System Changes are Needed to Help Ensure Patient and Staff Safety at the Milwaukee County Behavioral Health Division

October 2010

Committee on Finance and Audit

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Milwaukee County

Jerome J. Heer • Director of Audits
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October 25, 2010

To the Honorable Chairman
of the Board of Supervisors
of the County of Milwaukee

We have completed an audit of patient safety at the Milwaukee County Behavioral Health Division (BHD).

The report provides examples of a small number of patients whose particularly aggressive behavior makes placement in the community difficult, whose treatment in BHD Adult Acute Inpatient units can be disruptive to the therapeutic environment for other patients, and whose behavior can pose a threat to their own safety as well as that of other patients and staff at the facility. Such patients can be caught up in a vicious cycle of aggression, arrest, court-ordered evaluation/placement at a state institution, and a 'not competent' court finding that ultimately returns the patient to BHD. The report notes that there are no 'easy fixes,' but identifies a limited number of options to address this issue.

A response from the Behavioral Health Division is included as Exhibit 6. We appreciate the complete and timely cooperation extended by administrators and staff of BHD during the course of this audit.

Please refer this report to the Committee on Finance and Audit.

Jerome J. Heer
Director of Audits

JJH/cah

Attachment

cc: Milwaukee County Board of Supervisors
Scott Walker, Milwaukee County Executive
Cynthia Archer, Director, Department of Administrative Services
Terrance Cooley, Chief of Staff, County Board Staff
Geri Lyday, Interim Administrator, Behavioral Health Division
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System Changes are Needed to Help Ensure Patient and Staff Safety at the Milwaukee County Behavioral Health Division

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Summary

On March 10, 2010 the *Milwaukee Journal Sentinel* reported that in February the federal Centers for Medicare and Medicaid Services (CMS) had cited the Milwaukee County Mental Health Complex for regulatory violations related to a failure to protect a female psychiatric inpatient from sexual contact with another patient. The female patient became pregnant as a result of sexual contact while at the facility. On April 30, 2010 the Milwaukee County Board Chairman directed the Department of Audit to conduct an audit of the Behavioral Health Division to address patient safety.

BHD has implemented corrective measures to address findings of a CMS review that resulted in notification of an Immediate Jeopardy to patient health and safety.

In response to a complaint, the CMS investigated conditions at the Milwaukee County Behavioral Health Division (BHD) in January 2010. Staff from the State of Wisconsin Department of Health Services, Division of Quality Assurance (DQA), conducted an on-site survey on behalf of the CMS from January 19 through January 21, 2010.

Key Survey Findings

Violations of the Code of Federal Regulations were cited in three areas:

- **Condition of Participation: Patient Rights (CFR 482.13)**
  Surveyors concluded that the "hospital failed to ensure that 11 patients were safe from inappropriate sexual contact in their environment." A finding of Immediate Jeopardy (IJ) to patient health and safety was communicated to BHD staff on January 21, 2010. The findings placed BHD at risk of losing approximately $15 million in federal and state Medicare and Medicaid funding received annually by BHD for acute inpatient treatment. The surveyors described eight separate incidents involving sexual contact among the 11 patients, and identified several instances in which policies were not followed or documented in the medical records. One of the 11 patients included in the surveyors' citations was involved in five of the eight sexual contact incidents. In addition, surveyors received the acknowledgement of BHD management that "it became clear to them that the front line staff was not aware the hospital had a 'no sexual contact policy.'"

- **Condition of Participation: Governing Body (CFR 482.12)**
  Surveyors concluded that "…the governing body failed to be effective in its responsibility for managing the hospital." Numerous instances are noted by the surveyors of incomplete medical records.

- **Condition of Participation: Nursing Services (CFR 482.23)**
  Surveyors cited instances of shortcomings in several aspects of patient records whose completion fall under the responsibility of Registered Nurses (RNs).

BHD Corrective Actions

A plan of correction was submitted by BHD on January 29, 2010 to address the IJ finding and a subsequent plan of correction was submitted on February 18, 2010 to address all remaining issues. Subsequent documentation from the CMS and State indicates acceptance of BHD's plans of correction. Details of the plans of correction are provided in the body of this report.

Adherence to Plan of Correction

Our review of BHD's adherence to the corrective action plans and correspondence from regulators indicates substantial compliance with the plans, but the need for continued diligence on the part of the BHD administration to monitor and measure staff compliance. In addition, we believe legislative oversight of BHD's progress in attaining and sustaining compliance is an important aspect of holding administrators accountable for results.

Patient acuity, including aggressive behavior, drives BHD staffing needs and is a critical factor affecting the institution's ability to maintain a safe environment for patients and staff.

Professional nursing staff at BHD has been vocal in expressing concerns about the level of staffing, particularly in the Adult Acute Inpatient units. In a member survey of 98 BHD nurses conducted in May and June of 2010 by the nurses' collective bargaining unit, 66% of respondents rated their units "very unsafe" (22%) or "somewhat unsafe" (44%). BHD administration notes that in the third quarter of 2010, 43% of nursing staff (including Registered Nurses and Certified Nursing Assistants) were referred for disciplinary action for excessive absenteeism. Unscheduled absences create additional coverage challenges for staff on duty.

BHD Staffing Levels

Total nursing staff hours worked has remained fairly stable in recent years, increasing a small amount (about 7%) from 2007 to 2008 and decreasing slightly (less than 2%) in 2009. Overtime hours as a percentage of total time worked was also stable, ranging between approximately 15% and 16% during the three-year period. During the same three-year period, total patient census days decreased nearly 10%. As a result, patient to nursing staff ratios declined during the three-year period, from four patients to every Registered Nurse (RN) or Certified Nursing Assistant (CNA) on duty in 2008 to 3.5 patients for every RN/CNA on duty in 2009. While the patient to staff ratios showed modest declines from 2007 to 2009, patient to staff ratios alone do little to provide insight into their adequacy in providing a safe environment for patients and staff. Rather, the complexity of the level of care needed by patients, known as patient acuity, has vital staffing level implications.

Heightened Patient Observations

Standard practice on the Adult Acute Inpatient units is that every patient must be monitored by nursing staff (typically a CNA) once every 30 minutes. However, an attending psychiatrist or psychologist may order behavior observation checks for a patient every 15 minutes to monitor for the effects of changes in medication, for inappropriate behaviors, or for other specific reasons. Further, when a patient exhibits behaviors that are deemed dangerous to the patient or others, an attending psychiatrist or psychologist may place a one-to-one (1:1) observation order to monitor patient behavior on a constant, around-the-clock basis. The frequency of such orders fluctuates with the mix of patients and patient behaviors, and can quickly skew patient-to-staff ratios by placing all of one CNA's attention on one patient in the unit.

While there is no summary data on the frequency of 15-minute behavior observation checks, our review of medical records for 42 patients receiving care in the Adult Acute Inpatient units during two days in August 2010 indicated 30 (71%) had been under 15-minute behavior observation checks in recent days. BHD has recently begun compiling summary data to track staff hours devoted to 1:1 observations. During the 10-month period tracked, 1:1 observations required an average of 2.5 FTE staff per month, or an annual rate of 29.5 FTEs devoted solely to 1:1 observations.

Incident Reports

Data for the five-year period 2005—2009 reflects an upward trend in the rate of incidents reported per 1,000 patient-days, for incidents in categories that are reflective of a high level of patient acuity. That trend spiked in 2009 (up 51% from the previous year) and is projected to subside by about 16% in 2010.

Data on the rate of incidents indicating aggressive patient behavior reflects a similar pattern, again documenting a significant spike in 2009. In 2009, the rate of incidents reported for these categories reflected a 55% increase over the previous year. Incidents reported in these same categories in 2010 are projected to be nearly 20% lower than in 2009. This is likely due, in part, to increased scrutiny of patient behaviors prompted by events leading to the January 2010 CMS survey findings and plans of corrective action. Another potential explanation for the reduction in reported incidents is the implementation of a 'zone system' for deploying CNA staff.

Base Staffing Levels and the Zone System

BHD base staffing levels for Adult Acute Inpatient units have been a source of controversy between management and nursing staff in recent years. Prior to 2006, Adult Acute Inpatient units routinely

operated with a bed capacity of 31. In recent years, bed capacity was gradually reduced; first down to 29, then to 27, and since May 2009, BHD operates with a bed capacity of 24 beds per unit. Since operating under the reduced bed capacity, management has considered base staffing per unit to be three RNs, rather than four. This did not affect all shifts for all units, however; there are frequently either three or four nurses scheduled at the beginning of a shift. There has been concern expressed by some nursing staff that, given the patient acuity level at BHD, a base staffing level of four RNs is needed.

Under the zone system, a CNA is given responsibility for one of three zones established on each unit. By assigning exclusive responsibility for monitoring each zone, accountability for surveillance of the entire unit is enhanced. The zone system was phased in during the past year. With implementation of the zone system, base CNA staffing was increased from two to three.

We reviewed detailed nursing staff schedules for the month of July 2009. Four RNs were on duty during the day (1st) shift about 65% of the shifts, with the base level staffing of three RNs about 33% of the shifts. For the evening (2nd) shift, four RNs were on duty about 49% of the shifts, while the base level of three RNs were on duty about 50% of the shifts. In a separate analysis in which we compared categories of Incident Reports indicative of an unsafe environment filed during the month of July against these staffing levels, we found that 46% were filed when three RNs were on duty, 50% were filed when four RNs were on duty, and 6% were filed when two RNs were on duty.

Staffing ranged from two to four CNAs for about 77% of the day shifts; about 84% of the evening shifts; and about 97% of the overnight shifts. A frequent criticism expressed by nursing staff, and a problem acknowledged by BHD administration, is the lack of a relief factor for lunch breaks or patient escort duties built into the scheduling of CNAs under the zone system. Our analysis of additional CNA hours necessary to provide a relief factor for the 1st and 2nd shifts indicates an additional 18 FTEs contained in the County Executive's Proposed 2011 Budget would be sufficient for that purpose.

Unsafe Staffing Forms

The collective bargaining unit that represents RNs at BHD, has developed a form called an Unsafe Staffing Form. A union official told the Milwaukee County Board's Health and Human Needs Committee at its May 19, 2010 meeting that there had been an alarming increase in the number of Unsafe Staffing Forms filed by its members at BHD, citing inadequate staffing and an increase in the number of patients needing one-to-one observation as concerns.

We plotted all Adult Acute Inpatient hospital Unsafe Staffing Forms on file with the union for the six-month period July through December 2009 and compared them to nine categories of Incident Reports indicative of unsafe patient or staff behavior during the same period. The results indicate that Unsafe Staffing Forms alone are not a reliable predictor of incidents indicative of unsafe conditions. Incident Reports were filed in only about 14% of the shifts in which an Unsafe Staffing Form was filed by an RN. Conversely, Unsafe Staffing Forms were filed in only about 3% of the shifts during which an Incident Report was filed.

While this analysis suggests that Unsafe Staffing Forms cannot be used to reliably document unsafe conditions, they document RN's perceptions of an unsafe environment. Further, based on our analysis, along with interviews with nursing staff and observation of the units, those perceptions are based on the reality of an environment that can be volatile and can rapidly deteriorate.

Current Model Not Suited for Particularly Aggressive Patients

This report details three examples of a small number of patients whose particularly aggressive behavior makes placement in the community difficult, whose treatment in the Adult Acute Inpatient units can be disruptive to the therapeutic environment for other patients, and whose behavior can pose a threat to their own safety as well as that of other patients and staff at the facility. Such patients can be caught up in a vicious cycle of aggression, arrest, court-ordered evaluation/placement at a state institution, and a 'not competent' court finding that ultimately returns the patient to BHD.

To help place the number of particularly aggressive patients in context, we utilized the database of Incident Reports maintained by the Quality Improvement unit at BHD. During a 44-month period ending September 10, 2010 there were a total of 2,746 Incident Reports filed pertaining to the Acute Adult Inpatient units. From this total, there were 808 incidents, involving 411 unique patients, in categories indicating dangerous patient behaviors. During that same time period, there were a total of 5,328 unique patients admitted to the Adult Acute Inpatient hospital.

Of the 411 patients exhibiting potentially aggressive/assaultive behavior in reported incidents, there were 19 patients that appeared five or more times as the primary person involved. Of those 19 patients, 10 had been found by the court to be not competent to stand trial due to mental defect or disease on one or more occasions. While relatively few in number, particularly aggressive patients require greater attention from staff and can agitate other patients on the Adult Acute Inpatient units.

Nurses we interviewed at BHD expressed frustration with the current environment. Suggestions for improvement included increased security presence on the inpatient units, and a greater effort on the part of law enforcement to hold patients that understand right from wrong accountable for acts of violence. Discussion with staff from the Milwaukee County District Attorney's Office, the Milwaukee County Sheriff's Office and BHD administrators confirmed there are no readily available, 'easy fixes' to address the needs of these small number of patients.

Options

A limited number of options were identified to address the problems involving the accommodation of particularly aggressive/assaultive patients.

- **Development of Community Support Infrastructure.**
  One potential option identified by BHD administrators in discussing the issue of particularly aggressive/assaultive patients was developing community support infrastructure to provide intense, close supervision of very small numbers of patients, such as a specialized group home for four to eight residents.

- **Single-Gender Wards.**
  An option that BHD administrators were instructed by the Milwaukee County Board of Supervisors to review was the potential implementation of single-gender, rather than mixed-gender, acute inpatient units. That review is underway. BHD administrators concluded that mixed gender wards for psychiatric hospitals are the norm in Wisconsin, and that there is a lack of evidence-based literature on the implications of single-gender wards in the U.S. BHD continues its review; a survey of patient attitudes with regard to such a change was recently completed, and a survey of staff attitudes is underway.

- **Secure Unit.**
  Both State Mental Health Institutes (Mendota and Winnebago) operate secure units for high-risk patients. However, unless placement is court-ordered, the State institutes must agree that the placement is therapeutically appropriate, and the County of origin must pay a daily fee (currently approximately $1,000 per patient per day). Available space for such voluntary placements fluctuates, but is limited.

  Milwaukee County formerly operated a secure unit, but it was discontinued in 1996 due to budgetary constraints and in accordance with a movement to downsize institutional care in favor of community based services. According to BHD staff, there was also concern that practices at the secure unit could adversely affect Joint Commission accreditation. Estimating the additional cost of operating a high-risk secure ward would require detailed analysis but could easily reach $2 million annually, would incur additional start-up capital costs, and would be inefficient to operate due to a high staff-to-patient ratio.

Federal and state regulators provide system accountability; personal accountability of medical staff is generally left to confidential internal processes.

A key question arising out of the incidents highlighted in the 2010 Center for Medicare and Medicaid Services survey at the Behavioral Health Division is that of accountability within the system.

System Accountability

BHD administration assumes primary responsibility for ensuring that appropriate policies and procedures are in place to provide a safe and healthy environment for the appropriate treatment of mental health patients at County facilities. Accountability at this systemic level is achieved through the federal CMS and the State Division of Quality Assurance, which routinely survey BHD and other health providers to ensure compliance with applicable federal and state regulations. These same agencies investigate individual complaints of substandard care or abuse, the January 2010 survey of BHD being a case in point.

Personal Accountability

With certain exceptions, CMS and State DQA surveys generally do not directly enforce personal accountability for staff performance. (Referrals can be made to other state agencies to investigate specific incidents of caregiver and medical staff improprieties). Rather, BHD relies on two mechanisms to achieve personal accountability for medical staff performance. The first, and most commonly used mechanism, is the regular human resource/supervisory relationship and disciplinary process practiced by every Milwaukee County department.

The second mechanism to establish personal accountability for medical staff performance, used by BHD as well as all other hospitals in the United States, is a system of internal review and corrective action that includes enforcement actions up to and including reporting to professional licensing authorities.

We requested that BHD administration provide evidence that any disciplinary procedures were applied by the Medical Staff Peer Review Committee to any BHD medical staff relative to incidents and findings highlighted in the January 2010 CMS survey. Alternatively, we requested affirmation that no disciplinary action was warranted in that regard.

However, BHD administrators are prohibited from providing documentation regarding any Medical Staff Peer Review activities that may have been conducted in conjunction with the incidents highlighted in the January 2010 CMS survey. They noted that shielding such activity from public disclosure is critical to encourage frank and open participation in the critical incident review process, as well as to encourage future reporting of events. They note that the Medical Staff Peer Review function includes careful analyses of root causes of weaknesses in systems and processes, as well as individual practitioner performance. We confirmed that such confidentiality is standard practice in the medical field, and that Wis. Stat. s. 146.38 protects the confidentiality of records and conclusions of Medical Peer Review Committees.

Consequently, we agree that BHD administration is prohibited from disclosing whether or not Medical Staff Peer Review disciplinary actions were applied, or not warranted, with regard to the incidents highlighted in the January 2010 CMS survey. We acknowledge that this important safeguard to protect the integrity of the peer review process conflicts with the concept of absolute public accountability. It is a matter of public record that, in the aftermath of extensive media coverage of issues related to the January 2010 CMS survey, the BHD Administrator was demoted to a position of lesser responsibility in another County division, and a BHD staff psychiatrist has been recommended to the County Personnel Review Board for discharge.

Reported Falsification of Records

Elected officials have publicly demanded that individuals be held accountable for any known instances of BHD employees falsifying records, as was widely reported in the media. It is possible to infer, solely from the CMS survey comments, that County staffers allowed a patient to repeatedly leave the ward unsupervised, then falsified documents to say the patient was being checked every 15 minutes.

However, based on our review of the CMS survey document, an examination of pertinent medical records, security logs and other BHD documents, as well as interviews with multiple BHD staff members (including those interviewed by the surveyors), we conclude that none of the findings or comments contained in the 2010 CMS survey of BHD, upon further scrutiny, support a conclusion that BHD employees falsified records.

Professional Credentials Check

As part of our audit work, we checked with the Wisconsin Department of Regulation and Licensing and verified that all 68 psychiatrists, psychologists and physicians currently on staff at BHD have current licenses. None were operating with current orders of restriction on their licenses. We also verified there were current licenses on file for all 255 Registered Nurses on staff at BHD. None of the 255 nurses had current orders of restriction on their licenses.

BHD has implemented most of the corrective measures recommended by the Milwaukee County Sheriff's Office to enhance physical security at the institution.

On June 28, 2010 a safety survey performed by the Milwaukee County Sheriff's Office regarding the Behavioral Health Division's Charles W. Landis Mental Health Complex was issued. The report identified various safety issues and provided recommendations to improve the overall safety of the complex. The County Executive's 2011 Proposed County Budget contains $80,000 for security

cameras and $30,000 for electronic card readers to facilitate implementation of the recommendations in the Sheriff's Office report. We verified that all the recommendations have been implemented or are in the process of being implemented, with the exception of the recommendation to screen individuals using the Walk-In Clinic. BHD administration continues to take the position that the screening of individuals who wish to use the Walk-In Clinic would have an adverse effect on voluntary participation--individuals would be apprehensive about a weapons screening process and therefore may not seek the treatment that they need.

We wish to acknowledge the complete and timely cooperation of staff from BHD throughout the audit process. A response from BHD management is presented as **Exhibit 6**.

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Background

The Milwaukee County Department of Health and Human Services Behavioral Health Division (BHD) is a public sector system for the integrated treatment and recovery of persons with serious behavior health disorders. The Adopted 2010 Budget indicates that BHD administers and coordinates the following programs:

- **Management/Support Services** is comprised of centralized programs, services and related costs necessary for the overall operation of the Behavioral Health Division. Management/Support Services section is responsible for maintenance and housekeeping, including other management support services. Expenditures are allocated to the Inpatient Services/Nursing Facility, Inpatient Services/Acute Adult/Child, Adult Community, AODA, Adult Crisis and Child and Adolescent Programs, according to Medicare and Medicaid cost allocation methodologies and reflective of the services consumed by the programs.

- **Inpatient Services: Nursing Facility Services** are Title XIX certified facilities that provide long-term, non-acute care to patients who have complex medical, rehabilitative, psychosocial needs and developmental disabilities. BHD operates two facilities. The Rehabilitation Center-Central is a 70-bed skilled-care licensed nursing home that serves individuals with complex and interacting medical, rehabilitative and psychosocial needs. The Rehabilitation Center-Hilltop is a 72-bed facility for the developmentally disabled that provides active treatment programs and an environment specially designed for residents with dual diagnoses of developmental disability and serious behavior health conditions.

