SECTION – ENVIRONMENT OF CARE
POLICY NO. 32.00

Effective Date: 3/14/12

TITLE: TOBACCO-FREE ENVIRONMENT

This replaces CMHIP policy 32.00 dated 11/9/11.

PLEASE NOTE: This policy supersedes all hospital, division and department policies referencing tobacco or smoking.

I. PURPOSE

It is the policy of the Colorado Mental Health Center at Pueblo (CMHIP) to prohibit smoking or the use or sale of any tobacco products on the CMHIP campus.

As a health care provider committed to the health and safety of staff, patients, physicians, visitors, and business associates, the Colorado Mental Health Institute at Pueblo is taking a leadership role on the major public health issue of tobacco use. To promote CMHIP's commitment to public health and safety and to reduce the health and safety risks to those served and employed at the workplace, all CMHIP facilities, campuses, state vehicles, and properties are tobacco-free environments as of June 1, 2008. No smoking of cigarettes, cigars, or pipes or use of chewing tobacco in any form or any other tobacco product will be permitted in facilities or on properties of CMHIP on or after that date.

This policy is applicable to all State employees on the CMHIP campus (see map on page 5) whether they are employees of CMHIP or other agencies, to medical staff, visitors, students, volunteers, vendors, lessees and contractors. This policy is applicable to all inpatients and outpatients.

A ban on tobacco does not take away an individual's rights as there is no "right to smoke" in Colorado. CMHIP does not require staff, patients or visitors to stop using tobacco; however, it is required that people do not smoke or use other tobacco products on this hospital campus or during work time.

The purpose of this policy is to describe how the tobacco-free workplace requirements will be implemented.

DEFINITIONS

Tobacco Products – Cigarettes, pipes, pipe tobacco, tobacco substitutes (e.g., clove cigarettes), chewing tobacco, cigars, dissolvable tobacco products (e.g., orbs (mints), sticks (toothpicks), strips (product that looks like breath strips, etc.).

Tobacco Paraphernalia – cumbustible material is contraband unless authorized (see CMHIP policy 32.12, Declaration of Contraband).

Workplace – CMHIP workplace means facilities or properties including, but not limited to, patient care buildings, clinics, facilities, office buildings, parking lots, CMHIP or State-owned vehicles, or property leased or rented out to other entities. This policy applies regardless of whether a CMHIP facility or property is owned and whether or not

the other tenants follow similar guidelines. Employees and patients at off-site patient activities shall not use tobacco products.

II. ACCOUNTABILITY

It is the responsibility of all staff members to enforce the hospital's tobacco-free environment policy by encouraging their colleagues, patients, visitors and others to comply with the policy. Supervisors are responsible for implementing and enforcing CMHIP's Tobacco-Free Environment policy.

The community, staff, patients and visitors will be informed of the policy through a variety of communication methods.

III. PROCEDURE

GENERAL POLICY PROVISIONS

1. No tobacco products, related paraphernalia such as lighters, matches and e-cigarettes or products that give the appearance or could be construed as tobacco products by other staff members or patients (e.g., mint chew/snuff) shall be used, sold or bartered anywhere on the CMHIP campus (see map on page 5) and may be possessed only in locked personal vehicles.
2. Signs declaring this hospital campus "tobacco free" shall be posted at the hospital campus entrances and other conspicuous places.
3. Hospital employees and other State employees who work on the CMHIP campus will be advised of the provisions of this policy during New Employee Orientation.
4. The hospital will post this policy in employee common areas and in the CMHIP New Employee Orientation Handbook.

A. State Employees, Volunteers, Physicians, Students and Contract Workers

1. Respectful enforcement of this policy is the responsibility of all CMHIP employees.
2. State employees, students, medical staff, volunteers, vendors, lessees and contractors are expected to comply with this policy.
3. This policy will be explained to employees during New Employee Orientation.
4. Job announcements for all positions on the CMHIP campus will display a notice that CMHIP has a tobacco-free work environment policy.
5. Employees are prohibited from smoking or using other tobacco products during any and all parts of their paid work shift excluding breaks. Employees may not smoke or use other tobacco products in their private vehicles while the vehicle is on CMHIP grounds.
6. Employees who encounter staff or visitors who are violating the tobacco policy are encouraged to politely explain the policy and report the violation to the person's supervisor, if known.

7. Staff who fail to adhere to this policy or supervisors who fail to hold their employees accountable may be subject to progressive discipline culminating in corrective or disciplinary action as defined in CMHIP, Colorado Department of Personnel and Administration (DPA), CDHS Human Resources and Medical Staff policies.

B. Patients

1. Inpatients and outpatients are prohibited from smoking or using any tobacco product or paraphernalia on campus.
2. All patients admitted to CMHIP will be assessed for history of tobacco use and the need for interventions related to tobacco addiction including nicotine replacement and cessation education.
3. Patients may not possess any tobacco-related items on the unit or on the hospital campus except in the patient's locked personal vehicle.
4. Employees who encounter patients who are violating the tobacco policy are encouraged to politely explain the policy, and report the violation to the patient's treatment team, if known.
5. Violation of this policy by patients is a treatment issue to be addressed by the treatment team.
6. When a patient is reintegrating into the community and will be followed by Forensic Community-Based Services (FCBS), use of a vapor cigarette will be considered on a case-by-case basis. In such cases, the following applies:
   a. The treatment team must submit a request for a policy waiver to Executive Committee including the clinical rationale for the request.
   b. If approved by EC in conjunction with FCBS case management staff, the patient may use the product only during community re-integration activities and may not use them on the CMHIP campus.

C. Visitors

1. Signs are posted at campus entrances and in selected locations inside and outside of the facility.
2. Employees who encounter a visitor who is violating the tobacco policy are encouraged to politely explain the policy to the visitor.
3. Visitors who become agitated or unruly or repeatedly refuse to comply when informed of the tobacco-free campus policy may be reported to the Department of Public Safety (DPS). DPS will respond to the situation as appropriate, according to their professional judgment and need to maintain a safe environment.

D. Outside Groups

Outside groups who use CMHIP facilities for meetings will be advised of this policy. Violation of the policy will result in the rescinding of approval for the group to meet on this campus.

E. Guidelines for Enforcement

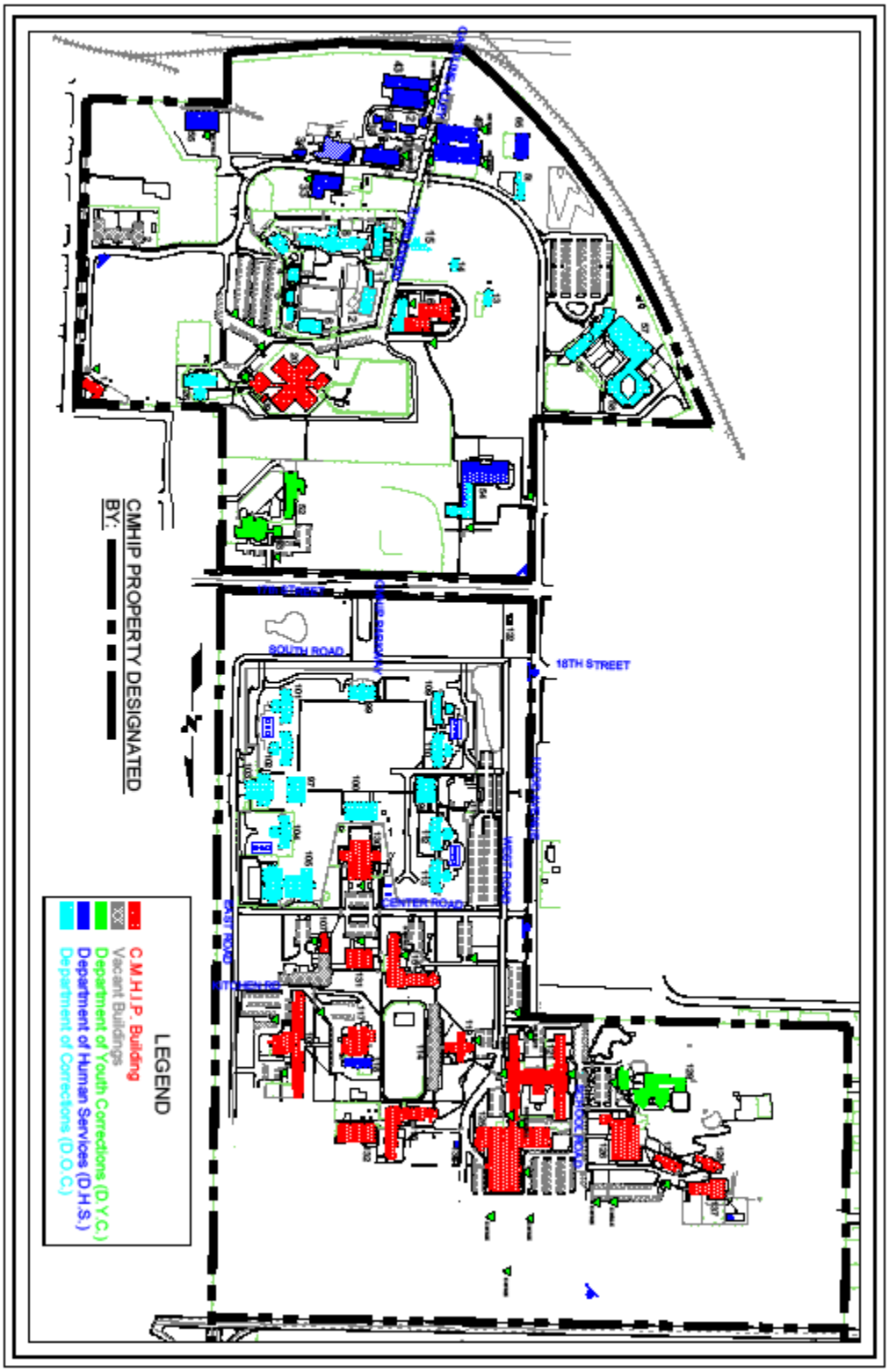
Violation examples	**First Offense**	**Second Offense**	**Third Offense**	**Fourth Offense**
Smoking outside on property but complies with request to stop Smoking outside on property and refuses to comply with policy Smoking in personal vehicle on campus *Excessive absences from the workplace during assigned shift (extra breaks, longer lunch breaks, etc.) *Employee's clothing smells strongly	The supervisor must have verifiable reports of the infractions and/or have witnessed the infraction directly. Verbal intervention with employee. Review policy and perimeter of the campus, give clear expectation it is not to reoccur. Review the Help Quit education available and possible assistance with nicotine replacement and acupuncture for difficulties with compliance while at work.	The supervisor must have verifiable reports of the infractions and/or have witnessed the infraction directly. Repeat first offense interventions and document all discussion in a supervisory log. Refer also to the first verbal intervention and make the expectation clear in writing. Sign the log and have the employee sign that this was reviewed and discussed with them. Again review the assistance available to comply at work.	The supervisor must have verifiable reports of the infractions and/or have witnessed the infraction directly. Present the employee with a Memorandum of Expectation or a JPPA Performance Improvement Plan clearly stating the expectation and consequences if the policy is violated again. Clarify that the behavior will affect the JPPA performance rating and may result in further corrective or disciplinary action.	The supervisor must have verifiable reports of the infractions and/or have witnessed the infraction directly. Document the new infraction and forward with previous documentation to the appointing authority for consideration of an R-6-10 meeting for corrective or disciplinary action that may affect pay, status, or tenure and possible termination.

Staff who witness infractions of any kind are asked to remind the person of the Tobacco Free campus policy using the scripted phrase on the reminder card. If the offender is a patient, please report the offense to the unit if known. If the offender is staff, please report the offense to the supervisor if known.

*Please refer to related polices, CMHIP Professional Image and Appearance, 30.13 and Nursing Department Manual for Break Procedures

_____ _____

Teresa Bernal, RN, C, BS Date
Interim Superintendent


SOUTH ROAD
18TH STREET
CENTER ROAD
EAST ROAD
CMHIP PROPERTY DESIGNATED BY:
LEGEND
C.M.H.I.P. Building
Vacant Buildings
Department of Youth Corrections (D.Y.C.)
Department of Human Services (D.H.S.)
Department of Corrections (D.O.C.)

SECTION –ENVIRONMENT OF CARE
SAFETY MANAGEMENT
POLICY NO. 32.02

Effective Date: 6/11/14

TITLE: INCIDENT REPORTING

This replaces CMHIP policy 32.02, dated 7/10/13.

I. PURPOSE/DEFINITION

It is the policy of CMHIP to collect, analyze and report data on critical incidents in order to improve patient and staff safety through Quality Improvement initiatives.

The purpose of this policy is to describe what type of events constitute a critical incident, and to whom certain incidents must be reported, including the Colorado Department of Public Health and Environment (CDPHE) per C.R.S. 25-1-124 (2).

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include all staff involved in, witnessing or informed of a critical incident.

III. PROCEDURE

A. Procedures for Completing the Incident Reporting Form (Form 1300)

1. The following incidents must be recorded on form 1300 and faxed to Quality Support Services (QSS) (x4996) within 2 hours of the occurrence.

Accident – Auto*	Contraband – Other*	Missing Drugs*+
Accident – Recreational	Contraband – Weapon*	Patient Abuse by Staff*+
Accident – Slip/Trip/Fall	Death*+	Patient Neglect by Staff*+
Accident - Other	Death – Suicide*+	Property Damage/Loss*
Assault – Physical*+ (includes deliberate body fluid exposure	Diverted Drugs+	Security/Safety Violation*
Assault – Attempted*	Escape*	Seizure
Attempted Suicide*+	Fire*	Self Harm
Body Fluid Exposure – Accidental	Hazardous Materials Exposure*	Sexual – Assault*+
Bomb Threat*	Medical Equipment Malfunction	Sexual – Harassment*+
Medication Variances (D or higher)	Menacing/Threatening*	Theft*
***Any ASTERISK = Report to Hospital Police**		
+ Any PLUS SIGN = Report to Lead Nurse (do not leave message – must speak with LN or DCN)		

2. The responsible staff person on the unit or in the department shall legibly and fully complete the Incident Reporting Form (form 1300) as soon as possible but no more than two hours after the occurrence. The description of the incident should explain exactly what occurred with as much detail as can be provided including but not limited to correct dates/times, precipitating events, names and Avatar number(s) of patient(s), name of staff member(s) involved, where the event occurred, and description of injuries and treatment, if any.

3. The entire Incident Reporting Form is immediately faxed to QSS, extension 4996, within two hours of the incident.

4. The original form 1300 is then sent to the Clinical Team Leader/Coordinator after the report is scanned to both the Lead Nurse and Program Chief Nurse immediately and faxed to QSS.

5. The Clinical Team Leader/Coordinator or designee shall complete #11 on page 2 of the Incident Reporting Form and transmit the original to the Program Director. The Program Director or designee shall complete #12, adding information not already documented and/or his/her findings, and transmit the report to QSS within five (5) business days that the incident occurred.

B. Documentation on the Medical Record

Any event that requires an Incident Reporting Form should also be documented in the patient's medical record, if applicable. Documentation in the medical record should **not** state that an Incident Reporting Form was completed. Also, other patients' initials and Avatar #s should **not** be in the progress notes. Only the details of the event should be documented in the medical record. Staff might be requested to make a late entry if sufficient information was originally not included in the progress note.

C. Department of Public Safety (DPS) Notification – DPS must be notified of all incidents as indicated by an asterisk (*) after the incident type listed in # 4 of form 1300.

D. Department of Nursing Notification – The Lead Nurses or Program Chief Nurse must be notified of all incidents as indicated by a plus sign (+) after the incident type listed in # 4 of the form 1300. Staff must "speak" to a Lead Nurse or Program Chief Nurse; they cannot leave a voice message. A copy of the Incident Reporting Form must be made for the Lead Nurse on the unit. The Lead Nurse will review the incident report and then discard in the HIPAA bin.

E. Administration - Notification to the Office of Behavioral Health (OBH) Director of Mental Health Services and the CDHS Public Information Officer.

1. The following incidents shall be reported to OBH and CDHS **immediately** by the Superintendent or the Administrator on Call:

a. Death of a patient or staff member as a result of an accident, suicide, assault or any cause other than natural while at the hospital. This includes death of a patient on authorized or unauthorized leave or staff while away from the campus on hospital business.

1) During normal business hours, the Program Director or designee shall immediately notify the Superintendent, the Chief of Medical Staff, Director of Nursing, and the Director of QSS of all patient deaths.

2) Outside business hours, unexpected deaths shall be reported to the Administrator on Call who shall notify the Superintendent, the Chief of Medical Staff, Director of Nursing, and the Director of QSS at 8:00 a.m.,

the next day, including weekends and holidays (refer to CMHIP policy 3.38, Root Cause Analysis and Sentinel Event Investigation).

b. Suicide attempt by a patient while at the hospital or while on authorized or unauthorized leave, which requires outside medical attention as a result of the attempt

c. Unauthorized absence of a patient when the patient is determined to be dangerous to self or others, or whose absence is likely to raise public or media attention or concern (both civil and forensic patients)

d. Significant fire or other events that may require emergency relocation of patients or staff (e.g., patients or staff are not able to return to patient care or office areas).

2. The following incidents shall be reported by the Superintendent or the Administrator on Call, **the next business day**:

a. Death of a patient from natural causes

b. Unauthorized absence of a patient determined not to be dangerous to self or others, notorious, or whose absence is not likely to raise public or media attention or concern (civil and forensic patients)

c. Accident/illness that requires medical attention

d. Assault on a patient, staff member or visitor that:
   1) results in an injury requiring medical attention
   2) results in summoning of an outside law enforcement agency; or,
   3) meets the definition of assault in C.R.S. 18-3-201, either "first degree assault" (with intent and causing serious bodily injury with a deadly weapon) or "second degree assault" (with intent and causing serious bodily harm);

e. Abuse, or alleged abuse, of patients while at the hospital including any allegation of malpractice, neglect, verbal, physical, or sexual abuse or any allegation of such abuse that results in an investigation by an outside law enforcement or a social services agency

f. Theft or destruction of property in excess of $1,500.00

F. Notification to CMHIP Public Information Officer

The Superintendent, the Administrator on Call, or the Director of QSS shall immediately report to CMHIP's Public Information Officer the following incidents:

1. Unauthorized absence of patients when the patient is determined to be dangerous to self or others, notorious, or whose absence is likely to raise public or media attention or concern (both civil and forensics patients)

2. Any situation listed above that may get media attention.

G. Quality Management Information

1. Incident Reporting Forms are confidential quality management documents. The reports and information reported via the critical information process are for CMHIP use only. The QSS Director who is the Occurrence Administrator, must authorize copies for use for quality management or personnel matters only.

2. Unless authorized, staff shall not make copies nor maintain files of confidential quality management material including Incident Reporting Forms. A copy of form 1300 should be made and forwarded to the Lead Nurse of a unit when the incident occurred on that unit. Incident Reporting Forms shall never be placed in the patient's medical record or in employee personnel files. Staff violating this policy may be subject to corrective or disciplinary action.

3. QSS maintains a central file of Incident Reporting Forms. Incident Reporting Forms shall be maintained for three (3) years.

H. Notification and Reporting to the Colorado Department of Public Health and Environment (CDPHE) (Occurrence Administrator ONLY)

1. The Occurrence Administrator will review all incidents, and if any meet the reportable occurrence criteria of CDPHE, shall report them through the occurrence reporting system to the CDPHE Health Facilities and Emergency Medical Services Division (HFEMSD) by the next business day or as soon as CMHIP becomes aware of the occurrence.

2. All disclosures of Protected Health Information made to the HFEMSD must be recorded using form 600, Record of Protected Health Information Disclosures, and retained in the patient's medical record.

3. The following occurrences shall be reported to the HFEMSD:
   a. **Death** – All unexpected deaths t from an unexplained cause or under suspicious circumstances that are reported to the coroner (see CMHIP Policy 8.68, Death Notification and Autopsies and Policy 3.38, Root Cause Analysis and Sentinel Event Investigation).
   b. **Brain injury** – Any injury that occurs to the brain and as a result, causes a change in the level of consciousness and/or loss of bodily function; or, diagnostic test that shows brain injury.
   c. **Spinal cord injury** – any injury that is the result of an occurrence, and causes temporary or permanent functional loss consistent with spinal cord injuries.
   d. **Life-threatening complications of anesthesia** – The occurrence must be the result of anesthesia and the complication or reaction must be life threatening.
   e. **Burns** – Any occurrence that results in second- or third-degree burns that affect 20% or more of an adult's body or 15% or more of a child's body.
   f. **Missing persons** – Any time a patient cannot be located following a search of the facility, its grounds and surrounding areas and who is considered a risk to themselves or other or if the patient is missing for more than eight hours, regardless of risk.

g. **Physical abuse -** Any such occurrence, whether by another patient, staff member or visitor. There must be intent, knowingly or recklessly, to harm and bodily injuries present. Physical abuse may also include unreasonable confinement or restraint.

h. **Sexual abuse -** Any such occurrence where the perpetrator is another patient, staff member or visitor must be reported. There are several elements, any of which can be present to be considered sexual abuse. These include "knowingly" touching; sexual intrusion, touching intimate parts of the body, observation or photographs of intimate parts, consent not given, physical force or threat used.

i. **Verbal abuse -** Verbal abuse, for occurrence reporting purposes, must contain these elements to be reportable: it is done knowingly; it is perceived as a threat; there is physical action (threatening gestures) that puts the alleged victim in fear of imminent, serious injury.

j. **Neglect -** Any act or omission where a patient is harmed by a staff member who has a history of neglect or by a staff member who intentionally failed to follow policy and procedure.

k. **Misappropriation of patient property -** Deliberately misplacing, exploiting, or wrongfully using a patient's property (belongings or money), or a pattern of misappropriation of patient property, without the patient's consent.

l. **Diverted drugs -** Any drug (including non-prescription products) intended for use by that patient which is diverted for use by others.

m. **Malfunction or misuse of equipment -** Any occurrence involving the deliberate or accidental misuse of or malfunction of equipment being used for diagnosis or treatment of the patient. The equipment occurrence must have had adverse effects or the potential for adverse effects on the patient.

I. Performance Measurement/Performance Improvement

1. Information Management will review and compile the data from the Incident Reporting Forms, including actions taken.

2. The Occurrence Administrator will provide the Critical Incident Committee with a weekly report of critical incidents.

J. Critical Incident Committee

1. The Critical Incident Committee meets weekly to review, discuss, and identify significant trends in reported incidents that are then reported to Executive Committee (EC).

_____ _____

Birgit M. Fisher, PhD Date
Interim Superintendent

SECTION – ENVIRONMENT OF CARE SAFETY MANAGEMENT
POLICY NO. 32.03

Effective Date: 10/10/12

TITLE: PLASTIC MATERIAL CONTROL AND PERMITTING

This replaces policy 32.91, Control of Plastic Materials, dated 12/9/09.

I. DEFINITION/PURPOSE

It is the policy of the Colorado Mental Health Institute at Pueblo (CMHIP) to ensure a safe environment for patients, staff and visitors by conducting proactive risk assessments to identify materials or items in the environment that could increase risk.

The purpose of this policy is to describe the process by which CMHIP approves the use of plastic bags, plastic wrap, balloons, surgical gloves and other plastic materials on patient units, clinical departments, administrative areas, grounds and maintenance, and other areas on the CMHIP campus where patients may be present.

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include all CMHIP and CDHS Southern District staff (but does not include the Pueblo Youth Services Center staff).

CMHIP and CDHS Southern District buildings exempt from this permitting process have been identified as having controls in place that prevent patient access to plastic materials. Exemptions may be rescinded based on changes to building use and/or patient access to plastic materials in the building.

The Safety and Risk Management Office (SRMO) will maintain a list of plastic permitted and permit exempted locations.

