

COUNTY OF MILWAUKEE

Inter-Office Communication

DATE: March 25, 2011

TO: Supervisor Sanfelippo, Chairman - New Behavioral Health Facility Study Committee

FROM: Geri Lyday, Interim Director, Department of Health and Human Services
Paula Lucey, Administrator, Behavioral Health Division

SUBJECT: From the Interim Director, Department of Health and Human Services, submitting an informational report outlining factors to consider in evaluating options for replacing the existing Mental Health Complex and the feasibility of such options for assuring continued high quality service to individuals with mental health service needs in Milwaukee County.

Issue

At the last two meetings of the New Behavioral Health Facility Study Committee, questions have been raised regarding the physical requirements of a new mental health facility if one were to be built on the County Grounds. Further discussion focused on the need to downsize and to what extent that could occur.

The Committee requested that the Department of Health and Human Services (DHHS) and the Behavioral Health Division (BHD) develop a model or different models for the kind of facility that might be built, the related actions that would have to occur for any downsizing to be successful, and some rough estimate of the fiscal impact of the model(s).

The Department acknowledged the complexity and importance of this assignment, noting that the, of necessity, limited hours that were spent thus far responding to the Committee's request, represent the beginning of any process to develop a new model for BHD.

Developing a new mental health service delivery model, which must precede and form the foundation for the physical and fiscal planning that is being requested, should be based on a comprehensive analysis of the mental health needs in the Milwaukee community. This analysis should take into consideration the current requirements on the community-wide system, future trends in clinical populations and treatment interventions, the impact of shifting funding streams, and be based on current research literature searches and best practice models, and thorough fiscal impact analyses. The development and commitment of private provider networks is essential to the success of any reorganization of mental health service delivery for the citizens of Milwaukee

County. Developing a new model must be viewed from a systemic perspective and potential changes in any one program should not be viewed in isolation.

Background

There have been previous studies done that have addressed some of the questions being raised by the Facility Study Committee.

The 1993 Master Plan

The *Master Plan for the Public Sector Mental Health System for Adults in Milwaukee County*, December 15, 1993, was done by the Center for Community Change Through Housing and Support, a national consulting firm. It was a lengthy comprehensive planning effort with significant stakeholder input.

The 1993 Master Plan recommended a mental health system with significant emphasis on non-institutional services including: an extensive array of services grouped under Wellness and Rehabilitation Services (community assessment program, CSPs, Targeted Case Management, outpatient services, housing, health management, day activities, support, medication management, etc), Pre-Crisis Services (Warmline, respite apartments, homeless outreach, dual diagnosis services, assist teams, jail/forensic services) and Crisis Response/ Stabilization Services (Mobile Crisis, mental health police liaison, hotline, crisis specialists, crisis apartments, emergency room walk-ins, psychiatric crisis services).

The Report proposed that the May 1994 total inpatient bed capacity of 458 be reduced to 245 beds. Some of the reports recommendations were implemented resulting in the current system, though many of the recommended investments in community resources were not realized.

St. Michael facility assumptions related to downsizing

The study of alternative BHD facility options and the debate about relocating to the St Michael Hospital facility beginning in 2006 also reviewed facility size but not as the result of a strategic planning effort; rather, as more of a business decision to possibly take advantage of the availability of a hospital site. Since the New Behavioral Health Facility Study Committee was created as a result of this debate there is no need to restate the issues here. Incorporated in the analysis, however, were assumptions that are relevant to the discussion of the size of any new mental health facility.

In a July 3, 2007 report to the County Board, DHHS noted an alternative option to renovate less square footage at the St Michael facility, by implementing “downsizing initiatives that have been discussed in previous strategic planning reports.” Specifically assumptions were made that “BHD would downsize both Rehab Central and Hilltop from three units to two” and “would eliminate its Children and Adolescent Inpatient Service” (a 22 bed unit with a then average daily census of 10).

The proposed lease of the St Michael facility was for a mental health facility sized at 352,000 square feet.

HSRI Study

The most recent comprehensive assessment of the Milwaukee County mental health care system was done by the Human Services Research Institute (HSRI), *Transforming the Adult Mental Health Care Delivery System in Milwaukee County* (October 2010). This project was spearheaded by a public-private partnership and involved numerous diverse stakeholders, including advocates and consumers.

The HSRI report made a number of conclusions and recommendations related to the eventual size of any mental health facility but did not specify actual numbers of beds needed or square footage. The report noted that a “multi-year plan that involves collaboration with community providers and private hospitals to phase down the current number of beds” was needed. The report added: “Planning is critical to the successful closure or downsizing of inpatient facilities...” Through this implementation planning process, specific bed need could be assessed.

Specific recommendations in the HSRI Report related to eventual size of any needed mental health facility included initiatives to:

- “Gradually reduce inpatient units at the current BHD complex.”
- “...develop and implement a plan to phase down the Hilltop Inpatient Program.”
- “Outsource BHD inpatient bed capacity to the private health systems.”

Like the 1993 Master Plan, the report also made numerous recommendations related to expanding and enhancing non-institutional mental health services such as crisis alternatives, reducing emergency detentions and shifting resources from inpatient to community-based services.

The HSRI Study also emphasized the inter-related nature of the interventions proposed and the importance of sequencing any initiatives. It noted “special attention” should be “paid to the ways the success of certain interventions hinge on the implementation of others.

Chairman Holloway’s Mental Health Initiative

Most recently, the County Board voted (March 17, 2011) to adopt the resolution to accept the concepts of the Chairman’s Mental Health Initiative and directing DHHS to develop a report describing the details of a pilot project creating a model for a managed care system with small mental health facilities located in the community to be included in a Request for Proposal (RFP).

Current BHD Facility Capacity

Crisis Services

- Psychiatric Crisis Services (PCS) 18 patient capacity
- Observation (OBS) 18 beds
- Mobile Crisis staff go to off site
- Respite House (off site) 16 beds
- Crisis Walk In Clinic
- Crisis Line staff at BHD

Inpatient Acute

- Adult Acute 96 beds; 4 units
- CAIS (child) 24 beds

Rehabilitation Central

- Maximum census 68; 3 locked units

Hilltop Rehabilitation Center

- Maximum census 69; 3 unlocked units

Community Services Day Treatment

- Capacity at full staffing 36 individuals

Community Services Targeted Case Management

- See patients in community
- Some direct client contact on site
- Staff offices located at BHD

Community Services: Service Access to Independent Living

- Not a direct patient care program
- Staff offices located at BHD

Wraparound Milwaukee

- See patients mostly in the community
- Staff offices located at BHD

Earlier reports provided to the New Behavioral Health Facility Study Committee provide more detail on the space usage of the clinical programs.

Discussion

To address the request of the New Behavioral Health Facility Study Committee, DHHS assembled a workgroup of BHD clinical experts, managers and program directors. In two, two-hour, brainstorming sessions guided by a facilitator, the group responded to the following question: "If a new mental health facility were to be built, what would be the minimum size needed and what would need to occur to assure continued service to individuals with mental health service needs in Milwaukee County?"

The workgroup considered the question but was concerned that the Facility Committee understands that the model offered here for a possible new mental health facility is only

a first step to any final design. The attached model presented should not be taken as the final recommendation for what a future mental health facility might look like. It is only an initial response to the question raised by the Facility Study Committee.

The workgroup appreciated the opportunity to be involved in the discussion, given the seriousness of the question being raised and the importance of it for the future of the public mental health system in Milwaukee County. Consistent with the previously mentioned recommendation of the HSRI Report, the group suggests that any future planning be developed by clinical experts, managers, and staff with collaboration with private partners, advocates, families and other stakeholders.

Also, at this stage, the fiscal implications are difficult to project. It will take time to determine the cost of building up community infrastructure as BHD is potentially downsized. The workgroup cautioned that any proposed changes to individual parts of the system must be considered in the overall context of all proposed changes in both the public and private sectors. The interrelatedness of the various facets of mental health delivery cannot be understated. Thus, final plans need to be considered as a whole, acknowledging that changes to one aspect of any proposed plan may result in necessary changes to another aspect.

Important Considerations

In the course of the discussion, the workgroup of BHD clinical experts and managers noted the following considerations related to evaluating any options for a new mental health facility:

- This undertaking requires thorough consideration of significant clinical issues and the timeline for this process of assessing patient need to determine necessary community capacity must be based on the process itself.
- Future trends in the demographics of various mental health populations need to be considered.
- Decisions should be informed by appropriate data collection and analysis.
- Proposed changes are highly dependent on the development of a robust network of private care providers.
- Proposed changes are highly dependent on the ability of and support provided to private care providers to provide services to a population of individuals with severe and persistent mental illness, developmental disabilities, and other specialized needs.
- Proposed changes are highly dependent on the willingness of private care providers to serve certain individuals for whom the County has always cared. Providers would need to be willing to adopt a “zero rejection” policy for serving individuals with mental illness.

