be updated annually for Workplace Violence Prevention, Building, and Clinical Units.

Employee input is a key component of any high-reliability organization. Employee suggestions for enhancing safety are always considered through a hospital-wide process. Employees may make suggestions via e-mail or by contacting their Unit Director or EOC Chair.

The Safety Management Plan is incorporated into the “Learning Management System” (LMS). The staff takes this mandatory training related to various safety issues and certifies annually. This training includes safety and health training, emergency response, and incident reporting.

2. Hazard Surveillance, Prevention & Control:

The Hospital utilizes several data sources for collecting information relating to hazards in the environment. The following inspections take place at prescribed frequencies:

INSPECTION	CONDUCTED BY	FREQUENCY
Fire Safety	State Fire Marshal	Annually
Grounds Safety	Landlords Plant Engineer	Quarterly
EC Round in Clinical Areas	Rounds Team	Quarterly
Infection Control	Infection Prevention	Monthly

Reports of inspections are reviewed monthly at the EOC Committee meeting. Results and action plans are documented in the respective minutes.

3. **Privacy, Dignity, and the Therapeutic Environment**

The treatment units at Whiting Forensic Hospital are designed and maintained to promote patient privacy and dignity. An effort is made to enhance the environment with artwork, furnishings, and personal items within regulatory requirements.

Each patient's bedroom area includes furnishing to store their belongings. In the Dutcher Building patients are permitted to keep certain personal electrical items based on an assessment and their level of function, unit security concerns, and in compliance with relevant policies and procedures.

Patient rooms are designed to provide maximum privacy. EOC Rounds Team conducts quarterly environmental rounds to ensure that each unit is inspected once every six months. These environmental rounds include patient rooms as well as the suitability of storage units.

Privacy for patients is maintained through a system designed to prevent the public from associating a patient with a diagnosis through a) securing the patient's medical records, b) no identifying signage or other visual cues, and c) using space provided on each unit for private discussions with patients and their families about treatment issues and discharge planning. Visiting rooms are provided for these discussions in some areas.

As an integral part of the treatment process, WFH encourages the use of social activities through the provision of treatment spaces.

In addition to Patient activity centers in both buildings, Page Hall offers a variety of treatment opportunities including a Beauty Shop, Radio Station, and Boutique. The library is located on the 3rd floor, Dutcher patients have an opportunity to use the Page Hall amenities depending on thier current risk level.

4. **Smoking Policy**

The Hospital campus has a Tobacco-free policy prohibiting smoking in **all** buildings and grounds.

5. **Infant Abduction Procedure:**

In accordance with The Joint Commission standard EC.02.01.01.EP9 on Infant Abduction, Whiting Forensic Hospital does not accept any patients under the age of 18, therefore does not require an infant abduction policy needed.

Annual Evaluation Process

How and When the Annual Evaluation will occur: The Director of Plant Ops/Safety will perform an annual review each January. The report will address all elements of the Program and will review performance indicators such as equipment failures, user errors, equipment record maintenance, or equipment with out-of-date or missing Bio-Med stickers. The report will also review the effectiveness of the plan and make recommendations for improvement of the Equipment Management Plan.

Commented [CJE1]: Where is this tracked?

Circulation: The annual evaluation is presented to the Hospital EOC Committee by the end of the first quarter of each year. The Hospital EOC Committee reviews and approves the report. The deliberations, actions, and recommendations of the Hospital EOC Committee are documented in the minutes. The annual evaluation is distributed to the Governing Body and hospital leadership (Operations Group). This finalizes the evaluation process.

The Annual Evaluation will address Goals and Objectives Met & Not Met. The Annual Evaluation will also identify goals for the next year, evaluation of the performance, and effectiveness of the EC program.

2022 Safety Management Plan
Annual Evaluation

Effectiveness

What Went Well: Safety Committees (Morning Report, Hospital EOC, Quality Risk & Safety, and Workplace Violence Prevention) met regularly as scheduled, safety concerns were identified and corrective actions were implemented. Maintenance supervisors attended steering committee meetings to learn about patient concerns and safety issues. Improvement was noted in the communication of safety issues. Work orders were submitted in a timely manner; staff was not as likely to wait for a safety committee meeting to report safety issues.

What Didn't Go Well: Some safety concerns (i.e. sidewalk repairs and paving) had to be deferred due to a lack of available funding resources. Critical areas of concern (raised sidewalks, trip hazards, and potholes were either temporarily patched or marked with fluorescent spray paint). Some disciplines/services have poor representation at Hospital EC meetings.

Accomplishments: Promptly addressed unsafe or high-risk patient care, office, and/or grounds area concerns. Equipment control audits have greatly reduced looming issues in patient rooms and treatment areas.

Areas for Improvement: Continued use of the new work order system that will improve the maintenance department's ability track and resolve reoccurring safety issues.

