WEST TENNESSEE HEALTHCARE
MANAGEMENT GUIDEBOOK POLICY

SUBJECT: Inclement Weather Policy		**POLICY NO.:** 1125
APPLICATION: System-Wide		**PAGE(s):** 1 of 3
DEPT. RESPONSIBLE: Quality Council		**EFFECTIVE:** 02/12/01
		REVIEWED: 10/12/16
		REVISED: 01/19/21
APPROVED BY:		
	President/CEO	**Date:**

PURPOSE: To establish a policy that ensures adequate staffing during times of inclement weather. Examples of inclement weather are accumulated ice, heavy snow, flooding, tornado, etc.

POLICY: Employees are expected to make every effort to report to work during times of inclement weather, unless otherwise advised by their director. Staffing at sufficient levels must be accomplished on days of inclement weather as well as normal days.

OPERATIONAL CONSIDERATIONS

- Patient care areas must meet the needs of our patients regardless of the consequences of inclement weather. Facility leaders or their designees will determine essential services needed to support the provision of care.
- If inclement weather is predicted, all leaders must review their staffing proactively to meet the needs of their facility or department.
- In some cases the facility may be able to provide sleeping arrangements for employees who choose to stay overnight.
- Directors/managers should aggressively contact scheduled employees to alert them of potential weather issues, to enable employees to be proactive in planning for alternate travel plans to work.
- In the event of procedure/clinic cancellations, management will determine appropriate staffing levels needed to continue operations.
- All employees needed to provide and support patient care must have a backup plan for personal responsibilities (e.g., school or day care closure) should a weather-related event occur that would preclude them from coming to work as scheduled or requiring them to leave earlier.
- In the event that inclement weather begins while staff is at work, directors, managers, supervisors or charge nurses will call Clinical Services before sending any nursing staff home before the end of their shift. Employees may not leave

without permission of management. Employee are compensated according to established compensation rates.
- In the event an employee absolutely cannot report to work, appropriate department call-in procedures must be followed.
- The Director (or his /her designee) must approve an employee's request to leave early during inclement weather. Before sending employees home, supervisors should check with the Director or his/her designee (e.g., house supervisor in hospital settings) to ensure adequate staffing levels are met.
- If the staffing needs of the department or facility have been met and approval has been given to leave early, PET may be used to complete the regularly scheduled work hours for that day.
- Employees are compensated according to established compensation rates.

DEPARTMENTS THAT ARE ESSENTIAL FOR PROVIDING AND SUPPORTING DIRECT PATIENT CARE

- All scheduled employees needed to provide and support patient care are expected to report to work according to their established schedule.
- Employees not reporting to work are counted as having an occurrence of absenteeism even if they called in two hours prior to the shift.
- Employees who do not report to work due to inclement weather may not use accrued PET for compensation.
- Employees who call in sick during inclement weather are required to provide a note from a care provider. If the employee does not provide a note from a care provider, the employee will not be able to use accrued time (PET or PET Sick) for compensation.

DEPARTMENTS THAT ARE NOT ESSENTIAL FOR PROVIDING AND SUPPORTING DIRECT PATIENT CARE

- Department directors of departments that are not essential for the provision of care should develop departmental inclement weather protocols that ensure the availability of an adequate workforce and should denote which positions within the department are essential for departmental operation.
- Department plans need to address the capability of:
  - Excusing employees (unpaid time);
  - Offering employees the option of using accrued PET;
  - Offering employees the opportunity of making up the lost time later in the work week.

WORK RELATED INJURY DUE TO INCLEMENT WEATHER

According to Management Guidebook Policy 6500, if an employee sustains a qualified job-related injury, certain benefits may be applicable. A qualifying injury is one that meets these conditions:

- Occurs while the employee is involved in activities related to the course and scope of employment. This includes an activity of any kind for which an employee was hired and that has to do with the business or profession of WTH and that is performed by the employee for that purpose. This includes injury that occurs on the premises of the building for the employee's designated work location when he/she is coming to or departing from work;
- Is not a result of the employee's carelessness, negligence, failure to follow work rules, horseplay or other misconduct; and
- Is not the result of a pre-existing condition.