- The community would need to address and be educated about the potential increased risk of having patients, who were previously served at Hilltop or Rehab Central, living and being served in their neighborhoods.
- Conversely, the community needs to understand that with all initiatives to increase the use of less restrictive settings, there will be both an increase in freedom but also vulnerability to the clients.
- It may take three to five years for any new facility to be built, at the earliest. Currently, DHHS Operations continues to make building improvements in the current facility to ensure an environment of care that is safe and meets regulatory standards.
- It is essential that any fiscal savings resulting from changes to the delivery of inpatient care will need to be reinvested in the development and delivery of community based resources. It is also possible that community care may cost more until overhead savings at BHD can be achieved through closing the existing facility.
- Shifting care to the community will require a thoughtful review of the workforce requirements in terms of level of caregivers, training, and diversity.
- Staffing at the remaining BHD will need to recognize the level of intensity required by clients unable to be served elsewhere.
- The future of Medicaid reimbursement and other federal and state budget initiatives, many of which are still unknown, will impact any future facility and services development.
- The timeline for proposed changes needs to take into account the initiatives already underway, including the pursuit of Joint Commission Accreditation, the acquisition and implementation of an electronic medical record system, the Gender Unit Workgroup's recommendations, the Seclusion and Restraint Reduction Initiative and the Hilltop downsizing and Crisis Services Initiatives approved in the Budget.
- It must be recognized that changes in the system will require staff and leadership capacity. Current staff vacancies must be considered in the overall system's ability to make the changes needed to downsize, considering the fact that current staff resources must continue to focus on direct patient care.
- Any effort to redesign the mental health system would require careful implementation planning with system stakeholders and private partners and careful attention to sequencing system changes and their interrelatedness.

Conclusion and Recommendations

The workgroup of BHD clinical experts, managers and program directors very much appreciated the opportunity to examine the various implications of the potential changes that have been proposed to the provision of mental health care in Milwaukee

County. The process highlighted the complexity and importance of this endeavor. As such, the workgroup agreed that any ideas presented be qualified by the fact that each successive stage of decision making and planning will require further careful examination and input by appropriately informed parties. At present, the workgroup recommends:

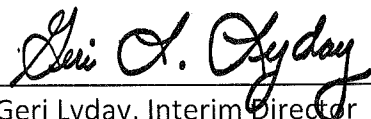
- 1) Continued clinical analysis of existing BHD inpatient and long-term care consumer needs.
- 2) Substantive discussions with private health systems and other community-based providers (including Care Management Organizations) to determine what is needed to shift additional individuals and certain types of care to the community.
- 3) A detailed financial analysis to identify funding sources for the enhanced array of community-based services necessary to safely accommodate extensive downsizing.

Again the workgroup expresses their appreciation for inclusion in this process and looks forward to additional collaboration.

For future consideration, with all of the above concerns noted, a **hypothetical** downsizing model is presented in the table in Attachment 1. The most important component of this model is the identification of the mental health system enhancements, expansion, and community capacity building that would be essential for any downsizing to be successful.

Preliminary Fiscal Considerations

Per recent work with Zimmerman Architectural Firm, the cost for the attached **hypothetical plan** would be \$242 per square foot and the recommended units and supporting staff would fit into 200,000 square feet. This would be a cost of \$48,400,000 to build the facility only. The cost per square foot does not include parking or detention ponds and assumes a three-story building due to Wauwatosa regulations. The fiscal analysis related to the staffing of the new facility and related necessary community services is not complete. Some more detail is provided on Attachment 1.



Geri Lyday, Interim Director
Department of Health and Human Services



Paula Lucey, Administrator
Behavioral Health Division

Attachment

Cc: Marvin Pratt, Interim County Executive
Lee Holloway, Chairman, County Board of Supervisors
Terrence Cooley, Chief of Staff, County Board of Supervisors
Jennifer Collins, Research Analyst, County Board
Toni Thomas-Bailey, Fiscal and Management Analyst, DAS
Jerome Herr, Director of Audits

Hypothetical Mental Health Facility Downsizing Model

Considering Five Major Service Areas: Hilltop, Rehab Central, Acute Adult Inpatient Services, Child Acute Inpatient Services, Psychiatric Crisis Services

Hilltop Rehabilitation Center

Expanded or enhanced mental health system capacity essential to support any facility downsizing effort & challenges to downsizing	What would be downsized from the current BHD facility	What would be in a new Milwaukee County mental health facility	Estimated square footage needed in new facility	Estimated fiscal & potential fiscal issues
Need to replace every Hilltop bed closed with a highly specialized, community-based residential slot. These would be structured, supervised and have programmed activities Need to assess current capacity in the community. There may be potential providers who could develop new and/or enhanced services Need to enhance/ expand community-based crisis capacity Need a high-level crisis response team Need high-intensity crisis capacity Need to enhance/expand PCS capacity and/or short term stabilization capacity Need to increase outpatient mental health capacity	2 Units could close (48 beds)	1 unit (or 2 smaller units) with approximately 24 beds for patients with dual diagnosis of developmental disabilities and mental illness to treat patients unable to be served elsewhere;	\$242/per square foot Does NOT include parking or detention ponds	Initial investment is needed to develop expanded community capacity before any units could be closed and any resources made available to invest in additional needed community infrastructure. Cost of community residential slots unknown Are Family Care reimbursement rates sufficient to build capacity? Cost of operating the

Need to address medical issues of individuals in the community since those needs are now met at the Hilltop facility Need to increase training of doctors (medical and psychiatric) to care for these individuals in the community Need to address strategies for getting individuals to appointments, clinics, activities etc. If individuals are at Hilltop, treatment services are on-site Could be zoning challenges With appropriate services and structure, living in the community could benefit some patients who might respond better Need to develop a quality assurance infrastructure				remaining unit with higher acuity/needs clients is unknown. BHD must develop a detailed staffing plan. When and to what extent overhead savings can be realized including fiscal, HR, utilities, operations, housekeeping etc is unknown.
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Note: A BHD and DSD sub-committee has been formed to develop and analyze essential information required to begin a downsizing planning process and develop a strategy and plan for downsizing. This Hilltop program downsizing initiative was included in the 2011 Milwaukee County Budget. An informational report (February 22, 2011) was just presented to the Health and Human Needs Committee with the progress as of that time.

Rehabilitation Central

Expanded or enhanced mental health system capacity essential to support any facility downsizing effort & challenges to downsizing	What would be downsized from the current BHD facility	What would be in a new Milwaukee County mental health facility	Estimated square footage needed in new facility	Estimated fiscal & potential fiscal issues
Capacity needed and challenges to downsizing similar to Hilltop Need to replace every Rehab Central bed closed with a highly specialized, community-based residential slot. These would be structured, supervised and have programmed activities There is some capacity in the community to serve these individuals but would need resources to expand There is a potential need for a police liaison Need to enhance/ expand community-based crisis capacity Need a high-level crisis response team Need high-intensity crisis capacity Need to enhance/expand PCS capacity and/or short term stabilization capacity	2 Units could close (48 beds)	1 unit with approximately 24 beds or fewer	\$242/per square foot Does NOT include parking or detention ponds	Initial investment is needed to develop expanded community capacity before any units could be closed and any resources made available to invest in additional needed community infrastructure. Determine appropriate license for unit that remains. Most patients receive care funded by tax levy. Significant initial investment is needed to develop community capacity before any units could be closed and any resources made available

Need to increase outpatient mental health capacity Need to address medical issues of individuals in the community since those needs are now met at the Rehab Central facility Need to increase training of doctors (medical and psychiatric) to care for these individuals in the community Need to address strategies for getting individuals to appointments, clinics, activities etc. If individuals are at Central, treatment services are on-site Could be zoning challenges since some individuals have criminal backgrounds With appropriate services and structure, living in the community could benefit some patients who might respond better Need to develop a quality assurance infrastructure				to invest in additional needed community infrastructure. Cost of operating the remaining unit with higher acuity/needs clients is unknown. BHD must develop a detailed staffing plan. When and to what extent overhead savings can be realized including fiscal, HR, utilities, operations, housekeeping etc is unknown.
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Child Acute Inpatient Services

Expanded or enhanced mental health system capacity essential to support any facility downsizing effort & challenges to downsizing	What would be downsized from the current BHD facility	What would be in a new Milwaukee County mental health facility	Estimated square footage needed in new facility	Estimated fiscal & potential fiscal issues
Need private health system(s) to accept patients and have a zero rejection policy	1 Unit could close	PCS only to assess children, no inpatient beds	0	Most of the children have insurance. BHD may not realize budget savings from closing the unit since revenues are currently slightly overstated. Need to determine if CAIS staff would be redeployed within BHD. Potential changes in Medicaid may affect private system willingness to expand capacity.