- **Inpatient Services: Acute Adult/Child Services** provide hospital inpatient services in five licensed, 24-bed units. One unit specializes in programs for children and adolescents age 18 and under, and four acute adult units provide inpatient care to individuals over age 18 who require safe, secure short-term or occasionally extended hospitalization.

- **Adult Community Services: Mental Health** is composed of community-based services for persons having a serious and persistent mental illness and for persons having substance abuse problems or a substance dependency. The majority of services in the mental health program area are provided through contracts with community agencies. The mental health program is composed of several major program areas for the medical and non-medical care of consumers in the community including Community Support Programs, Community Residential, Targeted Case Management, Outpatient Treatment and Prevention and Intervention services.

- **Adult Community Services: Alcohol and Other Drug Abuse (AODA)**, which is now called WIser Choice AODA services provides a range of service access, clinical treatment, recovery support coordination (case management) and recovery support services. The target populations include: 1) the general population including adults seeking assistance in addressing their substance abuse disorder; 2) a population involved with the State correctional system; and 3) a population involved in the local, Milwaukee County correctional system, with the two priority sub-populations being pregnant women and women with children.

- **Child and Adolescent Community Services** branch of the Behavior Health Division functions as a purchaser and manager for the mental health services system for Milwaukee County youth through the Wraparound Milwaukee Program and the Family Intervention Support Services (FISS) Program, and provides mental health crisis intervention services to the Milwaukee Public School System, Child Welfare System and to all Milwaukee County families in need of the services.

- **Crisis Services** function is composed of multiple programs that assist individuals in need of immediate mental health intervention to assess their problems and develop mechanisms for stabilization and linkage.

- **Emergency Medical Services (EMS) Program (Paramedics)** is a Milwaukee County-managed and sponsored program designed to benefit the entire community.

Table 1 presents recent expenditure and revenue figures for the division, along with the number of funded Full Time Equivalent (FTE) positions.

Table 1
BHD Budget Highlights
2008—2010

	2008 Actual	2009 Budget	2010 Budget	2009/2010 Change
Total Expenditures	$241,918,557	$187,598,123	$186,388,758	($1,209,365)
Total Revenue	$186,060,122	$130,761,942	$130,296,449	($465,493)
Direct Total Tax Levy	$55,858,435	$56,836,181	$56,092,309	($743,872)
Position Equivalents (Funded)	890.9	893.2	827.7	(65.5)

Source: Milwaukee County 2010 Adopted Budget.

On March 10, 2010 the *Milwaukee Journal Sentinel* reported that in February the federal Centers for Medicare and Medicaid Services (CMS) had cited the Milwaukee County Mental Health Complex for regulatory violations related to a failure to protect a female psychiatric inpatient from sexual contact with another patient. The female patient became pregnant as a result of sexual contact while at the facility.

A threat of sanctions, including the withholding of federal funding, was lifted after a corrective action plan was submitted and approved by the CMS.

On April 30, 2010 the Milwaukee County Board Chairman directed the Department of Audit to conduct a performance audit of the Behavioral Health Division to address patient safety. The directive included the following language:

> *"I believe that an audit of the Division would be a useful tool in understanding whether we have the appropriate procedures in place to ensure patient safety, whether those procedures are being followed and, if not, what is needed to improve the Division's performance. Therefore, I am directing your staff to conduct a performance audit to address patient safety. In addition to any items related to policies and procedures, I trust that you will examine staffing, training or any other factors that you deem relevant to this issue."*

Given the nature of the concerns that prompted the call for an audit, we focused our audit efforts on the safety of patients and staff of the Adult Acute Inpatient units at BHD.

BHD administration includes senior management positions in various disciplines and functional areas. Key organizational units impacting the Adult Acute Inpatient hospital include the following:

- Division Administrator;
- Crisis Services;
- Acute Inpatient Services;
- Medical Services;
- Nursing Administration;
- Environment of Care Compliance;
- Environmental and Support Services; and
- Fiscal/Budget Services.

In discussing a draft version of this report, BHD administrators noted that there were vacancies in key management positions at BHD during all or portions of the period under review include:

- Division Administrator;
- Medical Director of Adult Acute Inpatient Services;
- Chief Psychologist;
- Assistant Director of Nursing;
- Director of Education; and
- Several unit manager positions overseeing nursing staff.

Section 1: BHD has implemented corrective measures to address findings of a CMS review that resulted in notification of an Immediate Jeopardy to patient health and safety.

In response to a complaint, the federal Centers for Medicaid and Medicare Services investigated conditions at the Milwaukee County Behavioral Health Division in January, 2010. Staff from the State of Wisconsin Department of Health Services, Division of Quality Assurance (DQA), conducted an on-site survey on behalf of the CMS from January 19 through January 21, 2010.

Key Survey Findings

Violations of the Code of Federal Regulations were cited in three areas.

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- **Condition of Participation: Patient Rights (CFR 482.13)**

  Surveyors reviewed the medical records of 11 patients who had, according to BHD incident reports, been involved in suspected and/or confirmed instances of sexual contact. In addition, the medical records of six other patients were selected at random, resulting in a universe of 17 patients whose medical records were scrutinized. Surveyors also reviewed policies and procedures, BHD incident reports and conducted interviews with staff at BHD.

  Surveyors concluded that the "hospital failed to ensure that 11 patients were safe from inappropriate sexual contact in their environment." The surveyors also concluded that the "hospital failed to maintain safety for 11 patients." A finding of Immediate Jeopardy (IJ) to patient health and safety was communicated to BHD staff on January 21, 2010. The findings placed BHD at risk of losing approximately $15 million in federal and state Medicare and Medicaid funding received annually by BHD for acute inpatient treatment.

  The surveyors described eight separate incidents involving sexual contact among the 11 patients, and identified several instances in which policies were not followed or documented in the medical records. One of the 11 patients included in the surveyors' citations was involved in five of the eight incidents.

In addition, surveyors received the acknowledgement of BHD management that "it became clear to them that the front line staff was not aware the hospital had a 'no sexual contact policy.'"

Excerpts from the CMS Statement of Deficiencies relating to a finding of Immediate Jeopardy are included as Exhibit 2.

Excerpts from the CMS Statement of Deficiencies relating to the finding of Immediate Jeopardy are organized in summary form by the Department of Audit and included as **Exhibit 2**.

Our review of notes from the attending psychiatrist in the medical record of one of the patients casts doubt on whether sexual contact occurred between two of the patients cited by the surveyors. That incident involved an allegation by one patient that his roommate had sexually assaulted him the previous night. The attending psychiatrist concluded that no sexual contact had occurred, based on the patient's initial claim that his roommate had held him down and sexually assaulted him, then during the same interview stated that five of his roommate's friends had come in through the window (the room is on the 4th floor) and held him down while his roommate pointed a gun in his side.

Notes indicate the attending psychiatrist asked the patient twice during the interview if the episode could have been a nightmare/dream, to which the patient responded yes on both occasions. The discharge summary in the patient's medical record indicates the attending psychiatrist concluded the episode was a delusion based on the lack of a realistic story.

A surveyor's comments indicate that a BHD Medical Director acknowledged that in an allegation of sexual assault, a physical examination should have been done, and that it was not normal during a sexual assault interview for the interviewer to ask an alleged victim if it were a dream.

- **Condition of Participation: Governing Body (CFR 482.12)**

Surveyors concluded that "based on review of patient and personnel records, pertinent policies and incident report reviews, and staff interviews, the governing body failed to be effective in its responsibility for managing the hospital."

Numerous instances are noted by the surveyors of incomplete medical records.

Numerous instances are noted by the surveyors of incomplete medical records, including a lack of information about sexual activity and birth control on a form documenting a medical history and physical exam; failure to document a patient's inappropriate sexual behavior, for which she spent considerable time on 15-minute behavior observation, in a discharge summary; and failure to note another patient's inappropriate sexual contact with a peer in the patient's discharge summary.

Additional survey findings under this citation relate to BHD's failure to properly document and/or enforce contracted service provisions. For instance, one survey comment indicated that a form in a patient's medical record documenting an overnight pass for possible placement in a group home did not include information about the patient's recent inappropriate sexual behavior or that the patient was on 15-minute behavior observation for that purpose. BHD administrators told us that this particular patient has a Family Care case worker for the Developmentally Disabled who had previously provided a thick reference package to the group home, and that the group home was well aware of the problematic behaviors of this particular patient. However, the administrators acknowledged to the CMS surveyors that BHD did not document a specific communication to the group home outlining the scope of supervision required to keep other group home members safe.

- **Condition of Participation: Nursing Services (CFR 482.23)**

Surveyors cited instances of shortcomings in several aspects of patient records that fall under the responsibility of Registered Nurses (RNs).

Surveyors cited instances of shortcomings in several aspects of patient records that fall under the responsibility of Registered Nurses (RNs).

For instance, there is a form (Behavior Observation Flow Sheets—see **Exhibit 3**) to document compliance with a physician's order that a patient be observed every 15 minutes for certain behaviors. Often times, RNs delegate this responsibility to Certified Nursing Assistants (CNAs). Every 15 minutes, a CNA provides a check-mark attesting to whether or not the patient has exhibited a behavior for which s/he has been placed on 15 minute behavior observation status. The CNA initials each check-mark as it is made. When one CNA hands off responsibility to another (for a break, a change in duties or at the end of a shift), the CNA signs the back of the form. The form is segregated into three shifts, with a line at the bottom of each shift for signature by an RN. Surveyors identified a small number of interludes, ranging from 30 minutes to 90 minutes, in which no check-marks, or check-marks with no CNA initials, are present. Additionally, surveyors identified a small number of shifts in which no RN signature appears at the bottom of the form.

Other examples of non-compliance provided by surveyors include instances in which care/treatment plans were not developed and kept current with specific behaviors exhibited by patients, such as failure to include risk of elopement (unauthorized departure from the hospital) in a patient's care plan and failure to document sexually inappropriate behaviors exhibited by another patient in his treatment plan.

The DQA surveyors simultaneously cited violations of the Wisconsin Administrative Code in two areas:

- Governing Body (DHS 124.05)
- Nursing Services (DHS 124.13)

Those citations were based on the same or similar findings as those documented for the CMS survey. The CMS makes final decisions with regard to Medicare/Medicaid provider certification, with input from state agencies conducting the surveys.

BHD Corrective Actions

The finding of Immediate Jeopardy in the area of patient health and safety was verbally communicated to BHD administrators on January 21, 2010 and required a plan of correction within 10 days. An IJ plan of correction was submitted by BHD on January 29, 2010 and a subsequent plan of correction was submitted on February 18, 2010 to address all remaining issues. On February 9, 2010 and on March 22, 2010, the hospital was resurveyed by the State Division of Quality Assurance, on behalf of the CMS. In the first follow-up survey, the finding of Immediate Jeopardy to patient health and safety was removed. After the second survey, in a letter dated April 14, 2010, the CMS notified BHD that "…your psychiatric hospital continues to meet the requirements for participation in the Medicare program (Title XVIII of the Social Security Act). Subsequent documentation from the State also indicates acceptance of related BHD plans of correction.

In a follow-up survey, the finding of Immediate Jeopardy to patient health and safety was removed.

BHD's corrective action plans were designed to include the following:

- **Enhanced Assessment Procedures.** These modifications were implemented to heighten awareness and communication of risk behaviors, with appropriate supervision and interventions provided during the hospital stay.

    - Inpatient assessments were modified to include detailed assessment of special risks, including risk for sexually inappropriate behavior during hospital stay.

Inpatient assessments were modified to include detailed assessment of special risks, including risk for sexually inappropriate behavior during hospital stay.

- Patient transfer process and History and Physical examination procedures were modified to include consideration of special risks.

- **Enhanced Care Planning, Behavior Monitoring and Team Communication.**

  - Treatment Plans were individualized for patients with risk for sexual behavior to address specific problems, treatment objectives and methods.

Increased efforts were taken to ensure that staff monitor patient behaviors and complete documentation in accordance with policy.

  - Physician orders were updated to ensure specificity for behaviors to be monitored, and increased efforts were taken to ensure that staff monitor patient behaviors and complete documentation in accordance with policy.

  - Resource document *Specific Risk Behaviors to Look For* was developed so all team members are on the same page when communicating information about patient risk.

  - Off Ward Privilege assessment procedures were modified to ensure persons at risk remain on the inpatient unit.

  - Treatment Team Reports and Nursing Cross Shift Reports were revised to ensure communication of patient behaviors between treatment teams and across changes in shifts.

- **Revised Patient Education.**

Patients are informed at the time of admission and in daily Community Meetings that sexual contact is prohibited during hospitalization.

  - Patients are informed at the time of admission and in daily Community Meetings that sexual contact is prohibited during hospitalization.

  - Patients are surveyed at regular intervals by the Client Rights Specialist and Peer Support Specialists to ensure teaching methods are effective and rights are understood and protected.

- **Mandatory Staff Training.**

  - Mandatory training on *Providing Care in a Safe Setting: Prevention, Identification and Management of Sexual Behavior* was provided to more than 600 clinical, support and contracted staff at BHD.

  - Pocket reference cards (see **Exhibit 3**) reinforcing the facility's policy prohibiting any sexual contact between patients, various reporting requirements when sexual contact is known or suspected, and other specific remedies to shortcomings noted in the January 2010 CMS survey.

- Post training management audits and assessments are conducted to measure staff compliance and to demonstrate working knowledge of the policy.

- **Increased Environmental Surveillance.**

  - Community bathrooms, where some incidents of patient to patient sexual contact is known to have occurred, are locked at all times when not in use.

BHD has added video cameras that provide coverage of areas that are out of the view of nurses' stations.

  - Video monitoring. Although not part of the plan of correction submitted to the CMS, BHD has added video cameras for surveillance by BHD Security. The cameras are located to provide coverage of areas that are out of the view of nurses' stations (patient rooms are not equipped with video cameras).

  - Unit zone surveillance. Although not part of the plan of correction submitted to the CMS, BHD has implemented a change in staffing patterns whereby each Acute Inpatient unit is divided into three zones, with a Certified Nursing Assistant assigned to each zone to monitor for safety. The unit zone system is discussed in greater detail in **Section 2** of this report.

- **Post-Incident Investigation and Follow-Up.**

A post-incident protocol calls for reporting all cases of known or suspected patient sexual contact to the Sheriff's Office.

  - A post-incident protocol was developed (see **Exhibit 4**) to ensure uniformity in performing proper assessment, notifications, care and follow-up in the event of a known or suspected incident of sexual contact. The protocol calls for reporting <u>all</u> cases of known or suspected patient sexual contact to the Sheriff's Office.

- **Compliance Plan.**

  - The Acute Executive Committee was assigned responsibility for monitoring and sustaining compliance with the plan of correction. The Acute Executive Committee is comprised of managers from various disciplines within the division, including Acute Inpatient Services, Medical Services, Clinical Operations, Nursing Administration, Recovery and Peer Support Advocacy, and Security.

Adherence to Plan of Correction

As part of its plan of correction, BHD instituted mandatory training regarding its patient sexual contact policy for all staff and contractors with direct patient contact. We examined training records of 198 staff involved in direct patient care at the Adult

Acute Inpatient hospital as of February 2010 to verify that each person attended and/or attested to receiving and understanding the policies regarding patient sexual contact. We verified that signatures on attendance logs for training sessions were on file for 173 staff members and that 16 staff members signed attestations that they had received and understood the training material. Four members were on leave or had terminated employment prior to the training sessions. No signatures were on file for five staff members. The results of this verification were provided to BHD management for follow-up to ensure the small number of employees identified as exceptions have received the appropriate training.

Minutes of the Acute Executive Committee reflect significant management attention to monitoring plan of correction efforts.

In addition, we reviewed minutes of the Acute Executive Committee to verify that BHD administrators were following through with efforts to monitor compliance with measures contained in its corrective action plan. Minutes reflect significant management attention to monitoring plan of correction efforts, including detailed internal audits and reports by individuals that are assigned responsibility for ensuring improved staff compliance. For instance, the April 21, 2010 minutes contained the following entries:

- *The current focus is on units 43-C and 43-D, as the data suggest lower and inconsistent scores. Review of the audit summary reflects an audit of units 43-C/D by sample size, problems written, objectives written, method written and percentage complete by team by all special risk factors. Refer to audit summary for details.*

  The risks identified most often in charts (out of 223 audits completed over 5 weeks) are self-harm and violence, not surprising as these behaviors may result in admission. Auditors continue to provide individual feedback to unit staff and managers, as to sustain improvements.

  DECISION/ACTION TAKEN: Audits continue on units 43-C/D on a bi-weekly basis.

- *…the last audit of the psychiatric/psychological inpatient assessment was above 96%. There were some irregularities noted in the plan. Another audit will be completed and will*

incorporate all areas of risk. A target rate of compliance should be fairly high, most likely well above 90%, probably 95%. If the next audit remains high, probable recommendations will be to discontinue audit, complete a random audit every other month or target those practitioners until their rates are higher.

DECISION/ACTION TAKEN: Additional audit of the psychiatric-psychological inpatient assessment to be completed.

- *Another area in need of monitoring included the nursing cross reports to include communication of those patients identified at an increased risk for sexual behavior, monitoring cross shifts to verify the above and team representation at morning report. Audits suggested compliance. Future random audits to ensure continued compliance are indicated. The Associate Administrator for Nursing indicated the nursing department would conduct some spot checks on the above. Further monitoring of the above has been referred to the Nursing Executive Team for continued audit and improvements.*

  The Director of Acute Inpatient Services will continue to ensure compliance with the sexual contact policy and adherence to the post incident protocol checklist. The Director will continue to review any suspected or known instances or allegations of sexual behavior and monitor policy compliance.

  DECISION/ACTION TAKEN: Director of Acute Inpatient Services to follow-up.

We noted evidence that continued vigilance is necessary to ensure staff compliance with BHD's plan of correction.

Despite documented management attention to implementing and sustaining staff compliance with its plan of correction, we noted evidence that continued vigilance is necessary. For instance, the June 2, 2010 minutes from the Acute Executive Committee contains the following entry:

- The Associate Administrator for Nursing reported that she has conducted face-to-face interviews with RNs and CNAs regarding their knowledge of BHD policies and expectations addressing sexual contact. She reports that the responses have been good, but has also found that new staff and CNAs picking up hours from other hospital areas need prompting/reminders.

  DECISION/ACTION TAKEN: Audits will continue.

Behavior Observation Flow Sheet Signatures

Behavior Observation Flow Sheets are used by nursing staff to document compliance with orders to monitor patients for exhibiting specific problematic behaviors.

We also conducted a review of the Behavior Observation Flow Sheets used by nursing staff to document compliance with orders to monitor patients for exhibiting specific problematic behaviors. We performed the review to determine if the common practice of RNs signing the form at the beginning of their shifts, as noted in the January 2010 CMS survey, had been remedied. The survey contained the following observation:

> *"The RNs are completing the behavior check form at the beginning of each shift and would be unable to account for behavior during times that show documentation as incomplete."*

Our review of numerous medical records from 2009 confirmed that in almost every instance, RNs signed the sheets at the beginning of their shifts.

Our review of numerous Behavior Observation Flow Sheets in medical records of patients in the Adult Acute Inpatient units during 2009 confirmed that in almost every instance, RNs signed the sheets at the beginning of their shifts.

During a two-day period in August 2010, we randomly selected medical records for current patients in each of the four Adult Acute Inpatient units at BHD to review nurses' signature information recorded on the Behavior Observation Flow Sheets. Results of that review are summarized in **Table 2**.

Table 2
Behavior Observation Flow Sheets
RN Signature Review

Patient files viewed	42	
Patients with observation sheets	30	
Total Number of signature lines*	632	
	No. of Signature LIne	**% Total Signature Lines**
Observation sheets signed at the start of the shift	18	2.8%
Observation sheets signed during the shift	20	3.2%
Observation sheets signed at the end of the shift	509	80.5%
Observation sheets that listed the start and ending time of shifts (time of signature was indeterminate):	38	6.0%
No signature after shift was completed:	33	5.2%
Signed but no time listed:	13	2.1%
Unable to read time listed:	1	0.2%
Total	**632**	**100.0%**

*One line for each shift a patient is on behavior observation status.