Compliance: The Safety Management Plan complies with TJC EC 02.01.01 EP 9 & WFH Operational Procedure 7.5 Safety Hazards.

Information Collection and Evaluation System (ICES): The Hospital's incident reporting is compiled through a decentralized system of data entry. This incident reporting system yields valuable information, which is used in preventing future accidents and incidents. Aggregated information is analyzed at the Unit, Division and Hospital-wide level on a quarterly basis. Conclusions are drawn and recommendations for improvements are made and implemented.

Goals & Objectives of 2022 Management Plan. Met or Not Met

Objective	Met	Not Met	Comments
Change the trash containers on all units to large sturdy bags for overall unit safety.	X		All patient areas are now using the bags.
Conversion of the Safety Committee into The Workplace Violence Committee.	X		
Improve the flow of information by holding people accountable for attending meetings	X		Sign in sheets used to ensure attendance
Conduct an active shooter drill		X	

WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7:	Management of the Environment of Care
	HAZARDOUS MATERIALS & WASTE MANAGEMENT PLAN
NEW:	December 12, 2022
GOVERNING BODY APPROVAL:	May 5, 2023
EFFECTIVE DATE:	May 5, 2023

SCOPE:

Whiting Forensic Hospital, in conjunction with its landlord facility CVH, has established the Hazardous Materials Management Program, which addresses chemicals, medical sharps, and regulated medical wastes. Implementation of the program is the responsibility of all staff members responsible for the handling of any materials listed.

FUNDAMENTALS

I. The scope of the hazardous materials and waste management program includes all materials in use and the wastes generated by Whiting Forensic Hospital.

II. Hazards associated with materials and wastes are defined by law or regulation and are identified in Safety Data Sheets (SDS) or similar documents provided by suppliers and manufacturers.

III. For each product used, there is a Safety Data Sheet (SDS) available to all staff on the Whiting Forensic Hospital T: Drive in a folder immediately available to all staff named Safety Data Sheet (SDS)

IV. All appropriate staff are given training during orientation at the time of hire and receive annual refresher training on the nature of the hazards of materials used, proper handling, and disposal techniques.

V. Procedures for proper notification and rapid, effective response are established for a spill, release, or exposure to hazardous material and waste.

PURPOSE

Whiting Forensic Hospital's mission is to improve patients' health by providing efficient, effective, quality healthcare services. Consistent with this mission, the Governing Body, medical staff, and administration have established and provide ongoing support for the Hazardous Materials and Wastes Program described in this plan.

The purpose of the Hazardous Materials Management Plan is to identify and manage materials known to have the potential to harm humans or the environment and to provide employees with the necessary information to enable them to use chemicals with caution and care. The plan includes processes designed to minimize the risk of harm. The process consists of education, procedures for safe use, storage and disposal, and management of spills and exposures.

PERFORMANCE:

ORGANIZATION AND RESPONSIBILITY

I. The Environmental Safety and Emergency Preparedness Director, as chairman of the Environment of Care committee, directs the functional work team and assures that the Hazardous Material and Waste Management Program complies with Federal, State, and local requirements.
   a. The functional work team comprises the Environmental Safety and Emergency Preparedness Director, Chief of Operations, Safety Officer, Infection Preventionist, and the landlord agency Plant Facilities Engineer 2.
   b. The responsibilities of the work team include developing the management plan, reviewing incidents, and the annual evaluation of the effectiveness of the management plan.

II. The Environment of Care Committee is responsible for establishing priorities for the investigation and/or the resolution of identified problems with hazardous waste. It shall refer these priority settings to the appropriate Department, Committee(s), or individual(s), as needed at WFH.

II. The EOC Committee is responsible for reviewing all policies and procedures relating to the operation of the Hazardous Material Management program and evaluating its effectiveness. This evaluation occurs annually.
   a. The EC Committee Chair will report its findings to the Hospital Governing Body.

IV. The Environmental Services Staff is responsible for delivering all solid waste to the designated holding area.

V. The responsibility for disposing of chemical wastes rests with the Plant Operations Department.

The organization will measure the performance of this Hazardous Management Plan through the oversight of the monthly hospital Environment of Care Committee meetings, Governing Body and Quality Risk and Safety Committees, and the reporting and remediation of hazardous material.

EFFECTIVENESS:

This Management Plan addresses compliance with and cross-references TJC EC 02.02.01 EP1, EP3, EP11.

PROCESSES OF THE HAZARDOUS MATERIALS MANAGEMENT PLAN

I. **Selection**
The supervisor of each department with an inventory of hazardous materials is responsible for the safe storage, handling, use, and disposal of such hazardous materials within their department.

II. **Waste Handling**
The supervisor of each department is responsible for managing hazardous and regulated waste streams within their department.