Acute Adult Inpatient Services

Expanded or enhanced mental health system capacity essential to support any facility downsizing effort & challenges to downsizing	What would be downsized from the current BHD facility	What would be in a new Milwaukee County mental health facility	Estimated square footage needed in new facility	Estimated fiscal & potential fiscal issues
Improve community options first Need better short-term & long-term housing options Need increased crisis capacity, including crisis care management and short-term crisis case management Need increased outpatient capacity, including outpatient therapy Outpatient services need crisis walk-in capacity Need a continuum of case management and increased capacity Need better and more co-occurring services Need to expand and develop workforce (Need more psychiatrists, therapists) Need increased capacity in partial hospitalization, OBS, day treatment, short-stay beds Need to analyze high inpatient users and develop new care models	2 Units could close	2 units for 48 beds Expand Observation unit (OBS beds) Clinically, the smaller the unit the better Address resulting acuity in Day Treatment	\$242/per square foot Does NOT include parking or detention ponds	Private health systems need assurance of an income stream New agreements with private hospitals would need a zero rejection clause and a shared risk and responsibility for all patients. BHD may need to provide a subsidy to private hospitals for caring for indigent and underinsured clients. Revenue for BHD may decrease if more patients are sent to other facilities leaving the highest acuity, most indigent at BHD

Need to enhance/ expand active treatment Need to expand residential training and development and back-to-work programs Need agreements with private health systems to expand inpatient capacity and take patients not currently serving Need to develop a quality assurance infrastructure				Cost of operating the remaining unit if patients have higher acuity/needs is unknown. BHD must develop a detailed staffing plan. When and to what extent overhead savings can be realized including fiscal, HR, utilities, operations, housekeeping etc is unknown.
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Psychiatric Crisis Services

Expanded or enhanced mental health system capacity essential to support any facility downsizing effort & challenges to downsizing	What would be downsized from the current BHD facility	What would be in a new Milwaukee County mental health facility	Estimated square footage needed in new facility	Estimated fiscal & potential fiscal issues
The more people served in the community, the larger the need for crisis services and the higher acuity expected Need a “high-impact” (high-intensity) facility Need a bigger mobile crisis team with more doctors Need an admissions area or entry point Could expand telemedicine capability		Need enhanced space for PCS or admission area PSC should be located near or in medical facility	\$242/per square foot Does NOT include parking or detention ponds	Cost of additional resources will need to be determined as final plans are made including staffing patterns, costs of technology for telemedicine capacity, and additional obs/beds.

Note: The 2011 Milwaukee County Budget directs BHD to conduct a crisis bed analysis to survey the need for crisis beds in the County to alleviate the strain on the Psychiatric Crisis Services (PCS) Admission Center and build capacity for stabilization and linkages to services in the community. This analysis has begun and the next quarterly report to the County Board Health and Human Needs Committee should include further information as identified in the February 22, 2011 informational report to the Committee.

COUNTY OF MILWAUKEE
Inter-Office Communication

DATE: January 11, 2011

TO: Supervisor Michael Mayo, Chairman - Milwaukee County Board of Supervisors

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

**SUBJECT: INFORMATIONAL REPORT FROM THE INTERIM DIRECTOR OF
THE DEPARTMENT OF HEALTH & HUMAN SERVICES REGARDING
A FOLLOW-UP REPORT REGARDING MIXED-GENDER PATIENT
CARE UNITS AT THE BEHAVIORAL HEALTH DIVISION**

Issue

On April 14, 2010, the department received a referral from Supervisor Peggy West, Chairperson for the Health & Human Needs Committee, requesting a report from the Behavioral Health Division (BHD) on mixed-gender units for the acute psychiatric inpatient unit. The BHD Administrator assigned medical staff the responsibility to conduct a study and literature review, consistent with Joint Commission expectation that the medical staff have a leadership role in enhancing the quality of care, treatment and service, and patient safety.

On June 16, 2010, a preliminary report from the BHD Gender Unit Work Group was presented to the committee. The conclusion was that the mixed-gender acute inpatient units utilized by BHD are the norm among public psychiatric hospital systems in Wisconsin and have been the standard model for inpatient psychiatric treatment for decades. Any revision to the existing practice at BHD of mixed-gender units must look carefully at implications for safety, patient satisfaction and choice and therapeutic benefit. For these reasons, the Gender Unit Work Group recommended that BHD do a detailed study to more thoroughly evaluate the various options to ensure a safe inpatient unit environment. The work group presented an update to the committee in September and is now returning with a follow-up report that specifically addresses the current practice of mixed-gender units at BHD.

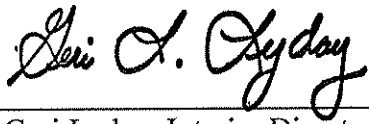
Discussion

The follow-up report from the BHD medical staff makes several recommendations important to the discussion of mixed-gender units. Specifically, the Gender Unit Work Group recommends a configuration of the four Acute Adult Inpatient units that would create a 12-bed Intensive Treatment Unit (ITU) that is expected to be predominantly male; a combined Women's-Option/Med-Psych Treatment Unit; and two mixed-gender General Treatment Units. More information about these recommended units, the rationale, and supporting documentation is included in the attached *Milwaukee County BHD follow-up report to the BHD Administrator: Mixed-Gender Units*, submitted by the Gender Unit Work Group.

Recommendation

This is an informational report. No action is necessary.

Respectfully submitted:

A handwritten signature in black ink, reading "Geri A. Lyday". The signature is written in a cursive style with a horizontal line underneath.

Geri Lyday, Interim Director
Department of Health & Human Services

Attachment

cc: County Executive Lee Holloway
Renee Booker, Director – DAS
Allison Rozek, Analyst – DAS
Jennifer Collins, Analyst – County Board
Jodi Mapp, Committee Clerk – County Board

MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION

FOLLOW-UP REPORT TO BHD ADMINISTRATOR:

MIXED - GENDER UNITS

Submitted by the

GENDER UNIT WORK GROUP

December 1, 2010

EXECUTIVE SUMMARY

Introduction

On June 16, 2010, the *Preliminary Report to BHD Administrator: Mixed-Gender Units (May 22, 2010)* was presented to the Milwaukee County Committee on Health and Human Needs. The Committee had requested a report from the Behavioral Health Division (BHD) on mixed-gender units for acute psychiatric inpatients. A Gender Unit Work Group conducted a comprehensive international literature review on mixed and single-gender units, obtained information from Wisconsin public psychiatric hospitals, reviewed BHD incident and inpatient consumer satisfaction data and explored the history of mixed-gender units, prevalence, patient perceptions and staff attitudes. The report concluded that the mixed-gender Acute Adult Inpatient units utilized by BHD are the norm and have been the standard model for inpatient psychiatric treatment for many decades. The Work Group recommended before there is any revision to the existing practice of mixed-gender units at BHD that a more detailed evaluation be done of the various gender unit options, while continuing the current practices in place to minimize risk and ensure a safe, therapeutic unit environment. This Follow-Up Report details the comprehensive study conducted by the Gender Unit Work Group of the current practice of mixed-gender acute units at BHD, specifically in the context of patient sexual safety.

Methods

To this aim, the study involved four phases. We administered semi-structured questionnaires to BHD Acute Adult inpatients to assess their perceptions of safety on the current mixed units as well as preferences for single-gender units. We surveyed BHD staff working on the Acute Adult inpatient units on their perceptions of patient sexual safety on the units, effectiveness of current safety practices and attitudes toward gender unit options. We communicated with other public psychiatric hospitals regarding the gender configuration of their acute adult units. We obtained input from community stakeholders on male and female patients residing on the same and single-gender units and on recommendations to improve quality of care in the acute hospital.