III. PROCEDURE

A. Plastic Bag Permit Application

1. Prior to any plastic material being brought into any CMHIP and CDHS Southern District building not on the permit-exempted list, the staff member responsible (permit applicant) for the area, activity, or event

requiring plastic materials must obtain a Plastic Material Permit. The permit applicant may contact the SRMO for guidance in completing the Permit application.

2. The Plastic Material Permit application is attached to this policy.

3. The permit applicant will complete the Permit request form and drawings of affected areas, equipment modifications, etc. and submit the documents to the SRMO.

B. Plastic Bag Permit Approval

1. Plastic Bag Permit Requests will be reviewed and approved by a committee consisting of the SRM and representatives from QSS, Nursing, and Housekeeping/Maintenance.

2. Requests will be reviewed at a regularly scheduled meeting of the Plastic Material Permit review committee. The meeting quorum for approving/denying permit requests is a minimum of three (3) committee members.

3. The committee is the sole authority for approving/denying Plastic Material Permits. There is no right of appeal.

4. Following the meeting, the SRMO will notify the Appointing Authority and permit applicant of the committee's decision.

5. The SRMO will sign approved permit applications on behalf of the committee.

6. The SRMO will assign a permit number for each approved Plastic Material Request, and will return the approved permit, drawings showing approved locations for plastic materials, and/or other documentation to the Appointing Authority and permit applicant. The SRMO will file a copy of all permit documentation in the SRMO.

7. A copy of the Permit shall be conspicuously posted in the affected area.

8. Denied permit requests will be returned to the Appointing Authority and the permit applicant. The SRMO will include in the returned request a reason(s) for denial. The permit applicant may re-submit a permit request following revisions to the original request.

C. Plastic Bag Permit Inspections

1. If approval is given, the SRMO, Environment of Care Rounds inspectors, Quality Support Services staff, and/or other CMHIP quality/compliance representatives ("auditors") will conduct random inspections of the area to verify plastic bags and/or other plastic materials are located, monitored, and/or secured per the approved permit.

2. If the area fails inspection, the auditor will notify the Appointing Authority (or his/her designee) who will then oversee the immediate removal of non-permitted plastic materials from the area. The auditor will educate the Appointing Authority and permit applicant about the reason(s) for the violation, and the requirements of the permit process and the Control of Plastic Material Policy. The approved permit for the area will be pulled.

3. The Appointing Authority may submit another permit request at any time following the failed inspection and will describe the corrective actions taken to prevent a reoccurrence of the violation(s).

4. Changes shall not be made to the location of approved plastic materials without completing a new permit application.

5. Violations detected will be reported via the Incident Report (form 1300).

_____ _____

William J. May Date
Superintendent

Plastic Material Permit Request Form

Requesting unit/department:	
Name of Requestor:	Extension
Appointing Authority:	Extension

Building and Location where the permit applies	
Number and approx size of plastic bags (each type) to be located in this area	

- Identify all areas
- Indicate if the permit is for a single room, multiple rooms (list each), entire unit, floor(s), building, or multiple buildings. Be very specific as an approved permit applies only to the areas listed. Some locations within a multiple location request may not be approved.
- For outdoor use, indicate the general area where plastic materials will be used.

Purpose for Plastic Bags or other plastic material in this area:	

Do patients have access to this area?	

- Answer Yes or No, and
    - For a Yes answer, describe how patient access to the plastic material will be monitored/controlled and how the Appointing Authority will ensure patients are not able to obtain the plastic material (e.g., plastic bags will be stored in a locked drawer in the OT room and OT staff will verify drawer is locked prior to patients entering the room)
    - For a No answer, describe how patient access is prevented (e.g., bags are stored in a locked room where patients are not allowed)

Date permit application received		
Permit review date		
Permit application status	Approved	Denied
If denied, reason for denial		
Date Appointing Authority notified		

Assigned permit number:	

Plastic Material Permit
(Post in Permitted Location)

Permit Number:	

Appointing Authority:	Extension

Building and Location where the permit applies	
Number and approx size of plastic bags or plastic material (each type) to be located in this area	

Purpose for Plastic Bags or other plastic material in this area:	

Permit approval date	
SRM signature	

Plastic Material Permit Inspection

Permit Number:	

Appointing Authority:	Extension

Building and Location where the permit applies	
Number and approx size of plastic bags or plastic material (each type) located in this area	

Inspector		
Date		
Permit Conditions Met (circle Yes or No)	Yes	No

* If No, pull the posted permit and immediately contact the Appointing Authority (or designee) and inform her/him that the permit has been canceled and the reason for cancellation. The inspector will oversee staff removal of all plastic material from the area. The Appointing Authority may then reapply for a new permit and will be required to provide additional documentation describing how the permit conditions will be met.

SECTION - ENVIRONMENT OF CARE
SAFETY MANAGEMENT
POLICY NO. 32.04

Effective Date: 8/14/13

TITLE: PREVENTING NEEDLESTICK AND SHARPS INJURIES

This replaces policy 32.04 dated 12/14/11..

I. DEFINITION/PURPOSE

It is the policy of CMHIP to decrease the risk of needle sticks and injuries from sharps to employees by providing safety needle devices and needle-less systems and to educate employees in the proper use of needle safety devices.

The purpose of this policy is to establish the Needle Exposure Control Plan, to improve staff safety and ensure compliance with the Needle Stick Safety and Prevention Act.

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include all staff involved in the use of needles, needle systems and other sharps, the Infection Control Manager, the Safety/Risk Manager and the Purchasing Department.

III. PROCEDURE

A. The Standardization Committee shall periodically meet with direct care staff and others to provide an opportunity to review new equipment and to participate in:
   1. Adjustments of techniques
   2. Ensuring equipment compatibility
   3. Evaluation of devices
   4. Selection of devices

B. This meeting shall include representatives of non-managerial direct care staff from departments and areas in which staff are involved in the use of needles, needle systems and other sharps, the Safety/Risk Manager, the Infection Control Manager, Infection Preventionist and a representative(s) from the Purchasing Department.

C. CMHIP shall provide safe and effective alternatives to needles or other sharps and shall implement the use of those devices determined to be the most safe and acceptable in the CMHIP work environment whenever reasonable and available.

D. The Infection Control Manager shall provide annual training regarding the safe and proper use and disposal of needles and sharps.

E. All needle stick and sharps injuries shall be reported on the Incident Report form (#1300).

F. Any employee with a potential bloodborne pathogen exposure shall be evaluated and treated in accordance with the Bloodborne Pathogen section of the CMHIP Emergency Procedures (Rainbow Book).

G. The Safety/Risk Manager shall maintain a sharps injury log to serve as a tool to identify high-risk areas and to aid in the evaluation of devices. This log shall include:

1. The type and brand of the device involved in the incident
2. The Department or Program and Unit in which the exposure incident occurred
3. The procedure being performed
4. The body part affected
5. A description of objects or substances involved, and how they were involved

H. All reasonable steps to protect the privacy of the injured employee shall be taken.

I. The Safety/Risk Manager shall produce a report semi-annually reflecting the numbers and types of injuries related to needle sticks and sharps. The Infection Control Committee reviews the semi-annual report.

J. The Safety/Risk Manager shall annually report to the Executive Committee, the Infection Control Committee and the Environment of Care Key Function Team the numbers and types of injuries related to needle sticks and sharps, the analysis and evaluation of this data, and any changes or recommendations in products and/or devices as a result of the report to the Standardization Committee. The Medical Equipment Management Plan shall be revised as necessary.

K. The CMHIP Blood borne Pathogen Exposure Control Plan shall be reviewed annually and revised as necessary based on the findings of this report.

_____ _____

William J. May Date
Superintendent

SECTION - ENVIRONMENT OF CARE – SECURITY
POLICY NO. 32.10

Effective Date: 5/5/14

TITLE: ESCAPES/AWAU/AWA – REPORTING UNAUTHORIZED ABSENCES

This replaces CMHIP policy 32.10, dated 4/9/14.

I. PURPOSE/DEFINITION

The Colorado Mental Health Institute at Pueblo (CMHIP) provides appropriate supervision of patients to ensure patient, staff and community safety. In the event of an unauthorized patient absence, CMHIP staff shall implement the procedure below in an effort to locate or return the patient as quickly and safely as possible.

"**Unauthorized Absence**" means that an inpatient or NGRI outpatient has left his/her assigned location without staff authorization; the patient has not been accounted for when expected to be present; or the patient has not returned from an authorized leave.

"**Patient**" means CMHIP inpatients and outpatients, including Forensic Community Based Services (FCBS) community placement and conditional release patients.

The three main groupings of Unauthorized Absence, related to the legal custody obligations of the Institute, and the role of the Department of Public Safety and law enforcement agencies in obtaining the patient's return are, Escape, AWAU, and AWA.

ESCAPE (From supervision, from unsupervised situation, from Off-Grounds Privilege): This status applies to patients committed for competency, sanity, or mental evaluations, patients found incompetent to proceed (ITP), Not Guilty by Reason of Insanity (NGRI), Not Guilty by Reason of Impaired Mental Conditions (NGRIMC), FCBS patients, civil committed patients (M-1 & M-3) admitted to CMHIP from jail, civil patients that have legal statuses with charges, Department of Corrections Inmates, and youth in custody of, or committed to the Division of Youth Corrections. Assistance from law enforcement agencies will be obtained for involuntary return of such patients. Notification sent to law enforcement agencies on a Be-On-the-Look-Out (BOLO) message sent via CCIC/NCIC. Patient entered into CCIC/NCIC as an Escapee – Temporary Felony Escape Warrant.

AWAU (Absent Without Authority: Return-Urgent): This status applies to civil involuntary patient whose departure was by force, or whose return is otherwise judged by the treating team to be urgent for the safety and well-being of the patient or community (M-1 & M-3 patients). Assistance from law enforcement agencies will be obtained for involuntary return of such patients. Notification sent to law enforcement agencies by on a Be-On-the-Look-Out (BOLO) message via CCIC/NCIC. Patient entered into CCIC/NCIC as Missing Person.

AWA (Absent Without Authority): This status applies to voluntary patients, and to civil involuntary patients whose condition does not merit a forced return for unauthorized absence or failure to return from an authorized absence. No notification (BOLO) sent to law enforcement agencies, and no entry in CCIC/NCIC as missing person. Department of Public Safety Police will search the campus for the patient, and if found, ask the patient to return voluntarily. The AWA status is valid for a maximum of 5 days after which time the patient will be discharged.

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include any staff member who becomes aware that a patient has left his or her assigned location without authorization and is absent, or that a patient's whereabouts have become unknown.

Staff members must report the unauthorized absence of a patient to the CMHIP Communication Center as soon as the staff member learns or suspects that a patient is absent without authorization.

For return of patients to CMHIP, see SECTION III.D - Process For Return of Patients from ESCAPE/AWAU/AWA

III. PROCEDURE

A. Immediate Steps to be Taken When an Inpatient or Outpatient is Believed to be Missing

1. The first staff person to become aware of unauthorized leave must conduct a brief search of the immediate area or quickly contact any other nearby staff to determine if the patient's location may be easily determined or accounted for.

2. If after conducting a brief search or brief inquiries regarding the person's whereabouts it appears the patient is missing, the staff member shall immediately notify the CMHIP Communication Center (Comm Center) and the Clinical Team Leader/Coordinator or FCBS Director, as appropriate.

3. The Comm Center notifies the Department of Public Safety (DPS) while collecting descriptive information about the patient and direction of flight (if known) from the staff person reporting the unauthorized leave. The Comm Center staff shall complete the Dispatch Escape Worksheet, including whether the team thinks a voluntary patient is a risk to him/herself or to the community (and therefore a candidate to be placed on an M-1).

4. The Comm Center staff must check the CMHIP "Current Patients" database on the computer to determine the patient's legal status.

5. The database is located at Y:\CAPP\CurrentPatients; open the database and single-click the "Legal Status" tab. For a patient to be voluntary, he/she can have only a voluntary status, with no other types of legal status (for example, a patient with both voluntary and short-term certified, or voluntary and NGRI, is not a voluntary patient).

6. If the team (including the physician) for a voluntary patient believes that the patient is a risk to him/herself or the community, the team must initiate an order for an M-1 legal hold as soon as possible and immediately notify the Comm Center that an M-1 is pending and that the patient should be considered as **not** voluntary.

7. The Comm Center staff then relays the patient's legal status to DPS officers.

a. If the patient's legal status is voluntary, DPS searches the campus only
b. If the patient's legal status is **not** voluntary, the Comm Center notifies Pueblo Police Department, Pueblo County Sheriff's Department, and law enforcement in the jurisdiction of the patient's last known location. The Comm Center also issues a statewide "Be On the Lookout (BOLO)" notification. A missing person entry or a temporary felony escape warrant will be issued via CCIC/NCIC depending on the legal status of the patient.

8. The Comm Center staff notifies the CMHIP Public Information Officer (PIO).

9. The PIO will notify the media about patients that may have committed escape as defined in the Colorado Revised Statutes. These patients include any patient with a jail, Department of Corrections (DOC), or Division of Youth Corrections (DYC) detainer, including:

   - Patients committed for competency, sanity, or mental condition evaluations;
   - Patients found incompetent to proceed, Not Guilty by Reason of Insanity (NGRI), or Not Guilty by Reason of Impaired Mental Conditions (NGRIMC), including FCBS clients;
   - M-1's and M-3's admitted to CMHIP from a jail;
   - Civil patients that have legal statuses with charges;
   - DOC inmates; or,
   - Youth in the custody of, or committed to, the DYC.

   In the Legal Status tab of the Current Patients database, all such patients are identified with a "yes" in the "/Elope Notify" column.

10. Upon notice from the Comm Center or DPS officer of an escape, the PIO will immediately post to the Flashalert website all information known at the time. Generally, this will be at least the name of the individual who has escaped, and last known location. This site is commonly used among Colorado media outlets, and provides them immediate access to information about CMHIP escapes.

11. Within 15 minutes of initial notification, the PIO will update the Flashalert system with the following information (also required on the CMHIP Media Notification Form):

    - Name, gender, date of birth, and physical description of the patient or inmate
    - Legal status
    - Date and county of commitment
    - Past criminal convictions, or alternatively, the public version of the person's criminal history, obtained from the CBI database
    - Any known pending criminal charges
    - Any known information regarding circumstances of escape, direction or means of travel
    - Photo of patient, when available (before being released as Conditional Release (CR) or Community Placement (CP), patients shall have an updated photo taken, which

FCBS staff will provide to Admissions staff so it may be placed on the LAN at Y:\CAPP\ADM\Patient Photographs). (All patient photographs are stored as JPG files using the patient's Avatar ID, and can be viewed by double-clicking on the file.)

12. After business hours or on weekends, the Command Officer on Duty shall notify the PIO who then will accomplish media notification through Flashalert.net.

13. The PIO notifies School Districts 60 and 70 of the escape of a patient from the campus during school hours, and makes additional notifications through the Flashalert system.

14. Duty to Warn and/or Victim Notification is initiated, if applicable. (See CMHIP policies 14.15 and 14.17.)

    Unit staff notifies the attending physician or on-call physician. **NOTE**: It is not necessary to wait for the physician's order to report an unauthorized leave but the order is required for Avatar data entry. (See CMHP policy 3.45, Patient Roster for unauthorized leave types and documentation requirements.)

15. Comm Center sends an all page regarding the escape.

16. Unit staff provide documentation in this order:
    a. progress note in the chart
    b. Incident Reporting Form, form 1300 (sent/faxed to QSS)
    c. Avatar entry (A physician's order is required to place the patient on any type of leave)

17. If there is a detainer, Department of Medical Records staff notifies the district attorney and Sheriff's department in the locale where the detainer was issued.

18. The Clinical Team Leader/Coordinator or FCBS Director notifies the patient's social worker or FCBS case manager to notify the patient's family, if applicable.

19. The Department of Medical Records staff notifies the court if an NGRI patient escapes.

B. Other Notifications

1. Patients in the Circle program are usually voluntary patients at CMHIP as a condition of probation or as a result of an Alcohol and Drug Abuse Division (ADAD) commitment. In these cases, the unit staff will notify the probation officer or ADAD of the patient's escape.

2. Patients will be informed through the "For Your Information" (FYI) folder and the FCBS Patient Agreement of the circumstances constituting an escape, and that they may be charged with a crime for escaping.

C. Additional Guidelines for Reporting Unauthorized Absences by FCBS Patients

NOTE: The procedure outlined in section A above shall be followed for all FCBS patients, including the submission of the Incident Reporting Form, form 1300.

An FCBS patient shall be placed on escape status under the following circumstances:

1. An NGRI patient on community placement status who fails to attend a scheduled appointment, and thereafter fails to respond within one hour to staff efforts to contact the patient, shall be placed on escape status.

2. A patient on community placement status who is asked by FCBS staff to return to CMHIP as an inpatient and fails to comply with this request will be placed on escape status, located by DPS and transported to CMHIP.

3. A patient on Community Placement status required to wear a Global Positioning System (GPS) tracking device whose device sends an alert that it has been disconnected, and (1) who fails to respond to FCBS staff efforts to contact the patient, or (2) whose explanation of the event is not credible and/or cannot be verified, shall be placed on escape status. DPS officers shall pick up the person for re-admission to the hospital if the person's whereabouts are known.

4. A patient on Conditional Release status who fails to comply with a court-ordered condition of release that requires the patient to reside at a specific location, and whose whereabouts have become unknown to FCBS, or a patient who has left the State without court approval, shall be placed on escape status immediately after these facts become known to FCBS.

D. Process for Return from Escape/AWAU/AWA

Any patient who is returned from an unauthorized absence must be re-admitted through the Admissions Department and evaluated by a physician, or midlevel provider (PA, NP) who will assess and document the patient's physical status, for change, illness or injury sustained during the absence. Referral to the appropriate medical clinic shall be initiated as indicated. This includes FCBS patients. (Refer to Policy 8.05, Health Assessments.)

The patient's medical chart must be available to Admissions at the time the patient is returned to the hospital. If the chart is on the patient's previous treatment unit at the time the patient is returned, the treatment unit shall bring the chart to Admissions. For FCBS clients, FCBS shall return the medical chart to Medical Records by close of business on the day of the escape.

William J. May
Superintendent

Date

SECTION – ENVIRONMENT OF CARE
SECURITY MANAGEMENT

POLICY NO. 32.12

Effective Date: 12/12/12

TILE: DECLARATION OF CONTRABAND

This replaces CMHIP policy 32.12, dated 11/15/10.

I. DEFINITION/PURPOSE

It is the policy of the Colorado Mental Health Institute at Pueblo (CMHIP) to ensure a safe treatment environment for patients, staff and visitors.

The purpose of this policy is to describe what is contraband on the grounds of CMHIP pursuant to 18-8-203, C.R.S. and 18-8-204, C.R.S. 1973, as amended.

Contraband is defined as any article, item or substance not allowed by law or that may be viewed as detrimental, or that may pose a threat to the safety/security or operation of the Colorado Mental Health Institute at Pueblo.

Nuisance Contraband - Items that are not dangerous, e.g. food items, newspapers, magazines, paper, clothing, etc. (usually found in excess of allowed limits).

II. ACCOUNTABILITY

The Declaration of Contraband is issued under the authority of the Superintendent, and the Colorado State statutes cited above. Individuals responsible for implementing this policy include all employees, consultants, students, and volunteers.

The Department of Public Safety (DPS) will investigate violations of this policy.

III. PROCEDURE

A. Determination of Contraband

1. The Superintendent, in conjunction with the Security Manager (Chief of the Department of Public Safety) will issue a Declaration of Contraband which lists articles, items or substances that are not allowed on the grounds, such as any article, item or substance that may be viewed as detrimental or may pose a threat to the safety/security or operation of the hospital, and any other article or substance that is not allowed by hospital or division policy.
2. Individuals who have knowledge of violations of this policy will immediately report violation(s) to DPS and complete a Critical Incident Report, form 1300. DPS will conduct an investigation of the incident. The results of the investigation will be forwarded to the Superintendent and to the District Attorney's Office, if applicable.

3. Searches of individuals, packages, and vehicles will be governed by CMHIP policy 32.13, Searches of Premises, Patients, Staff and Visitors.

B. Declaration of Contraband

The following items are deemed contraband by order of the Superintendent. It applies to all patients, staff, visitors, students, volunteers, and anyone who conducts services or business on this campus.

1. Any firearm, explosive device, ammunition, chemical self-defense agent, electronic restraint device, knife, or sharpened instrument, bludgeon, projectile device, replica or facsimile of such device, instrument, material, or substance, which is capable of causing or inducing fear of bodily injury or death.

2. Any combustible material such as matches or cigarette lighters or any other substance that would be considered hazardous to the health and safety of an individual unless authorized, and used in an authorized manner.

3. Any substance used for the purpose of inhaling or ingesting to produce an intoxicating effect, and paraphernalia used or identified with the use of drugs and/or narcotics and/or hallucinogens.

4. Any drug or medicine in quantities other than that prescribed and authorized by a physician, and needed during the term of a visit or stay.

5. Any hypodermic needle, syringe, parts thereof, or any other device that can be used to make injections into the body of a human being, unless authorized; i.e., staff using prescribed medication, such as insulin, are authorized.

6. Any intoxicating beverage, or ingredients and substances used for brewing or making such beverages; perfumes/colognes.

7. Any key, key pattern, key replica, lock pick, or any other device that could be used to breach the security of the CMHIP premises or any secured area or place therein. Staff and contract personnel are authorized to carry keys or key-related tools for areas designated by Division/Department Directors and/or the Director of Facilities Management. Patients who have home residence on the Advanced Cottage are permitted to have keys to their living quarters on the unit, i.e., exterior doors and their own rooms.

8. Any tool or instrument or sewing-related device such as scissors, needles, etc. which could be used to stick, cut, pry, dig or file, unless authorized and in an authorized area.

9. Any chain, rope, strap, belt, strip of material or sheeting, noose, ligature, shoelace, plastic bag greater than one (1) quart in size, etc., unless authorized and in an authorized area.

10. Any mop, broom or other cleaning tool on locked units unless the patient is formally participating in an IT assignment activity, and is supervised by staff while in possession of the mop, broom or other cleaning tool.

11. Any ladder, unless authorized and in an authorized area.

12. Any counterfeit or forged medium of exchange, or any molds, dies, stamping devices, or any other paraphernalia used, or capable of use to counterfeit or forge a medium of exchange or to defraud the operation of medium of exchange.

13. Any money or coin of United States currency or written instrument of value, unless authorized.

14. Any uncanceled postage stamp or implement of the United States Postal Service, unless authorized.

15. Any written message, item or object that is to be sent or brought to another patient, unless authorized.

16. Any obscene or pornographic or objectionable materials.

17. Any counterfeit or forged identification card.

18. Any mask, wig, disguise, or other means of altering normal physical appearance which could hinder ready identification.

19. Any visual or audio recording device, including but not limited to, camera cell phones, or personal data assistants (PDAs) in the possession of patients or visitors. (See CMHIP policy 6.60, Photo/Recording Patients.)

20. Any portable two-way communication devices, unless authorized.

21. Any other item in the possession of a patient that is prohibited by another hospital policy (e.g., Seclusion and Restraint), division policy, Physician's Order or unit rules is considered nuisance contraband**.** Nuisance contraband will not initiate a criminal investigation but will be confiscated.

C. Confiscation of Contraband

CMHIP staff will immediately seize any item determined to be contraband, if safe to do so. In cases where it is not safe for clinical staff to act immediately, clinical staff will notify the DPS officers, who will respond and assist clinical staff, if necessary.

CMHIP police officer(s) will collect and secure any items seized, as appropriate.

_____ _____

William J. May Date
Superintendent

SECTION – ENVIRONMENT OF CARE
SECURITY MANAGEMENT

POLICY NO. 32.13

Effective Date: 12/12/12

TITLE: SEARCHES OF PREMISES, PATIENTS, STAFF AND VISITORS

This replaces policy 32.13, dated 12/1/10.