III. **Gas Monitoring**
Whiting Forensic Hospital does not possess any piped medical gas systems.

IV. **Space Management**
A designated location has been assigned to store hazardous chemicals until proper disposal by a licensed environmental contractor has occurred. A designated location has been assigned to store Universal Waste until appropriate disposal by a licensed universal waste recycling vendor.

V. **Incident Reporting**
All incidents involving spills or exposure are investigated and reviewed by the Environmental Safety and Emergency Preparedness Director, Chief of Operations, Safety Officer, Infection Preventionist, and the landlord facility Plant Facilities Engineer 2.

a. Refer to the attached Spill Response Flow Chart.
   1) Incidental Spills Defined:
      i. A spill is considered incidental if the spill is a small quantity of a known chemical
      ii. No gases or vapors are present that require respiratory protection.
      iii. You have the materials and equipment needed to clean up the spill.
      iv. You have the necessary proper personal protective (PPE) equipment available.
      v. You understand the hazards posed by the spilled chemical.
      vi. You know how to clean up the spill.
      vii. You feel comfortable cleaning up the spill.
      viii. You know how to properly dispose of spill cleanup procedures.
      ix. You have a procedure to replace items used during the spill cleanup.

b. Corrective Actions and Recommendations are reviewed at the EOC Committee meetings.

VI. **Orientation and Education**

All relevant Plant Operations staff participate in an annual mandatory LMS and/or live training program that includes hazardous materials awareness and the proper procedures to request material safety data sheets

VI. **Performance Improvement**
Environmental Safety and Emergency Preparedness Director and Safety Officer are responsible for establishing performance improvement standards to objectively measure the effectiveness of the hazardous materials and waste program.

VII. **Emergency Procedures**
The local Fire Department (Middletown South Fire District) responds to all hazardous chemicals or waste spills. Emergency procedures include notification of WFH and landlord operations personnel, contracted environmental service companies, and potential activation of the Emergency Operations Center.

HAZARDOUS CHEMICAL WASTE MANAGEMENT

PURPOSE

To identify chemical wastes within the confines of Whiting Forensic Hospital and to ensure these wastes are handled and disposed of in accordance with the Environmental Protection Agency (EPA), CT Department of Energy and Environmental Protection (DEEP), Department of Transportation (DOT), and other State and local regulations and guidelines.

IDENTIFICATION

Annual Hazardous Waste Determinations will be done on all hazardous materials in accordance with the Resource Conservation and Recovery Act of 1976 (RCRA), Subtitle C, Hazardous Waste Regulations, 40CFR, Part 261. Said determinations will be kept on file with Plant Facilities Engineer 1. All drums, buckets, pails, or any other container used to contain a chemical hazard substance will have an evident, complete, conspicuous, and durable label identifying the chemical used.

STORAGE AND HANDLING

I. Hazardous chemicals being held for recycling will be stored in appropriately labeled containers maintained for this purpose.

II. Regular inspections will be made of the storage site to ensure there are no leaking or spilled containers.

III. All chemicals are appropriately contained and stored in approved containers.

DISPOSAL

The Hospital Safety Director and Plant Facilities Engineer 2 are responsible for assuring that proper permits are obtained for the disposal of all hazardous waste generated at this facility.

All hazardous waste manifests will be obtained from the receiver for all disposed hazardous waste off site. Copies will be provided to CT DEEP and manifests will be appropriately filed with the Plant Facilities Engineer and readily available for inspection by state or federal environmental agencies as required by the RCRA regulations.