Results

BHD Patient Perceptions. Most of the 130 patient respondents reported feeling somewhat or very safe on a mixed-gender unit. More than 90% of male patient respondents and nearly 84% of female respondents felt somewhat or very safe with men and women on the same unit. The majority of them explained that their feeling safe related to positive interpersonal interactions and denial of concerns about aggression. The small percentage of men and women patients who felt unsafe on a mixed-gender unit was concerned about safety from aggression. Respondents indicated that they would feel safer on a mixed-gender unit with improved interpersonal interactions and with unit and security staff presence, behavior and monitoring. Almost 50% of male and female patient respondents did not prefer to be on a same-gender unit. The primary reason cited for this finding was the perceived value of interpersonal interactions between patients and the negative impact a single gender unit would have on these interactions. A secondary, less predominant, reason was the potential for more aggression on an all-male or all-female unit. Only 15% of male patient and 29% of female patient respondents indicated that they would prefer a same-gender unit if it were available. The women who did prefer an all-female unit cited the positive impact of female-to-female interpersonal interactions, and did cite concerns about male aggression on a mixed-gender unit. Thirty percent of both male and female respondents were unsure of their preference for a same-gender unit, but commented on the mainly positive features of interpersonal interactions with both men and women on a unit.

Only one-quarter of the total of male and female patient respondents indicated that they would feel safer on a same-gender unit. A higher percentage of men would feel less safe (38%) than more safe (23%) on an all-male unit. The men who said they would feel less safe on a same-gender unit were mostly focused on the potential for aggression. Male respondents who gave reasons for feeling safer on a same-gender unit cited interpersonal benefits. A slightly higher percentage of women responded that they would feel less safe (32%) than more safe (29%) on an all-female unit. Women who said they would feel less safe on a same-gender unit were mostly focused on the potential for interpersonal conflict between women. Those who responded that they would feel safer on a same-gender unit cited safety from aggression and expected improvements in interpersonal interactions.

Women did not express a definitive preference for a women's-only lounge to be made available on the unit. Of the women who were opposed (39%) to a women's-only lounge, the majority of their reasons cited an expected negative impact on interpersonal interactions. The remainder of their comments cited expected verbal and physical aggression between women. Of the women who would prefer (32%) that there be a women's-only lounge on the unit, most reasons centered on an expected benefit in their interpersonal interactions and shared communication with other women. Only a few comments referenced a vague feeling that they would feel safer.

BHD Inpatient Staff Perceptions. More than 60% of the 82 staff respondents thought that men and women patients are somewhat or very sexually safe residing on the same unit. Nearly 40% of staff respondents think men and women patients are somewhat or very sexual unsafe residing on the same unit. Staff respondents' sexual safety concerns for both men and women on the same unit were related to the individual's vulnerability to sexual harassment, intimidation, exploitation and/or abuse, and also to the unit configuration, staffing pattern and patient mix. Staff respondents identified that both men and women raised sexual safety concerns about vulnerability to sexual harassment and intimidation; being concerned about personal boundary violations; and general (nonsexual) safety concerns. Nearly half of staff respondents said that men usually expressed no sexual safety concerns, and nearly one-quarter said women did not raise any sexual safety concerns.

Current practices were predominantly rated by staff respondents as being somewhat effective for ensuring the sexual safety of patients on the unit. Locked community bathrooms and the unit zone surveillance system were the highest rated practices with more than 40% of staff respondents rating them as very effective. Cross shift communication of special risk patients, the separation of bedroom hallways for men and women, and behavior observation for special risks were other practices rated by about one-third of staff as being very effective. In regard to other suggestions to improve sexual safety on the mixed-gender units, the largest percentage (32%) of staff respondents suggested an improved staffing pattern. Additional suggestions included better supervision and training of staff, better teamwork and hospital configuration of patient mix.

Nearly half of staff respondents thought it would be somewhat or very helpful for managing sexual safety on the units for BHD to develop plans for an all-women's unit. This group of respondents thought that this would reduce or eliminate sexual harassment and contact and could better serve the subset of women with sexual abuse and trauma issues. Unsure or neutral respondents cited the benefit of patients being able to interact and learn from the opposite sex on mixed-gender units and were concerned about not being able to control or prevent all sexual contact, including same-gender activity. Those not viewing the unit as being helpful were also concerned about same-gender sexual activity and felt that patients need to function in a normalizing environment similar to the community. Nearly half of staff respondents thought it would be somewhat or very helpful for managing sexual safety on the units for BHD to develop plans for an all-men's unit. Respondents thought that this could particularly help high-risk men from taking advantage of vulnerable females and provide a safer, less violent environment for the rest of the patient population. Those respondents that were unsure or not in favor of an all-men's unit cited concerns about the unit being more violent than a mixed-gender unit, that vulnerable males may be abused, and same-gender sexual behavior.

Only about one-quarter of staff respondents were in favor of a women-only lounge, citing it as a safe and secure place for women to go to when feeling threatened. Those staff respondents not in favor or unsure indicated that inappropriate sexual behavior occurs in places other than lounge areas, and that the area would require close monitoring by staff. Most staff respondents were unsure or did not think that having a men-only lounge on a mixed-gender unit would improve sexual safety. They indicated that inappropriate sexual behavior occurs in places other than lounge areas, and the area would require close monitoring by staff. Only one-fifth of staff respondents were in favor of a men-only lounge.

As for staff preference for type of unit work assignment, nearly half of staff respondents would not prefer to work on an all-women's unit. Primarily this was due to their concerns about having to deal with stressful demands, and secondarily their viewing the benefits of a mixed-gender recovery environment that reflects the community to which patients will return. Similarly, most staff respondents did not prefer or were neutral or unsure about working on an all-men's unit due to the potential for aggression and violence. Most staff respondents preferred to work on a mixed-gender unit due to the variety of patient needs and personalities of this arrangement, and the benefits of the current mixed-gender recovery environment that reflects the community.

Public Psychiatric Hospital Practices. Information from 9 Midwest public psychiatric hospitals with civil acute units revealed that none of them have single-gender civil acute units and most stated that their units have been coed for as long as they can remember. Of the hospitals that also have formally-designated state forensic units, some of these units are single-gender, some all-male and some all-female. Practices some hospitals use for patients identified at increased risk for dangerous behaviors include heightened levels of observation and monitoring to reduce opportunity for acting out, as well as a psychiatric intensive care unit to manage particularly violent or high-risk patients.

Community Stakeholder Input. A total of 216 community stakeholders shared a variety of responses about having male and female patients residing on the same acute adult inpatient units, as well as thoughts about having patients reside on all-male and all-female acute inpatient units. Nearly half of respondents offered comments citing advantages of mixed-gender units, and slightly more than a half cited reasons against such an arrangements. Consumers and families tended to be more favorable in their opinions of men and women on the same units, whereas advocates and "other" type respondents were more skewed in their focus on disadvantages as compared to advantages. The advantages of mixed-gender units fell into the two main content categories of *Therapeutic Recovery Environment* (beneficial effect on interpersonal interactions and treatment milieu, and practice standards) and *Quality of Care & Patient-Centered Treatment* (core issues of quality of care, staffing/supervision and screening/treating of most dangerous/vulnerable). Disadvantages of mixed-gender units fell into two main categories of *Therapeutic Recovery Environment* (negative impact on interpersonal interactions and treatment milieu) and *Vulnerability, Trauma and Patient Mix* (impact on safety, potential for harassment, abuse and re-traumatization of women and patient mix of vulnerable and dangerous).

With respect to having patients reside on all-male or all-female units, approximately two-thirds of respondents shared benefits of gender segregation and one-third focused predominantly on disadvantages. The advantages of single-gender units fell into the same two main categories as did the disadvantages of mixed units: *Therapeutic Recovery Environment* and *Vulnerability, Trauma and Patient Mix*. Likewise, responses focusing on disadvantages of single-gender units fell into the same two main categories as did the advantages of mixed units: *Therapeutic Recovery Environment* and *Patient-Centered Treatment*.

Conclusions

The results of the study indicate that when it comes to the issue of mixed and single-gender units, it is not about one answer but rather it is a process. There are reasons for and reasons against each option. BHD inpatients, hospital staff and community stakeholders, including consumers, are all of varying opinions and preferences. Of interest among all respondent types, regardless of their opinion about unit gender mix, is the recurrent theme that gender should not be the primary factor in determining best placement, and that quality of care and recovery focus will not be adequately addressed by resort to single-sex segregation. Other factors, such as severity of illness and risk of violence and vulnerability, are equally important, if not more so, in creating a safe and therapeutic inpatient environment. The Gender Unit Work Group concludes that segregation by gender of all BHD Acute Adult Inpatient units is too indiscriminate and compartmentalized an approach. We propose a configuration of the adult units that offers a blended model that is more thoughtful, flexible and pragmatic.