Source: Department of Audit BHD file review.

RNs were properly signing the Behavior Observation Flow Sheets at the end of each shift in more that 80% of the instances in our August 2010 sample.

As shown in **Table 2**, RNs were properly signing the Behavior Observation Flow Sheets at the end of each shift in more than 80% of the instances in our August 2010 sample. Less than 3% of the signatures were recorded at the beginning of a shift. However, signatures were absent from about 5% of the shifts, and the time of signature was absent from or indeterminate for about 8% of the shifts.

Subsequent CMS Survey

The January 2010 CMS survey was conducted in response to a specific complaint. In its capacity as the regulatory and oversight

agency for the federal Medicare program, the CMS regularly conducts unannounced full surveys of hospitals certified to receive federal funds, typically on a four-year cycle. In May, 2010, a full CMS survey was conducted of the Milwaukee County BHD Acute Inpatient hospital. Once again, the survey was conducted by the State Division of Quality Assurance on behalf of the CMS.

In a May 2010 survey, BHD was found to be out of compliance with Medicare Conditions of Participation for Hospitals in seven areas.

In the May 2010 survey, BHD was found to be out of compliance with Conditions of Participation for Hospitals at 42 CFR 482 in seven areas: Patient Rights, Medical Records, Pharmacy, Infection Control, Maintenance, Physical Plant (Environment), and Governing Body. Included in those findings were items requiring maintenance, repair and/or modification of infrastructure.

In response to the full survey Statement of Deficiencies, BHD submitted multiple plans of correction and was resurveyed. A letter from the CMS to the BHD Administrator dated September 9, 2010 stated, in part:

> *"…the Wisconsin Department of Health Services, Division of Quality Assurance (DQA) conducted a revisit survey on September 2, 2010 to determine Milwaukee County Behavioral Health Division's compliance with the applicable Medicare Conditions of Participation. Based on the findings of the revisit survey, we have determined that Milwaukee County Behavioral Health Division is now in compliance with all Conditions of Participation except the Condition of Participation for Physical Environment (42 CFR 482.41).*
>
> *We have reviewed your August 24, 2010 plan of correction for the deficiencies cited under this Condition and the schedule for the corrections. We find the plan acceptable. Therefore, the termination of your Medicare provider agreement has been postponed.*
>
> *We have also accepted your plan for the temporary measures that are being taken to protect the health and safety of the patients while the deficiencies are*

being permanently corrected. The State agency will revisit your hospital to monitor these measures as well as the progress made on the implementation of the plan of corrections.

We expect that your hospital will be in full compliance with the Conditions of Participation for Physical Environment by April 1, 2011, as specified in your plan. After your hospital has corrected the deficiencies and we have determined that it again meets all Medicare Conditions of Participation…your hospital will no longer be subject to State agency surveys. …Your Medicare provider agreement will be terminated effective May 1, 2011 if the deficiencies are not corrected as outlined in your plan."

In a September 2010 report to two County Board committees, BHD reported spending an estimated $550,000 in operating funds, on an emergency basis, to implement immediate corrective action related to the May 2010 CMS survey. The same report estimated additional cash expenditures related to corrective actions of $234,000. Also in September 2010, the Milwaukee County Board of Supervisors approved the release of $1.8 million in capital funding to pay for infrastructure repairs and equipment replacements necessary to address the remainder of the deficiencies cited in the May 2010 CMS survey. The $1.8 million was released from $12.6 million that had been placed in the allocated contingency fund of the 2010 Adopted Capital Budget for planning, design and construction of a new BHD facility and/or the renovation of the current facility.

The plans of corrective actions developed by BHD management have been accepted and remain subject to monitoring by the State Division of Quality Assurance on behalf of the federal Center for Medicare and Medicaid Services.

Recommendations

BHD management developed plans of corrective action to address deficiencies that threatened Medicare and Medicaid funding for the Adult Acute Inpatient hospital. The plans of corrective action have been accepted and remain subject to monitoring by the State Division of Quality Assurance on behalf of the federal Center for Medicare and Medicaid Services.

Our review of BHD's adherence to the corrective action plan related to the January 2010 survey and subsequent surveys and correspondence from regulators indicate substantial compliance with the plans, but the need for continued diligence on the part of the BHD administration to monitor and measure staff compliance. In addition, we believe legislative oversight of BHD's progress in attaining and sustaining compliance is an important aspect of holding administrators accountable for results. Therefore, we recommend BHD management:

1. *Continue monitoring and measuring compliance with key aspects of its corrective action plans related to the January 2010 and May 2010 CMS and DQA surveys.*

2. *Report results of its ongoing compliance measurements to the County Board Committee on Health and Human Services on a regular basis.*

However, problems identified in **Section 2** of this report show that ensuring the safety of patients treated at the Milwaukee County Behavioral Health Division Adult Acute Inpatient hospital will require more than complying with the corrective action plans resulting from the CMS surveys.

Section 2: Patient acuity, including aggressive behavior, drives BHD staffing needs and is a critical factor affecting the institution's ability to maintain a safe environment for patients and staff.

As previously noted, the January, 2010 CMS survey that led to a finding of Immediate Jeopardy with regard to patient health and safety at the BHD Adult Acute Inpatient hospital was initiated by the federal agency in response to a specific complaint regarding sexual contact among patients. However, concern for the safety of both patients and staff at BHD has been a matter of public record in recent years as the local mental health provider community has struggled to match rising demand for effective treatment with scarce resources.

Professional nursing staff at BHD has been vocal in expressing concerns about the level of staffing, particularly in the Adult Acute Inpatient units.

Professional nursing staff at BHD has been vocal in expressing concerns about the level of staffing, particularly in the Adult Acute Inpatient units. In a member survey of 98 BHD nurses conducted in May and June of 2010 by the Wisconsin Federation of Nurses and Health Professionals, 66% of respondents rated their units "very unsafe" (22%) or "somewhat unsafe" (44%).

BHD administration notes that in the third quarter of 2010, 43% of nursing staff (including Registered Nurses and Certified Nursing Assistants) were referred for disciplinary action for excessive absenteeism. Unscheduled absences create additional coverage challenges for staff on duty.

BHD Staffing Levels

We examined staffing levels at the Adult Acute Inpatient units for the period 2007 through 2009 to identify recent trends in patient census and total nursing hours worked. For nursing hours, we performed two separate analyses. One included both Registered Nurses (RNs) and Certified Nursing Assistants

(CNAs), the other included only RNs. The combined data for both positions are shown in **Table 3**.

Table 3
Average Daily Census and
Nursing Staff Levels
BHD Adult Acute Inpatient Units
2007--2009

	2007	2008	2009
Combined RN & CNA Total Hours Worked	215,586	230,231	226,262
Total patient-days for Acute Inpatient	36,069	35,917	32,573
Number of Days	365	366	365
Average Daily Census	98.8	98.1	89.2
Average Daily Census Per Unit (4 Units)	24.7	24.5	22.3
Average Daily RNs & CNAs on duty (3 shifts)	73.8	78.6	77.5
Average Daily RNs & CNAs on duty per shift*	24.6	26.2	25.8
Average Daily RNs & CNAs on duty per shift per unit	6.2	6.6	6.5
Patient to Nursing Staff (RNs and CNAs) Ratio	**4.0 : 1**	**3.7 : 1**	**3.5 : 1**
% of Total Hours Worked Straight Time Basis	85.1%	84.1%	84.6%
% Total Hours Worked Overtime Basis	14.9%	15.9%	15.4%

* For illustrative purposes. Actual staffing patterns vary by unit and by shift. For example, the overnight shift is typically staffed at a lower rate than the two day shifts.

Note: Includes time for staff assigned to Adult Acute Inpatient units. Time worked from other units on a 'fill-in- basis not available.

Source: Ceridian system payroll records and BHD census data.

Total nursing staff hours worked has remained fairly stable from 2007 to 2009.

As shown in **Table 3**, total nursing staff hours worked has remained fairly stable, increasing a small amount (about 7%) from 2007 to 2008 and decreasing slightly (less than 2%) in 2009. Overtime hours as a percentage of total time worked was also stable, ranging between approximately 15% and 16% during the three-year period.

During the same three-year period, total patient census days decreased nearly 10%.

During the same three-year period, total patient census days decreased nearly 10%, from about 36,000 in 2007 to just under 32,600 in 2009. As a result, patient to nursing staff ratios

declined during the three-year period, from four patients to every RN/CNA on duty in 2008 to 3.5 patients for every RN/CNA on duty in 2009.

Table 4 presents the same information for RN staff only.

Table 4
Average Daily Census and
RN Staff Levels
BHD Adult Acute Inpatient Units
2007--2009

	2007	2008	2009
RN Total Hours Worked	100,330	107,128	108,970
Total patient-days for Acute Inpatient	36,069	35,917	32,573
Number of Days	365	366	365
Average Daily Census	98.8	98.1	89.2
Average Daily Census Per Unit (4 Units)	24.7	24.5	22.3
Average Daily RNs on Duty (3 Shifts)	34.4	36.6	37.3
Average Daily RNs on Duty per Shift*	11.5	12.2	12.4
Average Daily RNs on Duty per Shift per Unit	2.9	3.0	3.1
Patient to RN Ratio	**8.6 : 1**	**8.0 : 1**	**7.2 : 1**
% of Total Hours Worked Straight Time Basis	91.5%	89.8%	92.4%
% Total Hours Worked Overtime Basis	8.5%	10.2%	7.6%

* For illustrative purposes. Actual staffing patterns vary by unit and by shift. For example, the overnight shift is typically staffed at a lower rate than the two day shifts.

Note: Includes time for staff assigned to Adult Acute Inpatient units. Time worked from other units on a 'fill-in- basis not available

Source: Ceridian system payroll records and BHD census data.

As shown in **Table 4**, total RN staff hours worked has increased somewhat (about 9%) from 2007 to 2009. Overtime hours increased as a percentage of total time worked from 8.5% in 2007 to 10.2% in 2008 (a relative increase of 20%), but returned to under 8% in 2009.

In conjunction with the previously-noted decrease of about 10% in patient census days, the modest increase in RN staff hours worked resulted in the patient to RN staff ratios decreasing from 8.6 patients for every RN on duty in 2008 to about 7.2 patients for every RN on duty in 2009.

Patient to staff ratios alone do little to provide insight into their adequacy in providing a safe environment for patients and staff.

While the patient to staff ratios showed modest declines from 2007 to 2009, patient to staff ratios alone do little to provide insight into their adequacy in providing a safe environment for patients and staff. Rather, the complexity of the level of care needed by patients, known as patient acuity, has vital staffing level implications. That is why there are no prescribed levels of patient to staff ratios specified in state or federal regulations governing acute mental health inpatient hospitals. Rather, according to Wis. Adm. Code DHS 124.13(1)(c):

The complexity of the level of care needed by patients, known as patient acuity, has vital staffing level implications.

> *Staffing.*
>
> 1. *An adequate number of registered nurses shall be on duty at all times to meet the nursing care needs of the patients. There shall be qualified supervisory personnel for each service or unit to ensure adequate patient care management.*
>
> 2. *The number of nursing personnel for all patient care services of the hospital shall be consistent with nursing care needs of the hospital's patients.*
>
> 3. *The staffing pattern shall ensure the availability of registered nurses to assess, plan, implement and direct the nursing care for all patients on a 24-hour basis.*

BHD administrators note that staffing levels have never been cited as a concern during numerous surveys conducted by regulators in recent years. But, they acknowledge that patient acuity at BHD is higher than most psychiatric facilities in the State.

BHD administrators note that staffing levels have never been cited as a concern during numerous surveys conducted by the federal CMS and state DQA in recent years. However, they acknowledge that patient acuity at BHD is higher than most psychiatric facilities in the State. As a public facility, BHD's patient mix is largely indigent, including patients that have exhausted private insurance benefits. As one BHD administrator put it, this results in BHD serving the sickest of the sick.

Indicators of Patient Acuity

We examined two indicators to provide some insight into the level of patient acuity at BHD: the frequency with which heightened levels of patient observation are ordered by attending psychiatrists and psychologists, and the number of incidents involving certain patient behaviors recorded by BHD staff.

Heightened Patient Observations

One indicator of BHD's high level of patient acuity is the frequency with which patients must be placed on heightened behavior observations.

One indicator of BHD's high level of patient acuity is the frequency with which patients must be placed on heightened behavior observations. For instance, standard practice on the Adult Acute Inpatient units is that every patient must be monitored by nursing staff (typically a CNA) once every 30 minutes. However, an attending psychiatrist or psychologist may order behavior observation checks for a patient every 15 minutes to monitor for the effects of changes in medication, for inappropriate behaviors, or for other specific reasons. Further, when a patient exhibits behaviors that are deemed dangerous to the patient or others, an attending psychiatrist or psychologist may place a one-to-one (1:1) observation order to monitor patient behavior on a constant, around-the-clock basis. The frequency of such orders fluctuates with the mix of patients and patient behaviors, and can quickly skew patient-to-staff ratios by placing all of one CNA's attention on one patient in the unit.

Our review of medical records for 42 patients receiving care in the Adult Acute Inpatient units during two days in August 2010 indicated 30 (71%) had been under 15-minute behavior observation checks in recent days.

While there is no summary data on the frequency of 15-minute behavior observation checks, our review of medical records for 42 patients receiving care in the Adult Acute Inpatient units during two days in August 2010 indicated 30 (71%) had been under 15-minute behavior observation checks in recent days. BHD has recently begun compiling summary data to track staff hours devoted to 1:1 observations. **Table 5** shows staff hours devoted to 1:1 observations in the Adult Acute Inpatient units from November 2009 through August 2010.

Table 5
Total Staff Hours Devoted to
One-to-One Observations
BHD Adult Acute Inpatient Units
November 2009—August 2010

Year	Month	Hours	FTE*
2009	November	3,984	2.2
2009	December	2,688	1.5
2010	January	4,536	2.5
2010	February	6,228	3.5
2010	March	5,752	3.2
2010	April	4,340	2.4
2010	May	3,880	2.2
2010	June	5,152	2.9
2010	July	4,272	2.4
2010	August	3,069**	1.7
	10-Month Total	**43,901**	**24.6**
	Monthly Average	**4,390**	**2.5**
	Annual Rate	**52,681**	**29.5**

* Full Time Equivalent positions based on 1,784 annual work hours (excludes off time).

**Projected based on data through August 16, 2010.

Source: BHD Quality Improvement records and Department of Audit calculations.

The data collected to date demonstrate the volatility in demand for staff time devoted to around-the-clock observations of seriously ill patients. As shown in **Table 5**, staffing demands devoted solely to 1:1 observations of patients on the Adult Acute Inpatient units ranged from a low of 1.7 Full Time Equivalent (FTE) positions in August 2010 to a high of 3.5 FTEs in Febraury 2010. During the 10-month period tracked, 1:1 observations required an average of 2.5 FTE staff per month, or an annual rate of 29.5 FTEs devoted solely to 1:1 observations.

During the 10-month period tracked, 1:1 observations required an average of 2.5 FTE staff per month, or an annual rate of 29.5 FTEs devoted solely to 1:1 observations.

Incident Reports

Another source of data maintained by BHD Quality Improvement staff that can provide insight regarding the severity of the mental health problems treated at BHD is the number of incidents

recorded that are reflective of patient aggression or behavior that requires close observation/attentiveness.

BHD policy states that "…any significant incidents and exposure to risk will be reported, monitored, and investigated if indicated. Serious incidents involving patients/residents, staff, students, volunteers, security or contracted personnel, and visitors will be reported on an Incident/Risk management Report Form." An Incident Report form is presented as **Exhibit 4**).

BHD Quality Improvement staff maintains a database of all Incident Reports. **Table 6** shows totals in all categories for the period 2005 through 2009, along with projected 2010 figures based on data through September 10, 2010.

Table 6
BHD Reported Incidents—All Categories
Acute Adult Inpatient Units
2005—2010

Incidents	2005	2006	2007	2008	2009	2010**
Falls	155	146	150	161	218	175
Altercations – PT/PT	101	120	105	82	125	71
Altercations – PT/EMP	67	50	66	64	78	75
Injuries – Accidental	59	58	49	58	69	36
Injuries – Self Inflicted	27	13	30	42	57	36
Code 4 (Medical Emergencies)	38	76	98	41	51	58
Missing Property	14	19	9	27	32	19
Caregiver Misconduct Allegation	1	2	8	11	26	16
Contraband	9	7	20	40	26	14
Property Damage	9	8	15	19	26	14
Sexual Contact*	-	-	7	8	11	7
Sexually Inappropriate Behavior	19	16	11	4	10	19
Elopement (Fleeing) from a Locked Unit	102	41	28	28	19	7
Failure to Return to Unit	-	30	45	32	11	1
Suicide Attempt	10	15	1	3	8	7
Seclusion & Restraint Injury	1	13	29	6	6	10
Confidentiality Breach	-	1	-	1	5	3
Exposure to Infection	3	6	3	6	2	4
Fires	2	-	3	3	1	-
Haz.Mat./Environmental Contamination	2	-	-	2	1	1
Choking	1	-	1	4	-	3
Elopement (Fleeing from Escort	1	1	6	-	-	-
Medical Device	1	2	1	-	-	1
Other	39	38	54	71	74	53
Total Incidents	**661**	**662**	**739**	**713**	**856**	**630**
Total Patient-Days	35,855	35,259	36,069	35,917	32,573	30,818
Incidents per 1,000 Patient-Days	18.4	18.8	20.5	19.9	26.3	20.4
Annual % Change in Incidents per 1,000 Patient-Days	--	2.2%	9.0%	-2.9%	32.2%	-22.4%

* Data in sexually inappropriate behavior category prior to 2007.
*** 2010 Projected based on actuals through 9/10/10.

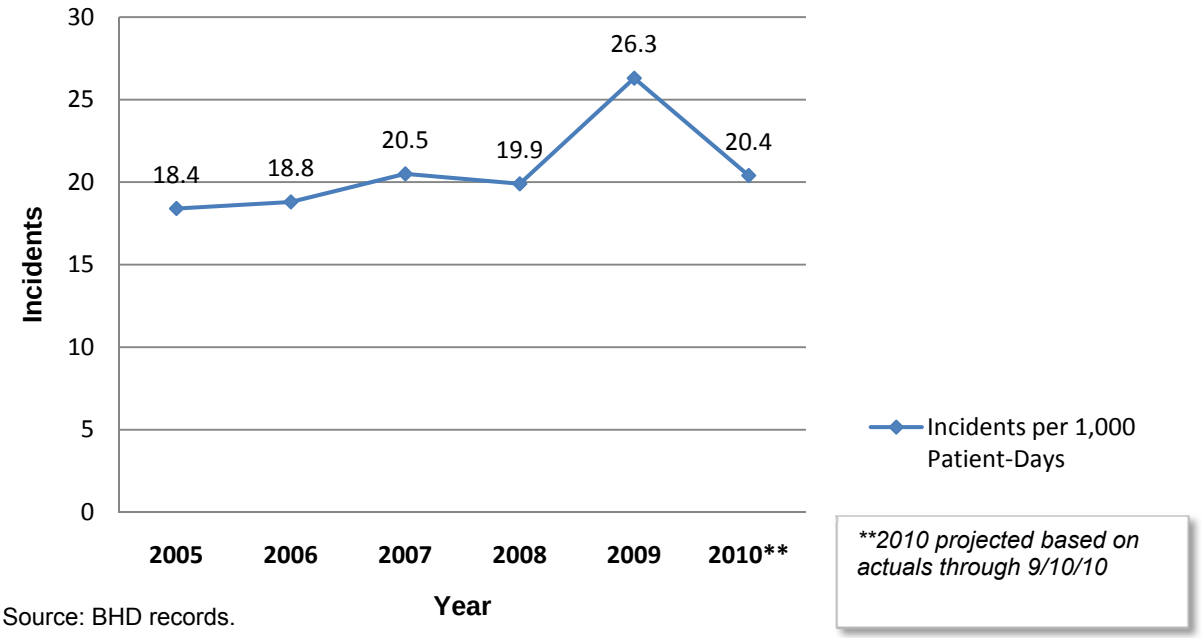
Source: BHD records.

For 2009, the rate of incidents reported per 1,000 patient-days was 32% higher than the previous year, and 43% higher than in 2005.

