Organization Response for Incident # 241474

General Information

Incident Number:	**241474**
Incident Date:	03/29/2016
Organization ID:	1635
Organization Name:	Winnebago Mental Health Institute
Organization Street Address:	1300 South Drive
Organization City/State/Zip Addr:	Winnebago, WI 54985-0009
Programs:	Hospital Accreditation Program

Incident Sites

Site Name	Address
Winnebago Mental Health Institute	1300 South Dr. Winnebago, WI 54985-0009

Did you contact Complainant?

Complaint Summary:

WMHI is incredibly understaffed, to the point of affecting patient safety. There was recently a patient on Sherman Hall South, who was given a call bell as she required assistance in transferring from her bed. There were several times that staff members were unable to answer her bell due to lack of staff. This led to the patient, who was a high fall risk, to transfer on her own. At least one time, she fell due to lack of assistance. She was unable to even toilet herself because staff were not available to assist in transfer. Staff are frequently unable to take breaks, monitor patient visits, or even use the restroom. When staff are instructed to monitor off-unit patient visits, there is only one staff member on the unit for hours at a time. On Sherman Hall South, one staff is to monitor the dayrooms from the vestibule at all times. This means that when they are they only staff, they are unable to perform patient care or even to open patient's rooms, which are locked. On the date mentioned above, there was only one staff member on the unit who was not sitting with a 1:1. Staff had to make the decision of whether to leave the dayrooms unattended or to retrieve toilet paper for the patient bathroom when it was empty.
The forced overtime is extremely high at this point, leading to staff exhaustion and low morale. Staff are forced to work for 16 hour shifts and are unable to split shifts per upper management discretion. Some staff members are being forced 2-3 days in a row, working as many as 48 hours in 3 days. Staff are also being "short-changed" so that they are not even allowed 8 hours between shifts. Staff members are

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returning to work with 4-5 hours sleep at best between 16 hour shifts. People are tired and frustrated and the patients are paying the price. The care given is substandard and the units are not safe. Staff cannot continue working at this pace. More staff and better management policies are needed. Patients are being removed from 1:1 supervision prematurely to avoid creating additional overtime. More than one staff member has slept while working on the unit. If management thinks that patients are being given adequate care, they are sadly mistaken.

Address the Specific allegation(s) and provide an analysis and review of related systems and processes:

Systems Improvements and/or Follow-up Actions:

Measurement/sustainability of compliance to related standards:

Response To 241474- 3/29 complaint Submitted: 5/9/16

WMHI is aware of the recent overtime concerns and has been working diligently to resolve these issues. Over the past few years, our average daily population and hospital acuity have continued to increase. WMHI has been very attentive to patient acuity and needs, which necessitates more 1:1 care. This active response to patient acuity and census has become a driving force in our overtime concerns.

Consequently, WMHI continues to hire and train staff at a higher frequency. The training department is hiring Psychiatric Care Technicians (PCT's) all of whom are Certified Nursing Assistants in back to back classes to assist with the overtime situation. All PCT's are thoroughly trained. This includes a 120 hour CNA course for PCT's who are not CNA certificated upon hire. After completion of the CNA course, all PCT's receive a three week PCT course with classroom and clinical orientation on the patient care units. This ensures that all PCT staff are well prepared for their roles on the patient care units, though it does delay bringing new staff into the schedule, which of course contributes to the overtime issue.

In addition to current hiring, WMHI has been gathering and presenting data to our state and department administration in order to determine correct adjusted staffing levels and whether additional positions can and should be funded.

WMHI is attuned to PCT overtime concerns and has been tracking related data. In March, the period addressed by the complaint, there were 19 double shifts, worked by 19 different employees; in other words, no employee worked more than 1 back-to-back double shift in March. 1 employee was assigned 3 doubles in a row, but none of those were worked as full double shifts; under WMHI procedures, he was able to 'give away' portions of each of those mandated shifts, so that the employee ended up actually working 1, 2, and 5.5 hours of overtime each day (9, 10, and 13.5 hour days back-to-back). In total 18.5% of all the hours worked in March were overtime hours and 1.6% of the overtime shifts were doubles.

At the time this complaint was written, there was a patient who did utilize a call bell on Sherman Hall South during the AM and PM shifts. Documentation notes the patient was moved to a room closer to the RN station in order for staff to respond quickly to the call bell. There is no documentation indicating the patient fell as a result of staff being unable to respond to the patient's call bell. There is a documented incident in which the patient was with 1:1 staff and began to lower herself from the side of her bed into a wheelchair. Staff noticed patient was beginning to lower toward the ground and attempted to prevent her from falling by placing a leg beneath the patient as a prop. The patient slid to the ground with staff and was then assisted back into bed.

The complaint states staff are unable to take mandatory breaks, monitor patient visits, or use the restroom. Per Winnebago Mental Health Center Policy, 15 minute breaks are not mandatory and staff may not always be able to take a break when wanted as they would need to coordinate times with other unit staff and activities. In the month of March there were only 10 instances in which a PCT was unable to take a lunch break due to various needs on the unit. Patient visits are always monitored and WMHI is currently developing a new process in which Security and an additional PCT who is not counted in unit coverage would assist in monitoring visits in order to ensure sufficient PCT coverage on the units.

There are times in which a patient may need to wait to use the restroom or for toilet paper to be retrieved, however the wait would not be longer than a few minutes. Staff do a good job at prioritizing and meeting patient care needs.

The complaints claim that a decision was made to remove a patient from 1:1 cares to decrease overtime is simply not true. Decisions to place a patient on or remove a patient from 1:1 care is based on the physician's assessment and does not take into consideration overtime or staffing issues.

Systems Improvements and/or Follow-up Actions

WMHI will continue to hire and train staff to assist with the overtime issues, monitoring attrition and overtime data in order to determine the optimal recruitment time for each new class. WMHI will continue to analyze and identify areas to improve staffing efficiency, potentially reduce overtime, and make projection on staffing needs based on data and the likelihood of continued increase in our population. WMHI will continue to monitor this data in collaboration with our state and department administration in order to determine correct adjusted staffing levels and whether additional positions can and should be funded. WMHI will continue to hold regular, ongoing listening sessions to give employees a chance to ask questions or provide feedback regarding hospital policy and any changes that may be occurring. The listening session panel includes senior management staff representing nursing, HR, the Director's office, and other senior leadership as needed.

Measurement/sustainability of compliance to related standards:

WMHI will continue to utilize the data collected to identify trends that will help aid in the related improvement efforts.

VanDyck, Jamie L - DHS

From:	complaint@jointcommission.org
Sent:	Wednesday, May 11, 2016 8:20 AM
To:	Speech, Thomas J - DHS; VanDyck, Jamie L - DHS; VanDyck, Jamie L - DHS; Speech, Thomas J - DHS; Speech, Thomas J - DHS
Subject:	Correspondence from The Joint Commission Office of Quality Monitoring: 11

Wednesday, May 11, 2016

Thomas Speech
Winnebago Mental Health Institute
PO Box 9
Winnebago, WI 54985-0009

Regarding: Winnebago Mental Health Institute
Incident ID 241474

Dear Dr. Speech:

I am writing to inform you that based on review of your organization's response to incident number 241474, The Joint Commission will take no further action at this time. However, should we receive additional information that may be relevant to these issues in the future, a determination will be made at that point if further evaluation will be required.

Thank you for working with the Office of Quality and Patient Safety in efforts to continuously improve patient safety.

Sincerely,

Ms. Kathleen E. Weeks, RN, JD
Office of Quality and Patient Safety