Recommendations

The Gender Unit Work Group recommends a configuration of the four Acute Adult Inpatient units that would create a 12-bed *Intensive Treatment Unit (ITU)* that is expected to be predominantly male, a combined *Women's-Option/Med-Psych Treatment Unit* and two mixed-gender *General Treatment Units*. The *Intensive Treatment Unit* would be designated for patients with high risk for aggression and violence, including sexual acting out. The ITU can be presumed to be predominantly, if not always, all male. Most women with aggression can usually be managed in the general population with enhanced monitoring. The ITU concept will need to be further developed, but the Work Group is united in its stand that the intention is not that the unit be a "secure" unit (all BHD acute units are secure and locked), a "forensic" unit (BHD has no such formally designated forensic services or specialty) or a "detention" unit (BHD is not a correctional facility). The ITU must have reduced beds. We recommend the ITU have a capacity of 12 beds. The implication is that BHD would have to reduce

its overall Acute Adult Inpatient bed capacity by 12 to a total of 84 beds. The benefit of the ITU is that it achieves separation, from the general patients, of predominantly those male patients with higher violence potential. Such separation addresses the main safety concerns of staff and patients, especially vulnerable male patients and many female patients. The concerns of women patients, however, are more complex due to higher rates of trauma and may not be fully resolved by segregation of high-risk men. For this reason, the Work Group recommends that one unit be designated as a combined ***Women's-Option/Med-Psych Treatment Unit***. The unit would consist of the small number of vulnerable geriatric and complicated medical-psychiatric patients whom BHD serves, with the majority remainder of beds prioritized for female patients at heightened risk of vulnerability to inappropriate sexual behavior, abuse and violence. Assignment would be per medical staff assessment and/or patient choice, depending on clinical safety needs and bed availability. With a new overall Acute Adult Inpatient bed capacity of 84 beds, the female beds on this unit (Women's-Option and Med-Psych) could conceivably accommodate more than half of the total estimated adult female patients at any given time. The remaining two units would be mixed-gender ***General Adult Treatment Units*** with separate bedroom hallways as is currently the case. The separation of those patients with highest violence and vulnerability potential would, hopefully, allow these units to better serve the general population in a therapeutically-focused milieu.

The Work Group believes that the proposed configuration offers a more individualized, needs-based and trauma informed care approach than simple division by gender. The model addresses many of the concerns of BHD staff, inpatients, community consumers and other stakeholders as well as coheres with accepted practices of public psychiatric hospitals. Aside from requiring a 12-bed reduction in Acute Adult capacity, the recommendation is feasible and offers flexibility with census management. It addresses gender-based safety concerns while affirming the current improvement practices in place. This recommendation of the Gender Unit Work Group is advisory to the BHD Administrator. Should it receive endorsement, a detailed planning process will need to be undertaken, addressing considerations in three areas of: Human Resources, Program Development and Physical Environment Audit. The estimated timeline for implementation of this unit configuration recommendation is during Quarter 3 of 2011 (July to September). Regardless of the final decision, BHD shall continue its current practices, policies and guidelines in place to maintain a safe, therapeutic unit environment.

MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION

FOLLOW-UP REPORT TO BHD ADMINISTRATOR:

MIXED - GENDER UNITS

December 1, 2010

Submitted By The

GENDER UNIT WORK GROUP

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INTRODUCTION

On June 16, 2010, the *Preliminary Report to BHD Administrator: Mixed-Gender Units (May 22, 2010)* was presented to the Milwaukee Committee on Health and Human Needs. The Committee had requested a report from the Behavioral Health Division (BHD) on mixed-gender units for acute psychiatric inpatients. A Gender Unit Work Group was formed, under Medical Staff leadership, to examine the issue of mixed-gender units. The Work Group conducted a comprehensive international literature review on mixed and single-gender units, obtained information on units in Wisconsin public psychiatric hospitals and reviewed BHD incident and inpatient consumer satisfaction data. The report explored the history of mixed-gender units, their prevalence, patient perceptions and staff attitudes.

The report concluded that the mixed-gender Acute Adult Inpatient units utilized by BHD are the norm among public psychiatric hospitals in Wisconsin and have been the standard model for inpatient psychiatric treatment for many decades. An extensive literature search failed to identify any published articles in the United States (U.S.) on the issue of mixed and single-gender units. Similarly, there is little research in the U.S. on whether female inpatients consider gender segregation to be either desirable or likely to contribute to their sense of safety. In the United Kingdom where the topic of single-sex accommodation has received much attention, there is little empirical research comparing single-sex and mixed-sex units. Available studies are small in size, the settings variable and generalizability limited across other systems and cultures. The views of their female patients and staff are more complex and reflect concern about overall safety that may not be wholly resolved by the introduction of single-sex units. An informed, aware and safe unit milieu depends on many factors beyond patient gender mix – among them, staff sensitivity and training, monitoring and environmental design. There are different ways that psychiatric hospitals here and across the country protect patient safety, including sexual safety.

Any revision to the existing practice of mixed-gender units at BHD must look carefully at assumptions regarding safety, choice, patient satisfaction and therapeutic benefit. For these reasons, the Work Group recommended a more detailed evaluation by BHD of the various gender unit options, while in the interim continuing the current practices put in place to minimize risk and ensure a safe, therapeutic unit environment. The Committee on Health and Human Needs endorsed this recommendation for further study by BHD of mixed-gender units.

This Follow-Up Report details the study conducted by the Gender Unit Work Group. The aims of the study were to: assess BHD inpatient perceptions of safety on the current units and preferences for gender composition; assess BHD staff perceptions of patient sexual safety on current units, effectiveness of current safety practices and attitudes towards gender unit options; attempt to identify public psychiatric inpatient facilities who have single-gender units and communicate with them regarding their experience; and obtain input from community stakeholders on recommendations to improve quality of care on acute inpatient units, including thoughts about gender composition.

The original Gender Unit Work Group reconvened on July 21, 2010 and members re-evaluated their continued participation in the next phase of the study. Additional members were nominated to represent consumers, direct care acute unit nursing staff, acute inpatient management, rehabilitative services and program evaluation and research. The Gender Unit Work Group met for 14 sessions (approximately 3 times a month) between July 28 and December 1, 2010 for over

28 hours, in addition to numerous times outside of meetings to design measures and procedures, compile results and analyze findings. A note about language: the terms single-gender and mixed-gender are used in this report to describe the types of units, though respondents may have used similar interchangeable terms of same-sex or mixed-sex. A number of terms are often used to refer to consumers of mental health services. This report uses the term *patient* to refer to a person receiving treatment in an acute inpatient unit, consistent with language for persons admitted to a general hospital and understandable to the public.

METHODS

Participants and Procedures

BHD Acute Inpatient Survey. A semi-structured questionnaire was administered to patients hospitalized on the Acute Adult psychiatric units between August 16 and September 10, 2010. The sample was drawn from the four Acute Adult inpatient units with a total patient capacity of 96 and approximately 184 admissions per month. All patients consecutively admitted to these units over this four-week period were eligible to participate in the survey after having been in the hospital for a minimum of one day. Patients considered by the primary unit RN to be too ill or acutely dangerous that day to participate were approached at a later date when more stable. Patients were limited to one survey per episode of hospital stay; if a patient was re-hospitalized during the survey period, they were eligible to do the survey again. Patients were interviewed on the unit using a semi-structured questionnaire. The two interviewers were independent of the patient's clinical treatment team and BHD management. One interviewer was the BHD Client Rights Specialist. The other interviewer was a part-time staff member from Vital Voices, a mental health advocacy organization with extensive experience conducting interviews of consumers of mental health services. Both interviewers had years of experiences working with persons with serious mental illness and conducting patient interviews and surveys. Each interviewer assumed primary responsibility for two units.

A semi-structured questionnaire was developed specifically for this study to obtain the opinion of BHD Acute Adult inpatients about men and women being on the same unit here (see Appendix A for copy of the survey tool). The questionnaire consisted of three main questions with objective ratings asked of both male and female patients, and then a fourth question for female patients only. Each objective question was followed by an open-ended question asking the patient to explain more in a narrative response. One question had an additional open-ended follow-up item. The questions were developed by the Work Group with careful attention to non-leading language and avoidance of intrusive questions about personal experiences that could provoke emotional distress. The three main questions asked whether patients: (1) preferred to be on an [*same gender as pt.*] all-men's/all-women's unit if it were available ("No" "Unsure/Doesn't Matter" "Yes") and then to explain why; (2) how they feel with men and women patients on the same unit ("Very Unsafe" "Somewhat Unsafe" "Somewhat Safe" "Very Safe") and to explain why and say what would make them feel safer; and (3) how they would feel if there were [*same gender as pt.*] all men/women patients on the unit ("Less Safe" "No Difference" "More Safe") and to explain why. The fourth question for women only asked whether they (4) would prefer there to be a women-only patient lounge available on the unit ("No" "Unsure/Doesn't Matter" "Yes") and to explain why.