As shown in **Table 6**, after adjusting for a gradual decline in patient-days, the rate of incidents reported is trending somewhat up over the period, with a substantial spike in 2009. For 2009, the rate of incidents reported per 1,000 patient-days was 32% higher than the previous year, and 43% higher than in 2005. For 2010, the rate is projected to fall back in line with more recent experience, but remains about 11% higher than in 2005.

Figure 1 illustrates the annual change in the rate of incidents per 1,000 patient-days from 2005—2010 in a line graph.

Figure 1
BHD Reported Incidents - All Categories
Adult Acute Inpatients Units
2005--2010



Source: BHD records.

To focus on trends in patient acuity, we selected categories of incidents that are more reflective of patient behavior that requires close observation/attentiveness. These include incidents that involve patient aggression, sexually inappropriate behavior, medical emergencies and other categories as shown in **Table 7**.

Table 7
Selected Incident Categories for Patient Acuity
BHD Acute Adult Inpatient Units
2005—2010

Incidents	2005	2006	2007	2008	2009	2010**
Falls	155	146	150	161	218	175
Altercations – PT/PT	101	120	105	82	125	71
Altercations – PT/EMP	67	50	66	64	78	75
Injuries – Self Inflicted	27	13	30	42	57	36
Medical Emergencies	38	76	98	41	51	58
Property Damage	9	8	15	19	26	14
Sexual Contact*	--	--	7	8	11	7
Sexually Inappropriate Behavior	19	16	11	4	10	19
Suicide Attempt	10	15	1	3	8	7
Seclusion & Restraint Injury	1	13	29	6	6	10
Total Incidents re: Acuity	**427**	**457**	**512**	**430**	**590**	**472**
Total Patient-Days	11.9	13.0	14.2	12.0	18.1	15.3
Incidents per 1,000 Patient-Days	35,855	35,259	36,069	35,917	32,573	30,818
Annual % Change in Incidents per 1,000 Patient-Days	--	9.2%	9.2%	-15.5%	50.8%	-15.5%

* Data in sexually inappropriate behavior category prior to 2007.

*** 2010 Projected based on actuals through 9/10/10.

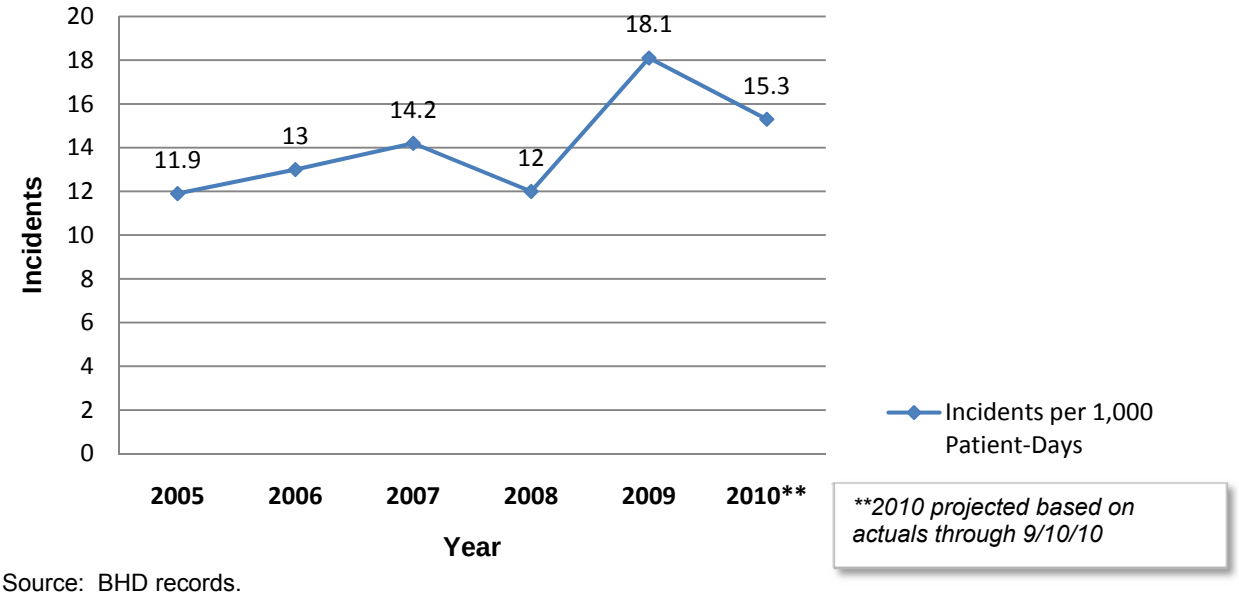
Source: BHD records.

The data also reflects an upward trend in the rate of incidents reported in categories that are reflective of a high level of patient acuity.

The data in **Table 7** also reflects an upward trend in the rate of incidents reported per 1,000 patient-days, for incidents in categories that are reflective of a high level of patient acuity. Once again, that trend spiked in 2009 (up 51% from the previous year) and is projected to subside about 16% in 2010.

Figure 2 illustrates the annual change in the rate of incidents reflecting patient acuity per 1,000 patient-days from 2005—2010.

Figure 2
BHD Reported Incidents
Selected Categories for Patient Acuity
Adult Acute Inpatients Units
2005—2010



Source: BHD records.

We further refined our trend analysis by focusing only on those categories of incidents that involve acts of patient aggression, violence or inappropriate sexual behavior. **Table 8** shows the data for 2005 through 2010 in those categories.

Table 8
Selected Incident Categories for Patient Aggression
BHD Acute Adult Inpatient Units
2005—2010

Incidents	2005	2006	2007	2008	2009	2010*
Altercations – PT/PT	101	120	105	82	125	71
Altercations – PT/EMP	67	50	66	64	78	75
Property Damage	9	8	15	19	26	14
Sexual Contact*	-	-	7	8	11	7
Sexually Inappropriate Behavior	19	16	11	4	10	19
Seclusion & Restraint Injury	1	13	29	6	6	10
Total Incident re: Aggression	**197**	**207**	**233**	**183**	**256**	**196**
Total Patient-Days	35,855	35,259	36,069	35,917	32,573	30,818
Incidents per 1,000 Patient-Days	5.5	5.9	6.5	5.1	7.9	6.4
Annual % Change in Incidents per 1,000 Patient-Days	--	7.3%	10.2%	-21.5%	54.9%	-19.0%

* Data in sexually inappropriate behavior category prior to 2007.

*** 2010 Projected based o actuals through 9/10/10.

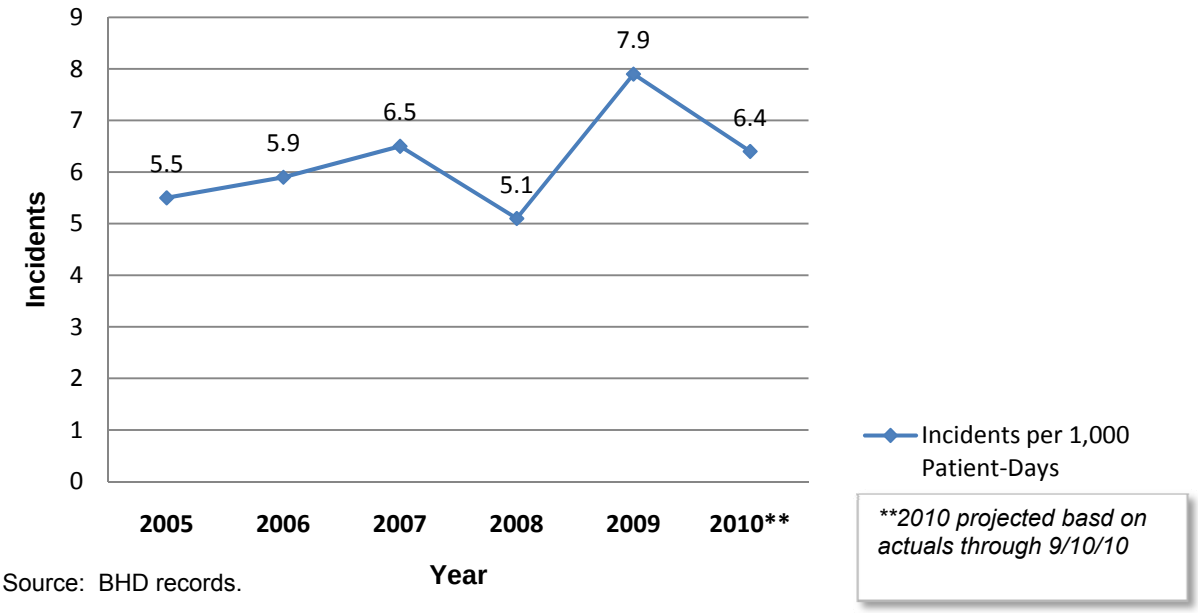
Source: BHD records.

In 2009, the rate of incidents reported for categories of patient aggression reflected a 55% increase over the previous year.

The data in **Table 8** shows a similar pattern in the rate of increase for categories of incidents reflecting aggressive patient behavior over the six-year period as for the broader categories of incidents, again documenting a significant spike in 2009. In 2009, the rate of incidents reported for these categories reflected a 55% increase over the previous year. For 2010, the rate is projected to decline 19% from the 2009 level, but remains 16% higher than the 2005 rate.

Figure 3 illustrates the annual change in the rate of incidents reflecting aggressive patient behavior per 1,000 patient-days from 2005—2010.

Figure 3
BHD Reported Incidents
Selected Categories for Patient Aggression
Adult Acute Inpatients Units
2005--2010



Source: BHD records.

Incident Reports may not fully document the extent of problems involving potentially dangerous patient behaviors.

Although a clear policy exists with regard to when an Incident Report should be completed, there is judgment involved and therefore some degree of subjectivity. Further, there is separate required documentation for the medical record if a patient is placed in seclusion and/or restraints. In such cases, if there is no injury to patient or staff, and no property damage, an Incident Report might not be filed, even though a patient's behavior might be so volatile that s/he is considered a danger to himself or others. Therefore, Incident Reports may not fully document the extent of problems involving potentially dangerous patient behaviors.

This was corroborated in our fieldwork. We reviewed the medical records of all 21 patients that had been hospitalized in one of the four Adult Acute Inpatient units on October 3, 2009. Within a 16-day period surrounding that date, we identified seven items in progress notes indicating a disturbance that may have resulted in the filing of an Incident Report. We verified there

were Incident Reports on file in five of the seven instances; the two instances that did not result in an Incident Report involved episodes of Seclusion and Restraint, which were properly documented on special forms within the medical record.

Despite the potential for variation in reported data, the Incident Report database maintained by the Quality Improvement section of BHD is the best available data from which to review trends in hospital incidents. With one exception, there is a steadily increasing trend in the rate of incidents indicative of potentially dangerous patient behavior at the BHD inpatient units from 2005 through 2009. The only annual decline in these categories of incidents occurred in 2008, which was followed by the highest annual total for these categories of incidents in the five-year period. Incidents reported in these categories in 2010 are projected to be nearly 20% lower than in 2009. This is likely due, in part, to increased scrutiny of patient behaviors prompted by events leading to the January 2010 CMS survey findings and plans of corrective action. Another potential explanation for the reduction in reported incidents is the implementation of a 'zone system' for deploying CNA staff.

With one exception, there is a steadily increasing trend in the rate of incidents indicative of potentially dangerous patient behavior at the BHD inpatient units from 2005 through 2009.

Incidents reported in these categories in 2010 are projected to be substantially lower than in 2009.

Base Staffing Levels and the Zone System

BHD base staffing levels for Adult Acute Inpatient units have been a source of controversy between management and nursing staff in recent years. Prior to 2006, Adult Acute Inpatient units routinely operated with a bed capacity of 31. This was eight more than it's licensed capacity of 24, but was permitted under a federal waiver. In recent years, bed capacity was gradually reduced; first down to 29, then to 27, and since May 2009, BHD operates without a waiver and within its licensed capacity of 24 beds per unit.

While operating under the higher bed capacities, base staffing for each unit included four RN positions and two CNA positions, with adjustments made based on patient acuity and other

considerations such as the need for additional staff to escort patients off ward for court appearances.

Since operating under the reduced bed capacity of 24 per unit, management has considered base staffing per unit to be three RNs, rather than four. This did not affect all shifts for all units, however, as nursing staff is permitted to self-schedule (subject to management revision and approval) and there are frequently either three or four nurses scheduled at the beginning of a shift. However, there has been concern expressed by some nursing staff that, given the patient acuity level at BHD, a base staffing level of four RNs is needed.

A zone system was phased in during 2010 to facilitate staff supervision of patients and surveillance of the environment so as to monitor and maintain patient safety.

While not a formal inclusion in BHD's plan of corrective actions in response to the CMS surveys, a zone system was developed to facilitate staff supervision of patients and surveillance of the environment so as to monitor and maintain patient safety. Under the system, a CNA is given responsibility for one of three zones established on each unit. Each unit is configured in a floor plan that resembles a 'V,' with two hallways of patient rooms converging at the central nursing station. Between the two hallways that form the 'V' is a common area. For each unit, one hallway comprises one zone, the common area comprises a second zone, and the other hallway comprises the third zone. By assigning exclusive responsibility for monitoring each zone, accountability for surveillance of the entire unit is enhanced. The zone system was phased in during the past year. With implementation of the zone system, base CNA staffing was increased from two to three.

By assigning exclusive responsibility for monitoring each zone, accountability for surveillance of the entire unit is enhanced.

We reviewed detailed nursing staff schedules for the month of July 2009. Results of that review are shown in **Table 9**.

Table 9
BHD Nursing Staff Levels
Acute Adult Inpatient Units
July 2009

		1st Shift	2nd Shift	3rd Shift
RNs				
	One	0.0%	0.0%	99.2%
	Two	0.8%	0.8%	0.8%
	Three	33.9%	50.0%	0.0%
	Four	64.5%	49.2%	0.0%
	Five	0.8%	0.0%	0.0%
	Total	100.0%	100.0%	100.0%
CNAs				
	One	4.8%	3.2%	0.8%
	Two	24.2%	29.0%	24.2%
	Three	29.9%	30.7%	57.3%
	Four	22.6%	24.2%	15.3%
	Five	11.3%	8.9%	2.4%
	Six	4.8%	4.0%	0.0%
	More than Six	2.4%	0.0%	0.0%
	Total	100.0%	100.0%	100.0%

Source: BHD nursing staff schedules for July 2009.

We found that 44% of Incident Reports indicating an unsafe environment were filed when three RNs were on duty, 50% were filed when four RNs were on duty, and 6% were filed when two RNs were on duty.

As shown in **Table 9,** four RNs were on duty during the day (1st) shift about 65% of the shifts, with the base level staffing of three RNs about 34% of the shifts. For the evening (2nd) shift, four RNs were on duty about 49% of the shifts, while the base level of three RNs were on duty about 50% of the shifts. In a separate analysis in which we compared categories of Incident Reports indicative of an unsafe environment filed during the month of July against these staffing levels, we found that 44% were filed when three RNs were on duty, 50% were filed when four RNs were on duty, and 6% were filed when two RNs were on duty.

Table 9 reflects a broader range of staffing levels for CNAs. In some instances, there were six or more CNAs on duty in a unit. Staffing ranged from two to four CNAs for about 77% of the day shifts; about 84% of the evening shifts; and about 97% of the overnight shifts.

Some nurses we interviewed indicated they felt a base staffing level of three RNs and three CNAs was safe when there were no 1:1 observations or a high number of 15-minute behavior observation checks ordered. Our interviews with nursing staff and surveys conducted by BHD administration indicate the zone system is viewed positively by staff and an improvement over the prior model. However, a frequent criticism expressed by nursing staff, and a problem acknowledged by BHD administration, is the lack of a relief factor built into the scheduling of CNAs under the zone system. For instance, there is no 'floater' CNA scheduled to relieve any of the three assigned CNAs for lunch breaks or patient escort duties.

The County Executive's Proposed 2011 Budget for BHD includes an additional 18 Full Time Equivalent CNA positions dedicated to the Adult Acute Inpatient units.

The County Executive's Proposed 2011 Budget for BHD includes an additional 18 Full Time Equivalent CNA positions dedicated to the Adult Acute Inpatient units. Our analysis of additional CNA hours necessary to provide a relief factor for the 1st and 2nd shifts indicates an additional 18 FTEs would be sufficient for that purpose.

Unsafe Staffing Forms

The collective bargaining unit that represents RNs at BHD has developed a form called an Unsafe Staffing Form.

The Wisconsin Federation of Nurses and Health Professionals, the collective bargaining unit that represents RNs at BHD, has developed a form called an Unsafe Staffing Form. The top of each form contains the following statement:

> *"The purpose of this form is to notify hospital supervision that you have been given an assignment, which you believe is unsafe for the patients or staff. This form will document the situation. Your union may use it to address the problem."*

A union official told the Milwaukee County Board's Health and Human Needs Committee at its May 19, 2010 meeting that there had been an alarming increase in the number of Unsafe Staffing Forms filed by its members at BHD, citing inadequate staffing

and an increase in the number of patients needing one-to-one observation as concerns.

The forms contain a section for RNs to fill in the following information (a blank Unsafe Staffing Form is presented as **Exhibit 5**):

- Normal staffing numbers
- Number at beginning of shift
- Number at end of shift

Despite BHD administration's contention that the base staffing level for Adult Acute Inpatient units is three RNs for the first and second shifts, in most of the Unsafe Staffing Forms we reviewed, RNs at BHD identify four RNs as the normal staffing level. The Unsafe Staffing Form is not recognized by BHD administration and is not addressed in the nurses' labor agreement.

Unsafe Staffing Forms alone are not a reliable predictor of incidents indicative of unsafe conditions.

We obtained all Adult Acute Inpatient hospital Unsafe Staffing Forms on file with the union for the six-month period July through December 2009, and an additional six forms BHD management had been given, which were not on file with the union. We compared them to Incident Reports in nine categories, that are indicative of unsafe patient or staff behavior, during the same period. Unsafe staffing reports are filled out by RN; Incident Reports are typically filled out by either RNs or CNAs. The results of our comparison, as shown in **Table 10**, indicate that Unsafe Staffing Forms alone are not a reliable predictor of incidents indicative of unsafe conditions.

Table 10
Comparison of Unsafe Staffing Forms and Incident Reports at BHD
July—December 2009

Month	Shifts with Incident Report	Shifts with Unsafe Staffing Forms	Match
July	40	13	3
August	36	10	0
September	36	6	0
October	30	8	1
November	33	4	1
December	38	9	2
Total	**213**	**50**	**7**

Percentage of shifts in which an Unsafe Staffing Form was filed and an Incident Report was also filed **14.0%**

Percentage of shifts in which an Incident Report was filed and an Unsafe Staffing Form was also filed **3.3%**

Source: BHD and Wisconsin Federation of Nurses and Health Professionals records.

As shown in **Table 10**, Incident Reports were filed in only about 14% of the shifts in which an Unsafe Staffing Form was filed by an RN. Conversely, Unsafe Staffing Forms were filed in only about 3% of the shifts during which an Incident Report was filed.

Unsafe Staffing Forms document RN's perceptions of an unsafe environment. Those perceptions are based on the reality of an environment that can be volatile and can rapidly deteriorate.

While this analysis suggests that Unsafe Staffing Forms cannot be used to reliably document unsafe conditions, they document RN's perceptions of an unsafe environment. Further, based on our review of the seven matches of Unsafe Staffing Forms and Incident Reports from our analysis, along with interviews with nursing staff and observation of the units, those perceptions are based on the reality of an environment that can be volatile and can rapidly deteriorate.