I. DEFINITION/PURPOSE

It is the policy of CMHIP to provide a safe environment for patients, staff and visitors. All individuals and their packages, handbags, vehicles, or other possessions are therefore subject to search at any time before being allowed to enter any area of the hospital premises. No one will be permitted to enter the area if, upon Department of Public Safety officer or staff request, he/she refuses to allow a search of person, packages, handbag, vehicle or other possessions. The thoroughness of the search is discretionary and will be determined by the nature of the reason for the search and the level of potential risk.

CMHIP respects confidentiality and privacy of patients. Searches will be conducted in a dignified and respectful manner, and in private, when possible. Respect for privacy will not be construed as a right to privacy, however.

The purpose of this policy is to describe when, in the interest of patient, staff and public safety and of further improving security (e.g., the prevention of contraband being introduced into any area, to include patient care and security areas), searches of the premises, staff, visitors and patients are conducted.

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include Department of Public Safety, Clinical Program Directors, Admissions and unit staff.

III. PROCEDURE

A. Emergency Searches by Department of Public Safety

The Department of Public Safety (DPS) will conduct searches of any area, individuals, packages, handbags, vehicles, or other possessions on the grounds of the CMHIP under the following emergent circumstances:

1. There is probable cause to believe that the search will uncover drugs, weapons and/or contraband determined to be dangerous by the Superintendent, or the individual appointed to act for him/her.

2. The Superintendent, or designee, directs the Chief of the Department Public Safety, or the Command Officer on duty, to conduct the search, and issues a verbal consent to search at that time.

B. Searches of Patients at Admission to CMHIP

1. An officer from DPS will thoroughly inspect the patient's property for weapons and other contraband, and conduct a touch search of patients admitted to CMHIP. The search will be performed at Admissions in either Building 125 or Building 140 by the DPS. DPS will also use a handheld metal detection device ("wand") during this search. The search will be documented on the Admission Summary, Form 190, page 1of the CMHIP Public Safety section by DPS officers in Admissions.
2. Another search and complete inventory of the patient's property also will be completed by staff on the units.
3. Searches may include the use of a canine(s) trained in the detection of drugs or other items determined to be dangerous.

C. Searches on Patient Care Units

1. Each CMHIP patient care unit and each area frequented by patients (e.g., Recreation Center, Treatment Mall, waiting areas in ancillary departments) will be searched at least once a month. Searches will be randomly scheduled in order to avoid a detectable pattern emerging. The search will be documented on the CMHIP Unit Search Form (form 1301).
2. Unit staff will search the patient's belongings when the patient arrives on the unit from Admissions. If unit staff find contraband that went undetected during the search performed in Admissions, they will confiscate the contraband per CMHIP policy 32.12, Declaration of Contraband, and fill out an Incident Reporting Form, form 1300.
3. Visitors to patient care units are required to leave items (that are not brought for patients), e.g., bags, purses, cell phones, etc., locked in the trunk of their vehicles or in the storage lockers provided on units. Any personal items brought onto patient care units including jackets and coats will be subject to search by either DPS officers or unit staff. Staff will ask visitors to leave coats in storage lockers; and to empty their pockets if they wear jackets. Units will post notices of these requirements in areas where visitors enter the premises.
4. Unit staff must search any item brought to patients by visitors before the patient is permitted to keep the items and the items must be documented on the Clothing/Property/Medication Record, form 375. Items brought to the patient may not exceed the maximum number of items allowed by the unit for that patient. Items currently in possession of the patient may be exchanged for items brought in by visitors and will be documented on the Clothing/Property/Medication Record, form 375. (See CMHIP policy 18.25, Patient Property.)
5. If linen is missing or has been tampered with at the time of exchange, it will trigger a room search and/or a further inspection of patient linens.

D. Searches of Patient Rooms

1. Staff may search patient rooms at any time on a routine or emergent basis. Reasons that an emergent search may be conducted include, but are not limited to, suspected or reported possession of contraband, suspected illicit drug or alcohol or tobacco use, other concerns for patient safety and security, and missing property, tampered with/defective equipment, or kitchen utensils.
2. Patients will not be permitted to remain in the room when the room is searched.
3. At least two staff will be present when conducting a search of a patient's room.
4. Searching a patient, patient's room or belongings is considered a clinical intervention; thus, clinical staff will complete the search and may be assisted by DPS officers. Clinical staff will address any concerns patients might have about searches. DPS officers will assume responsibility for handling and documenting any contraband, including illicit drugs, alcohol, stolen property or kitchen utensils. Clinical staff are responsible for removing excess property from the patient's room if the patient has exceeded the allowable amount and documenting on the Clothing/Property/Medication Record, form 375. (See CMHIP policy 18.25, Patient Property.)
5. If a patient has envelopes, paper bags or packages in his room containing correspondence from the patient's attorney, the patient will be required to empty the contents of the envelope, bag or package in front of staff, who will inspect the contents to see that only papers are contained therein, and not items that the patient might wish to hide from staff.

E. Other Searches

1. In general, room searches are completed when a patient is placed on suicide precautions (Levels I and II) and when the patient is placed in seclusion open door restraint, or forensic restriction.
2. When a patient is transferred to a different unit, both the sending and receiving teams will complete a search of patient and his/her property. Any items not permitted on the receiving unit will be removed from the patient's possession and complete a new property record, form 375, per CMHIP policy 18.25, Patient Property.
3. Patients discharged to CMHIP from outside hospitalization are required to be seen in Admissions before returning to units. The Admission search procedure is carried out for patients returned from outside hospitalization.
4. A basic search will include at least a pat down of the person by a DPS unit officer, or if DPS is not available, a staff member of the same gender, including checking pockets (staff should wear gloves), removal and inspection of hats or head coverings and shoes, and checking around waist bands and areas of elastic (including stockings and bras) in the clothing being worn at the time.
5. More thorough searches of persons might include the use of a metal detecting wand. A more thorough search of property might include carefully checking

inside the item, e.g., radio, battery compartment, etc. A search may include unit staff viewing DVDs or listening to CDs/audiocassettes prior to making them available to the patient. Staff will take reasonable care not to damage items during searches.

6. In some circumstances, patients might be subject to removal of clothing and placement in a hospital gown or suicide gown.
7. Staff may be subject to a search when the Department of Public Safety determines it to be warranted. At no time may staff or visitors bring cell phones, audio/video recording devices and cameras onto HSFI units unless authorized to do so.
8. Refer to CMHIP Policy 14.30, Body Cavity Searches for directions should such a search be required.

F. Inspecting Patient Mail and Searching Packages

1. Letters and packages sent to patients must be opened in the presence of staff, who will verify the contents are not contraband. If prohibited items are detected, staff will confiscate the items, and return the items to the sender at the patient's expense.
2. If the items sent in the package cause the patient to exceed the amount of property allowed on the unit, the items may be returned to sender at the patient's expense, placed with the patient's other property, or exchanged for other items in the patient's possession.
3. All mail addressed to Department of Corrections (DOC) patients will be examined for contraband by the DOC mailroom staff at the San Carlos Correctional Facility before delivery to HSFI. Money and packages will not be delivered to DOC patients. If an article is returned to sender or not released to the patient, DOC will be responsible for informing the patient as to why mail was withheld (contraband, no return address, etc.).

_____ _____

William J. May Date
Superintendent

SECTION – Environment of Care
Security Management

POLICY NO. 32.14

Effective Date: 5/14/14

TITLE: KNIFE, UTENSIL, AND FLATWARE ACCOUNTABILITY

This replaces policy 32.14, dated 4/20/11.

I. DEFINITION/PURPOSE

It is the policy of CMHIP, Nutrition Services Department to account for knives, utensils and flatware (controlled tools) used in preparation and serving of meals in all dining rooms, North Kitchen, and General Hospital Kitchen (GHK) Catering.

The purpose of this policy is to provide guidelines that all employees must follow when working with knives, utensils and flatware.

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include all Nutrition Services Department staff, Department of Public Safety (DPS), unit staff, Division of Facilities Management (DFM) and Housekeeping.

III. PROCEDURE

A. Nutrition Services Areas

1. DINING ROOMS: Each dining room has a secure area for controlled tools that is locked, when not in use. All employees must follow the specified procedure for recording data on count sheets and securing the area in which they are working. It is each employee's responsibility to make sure he/she knows the procedure for each area assignment.
   a. Counts are recorded on the Knife and Utensil Count (form #04) or the Hawkins Building Kitchen- Utensil Count. The forms are an inventory list of items supplied to each unit. It is kept on the dining room clipboard. The actual number of items counted is written in each box on the form. Each week when the form is completely filled it is then inserted in the daily envelope.
   b. Controlled tools are counted by the A.M. and P.M. Dining Services workers.
      1) Dining Room knives and utensils, including thermometers, are counted at 6am, 10am, 3pm, and 7pm.
      2) In Hawkins Building Kitchen, preparation and serving utensils are counted at 5:30am, 10am, 2pm, and 7pm.
      3) CMHIP Nutrition Services Security Management: The Meal Service Flatware Grid (form #10) identifies the type and amount of flatware per dining room.

4) Nutrition Services staff and unit staff count all flatware before and after each meal, documenting on the Flatware and Adaptive Equipment Count (form #12). Flatware is also counted before and after running through the dish machine. This flatware is kept in the locked area when not in use.

5) When a tray is prepared as a dayhall tray, disposable flatware is provided. Unit staff are responsible for the flatware after it leaves the dining room. In the Hawkins Building satellite dining rooms, the plastic flatware will not be counted.

6) Missing or lost tools will be reported and an Incident Report (form 1300) completed. (See Section C. Missing, Lost, or Unaccounted Tools.)

c. It is the responsibility of the Cook on duty to lock all drawers, cupboards, and refrigerators where controlled tools are kept when Nutrition Services workers are not in the dining room. Examples: lunch breaks, when attending in-service education, and when the dining room is closed for the day.

d. The Hawkins Building Kitchen shadow box is never left unlocked.

e. **NO** serving utensil, knife, or eating utensil will be loaned to unit staff for a patient or employee activity. Unit staff may bring the food item to the dining room preparation area and Nutrition Services staff will use the tool as needed if time allows.

2. NORTH KITCHEN: The following six areas count and record controlled tools independently. The completed count sheet for each respective area count is filed with the daily paperwork.

a. Conventional (Form #07) - counts 3 times a day.

b. Vegetable Prep (Form #09) - counts 3 times a day.

c. Bake Shop (Form #02) - counts 3 times a day.

d. Diet Kitchen (Form #03) - counts 3 times a day.

e. Store Room (Form #08) - counts 4 times a day.

f. Cleveland (Form #06) - counts 3 times a day.

3. GHK CATERING: These tools are used for preparing and serving catering events only. They are kept locked in refrigerator A106 when not in use.

a. Knives and utensils are counted in the a.m.

b. Catering staff or the relief is responsible for counting knives and utensils daily.

c. The employee doing the count will place his/her initials and time counted on the Knife and Utensil Count – GHK form (Form #05).

B. Searching for Flatware, Utensils, or Knives

1. Missing flatware at meal service

a. Unit staff are told of the missing/short count and are given gloves to recount flatware in the dining room.

b. Patients will remain in the dining room during the search.

c. The cook is notified and all dining room staff become involved in the search.

d. If still not located and it is suspected the utensil is in the dining room trash receptacle, the unit staff person with the key for the trash receptacle or Housekeeping have the ability to unlock the trash receptacle for searching.

2. Missing or lost utensils or knives

   Dining Room employees will search work area thoroughly including boxes, drawers, shelves, under cabinets, reach-in refrigerators, walk-in refrigerator, freezers, and take apart the dish machine, etc.

3. Searching trash and garbage containers is not recommended. However, trash containers in the food preparation areas are not locked and careful transfer of trash to an empty container, while searching for the item, would be allowed.

4. Unit staff may call DPS to provide a wand for searching patients, not trash or equipment.

5. A Dining Room employee will document in the communication book as to the status of the tool (damaged, in need of replacement, or unaccounted).

C. Missing, Lost, or Unaccounted Tools

1. Dining Room 137 and Hawkins Building Kitchen
   a. The loss of any utensil is reported to DPS, the Building Manager, unit Lead Nurse, and the Nutrition Services Supervisor or Manager on Duty immediately when identified as missing.
   b. If the tool is found, DPS is notified immediately that it has been found. If the supervisor or the Manager on Duty is available, this should be done through him/her.
   c. When the supervisor or the Manager on Duty is not available, the employee who discovers the loss or finds the utensil is to report it to DPS.
   d. The supervisor or the Manager on Duty will notify the Director of Nutrition Services about the incident.
   e. The cook who served the meal will complete an Incident Report and fax per form instructions.
   f. Employees are not to go off duty when a utensil is missing without permission from their supervisor and/or making a statement to DPS, and/or passing on all pertinent information to the Charge Nurse or his/her designee.

2. Dining Room 106, 115, 116 (67, CORe), GW1, Circle, and North Kitchen Areas
   a. Dining Room employees will take 30 minutes to search for the missing knife or tool. If not found after 30 minutes, the Dining Room Cook will notify the supervisor or the Manager on Duty, and DPS.
   b. If tool is found, and others were notified, re-notify DPS immediately that it has been found. If the supervisor or the Manager on Duty is available, this should be done through him/her.
   c. The supervisor or the Manager on Duty will notify the Director of Nutrition Services about the incident.

d. If the tool is not found, the Cook who served the meal completes an Incident Report (located in the forms folder) and faxes the form per instructions on the form.

e. The Dining Room cook will document the status of the tool in the communication book.

f. Employees are not to go off duty when a knife or utensil is missing without permission from their supervisor and/or making a statement to DPS, and/or passing on all pertinent information to the Charge Nurse or his/her designee.

3. GHK - Catering

a. The GHK catering employee will check the count sheet, and search the area

b. The GHK catering employee will contact the catering employee from the previous shift for information

c. If the tool is still not found, the catering employee will notify the supervisor or the Manager on Duty, and DPS. An Incident Report will be initiated by the catering employee and faxed per form instructions.

D. Disposal of Defective Controlled Tools or Tools No Longer in Use

1. Any knife, utensil, or flatware that is broken, has a cracked handle, or is worn out is to be turned in to the respective Dining Room Manager for exchange and disposal.

2. The Hawkins Building Kitchen Manager notifies the Chief of DPS for approval when a tool needs to be taken out of the Hawkins Building. The Chief of DPS must approve the replacement tool or any controlled tool being brought in to the Hawkins Building.

3. The Dining Room Manager will document the status of the tool in the communication book.

4. The Dining Room Manager will take the tool to the North Kitchen Manager on duty for disposal.

5. North Kitchen Manager will wrap the item to be disposed with masking tape and take it to DFM for final disposal.

6. The Dining Room Manager will provide a replacement tool.

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William J. May Date
Superintendent

SECTION – Environment of Care
Security Management

POLICY NO. 32.15

Effective Date: 6/11/14

TITLE: OFF-UNIT TRANSPORT OF PATIENTS, AND POLICE ESCORT LIST PROCESS

This policy replaces policy 32.15, dated 7/27/11.

I. DEFINITION/PURPOSE

It is the policy of CMHIP to transport patients in a safe, secure, and humane manner, in accord with CMHIP's legal obligations to the courts.

The purpose of this policy is to clarify when the use of restraint is appropriate during patient transport.

DEFINITIONS

Voluntary patient means a person who is not under a civil commitment status and is not under a commitment from the criminal courts or the juvenile courts.

Civil-Commitment patient means a patient whose **only** type of commitment is certification under Title 27, Article 65, C.R.S., such as an M-1, a short-term or long-term certification.

Forensic patient means a patient who has criminal charges pending or is serving a jail or prison sentence. These patients have detainers that require CMHIP to return the patient to jail or prison rather than discharge the patient to the community. This status includes juveniles who came from a Division of Youth Services facility and have a detainer from that facility. Other patients admitted to CMHIP can also be committed as forensic patients under C.R.S. Title 16, Section 8. (Note that some forensic patients may reside on 67, CORE unit. They remain classified as "forensic patients" because they have detainers and are committed under the criminal code.)

Physical Restraint for Transportation means the mechanical devices that are approved for use by the Executive Committee of the hospital. These include RIPP restraints, leather ankle restraints, leather wrist to waist restraints, or key-cuff nylon restraints.

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include all treatment staff and Department of Public Safety (DPS) officers.

III. PROCEDURE

A. Transport of Voluntary or Civil Commitment Patients

1. Patients on voluntary or civil commitment status will be transported in physical restraint if they meet the criteria for restraint using approved devices, as set out in Policy 6.45, Seclusion and Restraint, and have a physician's order authorizing the use of restraint and completion of required documentation on form 206sr, Behavioral Emergency Record.

2. DPS transport officers may be called to assist with transport of these patients. Treatment unit staff will apply the appropriate type of restraint, as directed by the physician's order, and will accompany the DPS officer during the transport. During transport, the unit staff person will monitor the patient and complete the required restraint documentation.
3. If a voluntary or civil-commitment patient engages in violent actions during a transport, DPS officers may apply restraints to assume custody, for the protection of the patient and/or the public.

B. Transport of Patients on Assault II Precautions or Suicide Precautions, levels I and II.

Unit staff will accompany patients who are on these precautions, even if the patient is transported by DPS. Civil commitment patients on these precautions will not be restrained unless they meet the criteria for restraint, as set out in Policy 6.45, Seclusion and Restraint, and have a physician's order for restraint.

C. Transport of Forensic Patients

DPS will transport forensic patients in physical restraints in accord with DPS internal guidelines and policies. Forensic patients residing on the Geriatric Treatment Center generally are not transported in restraints.

D. Police Escort List: Some patients require additional security measures (e.g., escort by Hospital Police officers). They should be placed on the Police Escort List.

1. The Director of Court Services or designee will alert the Chief of Public Safety, the Admissions Department, and the Clinical Team Leader/Coordinator of the team that is receiving the patient that the treating physician should consider ordering that the patient be placed on the Police Escort List.
2. If the physician writes such an order (only needed once per patient's admission), the charge nurse will notify the Clinical Team Leader/Coordinator, who maintains the Police Escort List. Transport of patients on the List will be done according to DPS internal guidelines. Treatment staff will assist with transport if requested to do so by DPS.
3. Patients must be assigned to a maximum-security unit unless they are removed from the Police Escort List by physician order.

E. Transport to Jail or other Detention or Correctional Facilities

When making an arrest or carrying out other law enforcement duties, DPS officers may use other types of restraint, in accord with Centers for Medicare and Medicaid Services (CMS) regulations and DPS policies and standard law enforcement practices.

SECTION – ENVIRONMENT OF CARE
SECURITY MANAGEMENT
POLICY NO. 32.20

Effective Date: 8/14/13

TITLE: GUIDELINES FOR NON-CMHIP SECURITY, SAFETY AND CRIMINAL JUSTICE PERSONNEL

This policy replaces 32.20, dated 2/23/11.

I. DEFINITION/PURPOSE

It is the policy of the Colorado Mental Health Institute at Pueblo (CMHIP) to provide visitors and non-CMHIP staff who provide clinical services with information about events or activities that may support or be detrimental to the therapeutic goals of patients.

The purpose of this policy is to describe the orientation process and responsibilities of non-CMHIP staff as it relates to interaction with patients, responding to unusual events, channels of communication, the use of security restraints, and use of seclusion and restraint for clinical purposes while on the CMHIP campus.

Non-CMHIP staff who provide clinical services are defined as correctional officers, guards, security officers, criminal justice agencies and other entities that conduct official business with patients or staff.

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include the staff of the Department of Public Safety, Communication Center and Admissions.

III. PROCEDURE

All non-CMHIP clinical staff shall be educated about their responsibilities as they relate to patient care. The primary method of education will be through an educational brochure entitled "CMHIP Guidelines for Visitors, Non-CMHIP Security/Safety and Criminal Justice Personnel." The brochure will address four specific areas, which include 1) interaction with patients; 2) response to unusual events or incidents; 3) CMHIP's internal channels of communication, and 4) security restraints.

A. Orientation

1. All non-CMHIP clinical staff will be oriented to the hospital about the four areas of responsibility.
2. An educational brochure will be provided along with an opportunity for questions and answers by CMHIP staff responsible for implementation.
3. Supplies of brochures will be available at the Department of Public Safety, Admissions, Communication Center, and the security stations of CMHIP.

B. Education regarding responsibilities related to patient care

1. Interactions with Patients

The following guidelines will be presented to visitors, non-CMHIP security/safety and criminal justice personnel for interacting appropriately with patients.

Guidelines for Interacting with Patients

- Provide the fullest possible measure of **privacy and confidentiality** to persons undergoing care and treatment for mental illness. Always maintain a professional and ethical relationship when interacting with patients.
- As a general rule, relate and talk to patients as you would with any person. Be courteous and respectful, direct and honest. Never patronize or "talk down to a patient." Treat them as your equal and insist that they do the same.
- Do not ignore patients or act as if they are invisible. Minimum courtesy would be to respond with a smile, nod or "Hello" or "Good Morning."
- If a patient appears to be angry or upset, provide space to the patient. Do not make any sudden moves or touch the patient. If members of the patient's treatment team are not present to intervene, stay calm and use the nearest telephone to **dial 4911 or "6"** to obtain assistance from the Department of Public Safety. Identify who you are, your location and the presenting problem.
- Do not talk to patients about their delusions, hallucinations or ask information that is considered confidential and treatment related. If the patient tries to engage you in such a conversation, instruct him/her to talk to someone on his/her treatment team.
- Do not share personal information with patients. Politely discourage patient's efforts to obtain personal information.
- Do not engage in any exchange of money, cigarettes, gifts or items considered to be contraband with patients. Introduction of contraband on State property is considered a felony and may be prosecuted to the full extent of the law.
- Always wear your nametag or badge. Visitor badges are available from the Department of Public Safety.

2. Responding to Unusual Clinical Events or Incidents and Proper Channels of Communication

The following information will be provided regarding what steps to take in the event of an unusual circumstance as well as other procedural matters.

Responding to
Unusual Clinical Events or Incidents

Emergency Assistance Phone Numbers
4911 or "6"

In case of an emergency, call the CMHIP Department of Public Safety at **4911** or **"6"** on any phone on the CMHIP campus. Report any medical emergency, criminal or suspicious activity to the Department of Public Safety.

In case of fire, pull the nearest fire alarm, **dial 4911 or "6",** provide information regarding location, extent of emergency and evacuate.

CMHIP Main Number ----------719-546-4000
Superintendent----------719-546-4147
Department of Public Safety---------719-546-4281
Public Information Officer----------719-546-4388

Interviewing Patients

Approval from CMHIP's Department of Pubic Safety, treating physician and treatment team must be obtained before interviewing any patient.

Contraband

Pursuant to 18-8-203 and 204, C.R.S., weapons, alcohol or illicit drugs are not allowed on the CMHIP campus. A copy of the contraband policy may be obtained at CMHIP's Department of Public Safety.

Firearms

Peace Officers and Security Officers who are armed are required to secure their firearms prior to entering Admissions, any clinical area or Security Station. Firearms will be secured in lock boxes located near the Communications Center on the west side of Building 125 as well at the Hawkins Building, Building 140.

Motor Vehicles

Please park in designated areas. DO NOT PARK IN FIRE ZONES. Turn off and lock unattended vehicles. Remove or secure items left in truck beds (tools, sharps, shovels, etc.).

Tobacco Use

The use of cigarettes, cigars, chewing tobacco, or other tobacco products is prohibited on the CMHIP campus (see CMHIP policy 32.00, Tobacco-Free Environment). All tobacco products should remain locked in personal vehicle.