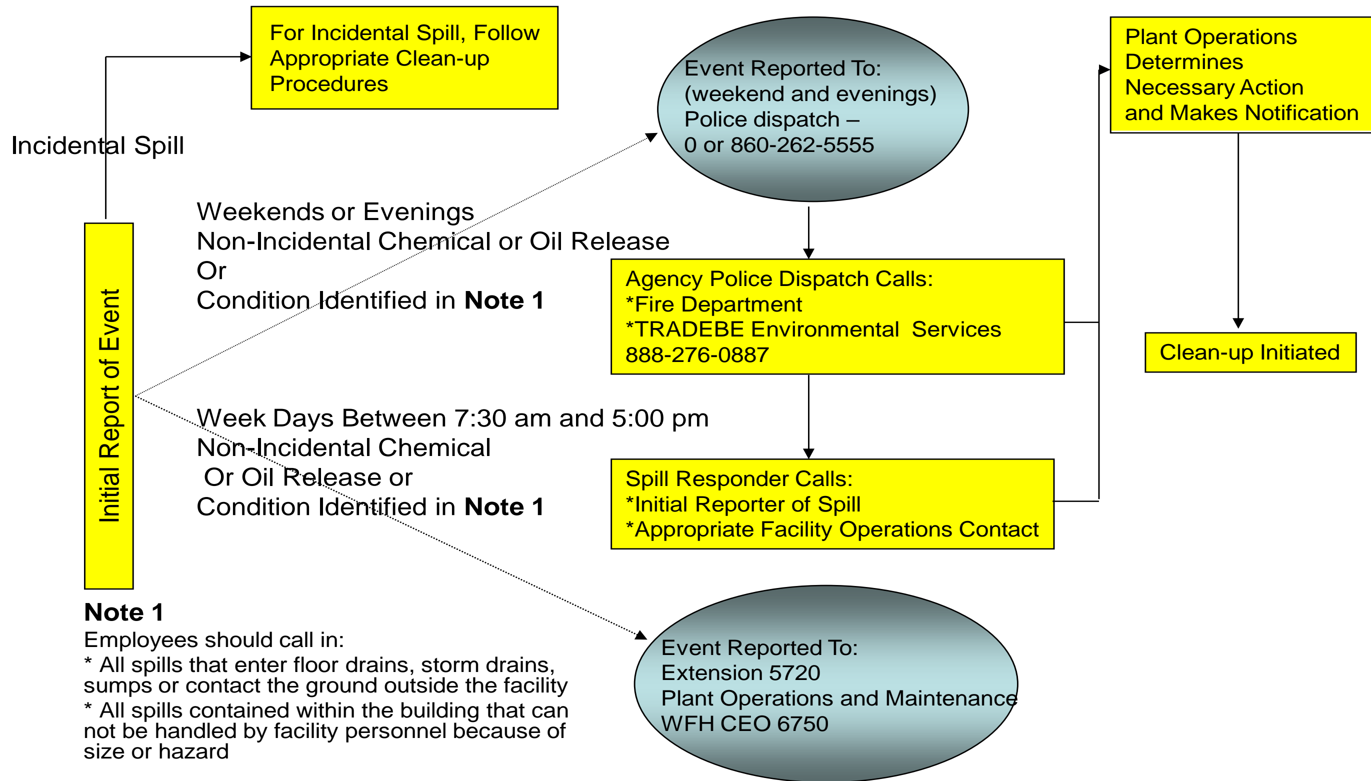
Goals for 2023

1. Create and maintain a WFH-specific SDS folder accessible to all hospital staff

2. Ensure all WFH staff are aware of how to access Safety Data Sheets quickly

3. Maintain 100% compliance with DOT-regulated waste certification for all staff directly responsible for handling regulated medical waste and their direct supervisor/manager

4. Continue to maintain conditionally exempt small quantity generator status by maintaining or reducing waste volume.


Whiting Forensic Hospital
Spill Response Flow Chart
For Incidental Spill, Follow Appropriate Clean-up Procedures
Incidental Spill
Event Reported To: (weekend and evenings) Police dispatch – 0 or 860-262-5555
Plant Operations Determines Necessary Action and Makes Notification
Weekends or Evenings
Non-Incidental Chemical or Oil Release
Or
Condition Identified in Note 1
Initial Report of Event
Agency Police Dispatch Calls:
*Fire Department
*TRADEBE Environmental Services
888-276-0887
Clean-up Initiated
Week Days Between 7:30 am and 5:00 pm
Non-Incidental Chemical
Or Oil Release or
Condition Identified in Note 1
Spill Responder Calls:
*Initial Reporter of Spill
*Appropriate Facility Operations Contact
Note 1
Employees should call in:
* All spills that enter floor drains, storm drains, sumps or contact the ground outside the facility
* All spills contained within the building that can not be handled by facility personnel because of size or hazard
Event Reported To:
Extension 5720
Plant Operations and Maintenance
WFH CEO 6750

WHITING FORENSIC HOSPITAL
HAZARDOUS WASTE MANAGEMENT

2022 ANNUAL EVALUATION

How the Annual Evaluation will Occur & **Who will create the Annual Evaluation**: The WFH Environmental Safety and Emergency Preparedness Director is responsible for performing the annual evaluation of the hazardous materials program, which is then approved by the COO, Infection Preventionist, and Plant Facilities Engineer 2. The annual review contains a balanced summary of the Hazardous Materials and Wastes Program performance over the previous 12 months. The purpose of the review is to evaluate the effectiveness of the plan and make recommendations to improve the performance of the plan.

When Will it be Created & Where Will It be Circulated: The Hazardous Management Plan Annual Evaluation will be created in January, reported and circulated to Hospital Environment of Care, Governing Body, and Quality Risk and Safety Committees.

Whiting Forensic Hospital is a mental health and addiction services facility. It is not a medical hospital and has no radioactive waste, no piped gases and limited medical waste.