For example, one Unsafe Staffing Form listed three RNs and four CNAs on duty, along with one Unit Clerk (not trained nursing staff) shared with another unit. Patient census is listed as 24. The description of the situation noted the following:

- *Very high acuity—several patients with developmental disabilities and several dangerous patients. Three patients on 1:1 observation status. Two staff assigned to the 1:1 observations are on overtime.*

- *One CNA (not assigned to 1:1 observations) on floor not enough—not able to break all 1:1 staff.*

- *RNs have to do CNA work—rounds, pass trays, break 1:1's. RNs had no lunch breaks.*

- *Code 1 (general call for Security) for two patients fighting. 1:1 patient put in ambulatory restraints—needing constant supervision of at least two staff. No staff available to monitor showers.*

Another Unsafe Staffing Form listed three RNs and four CNAs on duty, along with one Unit Clerk shared with two other units. Patient census is listed as 23. This unit typically treats elderly and frail patients. The description of the situation noted the following:

- *12 patients are on 15-minute behavior observation checks and two patients on 1:1 observation status.*

- *There are four diabetic patients and four patients whose daily intake and output of fluids must be charted. Many need pills crushed or placed in applesauce with lots of coaxing.*

- *There are seven patients that require 1:1 observation during feeding to monitor for choking. There are 12 fall risks, eight total cares and at least six others who need assistance with care.*

- *There are at least five treatments including a couple of wound cares.*

Another Unsafe Staffing Form listed four RNs and five CNAs on duty, along with one Unit Clerk shared with another unit. Patient census is listed as 23. The description of the situation noted the following:

- *There were four patients on 1:1 observation status. The CNAs had to take lunch breaks, so there were mostly four CNAs on the unit with four 1:1's. Therefore, the nurses were working without any CNAs to do rounds or help on the floor.*

- *One of the 1:1 patients was put into four-point restraints and then into ambulatory restraints because he punched another patient in the face with a closed fist. We had to call the Sheriff's department for charges to be processed.*

- *We believe it was an unsafe, volatile environment to work and we should have had more CNAs on the unit to help us.*

This last example of an Unsafe Staffing Form documents the action of a particularly aggressive patient with a history of violent behavior.

A relatively small number of particularly aggressive patients pose a difficult challenge for BHD administrators to maintain a safe environment for patients and staff.

Current Model Not Suited for Particularly Aggressive Patients

A relatively small number of particularly aggressive patients pose a difficult challenge for BHD administrators to maintain a safe environment for patients and staff in an Acute Adult Inpatient setting. Three examples illustrate this point.

Patient A

Records show that this patient had been a long term recipient of BHD treatment and had been placed in the Rehabilitation Center—Hilltop (Hilltop), where the patient was engaged in several episodes of sexual contact. According to BHD staff, the patient was transferred to Rehabilitation Center—Central (Central) in 2005 in conjunction with a downsizing of Hilltop. The patient remained at Central until 2008, when the patient attacked and seriously injured another patient. The patient was transferred to the Adult Acute Inpatient hospital and was discharged to the custody of the Sheriff soon thereafter to face a battery charge in connection with the incident at Central.

The patient remained at Central until 2008, when the patient attacked and seriously injured another patient.

According to Wisconsin Circuit Court Access summary records, the court suspended proceedings and ordered the defendant examined by the State to determine competency to stand trial. The "…Court finds the defendant is not competent to proceed and not likely to regain competency within time limits. Court orders the defendant discharged from this criminal case and

The defendant was found guilty of actually committing the crime charged, but was also found not be legally responsible because of the defendant's mental condition. As a result, the patient was returned to BHD.

orders defendant taken into custody and transported to the appropriate treatment center." The defendant "…was found not guilty by reason of mental disease or defect. The defendant was found guilty of actually committing the crime charged, but was also found not to be legally responsible under Wis. Stats. 971.65 for committing the crime because of the defendant's mental condition." As a result, the patient was returned to BHD.

Placement of the patient at BHD was complicated by a recent finding of Immediate Jeopardy (IJ) with regard to protecting patients at the Rehabilitation Center—Central from mistreatment by other patients. That IJ finding was issued on October 30, 2008 and was removed shortly thereafter. According to BHD staff, a key to resolving the IJ finding was an abatement plan that included transferring the assaultive patient, along with another patient who had participated in the incident, from Rehabilitation Center—Central to the Adult Acute Inpatient hospital. Consequently, the patient remained at the Adult Acute Inpatient facility from late 2008 well into 2009, at which time the patient was once again discharged to the custody of the Sheriff to face felony charges stemming from the patient's conduct in the hospital. The defendant's competency to stand trial was the subject of legal challenges but the patient was ultimately judged competent. That case is ongoing. It is the defendant's fifth criminal court case, encompassing two misdemeanor and four *felony charges, since 2005. BHD records show the patient was* involved in at least 13 incidents involving aggressive behavior during a total of about 400 days of Adult Acute Inpatient care from 2007 through 2009.

BHD records show the patient was involved in at least 13 incidents involving aggressive behavior during a total of about 400 days of Adult Acute Inpatient care from 2007 through 2009.

The BHD Adult Acute Inpatient hospital is designed to treat and stabilize acutely mentally ill patients. The median length of stay in 2009 was approximately seven days. The acute inpatient model is not intended to operate as a long-term residential facility and clearly is not an appropriate venue for this patient.

Patient B

Another example of a BHD patient with particularly aggressive behaviors is an individual who was initially admitted to the Acute Adult Inpatient hospital for a brief stay in 1987; for an approximately five-month stay in 1990-91; and for another brief stay in 1999. Records indicate the patient was receiving services under community support programs throughout the mid-1990s through 2005.

This individual was charged with felony arson in the fall of 2002. For more than a year, the defendant was alternately placed in the custody of the Milwaukee County Sheriff and the State Department of Health and Family Services for evaluation at a State Health Institute for competency to stand trial. In 2003 the defendant was found competent and a guilty plea was entered. A sentence of three years imprisonment and 12 years extended supervision was ordered and stayed, with the individual placed on probation for 15 years. Terms of the probation included placement in a community support program with a case manager.

Medical records indicate this patient was admitted to the BHD Adult Acute Inpatient hospital for another short stay in 2005 after starting a fire in the patient's apartment building.

Medical records indicate this patient was admitted to the BHD Adult Acute Inpatient hospital for another short stay in 2005 after starting a fire in the patient's apartment building. Notes indicate the patient was angry at the landlord for shutting off the air conditioning in the building. The patient reported a history of auditory and visual hallucinations.

In 2007, the same individual was charged with two serious felony counts, among other charges. The court ordered an evaluation of the defendant's competency, to be conducted at BHD.

In 2007, the same individual was charged with two serious felony counts, among other charges. The court ordered an evaluation of the defendant's competency, to be conducted at BHD. Based on that evaluation, the court found the defendant incompetent, but more likely than not to regain competency. The court ordered the defendant placed in the custody of the State at one of the Mental Health Institutes. During the next year, after several court appearances and reports from Mendota regarding

the defendant's competency, the court found in 2009 that the defendant was not likely to regain competency within the statutorily-prescribed time limit (generally up to one year for felonies) and suspended criminal proceedings. At that time, a conversion to a Civil Commitment was ordered and the patient was once again placed at the BHD Acute Adult Inpatient hospital. Most recently, in 2010, the patient violently struck a nurse on duty at BHD, resulting in the nurse losing nearly two weeks of work time. The patient was charged with misdemeanor battery but once again was found incompetent by the court and returned to BHD. BHD records show the patient was involved in at least 11 incidents involving aggressive behavior during a total of about 600 days of Adult Acute Inpatient care in 2009 and 2010.

A third example of a BHD patient with particularly aggressive behavior illustrates how such individuals can become caught in a vicious cycle of repetitive encounters with the judicial and mental health systems.

Patient C

A third example of a BHD patient with particularly aggressive behavior illustrates how such individuals can become caught in a vicious cycle of repetitive encounters with the judicial and mental health systems. This individual was admitted to the BHD Acute Adult Inpatient hospital on more than 20 separate occasions from 2006 through 2010. BHD records show the patient was involved in at least 28 incidents involving aggressive behavior during a total of about 300 days of Adult Acute Inpatient care from 2007 through 2010.

BHD records show the patient was involved in at least 28 incidents involving aggressive behavior during a total of about 300 days of Adult Acute Inpatient care from 2007 through 2010.

Court records indicate that since 2007, this patient has been charged with various crimes and civil citations on eight separate occasions.

Court records indicate that since 2007, this patient has been charged with various crimes and civil citations on eight separate occasions. One case, initiated in 2008, took two years to complete as the defendant was ordered for evaluation of competency at a State Health Institute (found not competent but likely to regain competency), was later found competent, and ultimately pleaded guilty. During this time, the defendant was frequently admitted to BHD for stabilization, then was discharged. During the two-year period this case remained open, the patient was charged on six additional occasions, with

During this time, the defendant was frequently admitted to BHD for stabilization, then was discharged.

the defendant's competency at issue in each instance. The defendant was found guilty on four misdemeanor charges, including 4th degree sexual assault; the other charges were dropped during periods in which the defendant's competency was questioned.

Conclusions and Context

Those are three examples of a small number of patients whose particularly aggressive behavior makes placement in the community difficult, whose treatment in the Adult Acute Inpatient units can be disruptive to the therapeutic environment for other patients, and whose behavior can pose a threat to their own safety as well as that of other patients and staff at the facility.

To help place the number of such patients in context, we utilized the database of Incident Reports maintained by the Quality Improvement unit at BHD. During the period January 2007 through September 10, 2010 there were a total of 2,746 Incident Reports filed pertaining to the Acute Adult Inpatient units. From this total we selected the following six incident codes within the database that would indicate potentially aggressive/assaultive patient behavior:

- Aggression—Patient/Patient
- Aggression—Patient/Employee
- Seclusion & Restraint Injury
- Known or Suspected Sexual Contact
- Property Damage
- Other Sexually Inappropriate Behavior

There were a total of 808 incidents, involving 411 unique patients, in the above categories during the 44 months from January 2007 through September 10, 2010. During that same time period, there were a total of 5,328 unique patients admitted to the Adult Acute Inpatient hospital.

Of 411 patients exhibiting potentially aggressive/ assaultive behavior that resulted in a reported incident, there were 19 patients that appeared five or more times as the primary person involved.

Of the 411 patients exhibiting potentially aggressive/assaultive behavior that resulted in a reported incident, there were 19

patients that appeared five or more times as the primary person involved. Of those 19 patients, 10 had been found by the court to be not competent to stand trial due to mental defect or disease on one or more occasions.

While relatively few in number, particularly aggressive patients require greater attention from staff and can agitate other patients on the Adult Acute Inpatient units.

While relatively few in number, particularly aggressive patients require greater attention from staff and can agitate other patients on the Adult Acute Inpatient units. Nurses we interviewed at BHD expressed frustration with the current environment. Suggestions for improvement included increased security presence on the inpatient units, and a greater effort on the part of law enforcement to hold patients that understand right from wrong accountable for acts of violence.

Discussion with staff from the Milwaukee County District Attorney's Office, the Milwaukee County Sheriff's Office and BHD administrators confirmed there are no readily available, 'easy fixes.'

Discussion with staff from the Milwaukee County District Attorney's Office, the Milwaukee County Sheriff's Office and BHD administrators confirmed there are no readily available, 'easy fixes' to address the needs of a small number of patients that can be caught up in a vicious cycle of aggression, arrest, court-ordered evaluation/placement at a state institution, and a 'not competent' court finding that ultimately returns the patient to BHD.

Options

A limited number of options were identified to address the problems involving the accommodation of particularly aggressive/assaultive patients.

- **Development of Community Support Infrastructure.**
  One potential option identified by BHD administrators in discussing the issue of particularly aggressive/assaultive patients was developing community support infrastructure to provide intense, close supervision of very small numbers of patients, such as a specialized group home for four to eight residents.

- **Single-Gender Wards.**
  An option that BHD administrators were instructed by the Milwaukee County Board of Supervisors to review was the potential implementation of single-gender, rather than mixed-

gender, acute inpatient units. That review is underway. BHD administrators performed an exhaustive literature search on the clinical implications of such a change. They concluded that mixed gender wards for psychiatric hospitals are the norm in Wisconsin, and that there is a lack of evidence-based literature on the implications of single-gender wards in the U.S. Our own literature review, as well as a survey of local psychiatric hospital units, confirmed that conclusion. BHD continues its review; a survey of patient attitudes with regard to such a change was recently completed, and a survey of staff attitudes is underway.

- **Secure Unit**
  Both State Mental Health Institutes (Mendota and Winnebago) operate secure units for high-risk patients. However, unless placement is court-ordered, the State institutes must agree that the placement is therapeutically appropriate, and the County of origin must pay a daily fee (currently approximately $1,000 per patient per day). Available space for such voluntary placements fluctuates, but is limited.

  Milwaukee County formerly operated a secure unit, but it was discontinued in 1996 due to budgetary constraints and in accordance with a movement to downsize institutional care in favor of community based services. According to BHD staff, there was also concern that practices at the secure unit could adversely affect Joint Commission accreditation. Estimating the additional cost of operating a high-risk secure ward would require detailed analysis but could easily reach $2 million annually, would incur additional start-up capital costs, and would be inefficient to operate due to a high staff-to-patient ratio.

Recommendations

There appear to be few options to properly accommodate the needs of a small number of particularly aggressive/assaultive patients at the Milwaukee County Behavioral Health Division. Due to their tendencies toward violent behaviors, supervised placement in a community support program can be difficult if not impossible, and long-term placement in the BHD Adult Acute Inpatient hospital, where the mission is to diagnose and stabilize individuals in crisis mode, is not an appropriate setting for such individuals. The recently formed Community Advisory Board for Mental Health, created in the aftermath of the incidents exposed in the January 2010 CMS survey, is best suited to identify long-term strategies and resources needed to address this complex

The recently formed Community Advisory Board for Mental Health is best suited to identify long-term strategies to address this complex issue.

issue. BHD could also utilize the expertise of a management consulting firm it has recently engaged to assist in patient safety and other issues. In the short term, changes are needed to help ensure patient and staff safety at the Milwaukee County Behavioral Health Division. Therefore, we recommend BHD management:

3. *Fashion a short-term strategy to address the small number of particularly aggressive/assaultive, difficult-to-place patients under the care of the BHD Adult Acute Inpatient hospital at any given time. Options considered should include:*

    A. *Re-configuring the present model of four mixed gender units (three general population and one for elderly/vulnerable patients) to include two single gender and one mixed gender units for the general population. While this would pose additional challenges to manage patient placements, it could help reduce the exposure of women with histories of sexual trauma to incidents of inappropriate sexual behaviors. The male-only unit would require enhanced security presence at an estimated additional cost of approximately $175,000 annually.*

    B. *Allocating additional funds to place such patients at one of the two State Mental Health Institutions (Winnebago or Mendota). The additional cost of placing a patient in one of the state facilities for a year is approximately $365,000.*

    C. *Re-establishing a high-risk secure ward for particularly aggressive/assaultive patients. Estimating the additional cost of operating a high-risk secure ward would require detailed analysis but could easily reach $2 million annually, plus additional start-up capital costs.*

4. *Work with BHD's recently acquired management consulting firm and the Community Advisory Board for Mental Health to develop a long-term strategy for accommodating the treatment needs of particularly aggressive/assaultive, hard-to-place patients, with a goal of facilitating an appropriate alternative to extended periods of treatment in an acute inpatient facility.*

5. *Staff the Acute Inpatient units with enough pool or 'floater' Certified Nursing Assistants to provide both sufficient coverage for heightened patient monitoring duties (e.g., behavior observation checks and patient escorts to court*

appearances), as well as a relief factor for staff breaks. The County Executive's 2011 Proposed Budget includes 18 FTE CNA positions, which we believe is adequate for these purposes.

Section 3: Federal and state regulators provide system accountability; personal accountability of medical staff is generally left to confidential internal processes.

A key question arising out of the incidents highlighted in the 2010 Center for Medicare and Medicaid Services survey at the Behavioral Health Division is that of accountability within the system.

System Accountability

Accountability at the systemic level is achieved through the federal CMS and the State Division of Quality Assurance.

BHD administration assumes primary responsibility for ensuring that appropriate policies and procedures are in place to provide a safe and healthy environment for the appropriate treatment of mental health patients at County facilities. Accountability at this systemic level is achieved through the federal CMS and the State Division of Quality Assurance, which routinely survey BHD and other health providers to ensure compliance with applicable federal and state regulations. These same agencies investigate individual complaints of substandard care or abuse, the January 2010 survey of BHD being a case in point.

Personal Accountability

With certain exceptions, CMS and State DQA surveys generally do not directly enforce personal accountability for staff performance. (Referrals can be made to other state agencies to investigate specific incidents of caregiver and medical staff improprieties). Rather, BHD relies on two mechanisms to achieve personal accountability for medical staff performance. The first, and most commonly used mechanism, is the regular human resource/supervisory relationship and disciplinary process practiced by every Milwaukee County department.

Hospitals in the U.S. rely on a system of internal review and corrective action to establish personal accountability for medical staff performance.

The second mechanism to establish personal accountability for medical staff performance, used by BHD as well as all other hospitals in the United States, is a system of internal review and corrective action that includes enforcement actions up to and including reporting to professional licensing authorities.

According to Wis. Adm. Code DHS 124.12, which governs hospitals licensed in Wisconsin:

> *(2) GENERAL REQUIREMENTS.*
>
> *(a) Organization and accountability.*
> *The hospital shall have a medical staff organized under by−laws approved by the governing body. The medical staff shall be responsible to the governing body of the hospital for the quality of all medical care provided patients in the hospital and for the ethical and professional practices of its members.*
>
> *(b) Responsibility of members. Members of the medical staff shall comply with medical staff and hospital policies. The medical staff by−laws shall prescribe disciplinary procedures for infraction of hospital and medical staff policies by members of the medical staff. There shall be evidence that the disciplinary procedures are applied where appropriate.*

"The medical staff by-laws shall prescribe disciplinary procedures for infraction of hospital and medical staff policies by members of the medical staff." **(Wis. Adm. Code DHS 124.12).**

At BHD, this role is performed by the Medical Staff Peer Review Committee. According to BHD's Medical Staff By-Laws:

> *"This committee shall be responsible for carrying out quality improvement activities including, but not limited to, the review of clinical performance of members of their discipline to assess compliance with discipline established standards of practice and codes of ethics, as well as the review of Medical Staff monitors and initiation of corrective action, when indicated. …This committee may conduct a focused professional practice evaluation when questions arise regarding a practitioner's quality of care, treatment and service, professional competence or professional ethics. When concerns regarding the provision of safe, high quality patient care are identified through clinical practice trends evidenced during the course of ongoing professional practice evaluation or are triggered by [a] single incident, the committee shall establish a monitoring plan and set a duration."*

The Medical Staff By-Laws also establish the Critical Incident Committee, a subcommittee of the Peer Review Committee, which duties include the following:

> *"This committee shall serve in a risk management capacity for the Behavioral Health Division and shall be responsible for review of sentinel events and lesser, but potentially significant, incidents involving physical or psychological injury, or risk thereof, or the variation in standard of care, policy or procedure for which a recurrence would result in risk of a serious adverse outcome. The committee shall determine possible causative factors and review compliance with applicable policy and procedure. It shall assign responsibility for any corrective recommendations and assure that appropriate action is taken. The committee shall report to the Administrator, Medical Director, Quality Improvement/Risk Manager and Corporation Counsel any incident, which could result in liability. Quality concerns about the individual performance of a member of the Medical Staff shall be referred to Medical Staff Peer Review for a focused review, as described in 5.3.3, or for initiation of corrective action, as described in Appendix I, Section 1.1 of these By-laws."*

We requested that BHD administration provide evidence that any disciplinary procedures were applied to any BHD medical staff by the Medical Staff Peer Review Committee relative to incidents and findings highlighted in the January 2010 CMS survey. Alternatively, we requested affirmation that no disciplinary action was warranted in that regard.

BHD administrators are prohibited from providing documentation regarding any Medical Staff Peer Review activities.

However, BHD administrators are prohibited from providing documentation regarding any Medical Staff Peer Review activities that may have been conducted in conjunction with the incidents highlighted in the January 2010 CMS survey. They noted that shielding such activity from public disclosure is critical to encourage frank and open participation in the critical incident review process, as well as to encourage future reporting of events. They note that the Medical Staff Peer Review function includes careful analyses of root causes of weaknesses in systems and processes, as well as individual practitioner performance. We confirmed that such confidentiality is standard

We confirmed that such confidentiality is standard practice in the medical field.

practice in the medical field, and that Wis. Stat. s. 146.38 protects the confidentiality of records and conclusions of Medical Peer Review Committees.

Consequently, we agree that BHD administration is prohibited from disclosing whether or not Medical Staff Peer Review disciplinary actions were applied, or not warranted, with regard to the incidents highlighted in the January 2010 CMS survey. We acknowledge that this important safeguard to protect the integrity of the peer review process conflicts with the concept of absolute public accountability.