3. Distinctions Between Security Restraints, and Seclusion and Restraint for Clinical Purposes

The use of security restraints and seclusion and and/or restraint for clinical purposes of CMHIP patients have distinct purposes.

Security Restraints

All personnel who transport individuals who are a security risk and/or in security restraints to and from the Colorado Mental Health Institute at Pueblo, will provide constant supervision and monitoring of the individual for safety and security purposes. Patients may never be locked in a room alone.

Security restraints are mechanical restraints and used on inmates or those facing serious criminal charges to provide security and safety while transporting. Some examples include:

- Department of Public Safety officers' use of security restraints while escorting a forensic patient to court.
- Security restraints applied on inmates to transport individuals from security areas to jail.

Seclusion and Restraint Used for Clinical Purposes

Clinical seclusion is the confinement of a CMHIP patient in a room or restricted area initiated by any qualified CMHIP treatment staff in an emergency situation to insure safety of the patient and others when less restrictive interventions have failed.

Clinical restraint is the use of physical or mechanical devices to restrain movement of the whole or portion of a patient's body as a means of controlling a patient's physical activities in an emergency situation to protect the patient or others from injury when less restrictive interventions have failed. Only qualified CMHIP treatment staff may initiate clinical restraint.

4. Interviewing of CMHIP Patients and Employees

Cooperation with outside law enforcement agencies, such as the 10th Judicial District Attorney's Office, Pueblo Police Department, Pueblo County Sheriff's Department, and the Colorado State Patrol is vital to the overall effectiveness of any law enforcement unit.

To this end, CMHIP will assist outside law enforcement agencies in interviewing CMHIP employees and patients when this action is indicated. The following procedures shall apply:

a. These agencies will contact the CMHIP Department of Public Safety and inform them of the incident or reasons for this interview before contacting the employee or patient and arranging for the interview.

b. CMHIP Department of Public Safety will make every effort to have these interviews set up in such a manner as to avoid any embarrassment or inconvenience to the employee or patient and to ensure the presence of a CMHIP Department of Public Safety representative during the interview, if the employee or patient so desires.

c. The employee or patient has the right to have an attorney present. This practice has proven to be mutually beneficial. Each request will continue to be evaluated on the merits of the incident or case presented.

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William J. May Date
Superintendent

SECTION – ENVIRONMENT OF CARE
SECURITY MANAGEMENT

POLICY NO. 32.21

Effective Date: 12/11/13

TITLE: ROBERT L. HAWKINS BUILDING (HAWKINS BUILDING) KEY AND PROXIMITY CARD ASSIGNMENT AND MANAGEMENT

This replaces policy 32.21, dated 4/19/11.

I. DEFINITION/PURPOSE

It is the policy of CMHIP to provide adequate security and safety for CMHIP patients, staff, and visitors. The Robert L Hawkins Building (referred hereafter in policy as Hawkins Building) key and proximity (prox) card systems are a significant part of the integrated security of the Hawkins Building.

It is the purpose of this policy to describe the procedures for Hawkins Building key and prox card assignment and management.

II. ACCOUNTABILITY

Any CMHIP employee who enters the secure areas of the Hawkins Building (that is, past the Department of Public Safety [DPS] Control Center) must wear and use a prox card. Proper use is discussed below.

III. PROCEDURE

A. Setting up Prox Cards and Key Access for the Hawkins Building:

1. The Hawkins Building Manager, or designee, determines what type of key or door access to assign to an employee, and notifies DPS of the access granted to each employee. The Program Chief Nurses (PCN) will approve prox cards and key access for the Department of Nursing employees.

2. DPS enters the information into the Global Facilities Management System database and issues a prox card to the employee.

B. Employee Use of Prox Cards, for Building and Key Box Access

1. Employees' prox cards serve three purposes:

   a. Timekeeping – the prox cards can be "swiped" through the Kronos readers.

   b. Access to areas of the Hawkins Building – the prox cards open doors in areas to which the Hawkins Building Manager, PCN and/or the DPS has granted access.

   c. Key Boxes – for some employees, the prox card opens a key box and allows the employee to remove a key set designed for his/her work assignment.

2. Prox cards must be worn at all times, with the employee's photo facing away from person's body and above waist level. .

3. Employees entering the secure areas of the Hawkins Building will pass through the Control Center, operated by DPS correctional security officers. These officers will check to be certain that each employee is wearing a prox card.

4. Employees must scan their prox cards at the reader upon entering Door D100 in Building B. The reader is located on the wall to the right, at the entrance of Building B. This scan places the employee on the roster of persons in the building. **If an employee fails to scan his/her prox card at this location, the employee will not be able to open doors or key boxes within the Hawkins Building secure areas.**

5. All employees must scan their prox cards on their way out of the secure facility, at the same location (Door D100, Building B). **Employees cannot re-enter the building unless they have scanned their prox card ("electronically signed out") at Door D100.**

C. Use and Management of the Hawkins Building Key Sets

1. Keys are checked out for an employee's use during a shift. They must be returned to the key lock box at the end of the employee's shift.

2. Employees who have been granted key access can swipe their prox card at the key lock box area and remove their designated key sets. When the box opens, the key sets available to the employee will light up. To release the desired set of keys from the lock box, turn the key set toward the left to a horizontal position, and then remove it from its lock.

3. **The key set must be properly returned.** Key sets have a tag with a number on them. The proper slot for return of the key set will have the same number on it. Open the lock box with employee's prox card, and insert the key set in the same "horizontal left" position, and then turned right so it is vertical. This will lock the key set in place, ready for the next user, and will register in the key security system that the employee has returned the key set.

4. Problems to avoid: If the key is returned to a lit, open lock that is not the same number as the key set, the system will report that the employee did not return the key set. If the key set is inserted into an open lock that was not lit after using the prox card, the key set cannot be turned into the vertical position to lock, leaving it accessible to unauthorized individuals.

D. Key Security Breaches

The misuse of the HawkinsBuilding keys constitutes a security breach. Security breaches are violations of CMHIP policy and procedures, and may result in progressive discipline or assignment of costs.

Listed below are some activities that compromise the Hawkins Building security systems and thus are prohibited:

1. Removing the Hawkins Building key sets from the Hawkins Building. Removal of key sets from the building can result in loss and/or in unauthorized individuals possessing keys allowing them access to a high security area.

2. Transferring key sets directly from one employee to another at, for example, shift change. The employee who removed the keys from the key box will be shown on record as continuing to possess (and be responsible for) the key set.

3. Inserting the key set into the incorrect lock in the lock box. This can block another employee from obtaining the appropriate key set, and registers in the security system that the employee who inserted the key is still in possession of (and responsible for) the key set.

E. Pool Staff, Temporary Employee Access, and Forgotten Prox Cards

1. DPS staff in Central Control will issue the employee a temporary prox card giving him/her access to the appropriate area and key boxes. The staff member must provide a Colorado driver's license or State-issued identification card, or other acceptable government-issued identification as approved by the Chief of Public Safety or the Chief's designee.

2. If an employee comes to work without his/her prox card, Central Control will call the unit supervisor on duty, who will approve a temporary prox card if appropriate.

3. Employees must return temporary prox cards to the Hawkins Building Central Control area when the employee leaves the Hawkins Building.

F. Damaged or Lost Prox Cards

1. Notify the DPS immediately if a prox card is lost.

2. Notify DPS immediately if the prox card is damaged and it will not work. A prox card may be damaged by pinning something to it, leaving it in a hot car, running it through the washing machine or dryer, or placing it long-term next to other magnetic cards or other computer chips.

3. In the case of lost or damaged cards, the correctional security officer working in Central Control will immediately deactivate the prox card.

4. Cards can only be reactivated and/or reissued by DPS. Employees must pay a fee of $25.00 to reissue a prox card. Employees will not be charged for damage from normal wear.

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William J. May Date
Superintendent

SECTION - ENVIRONMENT OF CARE - SECURITY MANAGEMENT

POLICY NO. 32.22

Effective Date: 12/12/12

TITLE: EMPLOYEE, STUDENT, VOLUNTEER, AND VISITOR IDENTIFICATION

This policy replaces CMHIP policy 32.22, dated 2/24/10.

I. DEFINITION/PURPOSE

It is the policy of CMHIP to promote safety and security by establishing procedures by identifying persons on the CMHIP campus.

The purpose of this policy is to provide the means of identifying Colorado Mental Health Institute at Pueblo (CMHIP) and CDHS Southern District employees, students, volunteers, contractors and visitors.

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include all state employees at the Colorado Mental Health Institute at Pueblo.

III. PROCEDURE

A. The Department of Public Safety (DPS) will issue all CMHIP and CDHS Southern District Employee Identification Badges. All identification badges will display:

1. Photo
2. First and Last Name
3. Employee's Position

B. If a "Proximity (Prox)" identification badge is misplaced or damaged, the employee is responsible for the replacement cost of $25.00. Proximity badges are more susceptible to damage and exposing the badge to any of the following should be avoided so that staff do not incur a charge to replace the badge:

1. Melting has occurred when badges were exposed to heat or direct sunlight, e.g., left in vehicles, washed, dried in dryers (which destroys Kronos capability and the Prox computer chip).

2. Puncturing the cards with employee length of service or other pins can destroy the Prox card antenna, computer chip or Kronos bar code.

3. Repeated swiping in Kronos machines scratches off the barcode, which destroys Kronos capability**.** However, the employee will not be charged for normal wear.

C. An identification badge shall not be issued to patients, DOC inmates or any other person receiving care.

D. CMHIP and other State of Colorado employees will display their identification badge above the waist with photo and name in plain view while on the grounds of the Colorado Mental Health Institute at Pueblo.

E. While on the CMHIP grounds, students and volunteers must wear name tags displaying first and last name that identifies them as a student or volunteer unless the school-issued badge displays only the first name and the first initial of the last name.

F. All CMHIP and CDHS Southern District personnel shall stop and question any unidentified person in their area. Any person not wearing a CMHIP identification badge is considered a "stranger."

IS THAT STRANGER A DANGER?

Do approach strangers in your area.
Ask if you can be of assistance.
Note anything out of the ordinary.
Give information or assistance if needed.
Evaluate what you see and hear.
Report suspicious circumstances to Public Safety.

G. Visitors on the grounds of CMHIP will be assisted by staff in the area. If the visitor requests a patient visit, unit procedures will be followed.

H. Official visitors may visit the grounds of CMHIP. Official visitors include, but are not limited to, members of regulatory agencies, reviewers from managed care organizations and mental health centers, elected officials, members of other State of Colorado agencies, attorneys/investigators, and private investigators.

I. If an official visitor without a state-issued or school-issued identification badge comes onto the grounds of CMHIP, staff shall immediately:

1. Notify DPS of the visitor.
2. Give DPS the name of the visitor and organization he/she represents.
3. Give DPS the reason for the visitor being on CMHIP grounds.
4. DPS may notify the Superintendent's Office or designee during normal business hours; or, after normal business hours, the Command Officer on duty will notify the Administrator on Call, when appropriate.
5. In the event that the official visitor is a regulator from CMS (Medicare), Joint Commission, Colorado Department of Public Health and Environment, Division of Behavioral Health, etc., Quality Support Services (QSS) is to be notified immediately per policy 24.10, External Reviews Protocol. QSS must also be immediately notified of all complaint investigations, records reviews and utilization review activities by visitors. Reviewers shall be re-directed to QSS if they arrive at the units unannounced.

J. Upon clearance, the visitor will be issued an Official Visitor Identification Badge by the Department of Public Safety, after providing proper identification.

K. CMHIP staff members will escort all visitors while in patient care areas at all times.

L. Upon completion of the visit, the Official Visitor Identification Badge will be returned to the Department of Public Safety.

M. Contractor Badges

1. Contract personnel performing maintenance and repair services for the Division of Facilities Management (DFM) will obtain a "Contractor" badge from DFM.
2. A contractor badge will be provided only after the contract employee passes a background check coordinated between DFM and DPS.
3. The Contractor badge must be worn by contractor employees while performing services on the CMHIP campus
4. DFM will ensure that contractors return badges to DFM at the end of the project.

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William J. May Date
Superintendent

SECTION – ENVIRONMENT OF CARE
SECURITY MANAGEMENT

POLICY NO. 32.23

Effective Date: 6/13/12

TITLE: SECURITY ACCESS CONTROL

This replaces Environment of Care policy SEC-16 dated 5/1/00.

I. DEFINITION/PURPOSE

It is the policy of CMHIP to exercise prudent management of state resources, and to provide adequate security and safety for CMHIP patients, staff, and visitors.

It is the purpose of this policy to describe the procedures for managing and replacing CMHIP keys and proximity access management systems including proximity cards.

Proximity access management systems are defined as any electronically controlled system that restricts access to a specific location or piece of equipment. These systems either require the input of a Personal Identification Number (PIN) or the use of a proximity (prox) card or badge to release an electronically controlled lock to gain access to the location or equipment.

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include all CMHIP and CDHS staff working on the CMHIP campus.

III. PROCEDURE

A. Individual Keys/Prox Cards

Individual keys/prox cards open a door or group of doors within a particular room, area, or unit. Individual key/prox card requests will be approved by the respective Division Director or the Department Head in charge of each room, unit, or area. A properly signed Key Request Card or E-Mail authorization is required to give the Department of Public Safety (DPS) Office authority to issue the requested individual key/ prox card.

B. Sub-master Keys/Prox Cards

Sub-master keys/prox cards open all locks for an individual floor or unit. A Sub-master key/prox card may be referred to as a "Building Master." Sub-master keys/prox cards will be approved by the respective Division Director or Department Head in charge of each floor or unit. A properly signed Key Request Card or E-Mail authorization is required to give the DPS authority to issue the requested Sub-master key/prox card.

C. Master Keys/Prox Cards

Master keys/prox cards open appropriate locks for a specific program (i.e. IFP or GAAPS) utilized by a department or division. Master keys/prox cards will be approved by the respective Division Director or Department Head. A properly signed Key Request Card or E-Mail authorization is required to give the DPS authority to issue the requested Master key/prox card.

D. Grand Master Keys/Prox Cards

1. Grand Master Keys open most locks in all CMHIP buildings except for HSFI on the institute campus. The Superintendent, Assistant Superintendents, or CMHIP Medical Director, will approve the issuance of Grand Master keys. A properly signed Key Request Card or E-Mail authorization is required to give the DPS authority to issue the requested Grand Master key.
2. HSFI Grand Master Keys/prox cards open all HSFI locks except for the Pharmacy and egress exits into the building's secure perimeter.

E. Special High Security Areas

The keys to special high security areas (such as Pharmacy, dietary food lockers, med carts, Public Safety weapons storage, critical supply and storage areas) designated by the division/department head and the Chief of Public Safety will be issued subject to approval only by the division/department director, Superintendent, Assistant Superintendent, or CMHIP Medical Director, and the Chief of Public Safety.

F. Key and Prox Card Issuance Process

1. All keys and/or prox cards will be issued by the DPS to personnel who have an approved Key Request Card or E-Mail authorization. A computerized record of all keys issued will be kept in the DPS and will be maintained by the Identification/Investigations Officers. It is prohibited to duplicate issued keys.
2. Keys and/or prox cards will be issued from 8:00 a.m. to 5:00 p.m. Monday through Friday of each week with the exception of holidays.
3. Keys, which are to be placed on a unit or staff key ring for random use by multiple shifts will be signed for on a key card by the responsible person designated after authorization, by written memo or E-Mail, from the division/department director concerned.
4. In the event that the issuance of a key, keys, or prox card could result in a security risk or violation, the authorizing official will be notified and a decision as to the issuance or denial will be made, in concert with the Chief of Public Safety.

G. Issuance of Keys and/or Prox Cards to Students

1. Keys and/or prox cards issued to students will be authorized by the discipline chief of that entity, e.g., the Director of Nursing will be responsible for nursing students, etc.

2. Keys and/or prox cards will be issued from the DPS to each individual student after signature or E-Mail authority is received from the discipline chief concerned.

H. Issuance of Keys and/or Prox Cards to Non-CMHIP Personnel

1. Non-CMHIP personnel such as vendors (e.g., pop vendors, canteen services, laundry services, pest control, elevator services, telephone services, etc.) requesting keys and/or prox cards, must be approved by the responsible department head/project manager, and the Chief of Public Safety.
2. Requests for keys and/or prox cards by outside contractors for maintenance and construction will be authorized by the Southern District Director of Facilities Management and the Chief of Public Safety.

I. Lost Keys/Prox Cards

1. In the event a key/prox card is lost or stolen, the individual responsible for that key/prox card will immediately report the loss to the DPS as well as to their supervisor.
2. An Incident Form (form 1300) shall be completed as soon as possible after discovery that any CMHIP key has been lost.
3. The loss will be reported to the DPS, (open twenty-four hours a day seven days a week) by telephone (ext. 4281) with details as to building(s) and unit(s) affected. A police report/investigation will be completed.
4. The Superintendent, Assistant Superintendents, or CMHIP Medical Director in concert with the Chief of Public Safety and the Division of Facilities Management (DFM) locksmith will determine the extent of risk to security resulting from the loss, and decide what action may be necessary to preclude further security degradation. Possible actions include the following:

   - Locks may be changed
   - Current keys/prox cards may be recalled
   - New keys/prox cards may be issued

4. If lost keys/prox cards are properly reported, the employee will only be required to pay a deposit for his/her new key(s)/prox card. The deposit may be refundable upon receipt of the lost key(s)/prox card by the DPS. A Release Slip will be issued for acknowledgment of the approved refund to the Finance Department. Deposits on lost keys/prox cards are as follows:

   - Individual Key $50.00
   - Sub Master Key $100.00
   - Master Key $300.00
   - Grand Master Key $1000.00
   - HSFI Proximity Card $25.00

5. If the lost key(s) are kept on a unit or staff key ring for shared use by multiple employees or shifts, the last staff member assigned that particular key will be

responsible for payment of the deposit. The Division Director or designee will ensure payment of the deposit is made by the responsible staff member.

6. If the loss of a key(s)/prox card is not reported or is due to willful misconduct or negligence, the Superintendent, Assistant Superintendents, CMHIP Medical Director, or a CDHS Southern District Director may recommend that the employee be dealt with according to the provisions of the Colorado State Personnel Board Policies and Rules, which may include investigation of the theft of State property by the DPS.

J. Key/Prox CardTransfers

Key/prox card transfers are **NOT** permitted between individuals, with the exception of those keys designated for shared use by multiple employees or shifts.

1. If an employee is transferred from one department or division to another, he/she will return his/her key(s) to the DPS. DPS will verify the return of all assigned keys.
2. If a new key(s) is needed, a new authorization for key issuance will be issued by the respective Division Director or Department Head concerned by signature or E-Mail. New keys will not be issued until all previously assigned keys are returned and/or deposit payments for missing keys has been made.

K. Key /Prox Card Audits

1. The DPS may periodically call for the return of all keys/prox cards in a given area. This procedure may be necessary for several reasons, including change of occupancy, temporary construction, suspicion of unreported loss or other violations of institute security policy, and to facilitate rekeying an area after a lost key/prox card had been reported.
2. The DPS will notify the Division Director or Department Head concerned that a key/prox card audit is necessary.
3. New keys/prox cards will be issued according to Section III. F. of this policy. Old keys /prox cards will be returned as described below in Section III. L.

L. Key/Prox Card Return

1. When a CMHIP or CDHS Southern Districtemployee terminates employment on the CMHIP campus, all keys/prox cards for which he/she is responsible must be returned to the DPS on his/her last day of work. Public Safety will verify the return of assigned keys/prox cards.
2. If keys/prox cards are not returned to the DPS at the time of checkout, the employee's final paycheck will be withheld until the missing key(s)/prox card deposit is paid.

M. Requests for New Locks or Replacements

1. Requests for new locks or replacements of existing locks will be made through the DFM. This would include mortise locks, cylindrical or key-in-knob, tubular, keypad, and padlocks.
2. Lock repair services are available by contacting the DFM.

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William J. May Date
Superintendent

SECTION – ENVIRONMENT OF CARE
POLICY NO. 32.24
Effective Date: 9/12/12

TITLE: BUILDING SECURITY

This replaces CMHIP Policy 32.24, dated 8/26/09.

I. DEFINITION/PURPOSE

It is the policy of CMHIP to enhance the safety and security of the environment of care for all patients, staff, consultants, contractors, and visitors, by limiting access by uncertified persons, after normal business hours, on holidays, and on weekends to the Administration Building and adjoining buildings by unauthorized persons.

The purpose of this policy is to describe how the building complex of buildings 120, 121, and 125 exterior entrance/exit doors will be secured after normal business hours, on holidays, and on weekends.

II. ACCOUNTABILITY

Individuals responsible for implementing this policy are all staff, consultants, contractors, and all members of the Department of Public Safety.

If entrance/exit doors to a building are located within a department/division, it shall be the responsibility of the staff members on that department/division to ensure the entrance/exit doors to that building are locked and secured after hours, on weekends and on holidays.

III. PROCEDURE

A. The Security Manager will determine which exterior building entrances and exits of areas are to be secured after normal business hours, on weekends and holidays to limit access to the aforementioned buildings in concurrence with the Superintendent and department/division directors.

1. Normal business hours for buildings 125 shall be 6:00 a.m. to 6:00 p.m., Monday through Friday, weekends and holidays excluded.

2. Normal business hours for building 120 shall be 6:00 a.m. to 8:00 p.m., daily.

3. Normal business hours for building 121 shall be 6:00 a.m. to 8:00 p.m., daily.

4. Signs will be posted on each entrance indicating access times.

B. BUILDING 125

The Command Officer on duty shall ensure that the following exterior entrance/exit doors are locked and secured, or have been locked and secured, if the door is within the area of a department or division.

The entrances to building 125 shall be secured at 6:00 p.m. as follows:

a. The east entrance/exit (automatic) doors (B007 - B008) of building 125, 1st floor.

b. The east entrance/exit stairwell door (B240) to the surgical suite.

c. Quality Support Services south exit door (B233), 1st floor.

d. The west entrance/exit door (B-034) between the Department of Public Safety Office and Medical/Surgical unit, 1st floor.

e. The east entrance/exit door (B-222) near the Mailroom, 1st floor.

f. The Nutrition Services dock entrance/exit (automatic) doors (A126 -A127), basement floor (8:00 p.m.).

g. The west tunnel doors (A114) leading from the basement of building 125 to building 126. **NOTE: These doors will be locked from 8:00 p.m. to 6:00 a.m. only.**

h. The Quality Support Services double glass doors (B235 and B236).

i. The west entrance/exit (automatic) doors (B001-B002 and B003-B004) of building 125, 1st floor will be locked from 8:00 p.m. to 6:00 a.m. only.

C. BUILDING 120.

The Command Officer on duty shall ensure that the following exterior entrance/exit doors are locked and secure, or have been locked and secured if the door is within the area of a department or division.

The entrances to building 120 shall be secured as follows:

a. The east entrance/exit door (B-056) next to the Housekeeping office, Geriatrics East, 1st floor.

b. The east entrance/exit (automatic) doors (B062) of building 120, Geriatrics East, 1st floor. **NOTE: These doors will be locked from 8:00 p.m. to 6:00 a.m. ONLY.**

c. The east tunnel gate (A020A) under building 120 (8:00 p.m.).

d. The stairwell exit (B011), southwest, building 120.

e. The south Geriatrics dock doors (B086) between buildings 120 and 121, 1st floor.

f. The south Geriatrics dock linen door (B085), between buildings 120, and 121, 1st floor.

D. BUILDING 121.

The Command Officer on duty shall ensure that the following exterior entrance/exit doors are locked and secure, or have been locked and secured if the door is within the area of a department or division.

The entrances to building 121 shall be secured as follows:

a. The west entrance/exit (automatic) doors of building 121, Geriatrics West, 1st floor. **NOTE: These doors will be locked from 8:00 p.m. to 6:00 a.m. ONLY.**

b. The stairwell exit, southeast, building 121.