Objectives	**Met**	**Not Met**	
DOT Medical Waste Certification for all Housekeeping staff	X		Currently 100% Compliant with TRC training (certificates on file)
Create WFH SDS database	X		Completed

WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7:	Management of the Environment of Care
Policy	**Hazardous Materials & Waste: Spill & Exposure**
Revised:	2/22/23
Governing Body Approval:	4/28/23
Effective Date:	5/1/23

POLICY

The safe and appropriate response to an accidental release or spill of hazardous materials is essential to the safety of employees, patients, and visitors. This policy covers the employees of Whiting Forensic Hospital's responsibilities in case of a spill or exposure.

DEFINITIONS

Hazardous Material & Waste (HAZMAT) Spill: Incidents involving hazardous materials or wastes. A general term used to define any hazardous material and waste activity.

MINOR (INCIDENT) SPILL: Spills of less than 5 ml and/or any spill that the people can clean up using the training and personal protection equipment (PPE) they have at hand or immediately available. Minor spills include most spills and clean-ups of a routine nature. The training and PPE would be determined before the spill occurred and provided in the area the chemical is used.

SPECIAL CONTENT SPILL: Special content spills include mercury and hazardous medications, such as chemotherapeutic, for which staff are trained in clean-up procedures and have specific spill kits. The volume of the spill is predictable in volume and hazard. Nurses and pharmacists trained to handle hazardous medications and specifically trained and equipped to handle minor mercury spills will manage and clean up these materials.

MAJOR SPILL: Spills larger than 5ml are beyond the training and PPE available to the staff. These spills may represent an immediate danger to personnel in the area because of physical and health effects (e. g., large quantities of Formalin and Xylene). In most cases, this is a decision made by the Director of Environmental Safety, campus Safety Officer or Administrator On-Call at the point of the incident or by the department manager based on knowledge of the material's hazards. Spills on soft surfaces such as rugs are treated as major spills or a spill that exceeds the limits of the personal protection available and staff training.

PROCEDURES

Regardless of the size or type of spill, staff should be aware of the different phases of a spill response:

A. Discovery, identification, notification, and decision-making
B. Response, Clean-up, and Disposal of the spill:
    i. Minor,
    ii. Special content, and
    iii. Major
C. Recovery

D. Discovery, Identification, and Decision-making

   When a spill (a spill of hazardous or unknown chemical or infectious/potentially infectious material) is discovered, it should be classified by the amount of the spill, such as a minor spill, special content spill, or major spill. If possible, attempt to identify the hazardous material from information provided by staff involved in the spill or evidence.

E. Response, Clean-up, and Disposal to the Spills:

F. Minor Spill
    1. The person that discovered or caused the spill without any special equipment beyond what they normally use can clean up a minor spill. These spills should be cleaned up promptly; no further action is needed. *Example: A few drops of blood or a few drops of a normally used chemical.*

    2. The personal protection required to clean up these spills is normally used for handling these materials and waste (e. g., Gloves, Apron, Eye Protection, etc.).

    3. Spill kits may be used on the specific material if the staff has proper training in their use (e. g., such as a formaldehyde-neutralization kit).

    4. If a spill kit is used or there is a potential risk to patients, staff, or visitors, an incident report should be completed.

    5. Dispose of the materials in the appropriate waste containers. If unsure of proper disposal

   ii. Special Content Spill

    1. For these specific spills of hazardous materials such as chemotherapeutic medications or mercury, refer to their specific policy on that content: Policy on Managing Chemotherapeutic Material and Waste (refer to Infection Control or Pharmacy policy) and Policy on Mercury Spills (refer to the policy on mercury)

2. An appropriate NIOSH-approved respirator should be used for either powder or liquid spills where an airborne powder or aerosol has been generated.

3. Liquids should be wiped with absorbent materials, and solids should be wiped with wet absorbent gauze. The spill areas should then be cleaned three times using a detergent solution followed by clean water. Special procedures are referred to for a mercury clean-up in the Mercury Policy (see reference policy).

4. Any broken glass fragments should be picked up using a small scoop or gauze pad (never the hands) and placed in a “sharps” container. The container should go into a heavy-duty disposal bag, contaminated absorbent pads, and other contaminated waste.

5. Where spill kits are available and staff is trained to use them, the spill kit may be used.

6. Refer to the specific policy on spill disposal and products associated with clean-up, if applicable.

iii. Major Spill

1. Immediately evacuate the area while closing all of the doors. Closing doors will help contain the vapors and odor; post staff at all doors into the area to control movement into the area.

2. Contact dispatch at 860 262 5555, who will contact the Engineer on Duty to shut off the affected area’s HVAC system.

3. Contact Security to assist in securing the area.

4. During regular business hours, contact the WFH Director of Environmental Safety and/or the campus Director of Engineering via dispatch at 860 262 5555, who will evaluate the situation and potentially notify ESIs

5. During off-duty hours, contact dispatch at 860 262 5555, who is authorized to call ESIs. Contacting them, explaining the situation, and asking for their advice may be helpful.