Interviewers were trained on the patient questionnaire by the Work Group Chair. Interviewers approached eligible patients individually, explained the purpose of the survey and that participation was voluntary and would not influence the services they receive. The questionnaire was administered in a semi-private location on the unit. The interviewer entered the date of the survey, patient's date of admission, age, gender, race/ethnicity and acute unit. The Interviewer read each objective question and response choices to the patient, and then circled the patient's response. The interviewer asked the follow-up open-ended questions and recorded the patient's narrative answer verbatim.

BHD Acute Adult Inpatient Staff Survey. *An Acute Adult Inpatient Staff Survey: Patient Sexual Safety* was distributed to all clinical staff working in the Acute Adult Inpatient program, either as their regular assignment or as pool/float staff. The purpose of the survey was to obtain staff's opinions specifically about the sexual safety of men and women patients residing on the same acute units here, as this was the main charge of the Work Group. For the purposes of the survey, *sexual safety* was defined as referring to preventing and managing sexual behavior between patients – including sexual contact, harassment, exploitation, intimidation and assault. The survey was printed on special paper to prevent photocopying and individuals submitting more than one survey. Surveys were delivered to staff mailboxes in sealed blue envelopes with staff name on envelope label but no staff-identifying information on the survey tool itself. Staff was assured that their answers were confidential. Work Group members briefed unit clinical treatment teams on the purpose of the survey and encouraged their participation. The surveys were distributed to 236 Acute Adult Inpatient staff, consisting of approximately 24 Medical Staff (MD- psychiatrists and physical care doctors, PhD-psychologists, APNP-advanced practice nurse prescribers), 22 Social Work/Rehabilitative Services (social workers, occupational therapists, music therapists), 104 Registered Nurses (unit, float, pool, nursing program coordinators, administrative resources), 76 Certified Nursing Assistants (unit, float, pool), 7 Peer Specialists, 3 Dietitians and 1 Chaplain. Of the RN and CNA staff, approximately 76 were pool or float. Surveys were disseminated on September 16 with due date of September 30, 2010.

The Acute Adult Inpatient Staff survey consisted of ten main items, nine of them questions with objective ratings followed by one or more open-ended follow-up questions requiring a narrative response. The remaining one item was solely an open-ended question giving staff an opportunity to make other suggestions to improve the sexual safety of men and women patients residing on the units (see Appendix B for copy of survey tool). The first item asked staff their opinion as to how sexually safe men and women patients are residing on the same unit in our hospital, followed by a series of items about what sexual safety concerns they have for patients and what concerns patients themselves have raised. Next, staff was asked to rate the effectiveness of 11 current practices for ensuring the sexual safety of patients on the unit, then followed by recommendations to improve them as well as any other suggestions to improve the sexual safety of men and women residing on the same units. Lastly, staff opinions were obtained on possible future strategies to improve unit safety for men and women, specifically developing plans for an all-women's unit, all-men's unit, and women-only and men-only lounges on the mixed-gender units. Staff was also asked to rate their preferences for working on all-women's, all-men's and mixed-gender units. Demographic/descriptive data recorded included gender, position, years of employment at BHD and years of employment in Acute Adult Inpatient.

Public Psychiatric Hospital Information. An attempt was made to locate other public psychiatric facilities with single-gender acute units and communicate with them regarding their experience. The search was narrowed to facilities in states from the Midwest geographic region

and close to a major metropolitan area. The only state included outside of the Midwest was Pennsylvania. Names of public psychiatric hospitals were obtained from the web sites of the National Association of State Mental Health Program Directors, the National Association of County Behavioral Health and Developmental Disability Directors and state departments of mental health. An effort was made to select those hospitals that appeared to have or might reasonably have a civil acute unit (versus medium/long-term stay civil units or forensic units). An email letter was developed describing the BHD Acute Adult Inpatient Service (# of beds, median and mean lengths of stay), the study we had undertaken of whether to continue to use mixed-gender units and a desire to communicate with public adult psychiatric hospitals that currently have, or had within the last 5 years, single-gender units. The hospital was asked to contact the Chair of the Work Group if they had relevant experiences they were willing to share with us about the gender configuration of their acute adult units. The email letter was sent to the hospital's chief clinical officer, chief operating officer, or administrator as identified by the site or by phone contact with the facility. The email letter was sent to a total of 24 public psychiatric facilities in the states of Illinois, Minnesota, Missouri, Michigan, Ohio and Pennsylvania. Except for one county-operated hospital, all other facilities were state-operated psychiatric hospitals and regional treatment centers.

Community Stakeholder Input. Community stakeholders (i.e., consumers, family members, behavioral health providers, advocates and other interested parties) were invited to provide input relevant to BHD's evaluation of the current practice of mixed-gender acute adult inpatient units and recommendations to enhance the quality of care in the acute hospital. Thoughts and opinions were requested specifically about men and women patients residing on the same acute inpatient units at BHD and having patients reside on all-male and all-female acute inpatient units at BHD. Respondents were asked to identify themselves as either a consumer/patient, family member, provider, advocate or other. They were asked to answer the two questions on the attached form and send their response by postal or email address to the BHD Manager of Community and Employee Outreach. The request for input was distributed on November 9 with deadline of November 17 (subsequently extended to November 19) and sent to relevant community stakeholders via organizational network lists of BHD as well as Disability Rights Wisconsin.

Data Analysis

Quantitative data from the inpatient and staff surveys were analyzed using SPSS (Statistical Package for the Social Sciences). Narrative answers from BHD inpatients, BHD staff and community stakeholders to the open-ended questionnaire items were analyzed using a content analysis descriptive approach. The content analysis was conducted by hand and involved grouping responses into categories and, for some items, counting the responses. The most formal content analysis was applied to the BHD inpatient survey and BHD inpatient staff survey question #3 because of the relevant and direct experience of these participants to the study questions at hand. The content analysis began with one judge sorting the verbatim responses into main content categories that occurred to her and writing a brief definition of the category. The preliminary categories and definitions were then presented to several members of the Work Group or the entire Work Group for them to sort the same set of responses without seeing the judge's results. They compared notes, discussed responses on which they disagreed and resolved differences. Based on this process, categories were added or deleted/combined and clearer definitions formulated.

RESULTS

BHD Acute Adult Patient Survey

Characteristics of Participants. One hundred thirty patients participated in the study. Of those 130, 74 (56.9%) were men and 56 (43.1%) were women. This gender breakdown very closely mirrors the latest BHD figures for Acute Adult Inpatient admissions of 59.8% men and 40.2% women (data from 01/01/2009 through 10/31/2010), slightly over-representing women. Fifty-nine were African American (45.4%), 58 White/Caucasian (44.6%), 5 Hispanic/Latino (3.8%), 1 Native American (0.8%) and 7 Other (5.4%). Average age was 40.9 years (median 41.5, range 18 -81 years). Median length of stay in the hospital at time of survey was 6.0 days (overall BHD Acute Adult Inpatient median LOS = 7.0 days). Thus, patients were surveyed after having been reasonably exposed to the inpatient unit and sufficiently stable in their treatment to provide informed opinions to the survey questions. Participation was representative of all 4 units and reflected slight differences in their admissions (43A – 26.2%; 43B – 18.5%; 43C – 25.4% and 43D – 30.0%).

Content Analysis and Main Patient Themes. A summary of all main patient content themes of responses to the open-ended follow-up items is contained in Appendix A. The main content theme categories and definitions are presented in Table 1.

Table 1. *Main Patient Content Themes*

<i>SAFETY FROM AGGRESSION</i>	<i>INTERPERSONAL INTERACTION</i>
❖ Concern about or experience of: ○ Verbal aggression ○ Physical Aggression ○ Sexual behavior ○ <i>Safety</i> issues ❖ Includes either <i>presence</i> or <i>denial</i> of concern about any safety issues	❖ Quality and mix of opportunities for patient interpersonal interactions, including: ○ Communication, sharing ○ Cooperation, respect ○ Socialization ○ Emotional or social attributes ❖ Includes either <i>positive</i> or <i>negative</i> interpersonal effects and expectations
<i>UNIT AND SECURITY STAFF</i>	<i>SELF ADVOCACY</i>
❖ Unit or security staff presence and behavior	❖ Feeling of confidence or ability to manage, advocate for or protect self
<i>OTHER</i>	
❖ Irrelevant to question ❖ Does not belong to available theme categories	

Perceptions of Safety on Mixed-Gender Units. Patient perceptions of how safe they feel with men and women patients on the same unit are reflected in their responses to Question 2a. of the survey (see Table 2).