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William J. May Date
Superintendent

SECTION – ENVIRONMENT OF CARE
SECURITY MANAGEMENT

POLICY NO. 32.25

Effective Date: 9/10/14

TITLE: PERSONAL DURESS ALARMS IN HAWKINS BUILDING

This replaces policy 32.25, dated 3/12/14.

I. PURPOSE

It is the policy of CMHIP to utilize the Hawkins Building Personal Duress Alarm (PDA) system, which is a significant part of the integrated security of this facility.

The purpose of this policy is to describe the security procedures necessary for the optimal functioning of the PDA system.

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include Hawkins Building staff with assigned PDA devices, and any staff person who enters the secure areas of the facility.

III. PROCEDURE

A **PDA** is a device that can send the location of an employee wearing the PDA to the Central Control Station, and can emit an audible alarm when an employee needs emergency assistance. To do this, the PDA must be properly set up, activated, worn and operated.

If an employee fails to return or check in a PDA and it cannot be accounted for within 72 hours, the employee will be charged the replacement cost of $400.

A. Distribution

1. Each unit and department will have a set number of PDAs assigned which will be checked in and out and documented on the PDA Accountability Log. Each log will cover three shifts per day (unit) or one period of work (department). Staff will sign a PDA out/in using the log. The log will be reviewed, signed and collected by the Clinical Team Leader/ Coordinator or Department supervisor daily. The Hawkins Building Manager will collect the seven logs from the previous week from each unit/department by 12 noon Monday. The Hawkins Building Manager will keep the Accountability Logs on file for three months. A shadow board will be utilized to help track the devices on the units or departments.

2. Staff who have a PDA permanently assigned to them are responsible for safe storage of the PDA when not in use. The Hawkins Building Manager will assist

with the weekly tracking of assigned PDAs. The units will maintain daily tracking forms, which will be collected every Monday by the Building Manager who will check for accountability.

3. Every staff person who enters the secure area of Hawkins Building must carry and use a PDA. If a PDA is not issued or one is not available on the treatment unit, the employee must stop at the Hawkins Building Central Control and check one out.

B. Proper Set Up and Operation

1. The PDA must be kept on setting "2" or "3" in order to make sure the device will automatically send an alarm, or it must done manually.

2. In setting 2, the PDA will advise Central Control of the employee's location. To activate the audible alarm, the call button must be pressed or the alarm cord must be pulled on the PDA.

3. In setting 3 (the "person down" setting), the PDA will advise Central Control of the employee's location and the alarm will activate automatically when the PDA is turned sideways (in the horizontal position).

C. Proper Activation

The PDA must pass under two red line-of-sight locator transmitters, located in the ceilings, before the PDA will track an employee's location. Each time a PDA passes under, or by a line-of-sight locator transmitter, the PDA will emit a single beep. (PDA's kept on the treatment units are **already activated.)**

D. Wearing the PDA

The PDA must be worn on the outside of clothing, or staff must use the lapel cord supplied with the PDA. If the PDA is worn beneath clothing, the device will be unable to serve as a location device; its only function would be the audible alarm.

E. Re-Setting after Emergency Use and Maintenance through Central Control

As soon as possible after using the alarm, the PDA must be returned to Central Control to be reset. If a PDA is not working properly, the Clinical Team Leader/Coordinator will log it into his/her accountability sheet and return it to the Building Manager for maintenance or replacement.

Birgit M. Fisher, PhD Date
Interim Superintendent

SECTION – ENVIRONMENT OF CARE
SECURITY MANAGEMENT

POLICY NO. 32.26

Effective Date: 9/12/12

TITLE: CIVIL DISTURBANCE / RIOT CONTROL / MAJOR DISTURBANCE / ACTIVE SHOOTER

This policy replaces 32.26, dated 9/1/09.

I. DEFINITION/PURPOSE

It is the policy of CMHIP to ensure the safety and security of the environment of care for all patients, staff, consultants, contractors, and visitors, by responding to and controlling incidents involving civil disturbance, riot, active shooter(s) or other major disturbances.

The purpose of this policy is to describe staff and Department of Public Safety (DPS) response to acts involving civil disturbance, riot, active shooter(s) or other major disturbance.

DEFINITIONS

ACTIVE SHOOTER is an armed person who has used deadly physical force on other persons and continues to do so while having unrestricted access to additional victims.

CIVIL DISTURBANCE/RIOT/MAJOR DISTURBANCE is two or more individuals who by tumultuous and violent conduct, create grave danger of damage or injury to persons or property or substantially obstruct the operation of any CMHIP function. A civil disturbance/riot/major disturbance can be started internally or externally.

COMMAND OFFICER is the designated on-duty DPS officer in immediate command of Law Enforcement/Security Operations.

FIELD COMMAND POST is an area designated as a safe place near the incident scene by the Command Officer, where the Command Officer, DPS officers, staff and others authorized by the Command Officer to be present, can assemble to formulate incident resolution. The Field Command Post will keep the Emergency Command Center, if activated, briefed of the current status of the incident. The Field Command Post will be identified by a flashing green light.

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include all CDHS/CMHIP employees.

III. UNIT/DEPARTMENT PROCEDURES

A. Upon notification of acts or threats of civil disturbance, riot, active shooter(s), or major disturbance on the unit and/or area, staff will report immediately to the DPS Communications Center by emergency phone call (x4911 or x6) or Nextel Radio the following information:

1. Location of the incident by building number and unit name /office number
2. Individuals involved, if known. For an active shooter situation, attempt to provide:
   - Assailant(s) location
   - Number of suspects
   - Race and gender
   - Clothing description
   - Physical features
   - Type of weapons (e.g., rifle or handgun), backpacks, "gym" bags, etc.
   - Number of explosions or shots fired
3. Injuries of individuals.
4. Explosives and/or bombs involved.
5. Fire, smoke and/or chemicals involved.
6. Persons not involved that are caught in the incident.
7. Staff actions to isolate and control the problem.
8. Progress of the disturbance.

B. Staff will immediately move all individuals not involved in the disturbance to an area of safety.

C. For an active shooter situation or situation involving other weapons, staff shall immediately instruct all patients and visitors to take cover, moving from the line of fire/threat to an area of safety.

1. Lock and barricade doors to units and/or offices.
2. If possible, staff will also perform a lock down of the unit, department, or building to contain the individual(s) with firearms/weapons to as small of an area as possible. Attempt to keep patients, staff, and visitors calm, quiet, and out of sight.
3. Turn off lights, close blinds, block windows.
4. Turn off radios and computers. Silence cell phones, pagers, and Nextel radios.
5. Consider risks before unlocking rooms.

   i. The shooter may not stop until they are engaged by law enforcement.

   ii. Attempts to rescue people should only be attempted if it can be accomplished without further endangering persons inside a secured area. If in doubt, keep the area secured.

D. Staff will conduct a census of patients, visitors and staff and report the information to the DPS Communications Center who will relay it to the DPS Command Officer on duty.

E. If entry by DPS is accomplished, all persons in the unit will stay within their area of safety/cover. **DO NOT** approach entering police officers until commanded to do so.
   1. Follow police officer's directions such as put down bags or packages, place hands over your head, etc.
   2. Provide incident information to responding police officers, including location of a shooter(s) if known.
   3. Police officers will not stop to aid the injured until the area is secured and the active shooter(s) have been apprehended.

F. The Command Officer on duty may create a Field Command Post, which will be formed by DPS in a safe location near the unit and staff of the unit. If available, the Command Officer on duty will report to the Field Command Post to assist in incident resolution. The Field Command Post will be identified by a green flashing light.

G. A plan of action will be accomplished to gain control of the unit. All efforts to gain control of the situation will be coordinated with DPS.

H. Upon regaining control of the unit, which will be considered a crime scene, a census will be conducted of the patients, visitors and staff. Witnesses may not be released from the area unit they have been interviewed by DPS. Medical staff will immediately attend to any injuries of individuals.

I. The Supervisor in charge of the unit/area will complete a critical incident report.

IV. DEPARTMENT OF PUBLIC SAFETY PROCEDURES

A. Upon notification of a impending civil disturbance/riot/active shooter(s) major disturbance in any CMHIP unit and/or area, the Command Officer on duty shall obtain all available information on the location, individuals involved, weapons involved, explosives and/or bombs involved, any fire/smoke involved, persons not involved who are caught in the disturbance/riot, staff actions to isolate and control the problem, and progress of the disturbance.

B. The Command Officer upon receiving information that the staff of the unit and/or area is no longer in control shall have all available police officers on duty respond to the area and create a security perimeter around the area.

C. The Command Officer will notify Chief of Public Safety and brief him/her of the situation.

D. With concurrence of Chief of Public Safety, the Superintendent and/or Administrator on Call will be notified, and the Emergency Disaster Plan initiated.

E. A Field Command Post will be formed in a safe location near the unit, if needed.

F. A plan of action will be accomplished to gain control of the unit based on the current information available to the Field Command Post staff and the Emergency Command Center, if it is activated. Telephone communication will be set up so the Emergency Command Center can be contacted.

G. Emergency communications by pager, two-way radio, Nextel, email, or overhead page will be provided by DPS Communication Center as the situation allows and is appropriate for staff and police officer safety.

H. All efforts to gain control of the situation by utilizing CMHIP staff should be exhausted before requesting assistance from outside agencies.

I. The following may be called for assistance if necessary, according to the circumstances involved:
   1. On duty clinical staff from the affected division and/or other divisions of the Institute
   2. On duty Department of Corrections officers and staff
   3. Off duty DPS police officers
   4. Off duty DPS security officers
   5. Pueblo County Sheriff's Department
   6. Pueblo Police Department
   7. Colorado State Patrol
   8. Colorado Bureau of Investigation (Crime Scene Investigation)
   9. Pueblo Fire Department
   10. Any other agency that is required and ordered by the CMHIP's Chief of Public Safety.

J. The Command Officer on duty of the location will give instructions to assemble to staff and/or other agencies responding.

K. The Command Officer on duty will direct an investigation conducted to determine the cause of the disturbance, persons involved, injuries, and damage.

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William J. May Date
Superintendent

SECTION - Environment of Care
Security Management
POLICY NO. 32.37

Effective Date: 11/9/11

TITLE: REPORTING ACCIDENTS OCCURRING TO THE PUBLIC

This policy was moved from the CMHIP Environment of Care Manual, SEC-14, Reporting Accidents Occurring to the Public, dated 4/30/03, to the CMHIP P&P Manual.

I. DEFINITION/PURPOSE

It is the policy of CMHIP to promptly and accurately report accidents or incidents occurring on CMHIP grounds.

The purpose of this policy is to describe the reporting procedure required when a non-vehicle accident occurs to a member of the general public on CMHIP grounds.

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include any employee observing the specified events, the employee's supervisor, and the Department of Public Safety.

III. PROCEDURE

Each employee shall report all accidents, incidents, or identified unsafe conditions on the "Non-Automobile Incident Report," (State Risk Management form DRM-02). The Non-Automobile Incident Report can be obtained from the CMHIP Safety Office or from the Department of Personnel and Administration's State Risk Management web site http://www.colorado.gov/cs/Satellite/DPA-DHR/DHR/1213129336300.

This form is not intended to replace any of the previously established safety reports, automobile accident reports, employee injury/accident reports, etc., but is in addition to them. It is to cover accidents, incidents, or unsafe conditions at CMHIP involving injury to persons who are not State employees. The primary purpose of the report is to advise appropriate officials of accidents, incidents or unsafe conditions in order that the State can protect itself against potential liability resulting from the Colorado Governmental Immunity Act. The importance of the timely submission of this report is emphasized. The reporting procedure is as follows:

1. The involved or witnessing employee shall prepare and submit this report to his/her supervisor within one working day of the observed accident, incident, or unsafe condition.

2. The supervisor shall check the report, add any pertinent comments, and forward the report to the CMHIP Safety Office and to the Department of Public Safety on the same day as received.

3. Accidents, incidents, or unsafe conditions at CMHIP involving injuries to persons who are not State employees which require or may require treatment by a physician, or hospitalization, shall be immediately reported to the Department of Public Safety by the involved or observing employee. The Department of Public Safety shall then conduct a complete investigation.

4. The CMHIP Safety Office will forward a copy of the report to the State Office of Risk Management.

_____ _____

Teresa Bernal, RN, C, BS Date
Interim Superintendent

SECTION – ENVIRONMENT OF CARE
HAZARDOUS MATERIALS MANAGEMENT

POLICY NO. – 32.40

Effective Date: 2/8/12

TITLE: HAZARDOUS MATERIALS USE AND DISPOSAL

This replaces CMHIP policy 32.40, dated 1/28/09.

I. DEFINITION/PURPOSE

It is the policy of CMHIP to provide a safe environment and protect patients and staff from exposure to hazardous materials and waste (HAZMAT).

The purpose of this policy is to describe the processes used to select, handle, store, transport, use, and dispose of HAZMAT.

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include the Safety and Risk Manager, supervisors, and all staff who use or have contact with HAZMAT.

III. PROCEDURE

A. Selection

1. Supervisors, the Purchasing Manager, the Safety and Risk Manager, the Standardization Committee, the Environment of Care Key Function Team and/or the Infection Control Key Function Team select and evaluate CMHIP chemical supplies used for conducting normal hospital business. The evaluation shall include determining if the substance is toxic or otherwise hazardous using federal regulation and product markings. When possible, non-toxic or less toxic materials shall be selected for use.

2. When unit staff must use chemicals, the following shall be observed:

   a. Harsh cleaning agents or chemicals will never be issued to patients.

   b. Products that may contain hazardous chemicals including some external medications and rubbing alcohol may only be used under direct staff supervision.

   c. Staff may use bleach for disinfection in the 1:10 solution described in the Infection Control Manual for clean up of body fluids. Staff may disinfect the washing machine with bleach between patient uses. If a patient's clothing is extremely soiled, staff may place bleach in laundry after the water has filled the tub.

d. Limited quantities of items such as laundry soap, deodorant, body soap, shampoo, and shaving lotion/foam may be given to patients for their use.

e. The potential risk to the patient(s) and environment shall be considered against benefit before allowing patient(s) to use items unsupervised.

B. Inventory and Use

1. Supervisors and unit safety representatives shall create and maintain the Hazardous Materials Inventory for their unit. The Hazardous Materials Inventory for each division/department is sent to the Safety and Risk Manager annually. The Hazardous Materials Inventory lists all supplies and materials used on the unit that have been identified as HAZMAT.

2. Supervisors, unit safety representatives, and/or the Safety and Risk Manager shall obtain the Material Safety Data Sheet (MSDS) for each item on the Hazardous Materials Inventory. MSDSs are obtained from the manufacturer or distributor of the item, or from the Internet. The Hazardous Materials Inventory and MSDSs are stored in a binder in a designated area of each unit.

3. MSDSs are required for all HAZMAT used at CMHIP and/or provided to patients. Patients who purchase their own personal care products off campus are not required to obtain MSDSs.

4. The Safety and Risk Manager will provide Hazardous Materials and MSDS training during New Employee Orientation. Supervisors and unit safety representatives shall provide training to unit staff regarding chemicals used on the unit that is consistent with OSHA "Right to Know" standards. The training includes the specific Hazardous Materials Inventory and MSDS's associated with the unit. The training shall be conducted after the Hazardous Material Inventory is complete each year. A copy of the training roster shall be placed in the unit MSDS binder.

5. The MSDS is used as the definitive guide for safe handling, storage, transportation, use, and disposal of each item on the Hazardous Materials Inventory. MSDSs are reviewed at least yearly for currency, and replaced by the unit safety representative.

6. CMHIP provides Personal Protective Equipment (PPE) to users of hazardous materials as appropriate to the material handled or used. PPE may include safety glasses, goggles, respirators, gloves, caps, aprons, smocks, gowns, Tyvek® suits, and booties. The user shall follow the guidelines specified by the MSDS for the material used or disposed.

C. Storage

1. Supervisors and the Safety and Risk Manager shall ensure that appropriate space is available for handling and storage of HAZMAT in each unit.

2. The appropriateness of space for handling HAZMAT is regularly evaluated as part of the Environment of Care Rounds to determine if current conditions and practices support safe handling and storage of HAZMAT.

3. Hazardous chemicals shall be stored in locked rooms or cabinets so that patients cannot have access to them. Examples include cleaning agents, floor wax strippers, harsh soaps, and bleach. External medication, hydrogen peroxide, and rubbing alcohol shall be kept in a locked area when not in use.

4. Supervisors ensure that only a one-day supply of hazardous products (the amount that can be expected to be used in a normal work day) is allowed to be stored in the work area during the performance of a task. Hazardous products that are not being used or exceed the one-day supply shall be stored in a locked cabinet, container, or room that is not accessible to patients.

5. Items that may contain hazardous chemicals but may be kept in an accessible place on the units include:
   - Laundry soap
   - Deodorant
   - Body soap and shampoo
   - Shaving lotion/foam
   - Perfume/cologne

D. Air Monitoring

The purpose of air monitoring is to assess the level of airborne contaminants that may be present in the air and thereby formulate methods to protect patients and staff from inhalation exposure to these hazardous substances. CMHIP shall contract with external vendors to perform air monitoring for hazardous materials when deemed necessary by the Safety and Risk Manager, the Physical Plant Manager, Infection Control Manager, hospital administration, and/or the Administrator On Call.

E. Transport and Disposal

1. The supervisor who generates HAZMAT also manages the hazardous and regulated waste. CMHIP hazardous waste consists of chemical, medical/ infectious waste (including sharps), and pharmaceuticals (including coumadin and nicotine patches).

2. Hazardous chemical waste is temporarily stored in Building 138 prior to disposal. A hazardous materials contractor retrieves and transports the waste for final disposal. The Laboratory Director maintains copies of the transportation and disposal records for hazardous chemical waste shipments.

3. Medical/infectious waste is double-bagged in red plastic biohazard bags and temporarily stored in Building 125, Room A120. A biohazard materials

contractor retrieves and transports the waste for final disposal. The Southern District Housekeeping Director maintains copies of the transportation and disposal records for medical/infection waste shipments.

4. Regulated pharmaceutical wastes are placed in the RCRA black box, and when filled, nursing staff return the container to Building 125, Room A-120 for proper disposal by the licensed hazardous waste company/transporter. (See CMHIP policy 32.41, CMHIP Pharmaceutical Hazardous Waste Guidelines.) The CMHIP Safety and Risk Manager maintains copies of the transportation and disposal records for regulated waste pharmaceutical shipments.

_____ _____

Teresa Bernal, RN, C, BS. Date
Interim Superintendent

SECTION – ENVIRONMENT OF CARE
HAZARDOUS MATERIALS MANAGEMENT
POLICY NO. 32.41

Effective Date: 9/10/14

TITLE: CMHIP PHARMACEUTICAL HAZARDOUS WASTE GUIDELINES

This replaces policy 32.41, dated 9/11/13.

I. DEFINITION/PURPOSE

It is the policy of CMHIP to manage and dispose of identified pharmaceutical hazardous waste to protect human health and the environment.

The purpose of this policy is to outline actions to be taken to ensure proper disposal of identified pharmaceutical waste.

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include nursing and pharmacy staff and other healthcare providers.

III. PROCEDURES

A. General Information

Pharmaceutical waste may include, but is not limited to the following:

- expired medications
- patients' personal medications
- waste materials containing excess medications (IV bags, tubing, vials, etc.)
- medications that can no longer be used
- containers that held medications
- medications that are intended to be discarded, and
- contaminated garments, absorbents, and spill cleanup material

Criteria used to determine pharmaceutical hazardous waste will include, but will not be limited to: the Resource Conservation and Recovery Act (RCRA), the United States Environmental Protection Agency (EPA), and the Colorado Department of Public Health and Environment (CDPHE). Criterion includes being listed on the P and/or U and/or D-List, which includes the following characteristics: ignitability, corrosivity, reactivity, or toxicity.

1. Determination of Hazardous Pharmaceutical Waste

   On an ongoing basis, the CMHIP Pharmacy staff will evaluate their pharmaceutical products to determine if they are or are not hazardous waste. (Initial list generated September of 2009.) Pharmaceutical hazardous waste has specific management requirements that involve labeling waste containers, time limits for storage of the containers, the type of transportation that can be used, disposal methods, disposal locations, manifesting, and recordkeeping.

2. Spills

   The management of pharmaceutical hazardous spills, which should be non-existent because of CMHIP's limited use of certain pharmaceutical products, will be handled via procedures outlined in the Emergency Procedures (Rainbow Book) or on the Material Safety Data Sheet (MSDS).

3. Emergency Coordination

   Any questions or concerns involving hazardous pharmaceutical waste can be directed to CMHIP's Safety/Risk Manager and/or the Director of Pharmacy.

4. Program Review

   Initially, Nursing Executive Committee, the Pharmacy and Therapeutics Committee, the Environment of Care Key Function Team, the Executive Committee of the Medical Staff, and the Policy and Procedure Committee will approve the Pharmaceutical Hazardous Waste Program. The program will be reviewed on an as-needed basis, or at the minimum, on an annual basis.

5. Training

   Staff involved with pharmaceutical hazardous waste (nursing, pharmacy, healthcare providers) will be trained on the program.

B. Identifying Hazardous Pharmaceutical Waste

1. P-listed RCRA Hazardous Waste (Acutely Hazardous)

   EPA considers P-listed chemicals "acutely hazardous." If a chemical on the P-list is the sole active ingredient of a discarded product, it causes the entire product including the container or packaging to be treated as a hazardous waste. These products, including Coumadin (warfarin) and Nicotine Patches, will be identified using a black label on the dispensed product.

2. U-listed RCRA Hazardous Waste

   U-listed chemicals must be the sole active ingredients to come under regulation and mainly encompass chemotherapeutic agents. These products, if used, would be identified using a black label on the dispensed product.

3. D001 RCRA Hazardous Waste (Ignitable)

   These products, if used, would be identified using a black label on the dispensed product.

4. D002 RCRA Hazardous Waste (Corrosive)

   These products, if used, would be identified using a black label on the dispensed product.

5. D003 RCRA Hazardous Waste (Explosive)

   These products, if used, would be identified using a black label on the dispensed product.

6. D004-D043 RCRA Hazardous Waste (Metal or Organic Chemicals in High Concentrations)

These products, if used, would be identified using a black label on the dispensed product.

C. Guidelines for Proper Disposal

1. All P and/or U and/or D-listed and other regulated pharmaceutical hazardous waste will be in a separate labeled container and/or original container and identified by a "Black Label." These wastes cannot be placed in a biohazard red bag. They must be placed in a separate "Black Box Container" labeled "RCRA Hazardous Waste" and these containers will be available on each unit and will be located in the locked medication rooms and/or attached to the medication carts. In clinic areas, and the Pharmacy, they will be placed in a designated location. In addition, the opened packages (such as opened unit-dose packages of Coumadin (warfarin) and nicotine packaging, med cups) will also be placed in the "Black Box Container."
2. Wasted medications, such as refusals, that have been removed from their unit-dose packaging or vials and/or medications that have been spit-out or refused by the patient must be placed in a separate "Blue Box Container" labeled "All Other Medications" and these containers will be available on each unit and will be located in the locked medication rooms and/or attached to the medication carts. In clinic areas, and the Pharmacy, they will be placed in a designated location.
3. Unused intravenous solutions or medications that contain P and/or U-listed compounds will be disposed of as hazardous waste and will be placed in the "Black Box Container." Only empty syringes used to administer the medication can go into the sharps container.
4. CMHIP will supply to the Pharmaceutical Hazardous Waste vendor, licensed by the EPA, with a list (profile) of all P, U, and D waste codes being generated and the vendor can pre-certify the list and create a waste profile and certified waste stream. All possible waste codes will be listed on the profile for a particular waste stream.
5. The "Black Box Container" and the "Blue Box Container", when filled, will be returned to Building 125, Room A-120 by nursing staff for proper disposal by the licensed hazardous waste company/transporter. The unit will then obtain new boxes from Central Sterile Supply. The hazardous waste transporter will supply a copy of the manifest and should be kept on site for three years by the Pharmacy Department.
6. Disposal of excess material in syringes and IV bags into the sewer system is prohibited unless they only contain saline, dextrose, lactate, nutrients, vitamins, potassium and other electrolytes. IV bags that contain RCRA products (identified by the Black label) must be placed in the "Black Box Container." Any other IV bags containing pharmaceuticals can be placed in the "Blue Box Container," which will be located in the locked medication rooms.
7. Empty pharmaceutical aerosol cans, such as inhalers or sprays, must be returned to the Pharmacy Department for proper disposal. These are placed in the unit designated pharmacy bucket for return to the Pharmacy Department.