6. Continue to secure the area and ensure that the area has been evacuated (to the extent practical without personal protection), that all staff, visitors, and patients are accounted for, and that all entrances have been secured. If noxious smells extend out of the area, secure a larger area. Use the Evacuation Plan noted in EOP and COOP to move patients and staff to alternate sites if necessary.

7. When the contractor arrives, please inform them about the spill and its location. If possible, have a Safety Data Sheet (SDS) for the chemical spilled available for their use. Have LS drawing/ floor plans available to them with the involved area's entry/access points.

8. If practical, have the person that discovered the spill available to explain the situation to contractor personnel. If they are not available, have someone familiar with the area.

9. WFH staff must **NOT** try to clean up spills for which they have not been trained or are not equipped. Housekeeping and Plant Operations staff are not trained to control or clean up major spills.

10. The contractor will be responsible for the clean-up and disposal of the product, PPE, and any materials used for clean-up.

11. If someone has been exposed or contaminated, respond immediately to the Emergency Room, report the chemical or bring the bottle to the Emergency Room and report to Employee Health for the First Report of Injury. Immediate decontamination may be appropriate.

G. Recovery

1. Once the affected area has been declared "*safe*" by the WFH Director of Environmental Safety, Campus Safety officer, Administrator on Duty, or contractor, housekeeping staff can enter the area to clean up the remainder of the incident. This process generally includes spent neutralizer, absorbent, packaging, and other materials.

2. The area should **NOT** be reoccupied for routine use until the Director of Environmental Safety, Campus Safety officer, and Administrator on Duty determine no remaining hazards from the clean-up process exist.

3. A narrative discussion of the event, staff, patient or visitor injuries, and the clean-up, disposal, and recovery process should be documented for all significant incidents involving hazardous materials and waste.

4. All significant spills will be reported to the Environment of Care (EOC) Committee and evaluated to potentially improve the process.

WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7:	Management of the Environment of Care
PROCEDURE 7.27:	**Panic and Body Alarms Security Systems**
NEW:	6/28/22
Governing Body Approval:	7/1/22
Reviewed :	6/29/23

PURPOSE: All staff members at Whiting Forensic Hospital (WFH) play a role in the safe operation of the facility. The Panic and Body alarm system facilitates a rapid response of additional staff resources to identified behavioral or medical crises. The ability to effectively manage these types of situations is a key component in the maintenance of a safe clinical care environment.

SCOPE: All staff members assigned to patient care areas.

POLICY:

WFH is dedicated to providing high quality health care in a safe environment.

PROCEDURE:

Assignment: Panic alarms are located on units throughout the Whiting Forensic Hospital. Body alarms are assigned to individual units and carried by staff members. Each alarm will only announce emergencies for its programmed location. All staff assigned to Continuous Observation or greater observation must wear body alarms at all times while in any patient care area where the system has been installed; otherwise, staff may choose whether to wear a panic alarm based on preference and acuity.

Staff working with patients in remote or secluded areas should also consider using a body alarm.

All staff members are responsible for obtaining a body alarm at the time they begin a special observation assignment.

The alarm will be returned at the conclusion of the assigned observation period, or when another alarm is issued to cover a designated “common use area.”

Wearing: Body alarms must be worn on the breakaway lanyard or belt clip provided.

Activation: Panic alarms are activated by pushing the button and holding it down for 10-15 seconds. A body alarm is activated by pressing the button in the center of the front side of the device. A staff member activating an alarm should also call out for help to identify their specific location on the unit to responding staff.

Schedule for Testing:

All Patient Care Buildings –
Whiting building wall mounted panic alarms are tested monthly, and body alarms are tested weekly. All testing in the Whiting building is completed by the Whiting Police. Troubleshooting of wall and body alarms is completed by Whiting Police in collaboration with our contracted vendor.

Dutcher wall mounted panic alarms and body alarms are tested annually by a contracted vendor; testing reports are forwarded to the EOC committee. Troubleshooting of wall and body alarms in the Dutcher building is initiated by a work order and completed by the facility's engineering department in conjunction with the contracted vendor.

Monitoring: Whiting building testing reports are forwarded quarterly to the EOC committee by Whiting Police. Dutcher building testing reports are forwarded annually to the EOC committee by the landlord's facility engineering department. Compliance with testing will be reported to Governing Body quarterly.

Staff Training**:** All staff using the alarms will be provided training on how to activate an alarm and how to cancel a false alarm.