It is a matter of public record that, in the aftermath of extensive media coverage of issues related to the January 2010 CMS survey, the BHD Administrator was demoted to a position of lesser responsibility in another County division, and a BHD staff psychiatrist has been recommended to the County Personnel Review Board for discharge.

Reported Falsification of Records

Elected officials have publicly demanded that individuals be held accountable for any known instances of falsifying records.

Elected officials have publicly demanded that individuals be held accountable for any known instances of BHD employees falsifying records, as was widely reported in the media. Based solely on the CMS survey comments, it is possible to infer that County staffers allowed a patient to repeatedly leave the ward unsupervised, then falsified documents to say the patient was being checked every 15 minutes.

The conclusion that County staffers falsified documents appears to be drawn from two survey comments:

- One comment related to BHD nurses signing behavior observation flow sheets (documentation of staff observing patient behavior every 15 minutes) at the beginning of their shifts. Specifically, the Statement of Deficiencies for the CMS survey completed January 21, 2010 contained the following comment:

The RNs are completing the behavior check form at the beginning of each shift and would be unable to account for behavior during times that show documentation as incomplete.

- Another comment indicated a patient was identified as confronting three visiting eight-year-old girls at a location off ward, when the patient's off ward privileges had been ordered discontinued, and the patient was supposed to be on 15-minute behavior observation status. Specifically:

  On 7/27/09 Psychiatric Social Worker (PSW) 'Q' documented in Patient #7's clinical record that PSW 'Q' was approached by MD 'S' who reported that while on an OWP, Patient #7 was accused of approaching three 8 year old girls and was asking personal questions and blocked their escape.

  Per interview with PSW 'Q' on 1/21/2010 at 10:50 a.m., PSW 'Q' told Surveyor that on 7/26/09 in the p.m. when MD 'S' approached PSW 'Q', he was quite upset about the OWP incident of Patient #7. According to PSW 'Q', MD 'S' was notified by an unknown nurse or security person that they had witnessed inappropriate behavior while Patient #7 was off the ward and on the 4th floor. According to PSW 'Q', Patient #7 "Was not in the right place."

  PSW 'Q' stated when Patient #7 was on OWP, "He generally listened to his iPod, or whatever it was, and wandered all over the building with it. Because of his strong history of sociopathic behavior, he was probably up to no good when he ran into these girls."

  Also present during this interview was Director 'H' who told Surveyor 326711, "The girls were most likely visitors as the nursing home is also on the 4th floor."

  There is no indication in the clinical record that Patient #7's OWPs were re-ordered after being discontinued for inappropriate sexual behavior on 7/23/09 by MD 'R'. Patient #7 remained on every 15 minute behavior checks during the time period of this reported incident (7/26/09). Leaving the unit on every 15 minute behavior checks is in opposition to the hospital policies of Behavior Observation Status and Passes and Off Ward Privileges.

  Review of Patient #7's Behavior Observation Flow Sheet reveals that the 15 minute behavior checks initiated on 7/23/09 through 8/7/09 showed that all checks were completed every 15 minutes. The 15 minute behavior checks do no indicate that Patient #7 was off ward on 7/26/09 when he approached the three 8 year old girls.

After conducting our own interviews with PSW 'Q,' MD 'S,' MD 'R' and Director 'H,' as well as other BHD administrators, we learned the following:

- PSW 'Q' was not approached by MD 'S' in the p.m. of 7/26/09. 7/26/09 was a Sunday, during which time PSW 'Q' worked from 10:10 a.m. to 01:55 p.m. MD 'S' did not work on Sunday 7/26/09. According to PSW 'Q,' he remembers clearly that MD 'S' contacted him by telephone on this issue, and that he wrote his note in Patient #7's medical record shortly after the telephone call because of its importance. PSW 'Q' was not sure what date or time the incident with the three 8-year-old girls occurred.

- MD 'S' said that he became aware of the incident with the three 8-year-old girls from a Safety Meeting, which is a meeting held daily (except for weekends) at noon among several different administrators, staff and security. MD 'S' said he was sure he found out about the incident after the 7/23/09 revelation that there was sexual contact between Patient #7 and Patient #2, but was not certain when the incident occurred, acknowledging it could have occurred a few days earlier.

- The only entry in Safety Meeting minutes remotely resembling the incident involving the three 8-year-old girls was discussed at the 7/27/09 Safety Meeting, the same day PSW 'Q' entered the note in Patient #7's medical record regarding the incident. The following entry is made in the Safety Meeting minutes (24-hour Staffing Report) for 7/27/09: *Pt. #7, reportedly confronting visitors in BHD lobby while on off-ward privileges.* The date of occurrence for this incident is 7/22/09, one day prior to the medical order from MD 'R' to discontinue OWP for Patient #7.

- PSW 'Q' told us that PSW 'Q' initially heard, "through gossip or whatever" that the incident had occurred in the lobby, "but later I was told it was on the fourth floor." PSW 'Q' does not recall who told him the incident occurred on the 4th floor, but he was sure it was not MD 'S,' who had initially telephoned him with the concern that was documented in Patient #7's file. Director 'H' told us that, based on the understanding that the incident occurred in the p.m. (which now comes into doubt because none of the principles seem to have first-hand knowledge of who observed and reported this incident, or what specific time it occurred), Director 'H' speculated that the girls were most likely visitors to the Nursing Home on the 4th floor because that is the only unit with unlimited visiting hours.

Based solely on the comments in the CMS survey, it is possible to infer that BHD staff falsified records to cover up mistakes.

Coupled with the earlier Statement of Deficiencies comment that nurses sign the Behavior Observation Flow Sheets at the beginning of their shifts, it is possible to infer that BHD staff falsified records to cover up mistakes. However, based on our access to medical records, we verified that nurses clearly documented the time of their signatures, and thus were not falsifying records to cover up mistakes in that manner. Further, our discussions with the above parties lead us to believe that the incident involving three 8-year-old girls occurred prior to the date that OWPs for Patient #7 were placed on hold.

Since there was no direct statement in the CMS survey document stating that BHD staff falsified records, we attempted to discuss our findings with the State DQA surveyors that conducted the survey. The Division Administrator refused to allow surveyors to discuss the matter or respond to written questions, offering the following comments by e-mail:

> *"…the Statement of Deficiency (SOD) is our position on the facility's actions that warranted the violations. Our role ends with the SOD, unless there is an appeal. We do not get involved with 3rd party post-review analysis of the actions that warranted to the SOD. That would be highly inappropriate for us to do. Therefore, I again deny your access to my staff for your review, but will review the questions you have and respond to those to which DQA is able to respond."*

After placing questions in writing, the following response was provided:

> *"…After reviewing those questions, I regret to inform you that is not appropriate for me to provide a response to these questions other than reiterate that our position remains what's been previously documented in the Statements of Deficiencies issued to the facility."*

We conclude that none of the findings or comments contained in the January, 2010 CMS survey of BHD, upon further scrutiny, support a conclusion that BHD employees falsified records.

Based on our review of the CMS survey document, an examination of pertinent medical records, security logs and other BHD documents, as well as interviews with multiple BHD staff members (including those interviewed by the surveyors), we conclude that, upon further scrutiny, none of the findings or

comments contained in the January, 2010 CMS survey of BHD support a conclusion that BHD employees falsified records.

Joint Commission Accreditation

The Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations (The Joint Commission, or TJC) is an independent, non-profit organization that evaluates and accredits health care organizations and programs in the United States. To determine and bestow accreditation status, TJC evaluates an organization's compliance with standards in the areas of Quality, Safety, Leadership, Management and Staff Practices. Among benefits of TJC accreditation cited in a January, 2010 report prepared by the Department of Health and Human Services are the following:

- Strengthens community confidence in the quality and safety of care, treatment and services.
- Improves risk management and risk reduction.
- Helps organize and strengthen patient safety efforts.
- Provides education on effective practices to improve business practices.
- Provides a customized, intensive process of review, grounded in the mission and values of each specific organization.

BHD formerly maintained TJC accreditation, but discontinued participation in 2003.

BHD formerly maintained TJC accreditation, but discontinued participation in 2003, primarily for financial reasons. In 2009, preparations began to re-apply for TJC accreditation. Current planning targets 2012 for accreditation.

Due to its emphasis on continual self-assessment and improvement, BHD's achievement and maintenance of accreditation by The Joint Commission is desirable.

Due to its emphasis on continual self-assessment and improvement, we agree that BHD's achievement and maintenance of accreditation by The Joint Commission is desirable. Therefore, we recommend BHD management:

6. *Continue its efforts to pursue accreditation from The Joint Commission, and prepare a report for the June 2011 meeting of the County Board Health and Human Needs Committee on progress toward, and any impediments to, achieving accreditation in 2012.*

Professional Credentials Check

As part of our audit work, we checked with the Wisconsin Department of Regulation and Licensing and verified that all 68 psychiatrists, psychologists and physicians currently on staff at BHD have current licenses. None were operating with current orders of restriction on their licenses.

We also verified there were current licenses on file for all 255 Registered Nurses on staff at BHD. None of the 255 nurses had current orders of restriction on their licenses.

Section 4: BHD has implemented most of the corrective measures recommended by the Milwaukee County Sheriff's Office to enhance physical security at the institution.

A report from the Milwaukee County Sheriff's Office identified various safety issues at BHD.

On June 28, 2010 a safety survey performed by the Milwaukee County Sheriff's Office regarding the Behavioral Health Division's Charles W. Landis Mental Health Complex was issued. The report identified various safety issues and provided the following recommendations to improve the overall safety of the complex.

Sheriff's Office Security Review Recommendations

Security Duties, Alert and Response/Police Services

- Security log entries should include that an Incident Report was generated and, if possible, an Incident Report number.
- All duress alarms should be checked on a regular basis for accessibility and functionality. Staff training on the effective use of duress should be conducted.
- Handheld radios already in BHD's possession should be assigned to each nurse's station floor for effective communication between responding security officers and staff at the incident scene.

Parking Lot/Perimeter Security

- Lights and light coverings should be replaced to allow for a brighter, whiter light.
- Closed circuit cameras should be placed overtly in all parking areas and on the loading dock area.
- A security position should be added as a rover in the parking lots.

Entrances at BHD Complex

- BHD's plan to restrict access to entrances and areas by key card readers should be rapidly implemented.
- All public entrances should be closed except for the main entrance. All visitors should sign in, receive a badge, then sign out and return the badge. All employees should use the same door and show ID badge.

- The reception area should be staffed with a security officer to monitor additional cameras, parking lot and assist with ID checks and badge issuance.

- Lockers should be set up for visitors.

- If another entrance must be open for other inpatients to have access to the outside, the entrance should be staffed to direct visitors to the main entrance.

- Encourage and empower all staff to challenge anyone without a visitor's badge. This should be done on a daily basis.

- Direct those utilizing the Walk-In Clinic to use the Psych Crisis Service (PCS) door and be screened.

BHD Courtroom

- Everyone must be screened by security for weapons as they enter the courtroom.

- The door going into the courtroom from the waiting room should be locked from both sides.

We verified that all the recommendations have been implemented or are in the process of being implemented, with one exception.

We verified that all the recommendations have been implemented or are in the process of being implemented, with the exception of the recommendation to screen individuals using the Walk-In Clinic. BHD administration continues to take the position that the screening of individuals who wish to use the Walk-In Clinic would have an adverse effect on voluntary participation–individuals would be apprehensive about a weapons screening process and therefore may not seek the treatment that they need. As a result, BHD administration does not believe the use of a metal detector is indicated in an outpatient level of care.

Internal surveys of Walk-In Clinic staff and clients recently conducted by BHD show mixed results but support the administration's view that increased security measures at the clinic would discourage some clients from voluntarily seeking help. A survey of 17 staff members showed that 88% of respondents felt 'somewhat or generally safe,' but no staff member felt 'very safe' at the clinic. The same survey showed

that 12% of clinic staff members agreed that 'more security measures in the clinic would make people less likely to seek treatment.'

Perhaps more importantly, however, a survey of 111 clients showed that 26% agreed or strongly agreed that 'more security measures in the clinic would make people less likely to seek treatment.' The client survey also showed that 82% of respondents felt 'generally or very safe' in the clinic.

According to the Sheriff's Office report, the Sheriff ordered the security survey after a psychiatrist in the Walk-In Clinic contacted a Milwaukee County Board Supervisor over safety concerns at the BHD. The psychiatrist stated that there were instances of patients carrying weapons into the BHD facility, particularly the Walk-In Clinic. The psychiatrist had unsuccessfully raised the issue with BHD administration.

Staff queried the security reporting system for the past five years and were able to identify seven instances of weapons at the facility:

- Four instances in which knives were intercepted at the security checkpoint entrance to PCS.
- Two knives discovered by doctors during visits in outpatient areas.
- One knife discovered upon admission to the facility.

There was no documentation related to a weapon being brandished about at the Walk-In Clinic. According to BHD administration, there was documentation of three knives voluntarily handed over by clients at the clinic.

The County Executive's 2011 Proposed County Budget contains $80,000 for security cameras and $30,000 for electronic card readers to facilitate implementation of the recommendations in the Sheriff's Office report. To ensure all the recommendations of

the Sheriff's Office have been fully implemented, we recommend BHD management:

7. *Provide a report to the County Board Health and Human Needs Committee for its December 2010 meeting detailing the status of compliance with each of the recommendations contained in the June 2010 security review conducted by the Milwaukee County Sheriff's Office.*

Audit Department Observations of Security Presence on Adult Acute Inpatient Units

BHD contracts with a private vendor to provide security throughout the buildings composing the mental health campus.

BHD contracts with a private vendor to provide security throughout the buildings composing the mental health campus. When a security emergency occurs anywhere on the premises, a 'Code 1' is declared and security staff immediately converge to the locale of the incident. On a routine basis, one security 'rover' is assigned to rotate among the four Adult Acute Inpatient units to engage with staff and patients, thereby providing a security presence and acting as a deterrent to disruptive patient behavior.

During audit fieldwork we conducted observations of operations on each of the four Acute Adult Inpatient units. We queried nurses on the frequency of rounds conducted by the security floater. Two separate nurses indicated that, aside from Code 1 responses and specific requests for security staff to render assistance during the administration of medications to some patients, security typically walked through their units two or three times per shift.

With the close proximity of the five inpatient units, it would be reasonable to expect a rover security staff member to appear at least once or twice per hour.

With the close proximity of the five units (including a children's unit), it would be reasonable to expect a rover security staff member to appear at least once or twice per hour, with exceptions for specific call for assistance. During observations of at least one hour on each unit, totaling more than seven hours during the course of three days, we recorded four instances of a security staff rover walking through units, one instance of three security personnel walking briskly through a unit, and one instance of a security staff person looking in the window of a

door to a unit, but not entering the unit. During these observations, there were five separate instances in which security responded to a specific incident or request for assistance. There were additional observations of security personnel walking through the halls outside the units, but not entering.

When security personnel are assigned to make rounds of the perimeter of the BHD facilities, there are electronic checkpoints that record the time each post is checked. Security personnel wave an electronic device near electronic pads installed at various locations for this purpose.

To ensure security personnel assigned to roam the Adult Acute Inpatient units are making regular and timely rounds, we recommend BHD management:

8. *Install electronic monitoring devices on each inpatient unit to record the frequency with which security staff assigned as a rover among the units is completing assigned rounds.*

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Exhibit 1

Audit Scope

The Department of Audit conducted an audit of the Milwaukee County Behavioral Health Division (BHD). The audit focused on the policies and procedures related to safety of patients and staff at the Adult Acute Inpatient hospital. The audit primarily concentrated on the period 2009 to the present.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

During audit fieldwork, we experienced one instance which we reported separately as a scope impairment. We were denied, on the advice of the Milwaukee County Corporation Counsel's Office and outside counsel, access to a consultant's report that was prepared as part of an operational review and a legal defense strategy in relation to the death of a BHD patient in 2008. While that incident was outside the scope of this audit, we have reason to believe the consultant's report may have included material relevant to a review of patient safety at BHD. While it is impossible to know the impact of this restriction without seeing the requested document, we do not believe lack of access to the requested document in any way invalidates the findings and conclusions contained in this audit report.

We limited our review to the areas specified in this Scope Section. During the course of the audit, we:

- Reviewed Adopted Budget information and the proposed 2011 budget related to the Behavioral Health Division.
- Reviewed Milwaukee County Board and committee minutes and Milwaukee County Board Resolutions related to BHD safety issues.
- Obtained and reviewed applicable BHD policies and procedures, internal forms, reports and correspondence related to safety issues.
- Obtained and reviewed the results of and BHD's responses to the State of Wisconsin and Federal surveys conducted in January and May of 2010.
- Obtained and reviewed the Milwaukee County Sheriff's Office *Site Security Survey of the Charles W. Landis Mental Health Complex* dated June 28, 2010, and verified that the report's recommendations were implemented.

- Reviewed applicable Wisconsin State Statutes, Wisconsin Administrative Codes and Federal regulations.

- Met with Disabilities Rights Wisconsin representatives to obtain their perspectives on safety related issues.

- Interviewed the President of the Wisconsin Federation of Nurses and Health Professionals.

- Interviewed Milwaukee County Sheriff's Office staff

- Interviewed Milwaukee County District Attorney staff.

- Interviewed BHD administrative staff to obtain a clear understanding of the acute care operations.

- Interviewed acute care staff regarding staffing and safety issues.

- Conducted Internet search for studies related to mixed gender units.

- Obtained 2007 through 2009 BHD acute care census data.

- Obtained 2007, 2008 and 2009 BHD payroll data to conduct an analysis of hours worked on the acute care units by nurses and nursing assistants.

- Obtained Unsafe Staffing Forms submitted to the Wisconsin Federation of Nurses and Health Professionals and BHD.

- Obtained and reviewed the results of the 2010 survey conducted by the Wisconsin Federation of Nurses and Health Professionals regarding BHD safety and staffing issues.

- Obtained and analyzed BHD's Incident Report data from 2005 through September 10, 2010 and individual Incident Reports for 2009.

- Compared Unsafe Staffing Forms data to Incident Reports data.

- Obtained and reviewed training records related to BHD staff providing direct patient care.

- Reviewed the Behavior Observation Flow Sheets contained in the medical records of August 2010 patients.

- Obtained and analyzed One-to-One Observation data from November 2009 through August 2010.

- Obtained and analyzed acute care nursing and nursing assistant schedules for July 2009.

- Compared Incident Report occurrences to Unsafe Staffing Forms data for the period July 2009 through December 2009.

- Surveyed Milwaukee area hospital regarding the issue of patient gender separation.

- Identified Wisconsin circuit court cases related to various BHD patients.

- Contacted The Joint Commission regarding psychiatric hospitals internal review process.

- Contacted Mendota and Winnebago State Mental Health Institutes regarding occupancy levels and cost data.

- Reviewed the medical records of various BHD acute care patients.

- Verified that all 68 of the psychiatrist, psychologists, physicians at BHD and all 255 registered nurses assigned to the Adult Acute Inpatient units have current licenses through the State of Wisconsin, Department of Regulation and Licensing.

- Observed security staff on BHD acute care units.

- Determined whether there was any relationship between the number of nurses scheduled to work and incidents reported.