WEST TENNESSEE HEALTHCARE
MANAGEMENT GUIDEBOOK POLICY

SUBJECT: SECURITY		**POLICY NO.:** 2360
APPLICATION: JMCGH CAMPUS		**PAGE(s):** 1 of 2
DEPT. RESPONSIBLE: SAFETY & SECURITY		**EFFECTIVE:** 02/08/17
		REVIEWED:
		REVISED: 01/19/21
APPROVED BY:		
	President/CEO	**Date:**

PURPOSE:
To establish a training program for security by developing an educational plan to address how to interact with patients, procedures for responding to unusual clinical events and incidents, the hospital's channels of clinical, security, and administrative communication and distinctions between administrative and clinical seclusion and restraint.

SCOPE: This policy addresses Jackson Madison County General Hospital, on-campus provider-based departments, and West Tennessee Healthcare North Hospital; all persons including patients, visitors, staff, and physicians who utilize our facility.

POLICY:

Training for security personnel identifies processes for:

1. How to interact with patients:
   Patients have the right to considerate care that safeguards their personal dignity and respects their cultural, psychosocial and spiritual values. Security personnel with questions concerning how to appropriately interact with the forensic or other patients should consult with the nurse assigned to care for the patient.
2. Procedures for responding to unusual clinical events and incidents.
   Security personnel that notice patients exhibiting an unusual clinical episode should immediately summon the closest hospital employee or activate the nurse call system for assistance. Emergency Codes: the following is a list of emergency codes. Security should follow the instruction of hospital employees to ensure the safety of patients, visitors and staff.

   Code Pink - Infant missing
   Code Blue - Cardiac/Respiratory arrest
   Code Yellow - Severe storm
   Code Orange Prisoner Escape
   Code Red - Fire
   Code D Black - Bioterrorism

Code D - Disaster External or Internal
Code Silver- A person brandishing a weapon

3. The hospital's channels of communication include:
Clinical - questions concerning the clinical aspects of a patient's care which should be directed to the nurse, nurse manager or nursing director who is caring for the patient. Security - questions regarding security should be directed to the hospital's security department. The chain of command is Security Officer, Security Supervisor, Security Manager, and Security Director. Administrative - questions regarding administrative issues should be directed to the patient's nurse or Security Department. Administrative communication includes the Vice President of the assigned Nursing Floor or On-Call Vice President.

4. Distinctions between administrative and clinical seclusion and restraint. Security personnel will respond to calls from the medical staff for the purpose of assisting in application of restraints and/or seclusion of patients as outlined in security department policy 3055. Law enforcement will be oriented in the distinction between administrative and clinical seclusion and restraint but will not assist in applying these devices. Clinical Restraints are defined as any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. This includes the use of a drug or medication used as a method to manage the patient's behavior or restrict the patient's movement and is not a standard treatment or dosage for the patient's condition. Examples of clinical restraints include leather restraints, posey vest, and soft restraints and/or mitts.

Administrative Restraints are handcuffs and leg shackles or other means of restraint applied by forensic staff or law enforcement officers, including police officers furnishing services pursuant to that certain Agreement for Security Services by and between JMCGH and JPD effective March 1, 2009. Administrative restraints are appropriate for forensic patients but are not acceptable in other patient care settings.

Clinical Seclusion is the involuntary confinement of a patient in a room or area from which the patient is physically prevented from leaving.

West Tennessee Healthcare

NURSING POLICY AND PROCEDURE

TITLE: Security	**POLICY NO.:** 6600
	PAGE(S): 1 of 1
	EFFECTIVE:
	REVIEWED: 8/14/18
CATEGORY: Ancillary Departments	**REVISED:** 8/11/2020

PURPOSE:

Provide guidelines for staff regarding security issues.

POLICY:

1. Hospital security officers are on duty twenty-four (24) hours a day, seven (7) days a week. They will assist in many situations appropriate to their services, and may be reached at Ext. 16006.
2. WTH has a strong commitment to zero-tolerance for violence and disruptive or dangerous behavior, verbal or nonverbal threats and bullying. Any acts or threats of physical violence including intimidation, harassment or coercion will not be tolerated.
   Hospital staff should contact the Security department when encountering any of these situations.
3. Hospital Security should be notified as soon as possible following theft or disappearance of a patient's, visitors, or employee's possessions. An Occurrence/ System Variance Report must be completed and filed electronically.
4. Hospital staff is encouraged to report suspicious activity to the Security Office.
5. Security officers make random rounds of parking lots, garages and buildings on the main campus. Staff should be encouraged to call for escorts as needed. Parking lots and garages are also monitored remotely by closed circuit television.

EDUCATION:

Employee education related to security issues is part of hospital orientation and annual mandatory safety training.