Common Area Alarms**:** Body alarms are programmed to specific physical locations within the building. Therefore, staff assigned to a "common area" who need to carry a body alarm must ensure they have the proper alarm for the designated area to ensure timely response to an emergency. Staff members will turn in previously assigned body alarms, and obtain the appropriate "common area" alarm prior to starting work in the designated area. The "common area" alarm will be turned in at the conclusion of the area assignment, and the appropriate body alarm for the next area of assignment issued prior to leaving the "common area".

Alarm Inventory**:** Body alarms issued to Nursing and other staff members (rehab, social work, etc) will be tracked as part of the Unit "Sharps" Count and must be accounted for at each change of shift. The "common area" supervisors are responsible for the daily reconciliation of the body alarms assigned to "common areas" which are not stored on patient care units. Alarms that are removed from their designated areas generate a signal to the Telecommunications Office, which will result in a phone call to account for the alarm location.

Note: The Body Alarm system is only designed for use in a behavioral emergency. A Medical Emergency response must still be initiated by dialing "5555", 860-262-5555, or pushing the emergency button on campus phones. 911 will notify off campus emergency services.

WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7:	Management of the Environment of Care
PROCEDURE 7.28	**Medical Equipment Failure & Emergency Response -** EC.02.04.01 EP9
New:	May 1, 2023
Governing Body Approval:	July 7, 2023
Effective Date:	July 20, 2023

POLICY

It is the policy of Whiting Forensic Hospital to respond to a failure of medical equipment and provide emergency clinical interventions when appropriate.

RESPONSE

The Adaptive Medical Equipment Department will be available on a 24-hour a day basis to respond to emergencies involving medical equipment malfunctions and or failures. During normal business hours, the Adaptive Medical Equipment Department can be contacted directly by telephone or pager. During evenings, nights, weekends and holidays, the on-call Adaptive Medical Equipment Department technician may be contacted on long-range pager through the Medical Center's telephone operators.

In the event of malfunction or failure of a piece of Life Support Equipment, staff shall follow the Clinical Intervention Protocol until replacement equipment can be obtained.

PROCEDURE

1. In the event of an emergency involving a medical equipment malfunction or failure, the medical and clinical staff members are instructed to take the required steps to ensure the safety of the patient and attempt to locate the appropriate replacement equipment.

2. The staff should then contact the Adaptive Medical Equipment Department immediately for a failure involving medical equipment providing life support functions.

3. The schedule for the on-call Adaptive Medical Equipment Department technician will be provided to the phone operators on a quarterly basis. The on-call schedule will consist of dates, names, pager numbers, and home phone numbers of the Adaptive Medical Equipment Department staff.

4. If for some reason the Adaptive Medical Equipment Department technician on-call cannot be contacted, the hospital operators are instructed to contact the Adaptive Medical Equipment Manager or his/her designee.

5. The Adaptive Medical Equipment Department staff member responding to the call will assess the medical equipment failure/malfunction and provide repair services for equipment that is needed before the normal repair cycle.

6. Medical equipment that is involved in an event that caused or has the potential for serious injury to patient, or is involved in the death of a patient, will be removed from service immediately. The equipment will be evaluated, and the incident will be reported and investigated according to SMDA criteria and Whiting Forensic Hospital policies.

7. Failure of medical equipment that is not considered an emergency will be report to Adaptive Medical Equipment Department as soon as possible.

8. The equipment shall be removed from service and identified "Not for Use" to prevent further use.

9. The appropriate documentation will be sent to the Adaptive Medical Equipment Department concerning the failure.

10. Department managers are responsible for identifying all items of medical equipment that would require replacement in the event the equipment is removed from service. This determination should be based on one or more of the following conditions:

    a. Equipment is critical to patient care and requires immediate replacement.
    b. Equipment is non-critical and requires replacement at the earliest possible convenience.
    c. Failure would necessitate patient relocation to another area with similar equipment.
    d. Failure would create a strain on department services resulting from a backlog of patient scheduling.

11. The department manager will contact Adaptive Medical Equipment Department to request assistance in:

    a. Locating similar equipment within the department and other areas within the Whiting Forensic Hospital
    b. Establishing interdepartmental protocols for borrowing equipment from other departments.
    c. Identifying areas with similar equipment to which patients could be relocated.

12. The department will follow the appropriate protocol for utilization of equipment cleaned and provided by Adaptive Medical Equipment Department and Infection Prevention Department.

13. The department manager will contact Adaptive Medical Equipment Department for assistance in:

    a. Identifying rental companies which specialize in medical equipment.
    b. Identifying vendors with loaner policies for equipment.

WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7:	Management of the Environment of Care
PROCEDURE 7.29	**1135 Waiver Policy**
New:	6/20/23
Governing Body Approval:	7/7/23
Effective Date:	7/20/23

It is the policy of Whiting Forensic Hospital that in the event of a federally declared public health emergency the organization will request an 1135 waiver if it decides that it needs to utilize alternate care sites for care or treatment.