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Summary of CMS Statement of Deficiencies for Survey Ending January 21, 2010
(Excerpted from and Paraphrased by Milwaukee County Department of Audit)

Exhibit 2

Charting of Statement of Deficiencies from 1/21/2010 Survey of BHD by WI DHHS for Centers for Medicare & Medicaid Services

Prefix Tag	Date	Patient #	Sexual Contact?	Description (Excerpted and Paraphrased from Survey Comments)
A-115		2		**42 CFR 482.13 Condition of Participation: Patient Rights: NOT MET**
		7		**42 CFR 482.13(c) Standard: Privacy and Safety: NOT MET**
		9		**Immediate Jeapordy determined 1/21/2010**
		10		**Universe (sample) of 17 patients. Hospital failed to maintain safety for 11 patients**
		11		**See Tag A-144**
		12		
		13		
		14		
		15		
		16		
		17		
A-144				**482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING**
				Universe (sample) of 17 patients.
				Hospital failed to ensure that 11 patients were safe from inappropriate sexual contact in their environment.
	Background	2	---	Admitted 7/01/09. History of Seizure Disorder, Mood Disorder, Iron Deficiency Anemia and mild Mental Retardation. Pt. #2 has a legal guardian--found incapable of making decisions independently prior to admission.
	Background	7	---	Admitted 12/04/08. Diagnoses of Conduct Disorder, Disruptive Behavior Disorder, Impulse Control Disorder, Post Traumatic Stress Disorder, Learning Disability, and mild to moderate Mental Retardation. A Behavior Treatment Plan dated 10/24/08 indicates Pt. #7 had exhibited sexually inappropriate behavior with hospitalized peers since June of 2004 when pt. entered the hospital system, with transfers to different levels of care. Pt. #7 transferred to Acute Unit after #7 and a peer "Chased down and brutally physically assaulted another peer on the unit" on 10/11/08. Pt. #7 has a legal guardian--found incapable of making decisions independently prior to admission.
	7/1/2009	2 & 7	Yes	CNA observed Pt. #2 leaving room of Pt. #7. Pt. #2 fully clothed; Pt. 7 in bathroom w/pants dropped. Both pts. Deny sexual contact. Pt. #2 put on 15 minute Behavioral Checks for inapproprite sexual behavior; Pt. #7 not put on Behavioral Checks. No update to Pt. #2's Recovery Plan; no contact of Pt. #2's Legal Guardian. No update to Pt. #7's Recovery Plan; no contact of Pt. #7's Legal Guardian. Progress Notes on 7/2/09 say Pr. #7 admitted Pt. #2 performed oral sex on him. Sexual History section in Pt. #7's History & Physical is not complete and does not reflect his history of sexually inappropriate behavior. Pt. #2 & Pt. #7 have separate treatment teams.
	7/23/2009	2 & 7	Yes	During a Recovery Plan meeting Pt. #2 stated she had been having sex w/Pt. #7 for at least 3 weeks, said latest contact 7/20/09 in community BR, said latest contact was forced upon her. Pt. #2 taken to sexual Assault Treatment Center and transferred to another unit. On 7/23/09 Pt. #2's Recovery Plan updated to include inappropriate sexual behavior. Documented interviews conducted on 9/14/09 indicate Pt. #2's claim of forced sex changes between consensual & non-consensual. On 7/23/09 Pt. #7's Recovery Plan updated to include inappropriate sexual behavior. Progress notes indicate Pt. #7 admits having sex w/Pt. #2. Pt. #7 placed on 15-min. behavioral checks. Pt. #7's Off-Ward Privleges (OWP) were discontinuted.

			Nursing Administrator 'D' acknowledged on 1/20/09 [sic] at 9:30 a.m. that the hospital had identified the lack of communication on the units and between the different teams. The teams on the same unit failed to protect Patient #2 and develop safeguards to prevent Patient #7 from continuing sexually inappropriate behavior for 22 days (7/01/09-7/23/09). In an interview with Director 'A' on 1/19/10 at 11:55 p.m. [sic], the hospital completed an internal investigation and education was completed to the mecical and management staff, and some social workers, between 9/14/09 and 9/24/09 regarding the duty of the staff to protect its patients. Director 'A' stated that it became clear to them that the front line staff was not aware the hospital had a "no sexual contact policy during the time the two patients (Patient #2 and #7) were on the unit." On 01/21/10 at 11:30 a.m. during an itnervie RN 'O' told Surveyor #22198, that she was not aware of a policy related to sexual contact between patients.
7/26/2009	7	---	Notes in Pt. #7's file from Pyschiatric Social Worker (PSW) indicate that on 7/26/09 PM a doctor reported that while OWP Pt. #7 was asking three 8-yr.-old girls personal questions and blocked their escape. Pt. #7 was on 15 minute Behavioral Checks at the time and no indication OWP suspension had been lifted. No indication that Pt. #7's Recovery Plan was updated to rreflect the 7/26/09 incident of inappropriate sexual behavior.
8/21/2009	7 & 9	Yes	Incident report states that Pt. #9 reported to RN that she had consensual sexual contact with Pt. #7 "a couple of days ago" for cigarettes. Pt. #9 refused to speak w/police or file a complaint. No indication of this incident in Pt. #7's progress notes. Pt. #7 was out on an overnight pass from 8/21/09 thru 8/23/09 to a group home.
8/24/2009	7 & 11	Likely	1:00 PM Incident report states that RN redirected Pt. #11 from going in male hallway at 12:55 PM and at 1:00 PM found Pt. #11 in community BR w/Pt. #7. Pt. #7 was fully clothed and Pt. #11 had her pants down. Pt. #11 was unable to comprehend questioning re: pressing charges due to her current psychotic state. 8/24/09 entry at 1:47 PM in Pt. #7's record by PSW notes "had a good pass" (referring to 8/21/09--8/23/09 overnight pass). No mention of another inappropriate sexual contact. 8/26/09 there is a physician's order to discontinue OWPs for a 24-hr. pd. For Pt. #7 in light of 8/24 incident and Pt. #7 must follow strict guidelines to regain OWPs. 8/27/09 PSW reports 8/24/09 incident to Pt. #7's group home, legal guardian and disability case manager.
8/28/2009	7	---	Pt. #7 gets a 2-day pass to the group home, accompanied by an escort. Returns to BHD 8/30/09.
8/30/2009	7 & 10	Yes	8:15 PM incident report states Pt. #10 told 3 separate staff in 3 separate interviews that she had secual intercourse with Pt. #7 on floor in Pt. #7's room. Pt. #7 placed on 1:1 observation until his incarceration on 9/22/09.
9/14/2009	2	---	Director "A" notified of a positive pregnancy test on Pt. #2 after Pt. #2 was transferred out of Acute Unit to another unit at BHD. Pt. #2's clincal record did not reflect that a pregnancy test had been conducted six weeks after 7/23/09 incident as per BHD policy.

9/17/2009	14	---	6:45 PM Pt. #14 was noted as dancing in his room with another pt. Pt. #14's clinical record indicates he has mild mental retardation and Impulse Control Disorder.
9/17/2009	14	---	9:00 PM Pt. #14 scared a female pt. By "touching her inapproprately--hugging and telling her he would come to her room during the night and take care of her."
9/19/2009	14	---	9:00 PM Pt. #14 asked RN "do you love me?" brushing his hand up against the RNs hand twice. The RN noted that Pt. #14 continued to be intrusive, needing constant redirection.
9/20/2009	14	---	9:00 PM Pt.#14 remains at desk constantly. Pt. #14 is intrusive and often breaks personal space of staff. Can be overly friendly, toucing and feeling others, then becomes angered by very minor problems. *Note: These appear to be notes of generalized observations; no specific incident cited.*
9/23/2009	14 & 15	Alleged	10:45 AM Pt. #14 alleges that his roommate, Pt. 315, sexually assualted him the previous night (anal penetration." Interviewed by psychiatrist, asked "if he could have had a nightmare/dream?" Pt. #14 responded "yes." Psychiatrist recorded as a "delusional episode and/or a dream." Pt. #14 was not physically examined; not note in Pt. #15's clincial record.
9/23/2009	14	---	2:20 PM Pt. #14 while at the nurses' station said he had marks on him and wanted to jump over the nurses' station beat beat the s**t out of a nurse. Notes indicate Pt. #14's hostile, agitated mood and threatening gestures and posturing required medication intervention. Pt. #14's treatment plans did not include his sexually inappropriate behaviors. Behavioral monitoring did not include Pt. #14's sexually inappropriate behavior. Psychiatry notes did not indicate the medical teeam had been informed of Pt. #14's inappropriate sexual behavior. Pt. #14 was discharged to a group home on 10/02/09 but group home not informed of his sexually inappropriate behavior.
10/5/2009	16 & 17	Yes	Incident report of a poossible sexual contact between P. #16 and Pt. #17 when a CAN found the pts. In the bathroom. One pt. Had an obvious erection in his pants and a packet of Vaseline iin his hand, the other pt. Refused to come out the the BR for several minutes, but was clothed. Pt. #17 denied any contact but Pt. 16 stated he did have sexual contact with Pt. #17 but refused to elaborate.
12/11/2009	12 & 13	Yes	Incident report is filed regarding an oral sex act between Pt. #12 and Pt. #13. Both patients admint to the act being consensual.

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Exhibit 3

Behavior Observation Flow Sheet Form

DATE_____ **BEHAVIOR OBSERVATION:** ☐ **1:1** ☐ **15 MINUTE CHECKS**

☐ **ORDER CHANGED: TIME:**_____

BEHAVIORS TO BE MONITORED:_____

☐ See BTP, IPP or Recovery Plan_____

SPECIAL PRECAUTIONS/NEEDS:_____

☐ See BTP, IPP or Recovery Plan_____

NIGHTS				*DAYS*				*PM'S*			
TIME	Monitored Behaviors Attempted		INITIALS/ SIGNATURE* (see back)	TIME	Monitored Behaviors Attempted		INITIALS/ SIGNATURE* (see back)	TIME	Monitored Behaviors Attempted		INITIALS/ SIGNATURE* (see back)
	Yes	No			Yes	No			Yes	No	
2300				0700				1500			
2315				0715				1515			
2330				0730				1530			
2345				0745				1545			
2400				0800				1600			
0015				0815				1615			
0030				0830				1630			
0045				0845				1645			
0100				0900				1700			
0115				0915				1715			
0130				0930				1730			
0145				0945				1745			
0200				1000				1800			
0215				1015				1815			
0230				1030				1830			
0245				1045				1845			
0300				1100				1900			
0315				1115				1915			
0330				1130				1930			
0345				1145				1945			
0400				1200				2000			
0415				1215				2015			
0430				1230				2030			
0445				1245				2045			
0500				1300				2100			
0515				1315				2115			
0530				1330				2130			
0545				1345				2145			
0600				1400				2200			
0615				1415				2215			
0630				1430				2230			
0645				1445				2245			

RN Signature:	RN Signature:	RN Signature:
Date: Time:	Date: Time:	Date: Time:

Addressograph

Milwaukee County Behavioral Health Division
Behavior Observation Flow Sheet

See Instructions on Back of Form

Form #309-R3

INSTRUCTIONS FOR COMPLETION OF BEHAVIOR OBSERVATION FLOW SHEET

1). RN will immediately delegate the monitoring of a patient placed on Behavior 1:1 or 15-minute checks to an appropriate staff member.

2). RN will initiate the Behavior Observation Flow Sheet when a patient is placed on Behavior Observation Status.

3). RN will complete top section of the Behavior Observation Flow Sheet including the behaviors to be monitored and any special precautions to be taken. Reference Recovery Plan, IPP, or BTP as appropriate.

4). RN will document any change in the physician order in the appropriate section at the top of the flow sheet (i.e. increase, decrease, discontinuation).

5). The assigned staff member will document every 15 minutes on the Behavior Observation Flow Sheet under the "Monitored Behaviors" section. A check mark will be placed in the "Yes" column if the patient attempted to engage in the monitored behavior. If the patient did not attempt to engage in the monitored behavior a check mark will be placed in the "No" column.

6). The assigned staff member will initial each entry.

7). The assigned staff member will document the date, his/her full printed name, signature, initials, and title on the back of the flow sheet.

8). The RN will direct and supervise the delegated Behavior Observation assignment per Nursing Standards. The RN will sign, date and record time on the Behavior Observation Flow Sheet at least once per shift.

9). Whenever there is a change in staff members assigned to the Behavior Observation monitoring, both the staff member ending the task and the staff member assuming the task will initial the "Initials/Signature" section at the time of transfer of responsibility.

10). The completed Observation Flow Sheet will be placed in the Flow Sheet section of the medical record at 2245 hours when a new Flow Sheet will be initiated.

NOTE: **Minimum RN Evaluation Documentation in Nursing Progress Record:**

- All patient every shift first 72 hour on Behavior Observation Status
- Acute Care & Crisis: Every shift thereafter
- Long Term Care: Every 24 hours thereafter

DATE	Full Printed Name	Full Signature	Initials	Title

Addressograph

Milwaukee County Behavioral Health Division
Behavior Observation Flow Sheet

Form #309-R3

O:\NrsAdm\NA\FORMS\2004\Behavior Observation Flow Sheet 8-12-04.doc

Incident Report Form

MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION {PLEASE PRINT} Quality Management No.
INCIDENT/RISK MANAGEMENT REPORT 4310-1 R6 2010 SEE INSTRUCTIONS ON BACK OF LAST PAGE

1. DATE of INCIDENT	2. TIME	3. LOCATION of INCIDENT Unit / Program / Room / Area	
4. NAME OF PERSON/S INVOLVED (Last, First, Initial)	5. Patient(P) Employee(E) Visitor(V), Security/Contract (S/C) Student Volunteer	6. MEDICAL RECORD NUMBER	7. Visitors, Students or Volunteers:
A.	☐ P ☐ E ☐ S/C ☐ V ☐ Studnt ☐ Volunteer		A. Home Address City State Phone B. Home Address City State Phone
B.	☐ P ☐ E ☐ S/C ☐ V ☐ Studnt ☐ Volunteer		For QA Use
C.	☐ P ☐ E ☐ S/C ☐ V ☐ Studnt ☐ Volunteer		

8. TYPE OF INCIDENT (Check all that apply / see back for description)

- ☐ Adverse Drug Reaction
  - ☐ Called 454-4262 pharmacy hotline
- ☐ Medication Variance Causing Harm
- ☐ Caregiver Misconduct Allegation
  - ☐ Supervisor notified immediately
- ☐ Code 4 Medical Emergency
- ☐ Confidentiality Breach
- ☐ Death
- ☐ Exposure to Infection
- ☐ Fall (*for patient fall complete blue Fall Incident Report*)
- ☐ Fire
- ☐ Hazardous Material/Environmental Contam.
- ☐ Injury
  - ☐ For employee injury Form 3676-1 sent to Human Resources
- ☐ Medical Device/Equipment Problem
- ☐ Missing Property/Money
- ☐ Physical Aggression
- ☐ Property Damage
- ☐ Sexual Contact
- ☐ Suicide Attempt/Self Injury

Unauthorized Patient Absence

- ☐ Elopement from locked unit
- ☐ Elopement from escort
- ☐ Fail to return to unit (unlocked, pass, OWP)
- ☐ Other

9. DESCRIPTION OF INCIDENT

10. DESCRIBE IMMEDIATE ACTION TAKEN

11 WITNESSES	12. NOTIFICATIONS (Complete for all immediate contacts)	TIME CONTACTED
	Physician/MOD	☐ Spoke to person
	RN	☐ Spoke to person
	Supervisor	☐ Spoke to person
	Attending/QMRP	☐ Spoke to person
	AR/NPC	☐ Spoke to person
	**Sheriff	☐ Spoke to person
	**Administrator	☐ Spoke to person
	Guardian/Family as appropriate	☐ Spoke to person

Supervisor, AR, NPC, QMRP, Administrator on call, medical staff will order notification unless emergency

13. REPORT COMPLETED BY

PRINT NAME AND TITLE | SIGNATURE | PHONE NUMBER | DATE & TIME

14. MANAGEMENT REVIEW

Findings/Recommendations

☐ Administrator/Designee notified for Sentinel Event or possible Injury of Unknown Origin/Caregiver Misconduct

Print Name and Title | Signature | Phone Number | Date & Time

15. ADMINISTRATOR/DIRECTOR REVIEW

☐ No further review recommended ☐ Further Review Pending Initials

INCIDENT/RISK MANAGEMENT REPORT
GENERAL INSTRUCTIONS

LEASE PRINT all information being described/identified on this form.
O NOT put a copy of the Incident/Risk Management Report in the patient/resident's medical record.
OMPLETE this form and **make sure** that your supervisor or designee has received it **before the end of your shift and before you leave the premises.**
OMPLETE Employee Accident/Loss Report, Fire Alarm Incident Report, P&T report or other required reports and send to appropriate persons.
EE Milwaukee County Behavioral Health Division Policy and Procedure for Incident Reporting for additional instructions.
O NOT complete this form for allegations of workplace violence or sexual harassment. Consult Milwaukee county policies for reporting procedure.

SPECIFIC INSTRUCTIONS FOR EACH ITEM

: Print the date of incident.
:: Print the time incident occurred, use military (24-hour) time.
;a: Print the location of the incident, indicate program and unit.
;b: Record room, area or any other location.
;: Print the name of each person involved in the incident (do not list witnesses here). If more than three individuals are involved, use another form.
;: Check if patient/resident (P), employee (E), visitor (V), security or contract personnel(S/C), student(Studnt), or volunteer involved in the incident.
;: If a patient was involved, the medical record number must be listed.
': If a visitor, student or volunteer was involved please record home address, city, state, and phone number here.
8: Check the type of incident. Check all that apply.
ADVERSE DRUG REACTION – A suspected or unintended physical and/or allergic reaction to a medication when prescribed and used in an approved manner. **Call the** BHD Pharmacy Hotline at 454-4262 and leave a message.
MEDICATION VARIANCE CAUSING HARM – Any medication action that is not consistent with routine medical operation or routine **care of a** particular patient which causes unintended physical consequences. Also complete the Medication Variance Report Form 472-1 and attach. For Medication Variance which **does not** cause harm complete Form 472-1 **only** and process as indicated in the Adverse Drug Reactions and Medication Variances Policy MS5.2.6.
CAREGIVER MISCONDUCT ALLEGATION - Report observed or reported physical, sexual, mental or emotional abuse, verbal abuse, and neglect of patients/residents. **Notify your supervisor immediately. Supervisor must notify Program Administrator/designee immediately.**
CODE 4/MEDICAL EMERGENCY– Serious medical emergency resulting in a "Code 4" being called. Follow Code 4 Policy for reporting.
CONFIDENTIALITY BREACH – Intentional or unintentional release of identifiable patient/resident information without consent. Before completing this form, consult with supervisor/designee or privacy officer to determine if violation of patient/resident confidentiality has actually occurred per HIPPA and chapter 51.
DEATH – File a report for all deaths. Follow sentinel event procedures.
EXPOSURE TO INFECTION – Direct contact with a communicable organism. Report exposures such as needle sticks, human bites, contact with blood and body fluids on non-intact skin (mouth, eyes, cuts, etc.) and contacts with patients diagnosed with active tuberculosis.
FALL – An individual is seen falling or reports having fallen. For Patient Fall, complete the Patient Fall Incident Report. Use this form for staff, visitor, non-pt.
FIRE – Report any fires or attempts at setting fires.
HAZARDOUS MATERIAL/ENVIRONMENTAL CONTAMINANT – Exposure to hazardous chemical substances, materials, or pollutants.
INJURY – Injury for which medical/nursing attention is required. Examples include accidents, self-injuries, and injuries during seclusion and restraint. **For Patient/Resident injuries which have an unknown origin notify supervisor immediately.** For employee injuries complete the Accident/Loss Report, Form 3676-1 give to supervisor and send to Human Resources.
MEDICAL DEVICE/EQUIPMENT PROBLEM – Failure of equipment involved with providing patient/resident care that results in injury.
MISSING PROPERTY/MONEY – Missing personal property, valuables, and money. **If caregiver theft alleged notify supervisor immediately.**
PHYSICAL AGGRESSION – An individual attempts to or causes bodily harm, such as when striking, hitting, kicking, biting, or grabbing another.
PROPERTY DAMAGE – Report damage of County property and private property.
SEXUAL CONTACT – Contact of a sexual nature between patients/residents or between a patient/resident and staff member, visitor, volunteer, or student. Consenting and non-consenting sexual contacts should be reported.
SUICIDE ATTEMPT/SELF INJURY – All attempts of self-injurious behavior such as overdose, hanging attempt, cutting, or burning self.
UNAUTHORIZED ABSENCE – Check one: 'elopement from locked unit', or 'elopement while patient/resident being escorted off unit', or 'failure to return to unlocked unit, or 30 minutes late from pass or OWP'.
OTHER - Report other incidents in which there was serious risk. Consult with supervisor before completing the form to determine if it should be reported.
9: Describe the incident. Report the **facts only.** Report **what** happened do not justify actions. Be concise and describe the incident completely. If necessary, attach an additional sheet of paper with one copy.
10: Describe the actions, which were taken. Detail **exactly** what was done. Report factually. Do not attempt to justify or give reasons.
11: Print the names of witnesses if any.
12: Notifications to complete as soon as possible after the incident.
-For Patient/Resident incidents, notify the physician/MOD, RN, and Attending psychologist during regular working hours, QMRP during regular working hours, NPC during regular working hours, and AR during other hours. Notify for all patient injuries, patient exposure to infection, patient sexual contacts, suicide attempts, unauthorized absences, allegations of caregiver misconduct, Code 4, and deaths.
-Notify the physician/MOD and RN for Adverse Drug Reaction(s), and Medication Variance Causing Harm.
-Notify your supervisor or designee for **all** incidents. For allegations of caregiver misconduct and injuries of unknown origin notify supervisor **immediately**
-Notify the Pharmacy using the BHD Pharmacy Hotline 454-4262 (or pharmacy director in person) for all adverse drug reactions.
-The Supervisor, AR, Administrator, or Medical Staff should notify the Sheriff (at the complex) or Community Police Department (off county grounds). Staff **should not** notify the sheriff/police unless designated to do so or the situation is emergent, Notification is necessary for physical assaults, for sexual contact involving non-consenting individuals (sexual assault), for theft, fires, and destruction of property, and for unauthorized absences of involuntary patients and patients who have Sheriff's or Police holds.
-Notify the parent or legal guardian (including power of attorney) if appropriate, and if ward is a patient/resident document notification in progress note.
13: Print your name, title, sign, and put in your work phone number. Put in the date and time when report was completed. Keep the pink copy.
14: Supervisor/designee to review the outcome, comment on the need for further review, and send to the treatment team if there is a clinical issue. **For allegations of caregiver misconduct, injuries of unknown origin, and Sentinel Events, check the box, and notify Administrator/Designee or Administrator on call immediately and begin investigation immediately.** Consult the Caregiver Misconduct or Sentinel Event policy and procedure for reporting and investigation process. Send original and yellow copy of incident report to Program Administrator/Designee.
15. Program Administrator/Designee must review the incident within three working days of receiving the report, determine the need for additional review, and refer for further programmatic, departmental or BHD committee review(s). Program Administrator/Designee should send original incident report within three working days to Quality management, and when completed, send supplemental reviews and additional outcomes.

