Organization Response for Incident # 251703

General Information

Incident Number:	**251703**
Incident Date:	09/03/2016
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:

This isn't about one specific incident. First, lately I have heard from numerous veterans that WMHI is not licensed to take in patients with developmental disabilities. Yet we CONSTANTLY get them. And the majority of them are put on 1:1s, causing loads of overtime. If this is true, something needs to be done. Our facility, regardless of certification, does not have the tools to help these patients when they are thrown in with the violent offenders. And again if we are not certified for these types of patients, our hospital causes major amounts of overtime that is wildly unnecessary.

Problem number two is our Gordon building, which is supposed to be lax for the long term patients before they hit their MR. But there are NO. RULES. At least three patients have been transferred back to Petersik over the last six months because they test positive for or are found to have street drugs, mainly oxy and heroin. Yet not one thing has changed with the visiting policies or procedures in that building. The place is a giant joke to the entire hospital and no one cares. And half of that building is supposed to be an AODA unit. Real therapeutic.

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

The complaint states that WMHI is not licensed as a facility for the care of developmentally disabled individuals. As a state psychiatric hospital mandated by WI State Statute Chapter 51 to admit individuals who are detained under an emergency detention, WMHI is unable to refuse admissions. Inpatient services at WMHI are intended to ensure that each unit provides appropriate treatment for patients to obtain an optimal level of functioning, support them in their recovery, and return them to the community at the earliest possible date. Planning for discharge begins upon admission and is a collaborative effort involving the patient/family/guardian; County Department of Human Services and Managed Care Organizations. Therefore, individuals are assessed according to their mental health treatment needs regardless of cognitive level. A 1:1 could be ordered for various reasons including security, vulnerability, aggression, or suicidal behavior. WMHI is very attentive to patient acuity and needs, which at times, necessitates increased levels of 1:1 care.

The complaint also states the Gordon Hall Building is "lax" and has "no rules". Gordon Hall is a minimum security building with two units; a general psychiatric unit and a treatment program that serves patients with dual diagnosis of mental illness and alcohol or other drug abuse issues. Policies and Procedures are regularly reviewed and updated. There has been one instance within the last 6 months in which a patient was found to have an illegal substance on the unit. The substance was identified by staff and immediate action was taken to include; 1) Collaboration with our local police department to identify the illegal substance, file appropriate charges, and use of the K9 to search the unit; 2) The following day visiting procedures were revised and staff were trained on new procedures; 3) email and 'hard copy' descriptions to all staff about the nature and risk of the substance discovered; 4) and, as with any time we become aware of a safety or security risk, the patient was transferred to Petersik Hall, a medium security building, due to the identified higher level security need.

Systems Improvements and/or Follow-up Actions:

As WMHI will continue to be mandated by WI State Statute 51 to admit individuals who are detained under an emergency detention, the institute will continue to work with its system partners, including a work group sponsored by the Bureau of Family Care, to help address discharge and placement issues.

As noted above, WMHI took several actions after the illegal substance was found on the unit. Further follow up action will include: 1) Further staff training; 2) Continued research and alerts to staff regarding trends in illegal substances; 3) Continued collaboration with the local police department; 4) Review of our in-house medical preparedness for managing overdose of illicit substances, particularly opioids.

We would also like to note that employees have opportunities to question hospital leadership or provide suggestions, including the Employee Council; regular, ongoing listening sessions with a panel that includes senior management staff representing nursing, HR, and the Director's office; an internet-based forum for asking questions directly of the Director's office; and an anonymous tip line.

Measurement/sustainability of compliance to related standards:

WMHI will continue to utilize data collected to identify trends that will aid in related improvement projects.

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VanDyck, Jamie L - DHS

From: complaint@jointcommission.org
Sent: Wednesday, September 28, 2016 8:47 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, September 28, 2016

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

Regarding: Winnebago Mental Health Institute
Incident ID 251703

Dear Dr. Speech:

I am writing to inform you that based on review of your organization's response to incident number 251703, 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,

Mr. Alan J. Pietrowski, RN, MSN, CPPS
Office of Quality and Patient Safety