These waivers under section 1135 of the Social Security Act typically end no later than the termination of the emergency period (unless terminated sooner), or 60 days from the date the waiver or modification is first published unless the Secretary of HHS extends the waiver by notice for additional periods of up to 60 days, up to the end of the emergency period.

Whiting Forensic Hospital is located in Region 1 and the contact information is as follows robosora@cms.hhs.gov 617-565-1185.

When requesting a waiver to the regional office our facility will provide

- Facility Name/Type.
- Full Address (including county, city/town, state).
- CNN (Medicare Provider Number).
- Contact person with contact information.
- Brief summary of why the waiver is needed.
- Type of relief sought (regulatory requirement/reference that is seeking to be waived).

The Centers for Medicare & Medicaid (CMS) (regional office) will review the 1135 waiver request to determine if the waiver will be granted.

Whiting Forensic Hospital will resume compliance with normal rules and regulations as soon as we are able to do so, and in any event the waiver or modifications that we are operating under are no longer available after termination of the emergency period.

Federally certified/approved providers must operate under normal rules and regulations, unless they have sough and have been granted modifications under the waiver authority from specific requirements.

WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 7:	Management of the Environment of Care
PROCEDURE 7.34	**Pressure Sensitive Door Alarms**
NEW:	December 16, 2022
Governing Body Approval:	December 22, 2022
Effective Date:	December 28, 2022
Reviewed :	September 29, 2023

PURPOSE: The purpose of the Pressure Sensitive Alarms procedure is to ensure the effectiveness of the pressure-sensitive alarms in mitigating risk of suicide.

SCOPE: All direct care staff

I. ALARM FUNCTIONING

a. Pressure-sensitive door alarms are installed on the top inside horizontal surface of the patient bedroom doors on Dutcher 1 North
b. When pressure is placed against the alarm surface, the alarm will be activated with a flashing strobe light on the hallway side of the door as a visual cue for staff.
c. The alarm monitoring station is located in the Nursing station with a lighted panel representing a labeled, numbered patient door with an audible alarm.
d. It is imperative that alarms are maintained in good working order and audible to staff on the clinical unit.
e. Pressure-sensitive door alarm activation requires immediate staff response to the source/cause of the alarm with necessary emergency measures ensuring patient safety.
f. Any incident requiring emergency intervention, as a result of pressure sensitive alarm activation, is processed with the patients on the involved clinical unit

II. PROCEDURE

a. Unit staff will respond immediately to the identified bedroom when the pressure sensitive door alarm sounds to identify the cause of the activation
b. Staff will inspect for items placed over the bedroom door that may have triggered the alarm; all areas covered by the activated alarm will be thoroughly checked
c. Staff will provide necessary emergency measures in response to any attempted/actual hanging, initiating a medical emergency response
d. The pressure-sensitive door alarm will not be silenced or cleared until the cause of the alarm activation has been identified; a census check of all patients is conducted as part of this evaluation
e. Staff will be assigned to continuously monitor the area until the alarm is reset
f. Reset key-switch is located in the hallway next to each patient's bedroom door and is reset by inserting the BUILDING passkey and turning the key CLOCKWISE

g. The attending psychiatrist and unit director will be notified of all occurrences of pressure-sensitive alarm sounding
h. A Focused Treatment Plan Review will be conducted for all patients exposed to the trauma of any attempted, or actual hanging resulting in a medical emergency response
i. As appropriate, a suicide risk assessment for patients deemed at risk will be conducted by a registered nurse who will confer with the attending/on call psychiatrist regarding the need for increased observation.

III. RESPONSIBILITY

a. The pressure-sensitive door alarms will not be disabled at any point without authorization of the Hospital CEO.
b. Nursing staff will check the door alarms for evidence of tampering each change of shift, which will be documented on the routine observation form with staff initials
c. Trouble alarms or active alarms unable to be cleared will be immediately reported to Telecommunications Dispatch for vendor contact and repair.
d. The affected hallway will be immediately place on an increased level of observation until the alarm system has been repaired as indicated by the attending/on-call Psychiatrist in conjunction with the Service Medical Director.

IV. ORIENTATION and EDUCATION

Building Specific Training: Dutcher specific building orientation including this procedure is completed on new employee orientation followed by an in-person orientation checklist which includes an in-person review and demonstration which is verified as completed and signed off by the Lead Mental Health Associate or designee prior to completion of unit specific orientation.

V. TESTING

a. Alarm system monitoring stations at the nurse station will be inspected and documented during census check twice an hour to ensure the display does not have any red lights indicating an active alarm.
e. Monitoring panel function, including strobe and audible alarms, will be tested during clinical environmental rounds quarterly with staff education and procedure review by the Hospital Environmental Safety Director, Safety Officer or EC rounds designee.