8. All insulin vials and pens either empty or partially full if not re-labeled for home use must be returned to the Pharmacy Department for proper disposal. These are placed in the unit designated pharmacy bucket for return to the Pharmacy Department.
9. Many prescription products such as aerosols, ointments, insulin, oral contraceptives, etc. may be re-labeled (for home use) for patients being discharged when legally prescribed by the physician. This prevents these products for entering the hospital's hazardous pharmaceutical disposal waste stream.
10. Personal medications will be returned to the patient upon discharge when so ordered by the attending physician. Those medications not returned to the patient upon discharge and over 120 days that are considered pharmaceutical hazardous waste, will be placed in the "Black Box Container" for destruction via CMHIP's hazardous waste/company transporter. All other personal medications will be placed in the appropriate "Black or Blue Box Container."
11. In the event the Pharmacy Department has P and/or U and/or D-listed pharmaceutical products that have a manufacturer's expiration date greater than 4 months, the Department can return these medications through the reverse distributor (Guaranteed Returns) for partial credit.

D. Pharmaceutical Recyclable Management Company (A Reverse Distributor)

The CMHIP Pharmacy arranges with the pharmaceutical recyclable management company to pick-up non-regulated pharmaceutical products for recycling and to credit certain medications if in the product's original packaging.

1. The pharmaceutical recyclable management company will be licensed by the State of Colorado. (CMHIP will retain a copy of the license.)
2. The pharmaceutical recyclable management company will be licensed to collect all returnable products.
3. The pharmaceutical recyclable management company will provide complete documentation to CMHIP that includes:

    a. Waste Detail Report,
    b. Returned Medication Report,
    c. Schedule Medication Waste Detail Report, and
    d. Returned Schedule Medication Report.

_____ _____

Birgit M. Fisher, PhD. Date
Interim Superintendent

SECTION – ENVIRONMENT OF CARE
EMERGENCY MANAGEMENT
POLICY NO. 32.50

Effective Date: 8/14/13

TITLE: INCLEMENT WEATHER

This policy replaces CMHIP policy 32.50, dated 4/11/12.

I. DEFINITION/PURPOSE

It is the policy of CMHIP to continue to operate essential services during weather emergencies.

The purpose of this policy is to define the weather declaration under which nonessential employees are granted authorized leave and do not report to work, and to describe the notification process. It also describes the leave that may be granted under other weather circumstances.

DEFINITIONS

Official weather emergency means weather conditions are such that all non-essential employees are released from work and granted authorized leave.

Weather alert means notification from the National Weather Service of weather advisories, hazardous weather outlooks/warnings, etc. in areas surrounding CMHIP and Pueblo County. A weather alert may activate weather emergency plans but does not approve the authorization of leave.

Essential services include, but are not limited to, the following:

1. Unit nursing care, including medication administration
2. Supervision of the unit
3. Housekeeping and infection control procedures on direct care units
4. Nutrition services
5. Public safety
6. Safety and risk management (emergency management and shelter)
7. Medical services
8. Utilities and life safety

Essential employees are those who must stay on duty, report to work, or be on call in a weather emergency and include the following:

1. Nursing staff – All direct care nursing staff are to report for duty as scheduled or normally assigned. The Program Chief Nurse or the Director of Nursing will determine the number of nursing staff assigned to each unit during the emergency situation. The number on each team will be set at a level consistent with patient care, safety and security. All nursing personnel in excess of that number may be deployed to other units.

Essential nursing staff includes: RNs, HCTs, CSSOIIs, Client Care Aides, Mental Health Clinicians.

2. Administration

   a. The following individuals are considered essential and will report as scheduled - Superintendent, Assistant Superintendents, Program Directors, Clinical Team Leaders, Chief of Public Safety, Division of Facilities Management Director (or Physical Plant Manager), Safety and Risk Manager, and Emergency Preparedness Coordinator.

   b. Even though the following individuals are considered non-essential, they have a duty to ensure safe coverage on the units and therefore may be required to report to work as directed by their Appointing Authority. The following individuals are non-essential, but will be on call during the weather emergency: Chief of Medical Staff, Director of Nursing, Program Chief Nurses, Lead Nurses, Staffing Office Manager, Central Sterile Supply (CSS), Clinic Nurses, Public Information Officer, Critical Incident Administrator, Quality Support Services Director, Medical Records Director, Social Work Director, Forensic Community Based Services Director, and Infection Control Manager.

   c. Essential personnel unable to report for duty and on-call personnel should be available by pagers, Nextel two-way radio, or telephone/cellular phone.

3. Nursing Staffing Office – Minimum of one employee per shift.

4. Physician – Minimum of one Department of Medicine physician on duty designated by the Chief of Medical Staff or designee.

5. Psychiatrist – Minimum of three on duty designated by the Chief of Medical Staff or designee.

6. Facilities Management – All employees report as scheduled for their regular shift except for Administrative Assistants and the Maximo programmer, including the Garage, Grounds, Heat Plant, Housekeeping, and all maintenance shops.

7. Nutrition Services – All employees (including Administrative Assistant I's) as scheduled for their regular shift except for Administrative Assistant IIs and IIIs and Program Assistants.

8. Purchasing – Minimum of two employees to work the Food and General Warehouses during normal business hours.

9. Department of Public Safety – All Department of Public Safety officers including those employees assigned to the Central Transportation Unit report as scheduled for their regular shift. Administrative Assistants are excluded from essential staff.

10. Communication Center - All employees report as scheduled for their regular shift.

11. Admissions – Minimum of one admission-coordinating employee per shift.

12. Central Sterile Supply – Minimum of one employee during normal business hours.

13. Laboratory technician – Minimum of two employees during normal business hours and one on call after hours.

14. Pharmacist – Minimum of four employees during normal business hours (on call as necessary).

15. Respiratory Therapy – Minimum of one employee on call.

16. X-ray technician – Minimum of one employee on call.

18. Other direct care staff including Occupational Therapists, Psychologists, Recreational Therapists, and Social Workers will be on-call.

19. Other staff not included in the above list may be required to report for work depending on patient care, hospital, and administration needs.

II. ACCOUNTABILITY

The Governor, the CDHS Executive Director, or the CMHIP Superintendent makes the declaration that grants nonessential employees leave to go/remain at home.

Individuals responsible for implementing this policy include the Superintendent (or designee) and the Public Information Officer.

III. PROCEDURE

A. Declaration of Weather Emergency or Weather Alert

1. The CMHIP Superintendent (or designee) may declarein consultation with the Office Director of OBH and/or the Deputy Director of Clinical Services, Mental Health Services, a weather emergency based on weather conditions in Pueblo and the immediate area (50 mile radius of Pueblo).

2. The Governor or the CDHS Executive Director may also make an emergency declaration based upon statewide weather conditions.

3. Essential employees must report to duty for their regular shift.

4. In a weather emergency, essential employees may be required to stay at work following the end of their shift. Director of Nursing, Program Chief Nurses, Program Directors, and Department Heads will determine the need for essential employees to work overtime during a weather emergency.

5. Staff with four-wheel drive vehicles willing to offer their assistance to transport essential employees to or from work are asked to call the Department of Public Safety at the time of the emergency. Conversely, essential staff needing a ride to or from work should contact either the Nursing Staffing Office or the Department of Public Safety Department, which will then try to match rider with vehicle. Volunteer drivers must provide a valid driver's license and proof of insurance for the vehicle they will be driving. A copy of the driver's license and proof of insurance will be given to the CMHIP Safety and Risk Manager or the Chief of

Public Safety for recordkeeping purposes. CMHIP will reimburse volunteer drivers at the current state reimbursement rate; proper documentation must be submitted for approval.

6. The weather emergency declaration will last only for the day(s) issued; employees will assume that they must report for work the following day after the end of the weather emergency unless otherwise notified.

7. Employees who are required to work during a declared weather emergency will be paid at their regular pay rate and will not be granted a future day of administrative leave.

8. Employees who are already on approved annual, sick, or other type of leave when a closure occurs will remain on leave and substitution of administrative leave will not be granted for the period of closure (see CDHS Inclement Weather Policy, VI-2.15).

9. All employees (whether considered essential or non-essential) must notify their supervisor or designee when they leave their assigned work shift due to a weather emergency.

B. Emergency Road Closure

1. Employees living in areas affected by emergency road closure decisions made by state, county or municipal governments or by the Colorado State Patrol will be granted administrative leave.

2. Essential employees unable to travel to CMHIP due to localized and impassible or dangerous road conditions that have not been declared closed may use annual leave without penalty.

C. Notification

1. The Office of the Superintendent is responsible for notifying Program Directors and Department Heads of a weather emergency. The Program Directors and Department Heads are responsible for ensuring all employees are notified of the weather emergency immediately. Communication may be via email, telephone/cellular phone, or emergency pager notification. Staff desiring information on the emergency should contact their immediate supervisor only.

2. Whenever the early morning weather is so inclement as to warrant closures or delays in opening schools, government offices, or other businesses in Pueblo and the immediate area, the Public Information Officer will call the Superintendent (or designee) at home for a decision regarding a declaration of an official weather emergency. The decision will be made no later than 5 a.m.

3. The Public Information Officer will then notify the Communications Center and southern Colorado television and radio stations when an official weather emergency is called.

D. Non-Emergency Weather Conditions

1. The Superintendent (or designee) may grant up to two hours of administrative leave for employees who arrive late to work because of severe weather conditions when no official CMHIP emergency has been declared. If administrative leave is not granted, the employee will be charged personal leave.

2. On days when weather conditions dictate, the Superintendent may authorize a staggered release of employees without making an emergency declaration. In such instances, employees will be granted administrative leave for time not worked.

_____ _____

William J. May Date
Superintendent

SECTION – ENVIRONMENT OF CARE
EMERGENCY MANAGEMENT

POLICY NO. – 32.51

Effective Date: 10/12/11

TITLE: BIOLOGICAL/CHEMICAL/RADIOLOGICAL TERRORISM PREPAREDNESS PLAN

This replaces Policy 32.51 dated 5/01/08.

I. DEFINITION/PURPOSE

It is the policy of CMHIP to protect patients and staff from hazards posed by a real or suspected biological, chemical, or radiological terrorism attack.

The purpose of this policy is to identify mitigation, preparedness, response, and recovery efforts that would be needed to address a biological or chemical terrorism incident.

Biological/chemical/radiological terrorism is defined as the introduction of a biological, chemical, or radiological agent(s) of unusual incidence that adversely affects the health and well being of a target population in an act or threat of terrorism.

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include all CMHIP staff.

III. PROCEDURE

A. Mitigation

Mitigation refers to any action taken to eliminate or reduce the degree of long-term risk to human life and property from natural and man-made hazards. Mitigation assumes the hospital is exposed to risks whether or not an emergency occurs.

Mitigation efforts performed by the Environment of Care Key Function Team for Biological/Chemical/Radiological Terrorism include:

1. A Hazard Vulnerability Analysis will be completed annually.

2. Identification of methods to prevent the spread of biological/chemical/radiological agents throughout CMHIP including but not limited to:

   a. Sheltering in place

   b. Building automation shut down procedures

   c. Building lock down procedures

B. Preparedness

Preparedness refers to any activity taken prior to an emergency that facilitates a coordinated response.

Preparedness efforts for biological/chemical/radiological terrorism include:

1. Education and training

   Employees are trained and/or informed by the Safety/Risk Manager as new information becomes available. Information concerning biological/chemical agents includes, but is not limited to:

   a. Types/categories of agents
   b. Routes of transmission
   c. Signs and symptoms of exposure
   d. Containment and control
   e. Treatment of exposure
   f. Vigilance-awareness of environment
   g. Reporting of incident

   Updates are provided to employees whenever changes and/or additions are made to the available information.

2. Drills

   The Safety/Risk Manager conducts semi-annual drills as part of the CMHIP Disaster Plan. Drills may simulate a biological/chemical/radiological threat to the campus.

C. Response

Response refers to any action taken to save lives, minimize property damage and enhance recovery immediately before, during, or directly after an emergency.

Response efforts for a potential or actual biological/chemical/radiological incident include:

1. Recognition

   The following are indicators that a biological/chemical/radiological event may have occurred and require increased surveillance and response.

   a. A large number of ill persons with similar signs and symptoms
   b. An increase in unexplained disease or deaths. **(See Infection Control Manual - Outbreak Control Plan for Infectious Diseases Deemed a Medical Emergency.)**
   c. The failure of patients to respond to usual therapy in association with a common disease or syndrome

d. A single case of disease caused by an uncommon agent (e.g., inhalation anthrax, smallpox, viral hemorrhagic fever)

e. An illness that is unusual or atypical for a given population or age group (e.g., outbreak of a chickenpox-like rash in adults)

f. An illness occurring out of season or at an unexpected time of the year (e.g., influenza in July)

g. Clusters of disease whether reportable

h. Drug resistance in pathogens usually sensitive to common antibiotics

2. Notification

a. Call the Department of Public Safety at extension 4911 (or 6) to notify them of potential or actual biological/chemical/radiological incidents

b. State "biological/chemical/radiological attack"

c. The Communications Center dispatcher will notify the Command Officer on duty, Superintendent, Assistant Superintendent, or Administrator On Call

d. The Command Officer on duty and the Superintendent, Assistant Superintendent, or Administrator On Call shall determine whether or not an emergency situation exists and activate the Disaster Plan as specified in the Rainbow book

e. The Communications Center shall notify external agencies of the attack at the direction of the Command Officer on duty

3. Confirmation

A Command Officer on duty shall receive confirmation of the threat or attack from the appropriate agency based on the biological/chemical/radiological agent(s) suspected.

4. Containment

a. The biological/chemical/radiological agent shall be contained as thoroughly as possible to prevent spread to other areas. Quarantine may be imposed to reduce or eliminate the spread of the agent.

b. The scene of any suspected terrorist incident shall be contained to preserve evidence.

5. Communication

The following information shall be included during communication regarding the incident:

a. Nature of the incident

b. Type/category of agent, if known

c. Current status, responsibilities and expectations

d. Process to implement based on available information

6. Decontamination

   The Pueblo Fire Department Hazardous Material Response Team performs decontamination following established guidelines for the agent involved.

7. Treatment

   a. Appropriate healthcare provider(s) will administer treatment following established guidelines for the agent(s) involved. The identification of the healthcare provider(s) is determined by the Command Center dependent on the agent(s) involved, condition of the victim(s), and resources available.

   b. Post-Exposure Prophylaxis (PEP) and Immunizations will be administered using established guidelines for the agent(s) involved.

8. Progress Reporting

   a. Command Center staff and the emergency response team will produce progress reports for the duration of the event. The Incident Commander will determine the frequency of reports.

   b. Progress reports may include, but is not limited to the identification of emergency planning and operational issues and actions taken, patient and staff injuries/illnesses, supply/equipment requests, emergency response expenditures, etc.

   c. Reports will be distributed as appropriate to emergency responders, CMHIP staff and patients, OBH, CDHS, regulatory agencies, etc. Copies of reports will be archived by the CMHIP Safety and Risk Manager.

D. Recovery

Recovery refers to both short-term activities to return vital life-support systems to minimum operating standards and long-term activities designed to return life to normal or improved levels.

Recovery efforts for biological/chemical/radiological terrorism may include:

1. Decontamination of scene
2. Lifting of quarantine
3. Return to normal operations.

SECTION – ENVIRONMENT OF CARE
EMERGENCY MANAGEMENT

POLICY NO. – 32.52

Effective Date: 10/12/11

TITLE: EMERGENCY MANAGEMENT PLAN AND POLICIES FOR CONTRACTORS

This replaces policy 32.52 dated 5/1/08.

I. DEFINITION/PURPOSE

It is the policy of the Colorado Mental Health Institute at Pueblo (CMHIP) to provide safe, effective care for the patients at all times, including during construction operations. Construction activities increase the risk of events that may require an emergency response for CMHIP, the contractor, and subcontractors. Emergency response plans for CMHIP are described in CMHIP's "Rainbow Book."

The purpose of this policy is to provide a guide for contractors in the event of an emergency while working at CMHIP. All contractors and consultants working at CMHIP are responsible for knowing all contents of the plan and relaying the information to their employers and subcontractors.

DEFINITIONS

Hazardous material: any substance or chemical for which a manufacturer is required to produce a Material Safety Data Sheet (MSDS).

Hazardous material spill: an accidental release of a hazardous substance.

Material Safety Data Sheet: manufacturer's printed material on hazardous substance.

Hazardous waste: any material (liquid, solid, or gas) that has been identified by the State as a hazardous waste, which meets the characteristics established by the State regarding toxicity, flammability, corrosivity or reactivity. Hazardous wastes commonly found in contractor work areas are as follows: aerosol cans, stains, solvents, waste oil, asbestos, lead, PCB's, batteries, etc.

Hazardous waste manifest: the document that the State requires to accompany hazardous waste during transport.

Hazardous waste label: once a material has been determined to be a hazardous waste, it is required to be labeled with a hazardous waste label that requires specific information including the site's EPA Identification Number and an accumulation start date filled out.

Physical hazard: a substance for which there is scientifically valid evidence that it is a combustible liquid, a compressed air, explosive, flammable, an organic peroxide, an

oxidizer, pyrophoric (i.e., capable of igniting spontaneously), unstable (reactive), or water reactive.

Health hazard: a substance for which there is statistically significant evidence based on at least one study conducted, in accordance with established scientific principles, that acute or chronic health effects may occur in exposed employees.

Contract personnel: non-State staff who are contractors, contract employees, subcontractors, and/or subcontract employees working at CMHIP.

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include CMHIP's Safety and Risk Manager, the Southern District Division of Facilities Management (DFM), and contract personnel.

III. PROCEDURES

A. General Information

Prior to the start of work at CMHIP, or at a minimum on the first day of work, the contractor shall provide in-service training covering the material in this plan to contract personnel and provide attendance forms verifying comprehension of the material covered to CMHIP's Safety and Risk Manager and the DFM Project Manager.

Whenever there is an overlap of the plan with federal, state, or local regulations or contract specifications, the most stringent shall apply.

CMHIP's emergency procedures are contained in the "RAINBOW BOOK" which is available on all units and provided to the general contractor at the start of a project. In the event of an emergency, contract personnel shall follow the procedures outlined within this policy and follow the directions of the Incident Commander, Safety personnel, or unit staff.

B. CMHIP Emergency Telephone Numbers for Contractors

When calling from a phone on the CMHIP campus, dial the 4-digit extension for a direct connection. When using a cell phone or other outside line, call **719-546-4000** to be connected to the CMHIP Switchboard Operator.

FIRE ..... "4911" or "6"
DIVISION OF FACILITIES MANAGEMENT (DFM), Maintenance ..... Ext. 4262
DIVISION OF FACILITIES MANAGEMENT (DFM), Director ..... Ext. 4471
SAFETY and RISK MANAGER ..... Ext. 4624
CMHIP ADMINSTRATION ..... Ext. 4146
HOSPITAL EMERGENCY COMMAND CENTER ..... Ext. 4146
(Operates only during declared emergencies)

C. Specific Instructions for Outside Contractors

This is a psychiatric care facility and the working conditions may be different than those encountered at other job sites. Contract personnel shall adhere to the following instructions:

1. Contract personnel will ensure proper safety procedures are followed at all times to maintain the level of life safety from the start to the finish of a job. Safety measures include, but are not limited to, barricades, warning signs and devices, safe equipment and tools, safe working environment, and safe working habits.

2. The contractor will keep DFM Maintenance (x4262), the DFM Project Manager (x4394), and the Safety and Risk Manager (x4624) advised at all times of any hazardous areas, such as excavations, open trenches, demolition, areas that are unsafe to use, etc.

3. The contractor shall schedule any work that impacts utility systems and life safety systems including exiting and egress through DFM and the CMHIP Safety Department. The contractor will provide written notice for planned shutdowns of utility systems or life safety systems. Forms are available in the CMHIP Safety Department. Where indicated, Interim Life Safety Measures will be implemented. (See CMHIP Policy 32.60.)

4. The contractor shall complete the Infection Control Risk Assessment Matrix in CMHIP Policy 32.82, Pre-Construction Infection Control Risk Assessment – Part 1 for indoor projects, and follow the precautions described in CMHIP Policy 32.83, Pre-Construction Infection Control Risk Assessment – Part II.

5. The contractor shall read and sign CMHIP Policy 32.52, Emergency Management Plan and Policies for Contractors, which outlines emergency response in the event of fire or other disaster. It also details requirements of the hazardous materials policies.

6. Contract personnel shall ensure all tools, equipment, and other construction materials are not left unattended at any time; these items present a danger to patients and staff. Count all tools prior to entering the unit and then again when leaving. Contract personnel shall notify a staff member on the unit immediately if any tool or equipment is missing.

7. Contract personnel will ensure all scrap is removed, and all areas are kept clean at all times. Scrap materials present a danger to patients and staff.

8. The contractor will keep the unit's Charge Nurse and/or Supervisor advised daily of active work areas and obstructions, and of water, electrical, other shut-offs and service interruptions.

9. The contractor will keep the Project Manager and DFM Operations fully informed of areas to be worked in, changes in work areas, and schedule, etc.

10. Contract personnel **shall not** open doors to allow patients off or on to the units; patients may be unable to care for themselves or may present a danger to themselves or others if unsupervised. Notify Charge Nurse and/or Supervisor of any problems related to patients.

11. Contract personnel **shall not** leave unattended any unlocked exits or windows. Other openings from the units that have been created during repair or construction projects shall be kept secure at all times.

12. Contract personnel **shall not** fraternize with the patients; **do not** engage them in conversation; **do not** touch them, **do not** arrange to contact them outside of the hospital**. Please do** be courteous and polite with them, such as saying "Good Morning," "Excuse me," etc., when appropriate.

13. Contract personnel **shall not** talk to people outside of the hospital about individual patients; the patients' care and treatment at the hospital is confidential.

14. Contract personnel **shall not** give or sell cigarettes, matches, lights for cigarettes, food, clothing, alcohol, or drugs or any other items to the patients.

15. Contract personnel **shall not** bring alcohol or drugs onto CMHIP grounds in violation of CMHIP Policy 32.12, Declaration of Contraband.

16. Contract personnel must immediately report any problems they have with patients to the staff on duty.

17. Clinical Team Leaders or Charge Nurses will inform contract personnel of what additional items may pose a problem for patients and ask the contractor to correct the matter. The Clinical Team Leader or Charge Nurse is authorized to request contract personnel to leave an area if his/her instructions regarding patient safety are not followed.

18. The Department of Public Safety will issue required keys to the contractor. The contractor and the contractor's company are responsible for issued keys and their use. The contractor may be charged for lost keys and the cost of changing locks.

D. Fire Procedures

In case of fire, follow the **RACE** procedures:

R = Rescue/Relocate Endangered Patients – Move patients to safety, reassure them.

A = Activate the nearest Fire Alarm.
Alert Hospital Operator – call "4911" or "6"
Identify yourself, report exact location and type of fire.