This form must be completed before the end of shift during which incident occurred and before leaving the premises. The original and yellow copy must be given to your supervisor or designee. If your supervisor/designee is unavailable leave in his/her mailbox and notify your supervisor and the program administrator by voice or e-mail. Remember to notify your supervisor immediately (or if unavailable any supervisor) for sentinel events, allegations of caregiver misconduct, and possible injuries of unknown origin.

UNSAFE STAFFING FORM

The purpose of this form is to notify hospital supervision that you have been given an assignment, which you believe is potentially unsafe for the patients or staff. This form will document the situation. Your union may use it to address the problem.

DO:

1. Call your supervisor for help **as soon as you realize** numbers are less than you need to provide safe, adequate care.
2. If help is denied, state you will do your BEST, but you fear for the safety and quality of care for the patients and staff.
3. Fill out the bottom form and send to the nursing/lab office. Send the union copy to your Area Representative or Union Officer or send to FNHP union office ASAP at **9620 W Greenfield Ave, West Allis, WI 53214-2645.** Keep member copy for your records.

DO NOT:

1. Use this form when you have adequate help. Its usefulness will be diminished if used indiscriminately and without justification.
2. Use this form if you failed to notify your supervisor (not the charge nurse). This form is only to document your request. If you didn't make a request, you cannot use the form.

FACILITY (CIRCLE ONE): MILW COUNTY BHD JAIL HOC ST. FRANCIS DYNACARE OTHER

Please Print

Name: _____ Title: _____ Name: _____ Title: _____

Name: _____ Title: _____ Name: _____ Title: _____

Work Area or Unit: _____ Shift: _____ Date: _____ Time: _____

Name of Supervisor Notified: _____ Other Persons Notified: _____

Response of Supervisor: _____

_____

	RNs	POOL	LPNs	CNA/PCAs	Unit Clerks	Patients
Normal staffing #s						
# at beginning of shift						
# at end of shift						

Please describe situation in space below: *(Include tasks or patient care not completed or dangerous situations that occurred.)*

_____

_____

_____

_____

_____

_____

_____

_____

As a patient advocate, this is to confirm that I notified you, in my judgement, this assignment is unsafe and places the patient or staff at risk. It is not my intention to refuse the assignment or an order given; but, to give notice to my employer of the above facts and indicate that, for the reasons listed, full responsibility for the consequences of this assignment must rest with the employer. Copies of this form may be provided to any and all appropriate State and Federal agencies.

Signature(s): _____ Date: _____

_____ Date: _____

Top copy to supervision *2nd copy to WFNHP* *3rd copy to member*

Wisconsin Federation of Nurses & Health Professionals AFT AFL-CIO
A Union of Professionals

WFNHP, 9620 W. Greenfield Avenue, West Allis, WI 53227
Phone: 414-475-6065 Fax: 414-475-5722

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COUNTY OF MILWAUKEE
INTER-OFFICE COMMUNICATION

Date: October 25, 2010

To: Jerome J. Heer, Director of Audits

From: Geri Lyday, Interim Director, Department of Health and Human Services

Subject: Response to Audit of Behavioral Health Division Patient Safety

Thank you for the opportunity to provide additional clinical perspective to the BHD audit. Specifically addressed in the response is an examination of patient safety, including policies and procedures, training, staffing and other factors relevant to ensuring patient safety.

The response that follows is in two sections. In the first section, BHD responds to the contents of the report, and in the second section, BHD addresses the eight recommendations set forth in the audit. The responses include:

1. How the recommendations in the report will be implemented;
2. Who shall be responsible from the Behavioral Health Division for seeing that implementation is carried out;
3. When the implementation will be completed; and
4. Alternative solutions to problems noted in the report if the recommendations are not to be implemented.

I. Response to Contents of the Audit Report

Adherence to Plan of Correction
The Audit states, *"Our review of BHD's adherence to the corrective action plans and correspondence from regulators indicates substantial compliance with CMS and State Deficiencies."* and the recommendation that, *"legislative oversight of BHD's progress in attaining and sustaining compliance is an important aspect of holding administrators accountable for results."* Per statute, BHD's governing body is the Director Health and Human Services. The DHHS Director provides informational reports related to BHD's Plan of Correction to Milwaukee County's Health & Human Needs Committee on an ongoing basis and will continue to do so.

Patient acuity, including aggressive behavior, drives BHD staffing needs and is a critical factor affecting the institution's ability to maintain a safe environment for patients and staff.
Staffing Resource and Effectiveness
The present standard on the Acute Inpatient units is for each patient to be monitored by nursing staff every 30 minutes. Due to the consistently high numbers of patients that have physicians' orders to have behaviors monitored more frequently, the standard for monitoring patients will change to every 15 minutes. This policy revision will result in nursing staff more consistently monitoring all patients. BHD is near completion of this revision.

The report describes that *patient acuity, including aggressive behavior drives BHD staffing needs* and is a critical factor affecting the ability to maintain a safe environment for patients and staff. In addition to patient acuity, multiple additional factors are used in the healthcare industry to determine "effective staffing." The Joint Commission cautions that *staffing is not just about numbers* and recommends that facility staffing be evaluated through review of Staffing Effectiveness Indicators (SEI's). The Joint Commission evaluates a hospital's staffing effectiveness based on Clinical/Service Indicators, Quality Measures and Human Resource Indicators. The recommended Human Resource Indicators include:

- Overtime
- Sick time
- Staff vacancy and turnover rates (includes direct care, support and management staff)
- Staff injuries
- Understaffing as compared to the organization's staffing plan
- Staff satisfaction
- Competency and training of staff (Source: 2010 Joint Commission Comprehensive Accreditation Manual: SEI Chapter)

Human resources factors such as attendance, FML/intermittent FML use, recruitment and retention of qualified staff, compliance with labor agreements critically impact BHD staffing virtually every shift. These include:

- Employee absenteeism and effects of last minute call-ins on staffing for 24/7 operation;
- Number of staff on FML and number of staff utilizing *intermittent* FML taken without notice;
- Well-documented cycles of OT shifts followed by call-in; majority of highest direct care OT earners are in disciplinary process for attendance and/or performance;
- Retention of newly hired staff (2007 study: 50% of nurses hired left prior to 1 year related to "seniority issues," attendance and performance issues);
- Use of float staff across units and programs impacts quality and safety because non-regular/inconsistent staff assigned or moved based on bargaining unit agreements;
- Efforts to cap OT hours individuals work not successful (not able to limit OT based on safety concerns, poor attendance or performance);
- Medical orders for 1:1 supervision spiked with the citations and repeated visits by surveyors.

The report addresses the impact of employee absenteeism on staffing. For the 2010 Quarter 3-time period (6/13/10-9/4/10) just completed, 43% of BHD's 406 Nursing employees (nurses and CNA's) were referred for disciplinary action due to excessive absenteeism.

- 35% of BHD RN's are referred for discipline related to attendance for Q3.
- 51% of BHD CNA's are referred for discipline related to attendance for Q3.
- Impact of FML and Intermittent FML:
  12% of BHD Nursing Staff (47) were on FML during Q3 2010 (20 nurses and 27 CNA's).
  32 Nursing employees are currently approved for use of intermittent FML.

The County Executive's 2011 budget increased the overtime allocation by $675,075 to reflect actual utilization. The majority of overtime use is to provide coverage for sick leave, vacation, FMLA and time off. Additionally, the County Executive's budget provided $1,929,283 to directly address staff scheduling issues. The budget proposes to add 53.5 FTE clinical positions to provide consistent staffing, redeployment of clinical staff, increased surveillance, and address sick leave, vacation and FMLA.

Staff Competency and Training

Staff competency and training related to violence prevention and safety interventions for persons with challenging behavior is mandated by federal regulations. Staff training is an essential factor impacting patient and staff safety. Competent, well- trained, well-supervised caregivers are essential to ensuring patient safety. Patient centered care and best practice standards guide our commitment to the use of non-physical, non-coercive techniques as the preferred intervention in behavior management. This includes expertise regarding:

- Trauma Informed Care;
- Therapeutic Communication;
- Management of the Acute Inpatient Milieu;
- Understanding and managing psychiatric illness and symptoms.

BHD will continue efforts that are underway to ensure a workforce that is competent to deliver quality care and ensure patient safety. Additional staff training in best practices is a high priority for DHHS and will be studied after the work of Critical Management Solutions is completed.

Unsafe Staffing Forms

Culture of Safety includes Patient and Staff Perception that they are in a Safe Place

The report includes RN perceptions of safety. However, there are many different disciplines working within the Division, such as psychiatry, psychology, social work, occupational therapy, rehabilitation services, dietetics. In addition, Certified Nursing Assistants are the largest staff group and their views in the report would have provided a more balanced picture. The bargaining unit's staffing complaint forms were found to be an unreliable and often inaccurate indicator of staffing effectiveness and are not recognized by BHD, yet are featured prominently in the report to detail staffing concerns. Further as described in the report, they were not shown to be a reliable predictor of circumstances for an unsafe event or correlate directly with shifts in which incidents occurred. The industry standard for reporting staffing effectiveness concerns is chain-of-command notification. A recent survey of area hospitals confirmed that no other hospital in the Milwaukee area (except a facility represented by the same bargaining unit) utilized or described a form detailing, "unsafe staffing" as a facility safety indicator. Representatives at these facilities described required chain-of-command notifications to address concerns about staffing effectiveness.

BHD's process for communicating a concern or potentially unsafe situation is chain-of-command communication. In addition, BHD has a daily safety briefing led by the Medical Director at which any BHD employee may bring a safety concern. BHD will continue to sustain and monitor the significant safety enhancements that have been implemented.

Current Model Not Suited for Particularly Aggressive Patients

BHD also agrees with Audit's findings that:

- A few patients with particularly aggressive behavior sometimes disrupt the Acute Units and are often caught in a cycle between BHD, State Institutes, and the court system;
- These patients often require additional staff attention;
- There are no easy solutions to this problem.

While BHD agrees with the findings, comments on the corresponding recommendations are detailed in Section 2 of this response.

Accountability at all Levels and Supervision of Workforce

Accountability is an additional factor that is relevant to the scope of the review and essential for ensuring patient safety. BHD has key positions that were vacant during all or portions of the time frame being reviewed. BHD is continuing significant recruitment efforts that are underway.

Reported Falsification of Records

BHD endorses the Audit finding, *"that none of the findings or comments contained in the 2010 CMS survey of BHD, upon further scrutiny, support a conclusion that BHD employees falsified records."* This is extremely important, due to the fact that the local media widely reported on alleged falsification of records at BHD, which the audit found not to be true.

BHD has implemented most of the corrective measures recommended by the Milwaukee County Sheriff's Office to enhance physical security at the institution

BHD agrees with the findings that all recommendations of the Milwaukee County Sheriff's Office "*have been implemented or are in the process of being implemented, with the exception of the recommendation to screen individuals using the Walk-in Clinic.*"

Adherence to Plan of Correction
BHD instituted mandatory training regarding its patient sexual contact policy for all staff and contractors with direct patient contact. Audit findings stated that there were: *"No signatures on file for five staff members."* These signatures are now complete and all BHD staff has been trained.

Case Examples: Current Model Not Suited for Particularly Aggressive Patients
BHD Administration provided feedback to the auditors at the exit meeting and expressed concern that the disclosure of patient protected health information in the patient case examples described on pages 46 – 50 were protected under HIPAA.

II – Response to Recommendations

1. *Continue monitoring and measuring compliance with key aspects of its corrective action plans related to the January 2010 and May 2010 CMS and DQA surveys.*

   The Milwaukee County Behavioral Health Division Acute Inpatient Administration will continue to monitor and measure compliance with key aspects of its corrective action plans related to the January 2010 and May 2010 CMS surveys. To ensure corrective actions are achieved and sustained, progress toward improvement actions will continue to be monitored by the Acute Executive Committee. The Director of Acute Inpatient Services will provide progress updates to the Milwaukee County Behavioral Health Division Leadership Team and Director of Health and Human Services.

2. *Report results of its ongoing compliance measurements to the County Board Committee on Health and Human Services on a regular basis.*

   The Director of Health and Human Services will provide the Milwaukee County Board Committee on Health and Human Needs results of on-going compliance measurements.

3. *Fashion a short-term strategy to address the small number of particularly aggressive/assaultive, difficult-to-place patients under the care of the BHD Adult Acute Inpatient hospital at any given time. Options to consider should include:*

   BHD concurs with the need to explore a multi-pronged strategy to address highly aggressive patients; however BHD would look at the short and long term solutions concurrently to ensure continuity of care and long-term success.

   A. *"Re-configuring the present model of four mixed gender units (three general population and one for elderly/vulnerable patients) to include two single gender and one mixed gender units for the general population..."*

      BHD will rely on the expertise of its internal clinical team in consultation with qualified experts, including Critical Management Solutions, in the field and similar inpatient psychiatric facilities. A BHD work group has already been appointed and has embarked on a detailed study of the existing mixed-gender unit model and evaluation of the desirability of alterative gender unit configurations in regard to improving the sexual safety of acute inpatients. The report is due in December 2010. Should a reconfiguration along gender lines be recommended, BHD administrative and clinical leadership will need to carefully plan for implementation and the impact on patients, staff and system – clinically, financially and operationally.

B. *"Allocating additional funds to place such patients at one of the two State Mental Health Institutions (Winnebago or Mendota). The additional cost of placing a patient in one of the state facilities for a year is approximately $365,000."*

BHD Administration acknowledges the challenges with the current system of addressing the needs of high-risk and difficult-to-place patients. High-risk patients who cannot be safely treated and managed within the BHD continuum of care shall continue to be evaluated on a case-by-case basis as to appropriateness for referral to one of the State Mental Health Institutes. The State Mental Health Institutes may not always be eager to accept admissions of such difficult patients, as length of stay is time-limited with expectation that the county of residence is responsible for eventual discharge disposition and placement.

C. *"Re-establishing a high-risk secure ward for particularly aggressive/assaultive patients. Estimating the additional cost of operating a high-risk secure ward would require detailed analysis but could easily reach $2 million annually, plus additional start-up capital costs."*

BHD shall utilize the expertise of its internal team of medical staff, clinical discipline heads, program administrators, Critical Management Solutions, and direct care practitioners to objectively evaluate inpatient unit options and make recommendations. An existing internal work group has already been charged with formulating recommendations for unit configuration as it pertains to patient sexual safety, with their report due in December 2010. Information gleaned from outside experts and similar facilities in the Midwest shall be utilized to guide best practice decisions. BHD Administration appreciates the auditors' recognition that cost estimates will require detailed analysis and must be well-grounded in specialized practices used by similar inpatient facilities in operating a high-risk unit when it comes to environmental modifications, capacity, programming and staffing (composition, skill set, number).

4. *Work with BHD's recently acquired management consulting firm and the Community Advisory Board for Mental Health to develop a long-term strategy for accommodating the treatment needs of particularly aggressive/assaultive, hard-to-place patients, with a goal of facilitating an appropriate alternative to extended periods of treatment in an acute inpatient facility.*

BHD recommends that a work group be developed specifically to address this small number of particularly aggressive patients at the Division. Because issues related to the care and treatment of these individuals cross multiple systems, BHD will facilitate the formation of a work group that includes representatives from the District Attorneys Office, Office of the Sheriff, State Forensic Unit, State of Wisconsin Division of Behavioral Health, State of Wisconsin Division of Long Term Care, BHD Administrative and Medical Staff and Milwaukee County Disability Services Department. Any potential solutions would likely require the involvement of representatives from each of these Divisions and would be best suited to identify long-term strategies and long term resources needed to address this complex issue. BHD would also "*utilize the expertise of a management consulting firm that has been recently engaged to assist in patient safety and other issues.*"

5. *Staff the Acute Inpatient units with enough pool or "floater" Certified Nurse Assistants to provide both sufficient coverage for heightened patient monitoring duties (e.g., behavior observation checks and patient escorts to court appearances), as well as a relief factor for staff breaks. The County Executive's 2011 Proposed Budget includes 18 FTE CNA positions, which we believe is adequate for these purposes.*

BHD's goal is to predominantly use regular, full-time CNAs to provide this coverage, as having consistent staff on units is the best practice for patients and treatment.

6. *Continue its efforts to pursue accreditation from The Joint Commission, and prepare a report for the June 2011 meeting of the County Board Health and Human needs Committee on progress toward, and any impediments to, achieving accreditation in 2012.*

   The Milwaukee County Department of Health and Human Services has retained the services of the consulting firm "Critical Management Solutions" to assist the Division in working towards the goal of Joint Commission accreditation. In addition, there is $48,830 dedicated towards maintaining this initiative in the 2011 Recommended Budget. An initial visit to determine survey readiness is scheduled for the last quarter of 2010.

7. *Provide a report to the County Board Health and Human Needs Committee for its December 2010 meeting detailing the status of compliance with each of the recommendations contained in the June 2010 security review conducted by the Milwaukee County Sheriff's Office.*

   BHD has submitted a full report on the status of the recommendations outlined in the Sheriff's report to the Health and Human Needs Committee for the October 27, 2010 meeting and will provide a follow up report at the December 2010 Health and Human Needs Committee.

8. *Install electronic monitoring devices on each inpatient unit to record the frequency with which security staff assigned as a rover among the units is completing assigned rounds.*

   Each security guard assigned, as a rover is to walk onto each unit from the main entrance or from the nurses station back entrance and perform the following activities:
   - Check in with nursing staff regarding any "potential hot spots/areas;"
   - Walk down both hallways;
   - Check that the community bathroom is locked along with other required locked doors;
   - Observe the environment for any concerns and stand by while nursing staff assess the situation and take action as directed.

   Each unit is currently equipped with an electronic touch pad at the nurse's station and at the end of the unit corridor. The contracted security company will purchase an additional wand for the rover, to use on a daily basis, by December 1, 2010. The data will be downloaded and reviewed by the security supervisor in conjunction with BHD Operations and Administration. Since the audit review was conducted, security cameras were installed on the Acute Adult units. These cameras cannot record data due to state and federal regulations but are viewed live by security personnel.

II. Conclusion

BHD would like to thank the Department of Audit for their work on this extensive project.

Respectfully submitted,

Geri Lyday, Interim Director