Organization Response for Incident # 237838

General Information

Incident Number:	237838
Incident Date:	01/18/2016
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:

Patient Name [redacted]

I was admitted into Winnebago Mental Health Institution on the morning of January 18th. I was detained from my own home while sleep walking. I suffer from PTSD and anxiety disorder. I have no other mental health issues. When I arrived at Winnebago I was awake and lucid. I refused to sign the admittance paperwork because I did not need to be detained. While in the facility I was treated very poorly, as were all the patients there. I started keeping a journal of events on the morning of the 19th. The main incident that concerns me occurred the evening of the 18th. I was standing in the hallway next to the day room inside of the unit. I had tried talking to the people working at the facility numerous times about going home and not belonging there. Not only were my requests denied but they decided they needed to restrain me even though I did not harm myself or anyone else. I stood there just bawling and wanting to go home to my little girl. They threw me down to the ground, someone had their knee on the back of my neck and about 4 or 5 other people jumped in restraining my arms and legs. They then carried me to the isolation room, where I was strapped down and injected with two different needles in which I have no idea what they were, but it burnt all the way down my veins. The first needle did nothing to me I still fought as hard

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as I could to get free of the restraints. The second needle must have put me to sleep because when I awoke I was in my room again and I had bruises all over my body and my butt was bleeding. I suspect I was anally raped while sleeping. I couldn't seem to get the feces to stop coming out and it felt like I had a tear in my rectum. When I asked to see a doctor after this occurred not only did they lie to me and say that they never abused me they refused to let me see any doctors. They eventually gave me some hydrocortizone cream but that took like hours of complaining. The staff in the facility are very over worked, all they talked about while I was in there was overtime and being under staffed. That is no excuse for treating any patient this way. They are rude and inconsiderate. They mocked and made fun of me while I cried and begged and pleaded for my life! This is not a hospital setting, more like prison. I will not rest until action is taken against this place. Please contact me for further information. I documented absolutely everything from the 19-21. Thank you for your time.

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 237838- 1-18-16 complaint- Submitted 4-6-16

Patient was admitted to the Winnebago Mental Health Institute (WMHI) from 1/18/16-1/20/16 on an Emergency Detention for suicidal ideation and psychosis. Patient's urine drug screen was positive for THC and her medical database notes a diagnosis of Diverticulitis.

Upon admission, Patient was provided with the unit guidelines, which she threw away. Documentation indicates that she was provided with a second copy of guidelines which she also threw away. Her initial assessment was completed on 1/18/16 at 10:37am and her medical database was completed at 11:50am on the same date. During her initial assessment the manikin diagram showed bruising on the right arm, left lower leg, and right flank.

While on the unit, patient began screaming in front of the nursing station and was making delusional statements. Patient then walked into the vestibule and was threatening the staff. Staff provided patient multiple redirections to walk to staff directed calming time, however patient continued to threaten with closed fists. As redirection attempts were unsuccessful, patient was lowered to the ground through trained CPM (Crisis Prevention Management) protocol and placed on the transboard. There were no reported/observed signs of injury and no signs of trauma.

Documentation indicates one PRN injection was ordered, to no effect, for calming purposes during the restraint and patient was awake when she was released from the restraint. There is no documentation regarding patient complaints of bruising or being raped.

On 1/19/16 Patient met with her assigned social worker and psychiatrist. Despite the social worker's repeated attempts to review and provide education regarding patient's legal status, court proceedings and treatment recommendations, Patient continued to claim she was being held at the facility wrongfully and was unwilling to consider any other options aside from demanding to be released from the facility. Patient did not mention or raise concerns regarding rape or abuse allegations. There is also no documentation that hydrocortisone cream was ordered or administered.

On 1/28/16, WMHI Client Rights Facilitator spoke with the former Patient via telephone regarding similar allegations of this complaint and asked Patient to provide information in writing however, Patient did not follow through with this request.

On February 9th and 10th, 2016 WI Department of Quality Assurance presented to WMHI for an unannounced onsite complaint investigation regarding Patient and forwarded findings to Centers for Medicare & Medicaid Services. WMHI was found to be in compliance with WI Administrative Code for Hospitals and was found to be in substantial compliance with Medicare Conditions of Participation for Hospitals with no citations issued, and the complaint was not substantiated.

WMHI is aware of the recent overtime concerns and has been working diligently to resolve these issues. It is true that staff does, at times, discuss overtime issues in front of patients. It is an expectation that staff does not engage in this type of discussion in patient care areas, and WMHI actively discourages such talk through ongoing reminders and customer service training. Staff have the opportunity to voice

concerns, question hospital leadership, and provide suggestions through Employee Council; regular, ongoing listening sessions with a panel that includes senior management staff representing nursing, HR, the Director's office; an internet-based forum for asking questions directly of the Director's office; and an anonymous tip line.

Systems Improvements and follow up Actions:

Customer Service continues to be a focus at WMHI. The customer service initiative was created to enhance staff/patient interactions to facilitate improved patient satisfaction/outcomes. Goals identified include decrease in patient complaints, decrease in patient acuity (less aggression, less S&R, and decrease in staff injuries), improved staff morale, improvement in staff teamwork/cohesiveness, and improved communication skills. The committee leading the way on our customer service work followed up on the original training with a survey to obtain feedback on the training, the initiative, and the state of customer service at WMHI. The survey identified many things we do well, as well as a number of areas that need improvement. The survey results were presented by the Customer Service committee to hospital leadership, who are in the process of developing strategies to improve these areas and advance the customer service focus throughout WMHI.

WMHI will continue to hire and train staff to assist with the overtime issues. WMHI will continue to analyze and identify areas where WMHI can improve staffing efficiency, potentially reduce overtime, and project staffing needs based on data and the likelihood of continued increase in our population. WMHI will continue to present this data to our state and department administration in order to determine correct adjusted staffing levels and whether additional positions can and should be funded.

Measurements/sustainability of compliance to related standards:
WMHI will continue to utilize the data collected to identify trends that will aid in the related improvement projects.

VanDyck, Jamie L - DHS

From:	complaint@jointcommission.org
Sent:	Thursday, April 07, 2016 3:59 PM
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

Thursday, April 7, 2016

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

Regarding: Winnebago Mental Health Institute
Incident ID 237838

Dear Dr. Speech:

I am writing to inform you that based on review of your organization's response to incident number 237838, 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. Tarynne R. Easley, RN MBA CPPS
Office of Quality and Patient Safety