C = Confine the fire by closing all doors and/or windows. Shut off oxygen if directed.

E = Extinguish if small fire and safe to do so.
Evacuate if necessary or when ordered.

NOTE: Turn off (do not unplug) all spark-producing devices (i.e., electric motors, portable heaters, HEPA vacuums, negative air machines, etc.).

Shut off all construction gases and remove cylinders from area (e. g., acetylene, propane, etc.)

If circumstances require asbestos or hazardous material's workers to evacuate without following decontamination procedures, they should avoid contact with others as much as possible.

E. Fire Safety

1. Know the location of the fire alarm pull boxes, emergency exits and fire exits, and the department's fire plan.
2. Know the location of fire doors, smoke compartments, and evacuation routes.
3. Contract personnel shall complete Hot Work permits for cutting, brazing, welding, and other heat generating activities. Hot Work permits can be obtained from the DFM Project Manager or the Safety and Risk Manager.

F. Use Of Hazardous Materials by Contractors

Whenever possible, non-hazardous or less hazardous chemicals should be substituted for known hazardous materials. All contractors and subcontractors that use hazardous chemicals shall maintain appropriate emergency spill kits and spill materials, and train their employees in the proper use of these kits.

Contract personnel who notice or cause a spill are responsible for:

- alerting the people close to the spill of the accident,
- keeping non-essential people away, and
- notifying the job foreman.

The job foreman is responsible for identifying the spilled hazardous chemical, knowing the recommended spill clean-up procedure, and providing notification as described in Section III G below.

G. Clean-Up Procedures for Hazardous Materials Spills by Contractor Personnel

The contractor and subcontractor shall take preventive measures (i.e., proper handling and storage) to prevent spills from occurring. The most important consideration in the event of a spill is the safety of the person(s) close to the spill and other CMHIP occupants.

Contract personnel will attempt to contain or clean up a spill, but only if it is safe to do so. Follow these spill clean-up guidelines:

1. Small spills (less than one gallon) of known hazardous, non-toxic materials

   For spills of small quantities of hazardous, non-toxic materials, refer to MSDS for spill clean-up procedure and clean up the spill. Notify DFM Maintenance (x4262), the DFM Project Manager (x4394), and the Safety and Risk Manager (x4624).

2. Small hazardous material spills involving unknown materials

a. Call the Operator at "4911" or "6" and report a small quantity hazardous material spill, your name, and location. The Operator will contact campus emergency response personnel.

b. Contain spill by using available absorbent materials, closing doors, and/or covering drains.

c. Establish barriers by posting or cordoning off area to prevent exposure to spilled product by patients, visitors, and staff.

d. In conjunction with campus emergency response personnel, attempt to identify the unknown material.

1. If the material is determined to be non-toxic, contract personnel initiate spill clean up procedures.

2. If the material cannot be identified or is determined to be toxic, call the Operator at "4911" or "6" and request assistance from the Pueblo Fire Department's Hazardous Materials Response Unit.

3. Large quantities of known and/or unknown hazardous materials

If a large quantity (greater than a gallon) of a hazardous materials spill occurs and relocation of patients, visitors, and staff is necessary:

a. Call the Operator at "4911" or "6" and report a hazardous material spill and the name of the spilled material, if known. The Operator will contact campus emergency response personnel.

b. Contain the spill and/or vapors by closing doors and/or using hazardous material spill kit's absorbent materials.

c. Relocate visitors, staff and patients out of the immediate danger.

d. Campus emergency response personnel will evaluate the need for Hazardous Materials Response assistance from the Pueblo Fire Department. If assistance is needed, campus emergency response personnel will contact the Operator and request Haz. Mat. Assistance.

e. Follow instructions of the Fire Department.

H. Management of Hazardous Waste by Contractors

1. The contractor must comply fully with regulations to determine and review current waste handling, transportation and disposal regulations for the work site and for each waste disposal landfill, as well as all U.S. Department of Transportation and EPA requirements, and state and local regulations.

2. Any contractor generating a hazardous waste, whether it is to be recycled or treated and disposed, shall report to the DFM Project Manager and the CMHP Safety and Risk Manager the type and quantity of hazardous waste generated.

3. Each contractor is responsible for identifying, storing and properly labeling hazardous waste generated in their work areas. In addition, contractors generating

hazardous waste as part of processes occurring in their work area are responsible for proper transportation and disposal of their hazardous waste.

4. Contractors shall contact the transportation, storage, and disposal facility's representative with whom they are contracted to determine proper information and signatures on hazardous waste manifests.

I. Hazardous Communication Plan

The purpose of the Hazardous Communication Plan is to communicate to all employees, physicians, volunteers and contract personnel the "Right-to-Know-Law" as it relates to:

- CMHIP's Hazardous Communication Plan, which is on file in CMHIP's Safety office.
- Unit and department staff maintain Material Safety Data Sheets (MSDS) in each patient unit and department where hazardous materials are stored and used. Additional information can be obtained from the Safety and Risk Manager.
- MSDS are made available to all contractors, employees, regulatory agency inspectors, and to others upon request.

1. Responsibilities of the contractor's foreman/supervisor:

   a. Identifying hazardous materials used or handled in the work area and obtaining MSDS for these substances.

   b. Developing polices and procedures pertaining to the receipt, storage, handling, and disposal of hazardous materials, and management of emergency situations involving hazardous substances.

   c. Assuring that copies of all MSDS have been submitted to the DFM Project Manager and CMHIP's Safety and Risk Manager, and that MSDS are available at the work area during each work shift.

   d. Educating contract personnel on the content of the Hazard Communication Standard and assuring that learned skills can be demonstrated and the proper competence level achieved.

   e. Documenting the in-service training given, making this documentation available and keeping training attendance rosters on file.

   f. Informing the DFM Project Manager, the CMHIP Safety and Risk Manager, and contract employees of new or revised MSDS received, pointing out significantly increased risks, or measures necessary to protect employee health as compared to those stated on a previously issued MSDS.

   g. Assuring that each container of hazardous substance is properly labeled, tagged or marked with the following information:

      NOTE: *The manufacturer or vendor has the responsibility for ensuring that each container of a hazardous material is properly labeled, tagged, or*

marked. However, if this labeling is not present or is inadequate, the responsibility for proper labeling rests with the contractor.

h. Assuring that protective clothing and equipment are available for employee use if the MSDS or container label so instructs.

i. Informing any subcontracted employer who has employees working at CMHIP of the hazardous substances to which the employee may be exposed while in the workplace.

2. Contract personnel are responsible for:

a. Practicing sensible, safe work habits
b. Reading labels
c. Knowing where MSDS are kept and reading them
d. Following instructions and warnings stated in the MSDS and on the labels
e. Using protective clothing and equipment correctly when handling hazardous substances
f. Learning emergency procedures

J. Tobacco-Free Environment

To promote CMHIP's commitment to public health and safety and to reduce the health and safety risks to those served and employed at the workplace, all CMHIP facilities, campuses, State vehicles, and properties are tobacco-free environments. No smoking of cigarettes, cigars, or pipes or use of chewing tobacco in any form or other tobacco product will be permitted in facilities or on properties of CMHIP.

All supervisors/foremen are responsible for enforcing CMHIP policy 32.00, Tobacco-Free Environment.

Violations of the Tobacco-Free Environment policy by contract employees are brought to the attention of the respective immediate supervisor. Non-compliance may result in removal from the job site.

Teresa Bernal, RN, C, BS
Interim Superintendent

Date

SECTION – ENVIRONMENT OF CARE
FIRE PREVENTION/LIFE SAFETY

POLICY NO. 32.60

Effective Date: 6/13/12

TITLE: INTERIM LIFE SAFETY MEASURES

This replaces policy 32.60, dated 10/12/11.

I. DEFINITION/PURPOSE

It is the policy of CMHIP to protect patients, staff, and visitors from risk to life and safety during periods when a building does not meet the applicable provisions of the *Life Safety Code®*.

The purpose of this policy is to establish guidelines and procedures regarding measures to take when building code deficiencies are identified and cannot be immediately corrected or during renovation or construction activities.

II. ACCOUNTABILITY

Individuals responsible for implementing and complying with this policy include all CMHIP employees, non-CMHIP employees on CMHIP property, contractors, volunteers, patients, and visitors.

III. PROCEDURE

1. Utilize attached assessment tool to determine Interim Life Safety Measures (ILSM) to implement when life safety code deficiencies exist in CMHIP buildings.
   a. SRM documents on the assessment tool the risk controls and frequency of actions for each life safety code deficiency identified.
   b. SRM maintains documentation of all life safety code deficiencies and associated risk control measures.

2. All exits shall be unobstructed. The Safety and Risk Manager (SRM) shall provide additional information and signage when alternative exits are designated.

3. The Southern District Division of Facilities Management (DFM) and/or the contractor shall ensure that buildings or areas under construction maintain escape routes for construction workers at all times, and the means of exiting construction areas are inspected daily.

4. The Department of Public Safety, DFM, and the contractor shall maintain free and unobstructed access to emergency services and for fire, police, and other emergency services.

5. The SRM shall notify the Pueblo Fire Department Station No. 5 (544-4371) and the Colorado Department of Public Health and Environment Life Safety Program Manager (303-915-9687) whenever Interim Life Safety Measures are implemented for four hours or more in a 24-hour period in an occupied building.

6. DFM and/or the contractor shall ensure temporary construction partitions are smoke-tight and built of non-combustible or limited combustible materials that will not contributes to the development or spread of fire.

7. The SRM, DFM and/or the contractor shall provide additional fire-fighting equipment and train staff in its use during construction activities that create Life Safety Code deficiencies.

8. Smoking shall be prohibited in and adjacent to the construction area. A smoking location near the construction area will be designated by the SRM and employees will be advised by the SRM of the approved smoking area. (See CMHIP policy 32.00, Tobacco-Free Environment.)

    a. Employee violations of this policy will be cause for a dismissal recommendation.

    b. Construction personnel smoking in construction areas will be removed from the project.

9. DFM and/or the contractor shall ensure storage, housekeeping, and debris-removal practices reduce the construction area's flammable and combustible fire load to the lowest level possible.

10. DFM, Public Safety, SRM, and/or the contractor shall increase surveillance of buildings, grounds, and equipment, with special attention to excavations, construction areas and storage, and field offices, to ensure construction site, patient, and staff safety and security.

11. Two fire drills per quarter per shift shall be conducted when Interim Life Safety Measures exceed 30 days.

12. Implement fire watches in identified locations as determined and documented in the ILSM assessment tool,. The fire watch shall be performed every 15 minutes using the Fire Watch Checklist found on Y:\COMMON\EOCstatus\Fire\ILSM Fire Watch Checklist.doc.

13. The SRM will train unit and/or department staff in ILSM affected areas to compensate for impaired structural or compartmentalization features of fire safety.

IV. EDUCATION

1. Employees and volunteers shall be informed of this policy during orientation and annual refresher training. Training shall include a description of ISLM measures

including compartmentalization, safe means of egress, alternate means of egress, and performing a fire watch.

2. Contractors shall be informed of this policy by DFM and/or SRM prior to arrival on CMHIP grounds.

3. Periodic updates or re-transmittals of this information will be provided as needed.

V. ENFORCEMENT

1. Employees are responsible for bringing this policy to the attention of persons observed violating any of the elements of the Interim Life Safety Measures policy.

2. Employees shall report the name(s) of any employee or contract employee who refuses to abide by this policy to that person's immediate supervisor for appropriate action.

3. Employees may report CMHIP or CDHS employees, contract employees, patients, and/or visitors who persist in violating this policy to the Office of Safety and Risk Management.

_____ _____

William J. May
Superintendent

Date

SECTION – ENVIRONMENT OF CARE
POLICY NO. 32.61

Effective Date: 12/12/12

TITLE: AUTHORITY HAVING JURISDICTION

This replaces policy 32.61, dated 4/1/10.

I. DEFINITION/PURPOSE

It is the policy of CMHIP to protect patients, staff, and visitors from risk to life and safety by complying with applicable sections of the *Life Safety Code®*.

The purpose of this policy is to identify the Authorities Having Jurisdiction (AHJ) for the *Life Safety Code®* and to identify situations in which the AHJ exercises their authority.

II. ACCOUNTABILITY

The CMHIP Safety and Risk Manager and the CDHS Southern District Director of Facilities Management jointly are the AHJ for all *Life Safety Code®* matters requiring the approval of the AHJ.

III. PROCEDURE

A. The AHJ is authorized to render decisions required by the *Life Safety Code®*. The AHJ is also authorized to intervene whenever conditions immediately threaten life and/or health of patients, staffing and visitors, or property of CMHIP. This authority may be exercised within the limits of the law, and CMHIP/CDHS policies. Situations likely to occur when this authority may be exercised include, but are not limited to:

1. Observation or notification and subsequent investigation that indicates a life safety issue has been, is currently, or is going to occur involving a patient, employee, visitor, or CMHIP/CDHS property
2. Fires/fire alarms or smell of smoke with no visible fire
3. Fire drills
4. Evacuation planning
5. Fire safety training
6. Construction and remodeling activities affecting life safety
7. Changes in life safety code occupancies
8. Fire equipment and fire systems inspection, testing, and maintenance
9. Code issues requiring a decision/approval of the AHJ
10. Other unusual events or circumstances.

B. Reference NFPA 101, *Life Safety Code®* (2000 ed.), A.3.2.2, for a description of the AHJ.

_____ _____

William J. May
Superintendent

Date

SECTION – ENVIRONMENT OF CARE
POLICY NO. 32.62

Effective Date: 10/12/11

TITLE: COMBUSTIBLE AND GENERAL MATERIAL STORAGE

This replaces policy 32.62, dated 11/29/06.

I. DEFINITION/PURPOSE

It is the policy of CMHIP to protect patients, staff, and visitors, as well as property, from fire, smoke, and other products of combustion and to implement procedures and controls to lower the potential for adverse impact on the safety and health of building occupants.

The purpose of this policy is to establish guidelines and procedures regarding measures to control the accumulation of combustible materials and general hospital or patient property in storage areas including, but not limited to, unit storage rooms, patient property storage areas, building basements, and tunnels.

Combustible material means a material that will ignite and burn. Examples of combustibles include paper, wood, many plastic products, and upholstered furniture.

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include the Safety and Risk Manager (SRM), division and department directors, clinical team leaders, clinical staff, division safety coordinators and fire marshals, building fire wardens, division property managers, and the Division of Facilities Management (DFM).

III. PROCEDURE

A. Materials shall be stored according to National Fire Protection Association (NFPA) codes and applicable building codes.

   1. Materials shall not be stored within 18 inches of sprinkler heads in sprinkled locations or within 24 inches of the ceiling in non-sprinkled locations.

   2. Materials shall not be stored within 36 inches of circuit breakers, electrical distribution panels, or electrical transformers.

B. The storage of combustible materials and hospital or patient property shall be limited to designated areas on direct care units, division patient property or general storage rooms, and designated locations in building basements.

C. Storage of furniture, combustible materials, patient property, and other hospital property is not allowed in any tunnel. Such materials may be stored in designated storage areas in tunnels and building basements.

Designated locations in building basements include storage rooms, locked storage cages, and areas marked by painted lines on the floor.

E. Maintenance tools and equipment belonging to DFM maintenance employees or contractors for projects may remain in basements and tunnels for the duration of the project. Tools and equipment must be secured, however, when not in use or unattended.

F. Nutrition Services Department's service carts, housekeeping transportation carts, linen carts, or other carts must be stored out of egress paths.

G. Equipment to be steam-cleaned may be taken to the cleaning area, cleaned and left to dry for a maximum period of 24 hours during the week.

_____ _____

Teresa Bernal, RN, C, BS Date
Interim Superintendent

SECTION – ENVIRONMENT OF CARE
LIFE SAFETY
POLICY NO. 32.65

Effective Date: 4/9/14

TITLE:	**CURTAINS, BLINDS, SOFT FURNISHINGS, AND LIFE SAFETY CODE REQUIREMENTS** **This replaces policy 32.65, dated 2/23/11.**

I. DEFINITION/PURPOSE

It is the policy of CMHIP to protect patients, staff, and visitors, as well as property, from fire, smoke, and other products of combustion and to implement procedures and controls to lower the potential for adverse impact on the safety and health of building occupants.

The purpose of this policy is to establish guidelines and procedures for the purchase and treatment of curtains, blinds, and soft furnishings. Requirements described in this policy are based on National Fire Protection Association (NFPA) 101, Life Safety Code requirements.

The terms drapery and curtain are used interchangeably. The term curtain also applies to cubicle curtains found in Medical Services' departments including, but not limited to the Clinic, ECT, Physical Therapy, etc. The terms carpets and rugs are used interchangeably.

Soft furnishings include mattresses, pillows, sheets, blankets and bedspreads, carpets, fabric wall hangings/decorations, and upholstered furniture.

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include all CMHIP and Southern District staff as well as tenant organizations occupying space in CMHIP buildings.

III. PROCEDURES

A. Curtains

1. Purchase of New Curtains

   a. Staff shall not purchase curtains by P-Card or any other method. New curtains shall only be purchased by the Southern District Procurement (Purchasing) or, for any construction/remodeling project, a DFM project approved vendor.

   b. Draperies and curtains shall be flame resistant as demonstrated by testing in accordance with NFPA 701, *Standard Methods of Fire Tests for Flame Propagation of Textiles and Films*.

   c. Each new curtain and/or curtain panel shall have a tag showing that it complies with NFPA 701.

d. Each curtain purchase shall include a requirement that the vendor certifies the curtain meets the requirements of NFPA 701 and provides a fabric sample. It is not the responsibility of Procurement, or any other CMHIP or Southern District employee, to determine if the curtain meets the requirements of NFPA 701.

e. Procurement or DFM shall forward a copy of the NFPA 701 certification and fabric sample to the Safety and Risk Manager (SRM) for filing.

2. Fire Treatment of Existing, Non-fire Rated Curtains

a. Existing, non-fire rated curtains may be treated with an approved fire retardant. Approved fire retardants include, but are not limited to, the following products: Flamex PF; Fabric Safe; Inspecta Shield; and, Safe-T-Guard.

b. Fire retardants must meet the NFPA 701 testing requirement and be applied according to the manufacturer's instructions.

c. The unit/department needing fire treatment of existing, non-fire rated curtains is responsible for ensuring the curtains are treated with the fire retardant.

d. The unit/department submits to the SRM documentation of the treatment of existing, non-fire rated curtains with an approved fire retardant for filing. Documentation in this file includes a description of the curtains treated (number and location, by building and room number), the date of treatment, and the name of the fire retardant that meets NFPA 701.

3. Cleaning Curtains

a. Curtains may be cleaned at any time per manufacturer's instructions.

b. No additional treatment is required following cleaning of fire rated, labeled curtains.

c. Curtains that are themselves not fire rated, but have been treated with a fire retardant, require the reapplication of the fire retardant after **each** cleaning. **Re-**treatment shall be per steps described in section III. A. 2. a. – d.

B. Shower Curtains

Shower curtains are exempt from the requirements for curtains in section III.A.

C. Other Window Coverings

1. Window blinds constructed of aluminum and other metal products, or vinyl blinds meeting NFPA 701 requirements, are approved for use in CMHIP and Southern District buildings.

a. Staff shall not purchase window blinds by P-Card or any other method. New window blinds shall only be purchased by the Southern District Procurement or, for any construction/remodeling project, a DFM project approved vendor.

b. Each new vinyl blind shall have a tag showing that it complies with NFPA 701.

c. Each vinyl blind purchase shall include a requirement that the vendor certifies the blind meets the requirements of NFPA 701. It is not the responsibility of Procurement, or any other CMHIP or Southern District employee, to determine if the vinyl blind meets the requirements of NFPA 701.

d. Flammability documentation is not required for aluminum and other metal window covering products.

e. Procurement or DFM shall forward a copy of the NFPA 701 certification to the SRM for inclusion in a CMHIP curtain "proof" book.

2. Other window coverings, constructed of cloth, fabric, wood, or any other combustible material, are approved for use if they are "fire rated" or that have been fire proofed with a flame retardant chemical.

a. Staff shall not purchase window coverings by P-Card or any other method. New window coverings shall only be purchased by the Southern District Procurement or, for any construction/remodeling project, a DFM project approved vendor.

b. These window coverings must either be marked "fire rated" by the manufacturer or they must be fire proofed with a flame retardant chemical as described in section III. A. 2. a. – d.

D. Personal Curtains and Window Coverings

To meet life safety code requirements, staff is not allowed to place personally purchased curtains or other window coverings in offices.

E. Mattresses

1. Staff shall not purchase mattresses by P-Card or any other method. New mattresses shall only be purchased by Procurement.

2. Mattresses are subject to fire rating requirements. Mattresses shall be resistant to smoldering and meet the char length requirements and the limited rate of heat release requirements specified in NFPA 101, *Life Safety Code*, Sections 10.3.2 (3) and 10.3.4.

3. Each mattress purchase shall include a requirement that the vendor certifies the mattresses meets the requirements of NFPA 101, *Life Safety Code*, Sections 10.3.2 (3) and 10.3.4. It is not the responsibility of Procurement, or any other CMHIP or Southern District employee, to determine if the mattress meets the requirements of this code.

4. Patients are not permitted to use personal mattresses.

F. Upholstered Furniture

1. Staff, or patients using Hinman and Weigand funds, shall not purchase upholstered furniture by P-Card or any other method. Upholstered furniture shall only be purchased by Procurement.

2. Staff shall not bring into the facility for personal use new or used upholstered furniture that does not have the appropriate certification tag.

3. Patients are not permitted to bring into CMHIP, or receive as gifts, personal upholstered furniture.

4. Upholstered furniture shall be resistant to smoldering, meet the Class I requirements, the char length requirements, and the limited rate of heat release requirements specified in NFPA 101, *Life Safety Code*, Sections 10.3.2 (1 and 2) and 10.3.3.

5. Each upholstered furniture purchase shall include a requirement that the vendor certifies the furniture meets the requirements of NFPA 101, *Life Safety Code*, Sections 10.3.2 (1 and 2) and 10.3.3. It is not the responsibility of Procurement, or any other CMHIP or Southern District employee, to determine if the furniture meets the requirements of this code.

6. CMHIP and Southern District furniture that is re-upholstered either on campus by an approved CMHIP program (for example, Voc Rehab) or off-campus by a contracted vendor shall meet the requirements specified in III.F.4.

   a. Voc Rehab shall maintain documentation that fabric used to re-upholster existing furniture meets the requirements specified in III.F.4. A copy of the documentation shall be submitted to the SRM.

   b. Contracted vendors shall certify vendor re-upholstered furniture meets the requirements specified in III.F.4, and this documentation shall be submitted to the SRM.

   c. Voc Rehab maintained or vendor-supplied documentation consists of a document certifying the fabric complies with the requirements specified in III.F.4, and a fabric sample stapled to the flammability certification.

G. Carpet

1. Staff shall not purchase carpets or area rugs by P-Card or any other method. New carpets shall only be purchased by Procurement, or for any construction/remodeling project, a DFM project approved vendor. Patients are not permitted to bring into CMHIP, or receive as gifts, personal area rugs.

2. Carpet and rugs shall be resistant to the spread of flame per the U.S. federal flammability standard, 16 CFR 1630 *Standard for the Surface Flammability of Carpets and Rugs*, FF 1-70 (ASTM D2859) and meet Class I interior floor finish requirements (critical radiant flux not less than 0.45 W/cm^2) as specified in NFA 253, *Standard Method of Test for Critical Radiant Flux of Floor Covering Systems Using a Radiant Heat Energy Source*.

   a. Carpets and rugs that do not meet flammability requirements are prohibited.

   b. Area rugs without a label stating they are flame retardant are prohibited.