DOCUMENTATION:

For situations when it may be necessary to fill out an Occurrence/System Variance Report, see Management Guidebook, Occupational Injuries and Illness (OJI), Policy No. 2160 http://wthintranet/Management Guidebook Policy 2160 - Occurrence/Variance Report and Occurrence/Variance Reporting – Patient/Visitor, Policy No. 2170. http://wthintranet/Management Guidebook Policy 2170 - Patient/Visitor

RELATED INFORMATION:

Refer to Category 2000 of the Management Guidebook for related policies.

WEST TENNESSEE HEALTHCARE
MANAGEMENT GUIDEBOOK POLICY

SUBJECT: Emergency Operations Plan—Internal & External Disaster		**POLICY NO.:** 2070
APPLICATION: JMCGH		**PAGE(s):** 1 of 2 +Manual
DEPT. RESPONSIBLE: Safety & Security		**EFFECTIVE:** 01/01/77
Revisions for tower transitions approved by Quality Council on 08/26/08 to be effective 09/28/08.		**REVIEWED:** 08/06/19
		REVISED: 11/26/19
APPROVED BY:		
	President/CEO	**Date:**
	Chief of Staff	**Date:**

PURPOSE: To establish a policy to be followed by hospital personnel during times of internal or external emergencies, which will help ensure continuity of hospital operations.

SCOPE: This policy covers Jackson-Madison County General Hospital (JMCGH) and all affiliates located on its campus as well as the West Tennessee Healthcare North Hospital, and any outlying affiliated clinics and wellness centers.

POLICY: Each department must prepare their departmental procedure in the event of an emergency. A copy of this protocol should be reviewed by the Safety Committee annually and should be updated as outlined in Policy No. 2240. The Director of Safety and Security, under the guidance of the Vice-President of Hospital Services and the Medical Staff, will be responsible for the Hospital Emergency Operations Manual and any necessary revisions and annual review.

The emergency plan will be exercised twice a year in response to an actual emergency or to a planned exercise. Drills will include volunteers or simulated patients. The emergency preparedness sub-committee will evaluate this exercise and recommendations will be made to the Director of Safety and Security for improvement in identified areas.

At least one exercise a year will include an influx of actual or simulated patients into the system. The hospital will participate in at least one community wide exercise a year. A community wide exercise with an influx of actual or simulated patients may be performed simultaneously. Participation in a community wide tabletop session is acceptable in meeting the community portion of drill requirements. Participation in a community wide tabletop session, alone, is not an acceptable substitute for two required exercises.

Planned exercise scenarios will be realistic and related to potential emergencies identified by the hospital's hazard vulnerability analysis (HVA). Preparation of the HVA is coordinated by the hospital safety officer in collaboration with the hospital leadership, local EMA, and Regional Hospital emergency response coordinator. The HVA includes community wide hazards such as natural and man made hazards, as well as hazards specific to the organization. The hospital utilizes its HVA as a basis for defining preparedness activities that will mobilize and organize essential resources. All exercises will be critiqued by the Emergency Management Committee, which is composed of members from different disciplines including the medical staff, to identify deficiencies and opportunities for improvement. A summary of the exercise will be compiled by the Chairman of the Emergency Management Committee and delivered to the Director of Safety and Security and Administration. Administration, Central Safety Committee, and the Medical Staff will review the summary.

The Life Safety Subcommittee is responsible for an annual evaluation of the Life Safety Management Plan's objectives, scopes, performance and effectiveness.

During orientation of new employees, the emergency plan is explained and reviewed. It is the employee's responsibility to become familiar with the overall plan.

It is the responsibility of each department director to orient new employees to the departmental procedures to be followed.

The hospital will adopt and utilize the Hospital Incident Command System (HICS) for actual emergencies and during emergency preparedness exercises. Required elements of National Incident Management System (NIMS) will be monitored and tracked by the hospital's NIMS designee to ensure NIMS compliance.

A copy of the Hospital Incident Command System (HICS) organizational chart is attached to this policy. This chart is intended to establish a clear command and control structure to be used during actual emergencies and emergency preparedness exercises.

It is to be understood that JMCGH maintains a mutual understanding with all other West Tennessee Healthcare (WTH) hospitals for sharing of resources and assets.

Included with the policy is a copy of the Hospital's Emergency Operations Plan.

Hospital Incident Command System Organizational Chart
(HICS Form 207)