Table 2. *Patient Feelings of Safety with Men and Women Patients on Same Unit*

2. How do you feel with men and women patients on the same unit?						
	MALES (n=74)		FEMALES (n=56)		TOTAL (n=130)	
	N	%	N	%	N	%
Very Unsafe	5	6.8	6	10.7	11	8.5
Somewhat Unsafe	2	2.7	3	5.4	5	3.8
Somewhat Safe	15	20.3	14	25.0	29	22.3
Very Safe	52	70.3	33	58.9	85	65.4
2a. Respondents' explanation of 'why'						
	MALES		FEMALES		TOTAL	
Somewhat / Very Unsafe	N	%	N	%	N	%
Safety from aggression	6	100.0	6	85.7	12	92.3
Interpersonal interaction	0	0.0	1	14.3	1	7.7
Unit & security staff	0	0.0	0	0.0	0	0.0
Self advocacy	0	0.0	0	0.0	0	0.0
Somewhat / Very Safe						
Safety from aggression	9	21.4	18	39.1	27	30.7
Interpersonal interaction	20	47.6	19	41.3	39	44.3
Unit & security staff	8	19.0	6	13.0	14	15.9
Self advocacy	5	11.9	3	6.5	8	9.1

- Over 90% of the men felt somewhat or very safe with men and women patients on the same unit. For these men, their comments centered primarily (48%) on potentially beneficial interpersonal interactions, and additionally (21%) on denial of aggression as a concern, with a few fearing there would be more fights with all men. Almost a fifth of the comments (19%) focused on how unit and security staff contributed to their feelings of safety. Another 12% of the men who felt safe gave as the reason their confidence in their ability to advocate for their own safety.

- Slightly less than 10% of men felt somewhat or very unsafe with men and women on the same unit. All of their explanations were concerned with the potential for aggression.
- Nearly 84% of women felt somewhat or very safe with men and women patients on the same unit. For these women, 41% of the reasons had to do with the positive interpersonal experience of having men on the unit. An additional 39% of the reasons why women felt safe centered primarily on feelings of safety from aggression. Another 20% gave reasons for their feeling of safety having to do with unit and security staff and confidence in their own self-advocacy skills.
- Approximately 16% of women felt somewhat or very unsafe with men and women patients on the same unit. Their reasons were primarily (86%) concerns about safety from aggression.
- Almost 88% of all patients said they felt somewhat or very safe with men and women on the same unit. The majority of them mentioned reasons related to positive interpersonal interactions and denial of concerns about aggression. Among these patients who reported feeling safe, a few mentioned unpleasant interpersonal experiences or safety concerns involving the opposite gender. The small percentage (12%) of patients who felt somewhat or very unsafe with men and women patients on the same unit cited primarily concern about potential for aggression.

As for what would make patients feel safer on the mixed-gender units, their suggestions fell into three main themes centering on improved interpersonal interactions, unit and security staff and reliance on self advocacy (see Table 3).

Table 3. *Patient Suggestions to Increase Feeling of Safety*

2b. How do you feel with men and women patients on the same unit? What would make you feel safer?						
	MALES (n=74)		FEMALES (n=56)		TOTAL (n=130)	
	N	%	N	%	N	%
Very Unsafe	5	6.8	6	10.7	11	8.5
Somewhat Unsafe	2	2.7	3	5.4	5	3.8
Somewhat Safe	15	20.3	14	25.0	29	22.3
Very Safe	52	70.3	33	58.9	85	65.4
<i>Respondents' explanation of 'What would make you feel safer?'</i>						
	MALES		FEMALES		TOTAL	
Somewhat / Very Unsafe	N	%	N	%	N	%
Interpersonal interaction	2	28.6	6	66.7	8	50.0
Unit and security staff	2	28.6	2	22.2	4	25.0
Self advocacy	1	14.3	0	0.0	1	6.3
Other	2	28.6	1	11.1	3	18.8
Somewhat / Very Safe						
Interpersonal interaction	7	11.3	8	14.3	15	12.7
Unit and security staff	41	66.1	32	57.1	73	61.9
Self advocacy	7	11.3	6	10.7	13	11.0
Other	7	11.3	10	17.9	17	14.4

- For the 10% of men who felt unsafe on a mixed-gender unit, no single factor stood out that would make them feel safer, with the few comments offered spanning interpersonal interactions, unit and security staff and self advocacy.
- For the more than 90% of men who felt safe on a mixed-gender unit, 66% of their suggestions for what would make them feel safer centered on unit and security staff presence, behavior and monitoring. Other factors identified that would make them feel safer were evenly split between improved interpersonal relations (11.3%) and reliance on self-advocacy and protection (11.3%).
- For the approximately 16% of women who felt unsafe on a mixed-gender unit, suggestions as to what would make them feel safer clustered mostly (67%) around improvements in overall interpersonal interactions, with just a few suggestions about unit and security staff.
- For the almost 84% of women who felt safe on a mixed-gender unit, their suggestions for what would make them feel even safer centered primarily (57%) on unit and security staff presence, behavior and monitoring. Other factors identified that would make them feel safer included a mixture of comments regarding interpersonal interaction (14.3%) and reliance on self-advocacy and management (10.7%).
- For the 12% of patients overall who felt unsafe on a mixed-gender unit, factors they identified that would make them feel safer included improved interpersonal interactions (50%) and, to a lesser extent, unit and security staff (25%). For the 88% of patients who reported feeling safe on a mixed-gender unit, nearly 62% of their suggestions as to what would make them feel safer focused on unit and security staff presence. This pattern was consistent for both men and women patients.

Preferences For and Attitudes About Single-Gender Units. On the question of preference to be on an all-men's/all-women's unit if it were available, almost 50% of male and female respondents did not prefer to be on a single-gender unit and about 30% were unsure of their preference. Results are presented in Table 4.

Table 4. *Patient Preferences for Single-Gender Units*

1. Would you prefer to be on an all-men's / all-women's unit if it were available? Explain why.						
	MALES (n=74)		FEMALES (n=56)		TOTAL (n=130)	
	N	%	N	%	N	%
No	41	55.4	23	41.1	64	49.2
Unsure / Doesn't Matter	22	29.7	17	30.4	39	30.0
Yes	11	14.9	16	28.6	27	20.8

	MALES		FEMALES		TOTAL	
No	N	%	N	%	N	%
Safety from aggression	6	14.6	3	9.7	9	12.5
Interpersonal interaction	35	85.4	28	90.3	63	87.5
Unsure / Doesn't Matter						
Safety from aggression	5	38.5	1	7.7	6	23.1
Interpersonal interaction	8	61.5	12	92.3	20	76.9
Yes						
Safety from aggression	0	0.0	7	38.9	7	35.0
Interpersonal interaction	2	100.0	11	61.1	13	65.0

- More than half of the men (55%) did not prefer to be on an all-men's unit. More than 85% of the explanations for this preference cited the negative impact it would have on interpersonal interactions with other patients. Less than 15% of the reasons related to safety from aggression.
- Almost 30% of men were unsure or felt it did not matter but cited mainly positive features of interpersonal interactions when a unit has both men and women.
- Less than 15% of men preferred to be on an all-men's unit and only two explanations were given related to interpersonal interactions.
- More than 40% of women did not prefer to be on an all-women's unit. Over 90% of the reasons related to positive interpersonal interactions with men and women on the same unit and expectation of negative interactions if there were only women. The remaining reasons why women do not prefer to be on an all-women's unit had to do with concerns about potential aggression with other women on the unit.
- Approximately 30% of women were unsure or felt it did not matter. However, their comments mentioned mostly positive expectations for interpersonal interactions and minimized concerns and problems with men on the unit.
- Almost 29% of women preferred to be on an all-women's unit. More than 60% of their explanations cited an expected positive impact all women would have on interpersonal interactions. Almost 39% of explanations for why these women preferred an all-women's unit centered on concerns about male aggression.
- Almost 50 % of men and women did not prefer to be on a same-gender unit. Another 30% were unsure or said it did not matter, whereas 20% said they would prefer to be on a unit with same-gender patients. All three groups cited reasons that overwhelmingly (>81%) had to do with the effect they thought a same-gender unit would have on the quality of interpersonal interactions with each other. The remaining reasons were related to safety from aggression.