3. Each carpet purchase shall include a requirement that the vendor certifies the carpet meets the requirements specified in III.F.2. It is not the responsibility of

Procurement, or any other CMHIP or Southern District employee, to determine if the carpet meets the requirements of this code. Carpet flammability certifications shall be sent by Procurement or, in the case of vendor supplied carpet for a construction/remodeling project, by the DFM Project Manager, to the SRM and will include the location(s) of installation.

4. Area rugs are discouraged due to the potential for slips, trips, and falls.

H. Fabric Wall Hangings and Decorations

1. Fabric wall hangings and decorations shall be flame resistant. These items must either be labeled as flame/fire resistant and the label must be intact on the item or be treated with an approved fire retardant as described in III. A. 2. a – d.

2. The unit/department is responsible for the treatment of non-fire rated fabric wall hangings and decorations. The unit/department submits to the SRM documentation of the treatment of the wall hangings and decorations with an approved fire retardant for filing. Documentation includes a description of the item treated (number and location, by building and room number), the date of treatment, and the name of the approved fire retardant.

3. Paper products and decorations, including soft furnishings, photographs and other combustible artwork, etc. may cover no more than 20% of any door or wall surface (exception, paper on wall mounted bulletin boards). Paper products and decorations of any type are not allowed on a fire rated door.

I. Bedspreads, Blankets, Pillows, Pillow Cases and Sheets, and Towels

Bedspreads, blankets, pillows, pillowcases, and sheets and towels are not currently regulated under NFPA 101, *Life Safety Code*.

J. Staff owned items not in compliance the Life Safety Code requirements described above shall be removed from CMHIP facilities within 30 days of the effective date of this policy.

_____ _____

William J. May Date
Superintendent

SECTION – ENVIRONMENT OF CARE
MEDICAL EQUIPMENT MANAGEMENT
POLICY NO. 32.70

Effective Date: 11/9/11

TITLE: MEDICAL DEVICE REPORTING

This policy was moved from the CMHIP Environment of Care Manual, policy ME-1, Medical Equipment Management, dated 4/16/03, to the CMHIP P&P Manual.

I. DEFINITION/PURPOSE

It is the policy of CMHIP to protect patients, staff, and visitors from hazards posed by defective medical devices and to comply with medical device regulatory requirements.

The Safe Medical Devices Act (SMDA) of 1990 and the Medical Device Amendments of 1992 require that a device user facility report incidents "that reasonably suggest that there is a probability that a medical device caused or contributed to the death of a patient or caused or contributed to serious injury or serious illness of a patient."

A **medical device** is any device that is used to diagnose and/or treat a patient, a device that is surgically implanted, or a device that is used to support or sustain human life.

A **patient** is defined as an individual being diagnosed and/or treated by a physician under the auspices of CMHIP who is working in, for, or who otherwise is affiliated with CMHIP.

II. ACCOUNTABILITY

Physicians are responsible for reporting any incident that reasonably suggests that there is a probability that a medical device caused or contributed to the death or caused or contributed to the serious injury or serious illness of a patient, staff member, or visitor. Reports shall be filed on the CMHIP Incident Reporting Form (form 1300). The Safety/Risk Manager, the Division Chief Nurse for Medical Services, and the Director of Quality Support Services (QSS) shall provide the oversight function to assure compliance with Medical Device Incident Reporting requirements.

The Division Chief Nurse (DCN) for Medical Services is designated as the Coordinator for Medical Device Investigation and Reporting and is also designated as the CMHIP official contact for the Food and Drug Administration (FDA).

III. PROCEDURE

1. The following individuals and/or committees are responsible for oversight and investigation:

The Safety/Risk Manager shall provide the oversight function to assure compliance with the Medical Device Incident Reporting requirements.

The Critical Incident Committee, which is charged with the responsibility to review all incidents at CMHIP, shall investigate all medical device incidents to determine if any such incident is reportable under the SMDA of 1990 and the Medical Devices Amendments of 1992, unless the incident is a sentinel event.

The Root Cause Analysis (RCA) Team shall investigate sentinel events and near misses that involve the malfunction of medical devices.

2. The Coordinator for Medical Device Investigation and Reporting shall be responsible for the following:

   - Notifying the Superintendent, Chief of Medical Staff, Assistant Superintendent, Safety/Risk Manager, Facilities Manager, QSS Director, and others as appropriate that an incident has occurred and an investigation has been initiated (if the incident is not a sentinel event. Otherwise the incident is investigated by the Root Cause Analysis Team.)

   - Reporting and filing to the FDA and the manufacturer adverse incident reports every six months and annually as required by the SMDA of 1990.

   - Maintaining a Medical Device Incident Investigating and Reporting System.

   - Providing reports to the Safety/Risk Manager within 10 business days of the adverse incident.

   Implementation consists of four elements:

   - Train CMHIP physicians as to their responsibility for reporting incidents.

   - Internally report events that might be reportable, investigate events (unless they are sentinel events, which are investigated by the QSS Director and the RCA Team), and determine if they are reportable.

   - Produce individual and summary reports.

   - Report the incident to the FDA and/or the manufacturer.

3. Training

   All CMHIP physicians shall receive training regarding the requirements of the SMDA of 1990 and the Medical Devices Amendments of 1992. Division directors, division chief nurses, lead nurses, team leaders, on-call administrators and Medical Services staff shall also be trained. All employees shall receive a brief overview of the SMDA requirements through the Safety/Risk Manager during new employee orientation and annual safety refresher training.

4. Reporting

   An incident shall be reported whenever CMHIP physicians become aware of information that suggests a medical device has caused or contributed to the death, serious injury or serious illness of a patient. The physician shall immediately complete the Incident Reporting Form (form 1300) and notify the DCN for Medical Services (if the event occurs after hours, notify the Administrator On Call; and, the QSS Director in the event of death or permanent injury). (See also CMHIP policy 3.38, Root Cause Analysis and Sentinel Event Investigation.)

   The person receiving the notification shall inform the person reporting the incident that unless medical necessity precludes such action, the medical device and all its accessories shall be left unchanged in their location and the location secured from access. If medical necessity dictates that the area must be used and the medical device moved, it shall be secured in a safe manner (preferably under lock and key).

   For incidents that are not sentinel events, the Safety/Risk Manager and the DCN for Medical Services will appoint an investigating team and begin the assessment and investigation. These two persons will take charge of the incident investigation until relieved of the authority by the Superintendent.

   The Safety/Risk Manager and DCN for Medical Services shall contact and coordinate with the Superintendent and the Director of QSS to determine whether the incident is reportable. If determined to be reportable, the Reportable Device Incident Form (Federal Food and Drug Administration form 3500A) shall be completed by the Safety/Risk Manager and the DCN for Medical Services, and approved by the Superintendent and the attorney representing CMHIP. For a death, serious injury or serious illness, the final report will be sent to the manufacturer. In case of death, or if the manufacturer is unknown, the final report will be sent to the FDA. CMHIP has 10 days from the time that the incident is determined to be reportable to submit the report.

   Semiannual summaries of reportable incidents, if any, shall be sent to the FDA, the Superintendent, and the Safety/Risk Manager

5. Documentation Requirements

   The Safety and Risk Manager shall maintain all documentation required to comply with the requirements of the Safety Medical Devices Act of 1990 and the Safe Medical Device Amendments of 1992.

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Teresa Bernal, RN, C, BS Date
Interim Superintendent

SECTION – ENVIRONMENT OF CARE
UTILITY SYSTEMS MANAGEMENT
POLICY NO. – 32.81

Effective Date: 10/12/11

TITLE: CONSTRUCTION OPERATIONS

This replaces CMHIP policy 32.81 dated 4/1/07.

I. DEFINITION/PURPOSE

It is the policy of CMHIP to provide safe, effective care for the patients at all times, including during construction operations. During the time of construction projects, every effort will be made to minimize disruption of patient care services as well as the construction process.

The purpose of this policy is to provide general risk assessment guidelines for contractors working at CMHIP.

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include the CMHIP Safety and Risk Manager, the Southern District Division of Facilities Management, and the contractors.

III. PROCEDURE

Contractors will work closely with CMHIP's administrative, clinical, and Division of Facilities Management (DFM) staff during the time of the construction process.

A. When a contractor is selected to perform demolition, renovation, modification, or other construction services, a team of qualified members of the contracting firm, sub-contractors, the DFM design professionals, and CMHIP staff will assess the impact of the contractual work on the patient care operations.

B. The assessment will evaluate the following factors that may be involved with a project:

- The potential for disturbance of dust that could cause respiratory irritation, infections, or expose anyone to hazards such as asbestos or hazardous chemicals.
- The noise and vibration associated with construction operations and the potential for impact on patient care or normal business functions.
- The potential for disruption of utility services and communication systems.
- The impact on fire and life safety.
- The impact on our security program and systems.
- Unique problems requiring special consideration during construction.

C. The risk assessment will be used to develop plans to minimize the impact of construction on patient care and business operations at CMHIP. The risk assessment process will be repeated as often as necessary to assure effective management of the issues listed above, which may vary from day to day. This will require flexibility on the contractor's behalf to meet patient care quality and safety.

D. The Joint Commission (TJC) accredits CMHIP. TJC requires documentation of the risk assessment, the plans developed to manage the impact of construction, and implementation of the plans.

Contractors may be required to participate in the documentation of compliance. Contractor participation may include training of the contractor's staff and subcontractors, supplying specialized equipment to create and maintain environmental conditions, monitoring staff behavior, and enforcing safe work practices.

Contractors are required to participate in implementation and enforcement of the plans and to cooperate when patient care considerations necessitate temporary disruption of construction.

_____ _____

Teresa Bernal, RN, C, BS Date
Interim Superintendent

SECTION – ENVIRONMENT OF CARE
UTILITY SYSTEMS MANAGEMENT
POLICY NO. – 32.82

Effective Date: 10/12/11

TITLE: PRE-CONSTRUCTION INFECTION CONTROL RISK ASSESSMENT – PART I

This replaces CMHIP Policy 32.82 dated 4/1/07.

I. DEFINITION/PURPOSE

It is the policy of CMHIP to contain potentially pathogenic material and dust during construction and renovation projects.

The purpose of this policy is to identify the scale of construction projects and construction risk levels, and based on those two factors identify the level of precautions required for the project.

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include the CMHIP Safety and Risk Manager, the Southern District Division of Facilities Management, and contractors.

III. PROCEDURE

A. For each project, use the table below to identify the scale of the project (Column 1) and the level of risk (Column 2, 3 or 4 headers – low, medium or high).

B. Based on the scale of the project and the level of risk, determine the level of precautions (Category 1, 2, 3, or 4) required for the project.

C. The precautions required for each project are described in CMHIP policy 32.83, Pre-Construction Infection Control Risk Assessment – Part II.

Project: Location: Date: Duration:	**Low Risk Areas** Offices, support areas, lobbies	**Medium Risk Areas** Patient care area, lab, pharmacy, radiology, clinics, food service areas, etc.	**High Risk Areas** Med Surg unit, Operating Room, areas with immuno-compromised patients
Minor: Inspections above ceiling; minor repair; painting (no patching); minor electrical work, plumbing, similar work with little/no drilling, cutting, or other dust-raising activity. Normal maintenance activity.	**Category 1 precautions**	**Category 2 precautions**	**Category 2 precautions**
Small Scale Projects: Installation of electrical and computer cabling; opening into chases and concealed spaces; cutting plaster and drywall, sanding and other dust making activity within a room or other controlled area. Usually one to three shifts.	**Category 1 precautions**	**Category 2 precautions**	**Category 3 precautions**
Larger Scale Projects: Removing floor coverings; sanding plaster walls; wall demolition and construction; duct work; electrical work above ceilings; major ceiling work. Usually more than three days work.	**Category 1 precautions**	**Category 2 precautions**	**Category 3 precautions**
Major Renovation and Construction: Major demolition of areas, particularly those open to patient care areas (less than one hour wall). Work on HVAC systems. Projects scheduled for more than three weeks total activity.	**Category 2 precautions**	**Category 3 precautions**	**Category 4 precautions**

Teresa Bernal, RN, C, BS
Interim Superintendent

Date

SECTION – ENVIRONMENT OF CARE
UTILITY SYSTEMS MANAGEMENT
POLICY NO. – 32.83

Effective Date: 10/12/11

TITLE: PRE-CONSTRUCTION INFECTION CONTROL RISK ASSESSMENT – PART II

This replaces CMHIP Policy 32.83 dated 4/1/07.

I. DEFINITION/PURPOSE

It is the policy of CMHIP to contain potentially pathogenic material and dust during construction and renovation projects.

The purpose of this policy is to describe the level of precautions required for the construction projects. The level of precautions are determined by comparing the scale of the project with construction risk levels (see CMHIP Policy 32.82, Pre-Construction Infection Control Risk Assessment – Part I).

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include contractors, the CMHIP Safety and Risk Manager, and the Southern District Division of Facilities Management.

III. PROCEDURE

A. Determine the level of precautions for the construction project using the table in CMHIP policy 32.82, Pre-Construction Infection Control Risk Assessment – Part I.

B. From the table below, implement the listed procedures based on the level of precautions identified in the Pre-Construction Infection Control Risk Assessment – Part I.

RECOMMENDED INFECTION CONTROL PRECAUTIONS, BY CATEGORY:

CATEGORY 1 PRECAUTIONS:

Protect patient care from activity, or enclose work area (close doors). Replace ceiling tiles promptly.
Minimize dust and dirt, clean or have area cleaned when done, and when dust or dirt builds up. Vacuum and/or damp mop areas when work has been completed.
Direct questions about work to Project Manager and Infection Control Manager.

CATEGORY 2 PRECAUTIONS:

Protect patient care areas from activity by closing doors, or enclosing area with plastic or equivalent. Replace ceiling tiles prior to removal of enclosures.
Use water spray mist to minimize dust when opening ceilings, and conducting activities that will cause dust or dirt to be airborne.
Close off HVAC system openings (exhaust and supply) with plastic or equivalent. If exhaust must be maintained, use "clean air machine", or powered HEPA filters in exhaust path, or exhaust directly to outside.
Use dust mats or tacky mats at entrances. Wet mop areas during and after construction to remove and control dust and dirt with suitable cleaning agents. Vacuum all areas thoroughly. Wipe down all horizontal surfaces (except floor and ceiling) with suitable disinfectant at conclusion of job.
Control of debris: Use covered container to remove debris when using internal hospital paths. Covers must be dust tight and secured to the container, not just laid on top.

AT JOB COMPLETION INVOLVING CATEGORY 2 PRECAUTIONS:

Replace all ceiling tile, or re-close ceiling.
Wipe down all horizontal surfaces (except floor and ceiling). Wet mop or extract floor with disinfectant approved by the Infection Control Manager. Vacuum all areas thoroughly.
Clean HVAC system as closure is being removed, and operate system for 24 hours prior to final cleaning of the job.
Maintain all enclosures as practical until post-job cleaning is complete. Use vacuum and wet mop during removal of barriers, as necessary.

CATEGORY 3 PRECAUTIONS:

Isolate the HVAC systems to minimize a route for dust movement. If exhaust is used to maintain the area negative in pressure to outside areas, the exhaust must go to the outside. If existing exhaust systems are to be used, they must be non-re-circulating exhausts. A pressure negative to the air in the patient care units must be maintained during construction activity.
Provide construction separations that are fire resistive, and dust tight, constructed of sheet rock or limited combustion plywood and plastic sheeting. Enclose work areas prior to any demolition work or opening any walls or ceilings. If work is being done in public areas, use control unit technology (similar to units developed to remove asbestos in areas that could not be closed down) and clean-air machines to maintain a pressure in the enclosure negative to the air outside the enclosure, with the exhaust going through a HEPA filter prior to releasing into the are in the patient care area.
Debris must be removed in tightly closed containers, with solid lid, or plastic taped into place. The debris removal containers should be vacuumed or wet-wiped prior to removal from the site, to remove all surface dust and dirt.

AT JOB COMPLETION INVOLVING CATEGORY 3 PRECAUTIONS:

Maintain barriers in place as much as practical until final cleaning is complete and the Infection Control Manager inspects the site. Removal of barrier materials should be accompanied by vacuuming using a vacuum with HEPA-filtered post-filters where required by the Infection Control Manager. Wet mop or extract the floor with disinfectant approved by the Infection Control Manager.
Clean the HVAC system as closures are being removed, and operate systems for 24 hours prior to final cleaning of the job and debris removal (to the extent practical based on the system).
The site must be thoroughly cleaned by damp wiping all horizontal surfaces with disinfectants approved by the Infection Control Manager.

CATEGORY 4 PRECAUTIONS:

USE ALL CATEGORY 3 PRECAUTIONS, PLUS:
Isolate HVAC system and seal with at least plastic and tape. Where pressure may exist, use sheet metal or similar rigid materials in addition of plastic and tape, to minimize accidental movement of air in ductwork. Isolate the ductwork as close to the construction barrier as practical.
Seal all holes, penetrations, and openings in the construction barriers and walls, which are part of the construction separation with appropriate materials. Hole in fire rated separations must be equivalent in fire rating. Other holes must be sealed with tape and plastic, or similar materials which are strong enough to withstand the pressure differential without leakage.
Create a construction anteroom where all clothing, tools, equipment, and other materials being removed are vacuumed or wet-wiped prior to being taken off site through the hospital patient care areas. Cart wheels should also be cleaned, and run over a tacky mat, or similar material to assure no dust is tracked out via wheels. All persons must walk across the tacky mats to clean their feet. Any person who has dust, dirt, or materials on their clothing must vacuum it prior to leaving the anteroom areas. Tacky mats will be maintained to keep the surface tacky, and to replace or remove layers when they become dirty. The anteroom will be wet mopped frequently (several times a day in usual construction activity), or similar methods will be used to satisfy the Infection Control Manager.
Personnel working in the area must either change clothing prior to leaving the job site, or use shoe covers, and cover clothing prior to leaving the area. (Modified asbestos rule: Showering is not required, but clothing changes are. If work shoes are worn off-site, the shoes must be covered by shoe covers. Dirty work clothing must be removed in sealed containers for laundering.)

AT JOB COMPLETION INVOLVING CATEGORY 4 PRECAUTIONS:

Maintain barriers in place until final cleaning is complete, and the Infection Control Manager inspects the site. Removal of barrier materials must be accompanied by vacuuming using a vacuum with HEPA-filtered post-filters. Air pressure should be maintained negative to patient care areas during final cleanup.
Clean HVAC systems as closures are being removed, and operate the system for 24 hours prior to final cleaning of the job and removal of barriers. If necessary, allow the HVAC to blow into the site with the clean air machine catching the output of the supply, and the machine feeding the air to the returns.
The site must be thoroughly cleaned by damp-wiping all horizontal surfaces with disinfectants approved by the Infection Control Manager. Prior to turning the construction site over to CMHIP, cleaning must be accepted by the Infection Control Manager.

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Teresa Bernal, RN, C, BS Date
Interim Superintendent

SECTION – ENVIRONMENT OF CARE
THERAPEUTIC ENVIRONMENT
POLICY NO. – 32.90

Effective Date: 10/12/11

TITLE: NON-STANDARD PATIENT ROOMS

This policy replaces Environment of Care policy TE-1 dated 4/23/03.

I. PURPOSE/DEFINITION

It is the policy of CMHIP that patients shall be treated with the same level of care throughout the Institute, including access to storage space for personal belongings in a manner that reflects respect and caring for the individual.

The purpose of this policy is to ensure that patients have reasonable and adequate personal storage space unless clinically contraindicated.

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include all treatment staff and administrative staff.

III. PROCEDURE

Patients shall be placed in standard patient rooms. "***Standard patient rooms***" are defined as rooms with bed frames, mattress, wardrobes or other provisions for storing personal items. If a non-standard patient room is being used for non-behavioral reasons, placement of a temporary dresser in the room qualifies the room as a standard patient room. When patients are placed in non-standard patient rooms (rooms without the above provisions) for behavioral reasons, staff shall implement the following:

1. Clinical team members shall conduct an interdisciplinary assessment, which will reflect assessment of the patient behavior and the benefits of a non-standard patient room for the patient's current condition, including the rationale for removing furniture or storage space. This assessment will be documented in the progress notes.
2. Placement in a non-standard patient room shall be entered in the treatment plan with criteria for movement into a standard patient room and staff interventions to assist the patient in meeting the criteria.
3. Staff will explain to the patient the reason for placement in non-standard room and will document the patient's understanding in the progress notes.

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Teresa Bernal, RN, C, BS Date
Interim Superintendent

SECTION – Environment of Care
Therapeutic Environment
POLICY NO. 32.92

Effective Date: 11/9/11

TITLE: DECORATIONS

This policy was moved from the CMHIP Environment of Care Manual, #TE-3, Decorations, dated 4/7/03, to the CMHIP P&P Manual.

I. DEFINITION/PURPOSE

It is the policy of CMHIP to provide a safe and therapeutic environment for patient care.

The purpose of this policy is to establish guidelines directing the decoration of patient living areas, identifying what is acceptable and appropriate material to adorn these areas, enhancing and supporting an environment that is both therapeutic yet comfortable within the boundaries of remaining free of offensive or objectionable material.

II. ACCOUNTABILITY

Individuals responsible for implementing this policy include all clinical staff.

III. PROCEDURE

A. Patients may personalize their particular living areas.

B. Decorations in patient living areas will not pose any fire or health hazards and will not impede observation of patients. Paper or other combustible material may cover no more than 20% of a patient's door or wall area per fire code. Decorations are not permitted on fire exit doors, smoke doors, and exit windows.

C. No materials, photographs, or language promoting, representing, glorifying, or suggesting violence, gang involvement, profanity, racism, drugs, alcohol, nudity, sexual violence, or explicit sexual behavior will be displayed. Examples include, but are not limited to:

1. Clothing that minimally or suggestively covers the body
2. Sleepwear, lingerie, or underwear
3. Provocative poses
4. Any picture that gives the illusion of/or contains transparent clothing
5. Any material perceived as offensive by others or deemed inappropriate for a specific patient based on clinical needs.

D. Patients may choose between discarding any objectionable material or mailing it out of the hospital at their own expense.

E. Decorations

1. Due to fire safety requirements and egress/exit notification purposes, decorations may not be placed on, hung from, or block the following: exit and egress lights; electrical equipment; electrical outlets; circuit breaker panels; smoke or heat detectors; fire extinguishers; fire alarm panels; fire pull stations; fire sprinklers or sprinkler lines; fire alarms; light fixtures; and/or ceilings.
2. Furnishings and decorations that impede egress in the hallways of patient care areas are not allowed, and they must not block exits, stairways, or automatic closing doors.
3. Non-flammable, fire retardant decorations, including artificial Christmas trees, wreaths, and garlands may be used. Combustible decorations, if used, must be treated with a fire retardant spray, and the Clinical Team Leader must document the fire-retardant treatment. Documentation may be kept on file on the unit.
4. Electric lights shall not be used on metal trees or any other metal surface.
5. Candles or any other open flame device shall not be used on any unit, division or department.
6. Decorations and electrical cords/surge protectors must be Underwriter's Laboratory (UL) approved, and extension cords and surge protectors cannot be connected together.
7. Cords shall not be strung across the floor where they could present a tripping hazard. Additionally, cords cannot pass under doors, above a doorframe, through windows, across ceilings, above drop in ceiling tiles, or under carpets.
8. All electrically powered decorations shall be turned off between the hours of 10:00 pm and 7:00 am, or when unattended.
9. Glass decorations including framed pictures with glass are prohibited.
10. All decorations including any electrical items or sharp objects must meet applicable safety standards appropriate to the area.
11. Maintenance recommends using 3M's Command adhesive products for hanging decorations.

F. Division of Facilities Management electricians have the authority to restrict or eliminate the use of any electrical equipment or device.

G. Refer to CMHIP policy, 32.12, Declaration of Contraband, for additional guidelines on items allowed.

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Teresa Bernal, RN, C, BS Date
Interim Superintendent