As for how safe patients thought they would feel if there were all single-gender patients on the same unit, only about 25% of both male and female patients indicated they would feel safer. Complete results are in Table 5.

Table 5. *Patient Expectations of Safety on Single-Gender Units*

3. How would you feel if there were all men / all women patients on the same unit? Explain why.						
	MALES (n=74)		FEMALES (n=56)		TOTAL (n=130)	
	N	%	N	%	N	%
Less Safe	28	37.8	18	32.1	46	35.4
No Difference	29	39.2	22	39.3	51	39.2
More Safe	17	23.0	16	28.6	33	25.4
3a. Respondents' explanation of "why"						
	MALES		FEMALES		TOTAL	
	N	%	N	%	N	%
Less Safe						
Safety from aggression	22	78.6	7	33.3	29	59.2
Interpersonal interaction	6	21.4	14	66.7	20	40.8
No Difference						
Safety from aggression	4	26.7	8	44.4	12	36.4
Interpersonal interaction	11	73.3	10	55.6	21	63.6
More Safe						
Safety from aggression	3	33.3	7	53.8	10	45.5
Interpersonal interaction	6	66.7	6	46.2	12	54.5

- Slightly less than 40% of men said they would feel less safe if there were all men on the unit. Just fewer than 80% of their reasons focused on concerns about safety from aggression, including serious fights.
- Approximately 40% of men felt there would be no difference for them being on a unit with all men patients because they recognize the potential for people to get along.
- More than 20% of men felt they would be safer on a unit with all men due to the expected quality of the interpersonal interactions.
- Slightly less than a third of the women said they would feel less safe on an all-women's unit. Approximately two-thirds of their reasons cited concern about increased interpersonal conflict with all women and one-third of the reasons related to the potential for physical aggression.

- Slightly less than 40% of women said there would be no difference for them being on a unit with all women patients. The majority of comments cited positive effects on interpersonal interactions with men and women together and a minimization of concerns about potential for aggression.
- Slightly less than 30% of women said they would feel safer being on a unit with all women patients. The two main reasons were safety from aggression and expected improvement in interpersonal interactions.
- Overall, about 40% of men and women felt that being on a same-gender unit would make no difference to them in terms of safety. Slightly more than a third said that they would feel less safe, whereas a fourth of all patients said they would feel safer. {This response pattern held true for both men and women pts. However, a slightly higher % of men than women expected to feel less safe on a same-gender unit, and a slightly higher % of women than men expected to feel more safe on a same-gender unit.}

Women's Preferences for Women-Only Lounge. Women were split in their preference for a women-only lounge on the unit and the majority of reasons for and against focused on the expected effect on interpersonal interactions rather than safety (see Table 6 for results).

Table 6. *Women Patient Preferences for Women-Only Lounge*

4. Women only: Would you prefer there to be a women-only patient lounge available on the unit? Explain why.		
	<i>N</i>	%
No	22	39.3
Unsure / Doesn't Matter	16	28.6
Yes	18	32.1
4a. Women respondents' explanation of 'why'		
	<i>N</i>	%
No		
Safety from aggression	5	20.0
Interpersonal interaction	20	80.0
Unsure / Doesn't Matter		
Safety from aggression	1	14.3
Interpersonal interaction	6	85.7
Yes		
Safety from aggression	4	22.2
Interpersonal interaction	14	77.8

- Women were split in their preference for a women-only lounge on the unit, with 39% saying no, 32% saying yes and 29% being unsure or neutral.
- Of women who were opposed to a women-only lounge, 80% of their reasons cited an expected negative impact on interpersonal interactions and 20% of the comments cited expected verbal and physical aggression between women.
- Of women who said they would prefer a women-only lounge, the vast majority (77.8%) of their reasons centered on an expected benefit in their interpersonal interactions and shared

communication with other women. Only a few comments referenced a vague feeling that they would feel safer.

- Of interest, all of the comments by the unsure or neutral group of women emphasized no problems with the current arrangement of a shared lounge with men on the unit.

BHD Acute Adult Inpatient Staff Survey

Characteristics of Participants. A total of 82 staff participated in the survey, a 34.6% return rate. Though lower than hoped for, this response rate is not unusual for this type of survey and is a more than adequate sample size for analysis. Of those staff who responded, 22 (27.2%) were male and 59 (72.8%) female. Breakdown of response by position and (% of total sample) was medical staff 11 (13.9%), social work/rehab services 8 (10.1%), registered nurse 38 (48.1%), certified nursing assistant 15 (19.0%), peer specialists 4 (5.1%) and other 3 (3.8%). Mean years of employment at BHD was 9.7 years with mean years of employment in Acute Adult Inpatient 7.8 years.

Content Analysis and Main Themes. A summary of main content themes of responses to the open-ended items is contained in Appendix B.

Staff Perceptions of Patient Sexual Safety on Mixed-Gender Units. More than half of staff respondents think that men and women patients are somewhat sexually safe residing on the same unit. An additional 9 % think they are very safe (total for somewhat and very sexually safe = 60.5%). Almost 40% of staff respondents think that men and women patients are somewhat (27%) or very (12%) unsafe residing on the same unit. Please see Table 7.

Table 7. *Staff Perceptions of Patient Sexual Safety*

1. HOW SEXUALLY SAFE DO YOU THINK MEN AND WOMEN PATIENTS ARE RESIDING ON THE SAME UNIT IN OUR HOSPITAL?		
	N	%
Very Unsafe	10	12.3
Somewhat Unsafe	22	27.2
Somewhat Safe	42	51.9
Very Safe	7	8.6
Total	81	100.0

Asked about specific safety concerns they have for women patients on the unit, staff respondents indicated that most (53%) of their concerns for women patients' sexual safety were related to the women's vulnerability to sexual harassment, intimidation, exploitation and/or abuse. Staff also noted that the unit configuration, staffing pattern, and patient mix contributed to their sexual safety concerns for women on the unit. Additionally, staff respondents identified concerns about women initiating or provoking sexual activity. As for sexual safety concerns they have for men patients on the unit, staff respondents indicated that most (46%) of their concerns for men patients' sexual safety also were related to some men being vulnerable to sexual harassment, intimidation, exploitation and/or abuse. Of note, 14% of staff responses indicated they had no sexual safety concerns for men patients. Staff respondents identified concerns about men initiating or provoking sexual activity. Staff also noted that the unit configuration, staffing pattern, and patient mix contributed to their sexual safety concerns for men on the unit.

With respect to sexual safety concerns that women patients have raised with them, of staff who responded, 33% reported women raising concerns about vulnerability to sexual harassment and intimidation. Almost 29% cited women being concerned about personal boundary violations, with another 12% of comments saying that women have raised general (nonsexual) safety concerns. Almost 22% of staff respondents reported women not having raised any sexual safety concerns. As for sexual safety concerns raised by men patients, of staff who responded, 30% reported men raising concerns about vulnerability to sexual harassment and intimidation. Almost 12% cited men being concerned about personal boundary violations, with another 9% of comments saying that men have raised general (nonsexual) safety concerns. Another 46% of staff said that men usually expressed no sexual safety concerns.

Effectiveness of Current Sexual Safety Practices. Current practices were predominantly rated by staff respondents as being somewhat effective (approximately 3.0) for ensuring the sexual safety of patients on the unit (see Table 8) Locked community bathrooms and the unit zone surveillance system were the highest rated practices with more than 40% of staff respondents rating them as very effective. Cross shift communication of special risk patients, the separation of bedroom hallways for men and women, and behavior observation for special risks were other practices rated by about one-third of staff as being very effective.

Table 8. *Staff Rating of Effectiveness of Current Practices*

2. HOW WOULD YOU RATE THE EFFECTIVENESS OF THESE CURRENT PRACTICES FOR ENSURING THE SEXUAL SAFETY OF PATIENTS ON THE UNIT? *									
CURRENT PRACTICES	Scale Avg.** Rank Ordered	Very Ineffective		Somewhat Ineffective		Somewhat Effective		Very Effective	
		N	%	N	%	N	%	N	%
Locked Community Bathrooms	3.2	3	4.1	9	12.3	30	41.1	31	42.5
Unit Zone Surveillance system	3.1	7	10.1	9	13.0	21	30.4	32	46.4
Cross Shift communication of special risk patients	3.1	4	6.0	7	10.4	35	52.2	21	31.3
Bedroom Hallways separate for M & W; no bed assignment beyond fire doors for W	3.0	6	8.3	10	13.9	32	44.4	24	33.3
Behavior Observation monitoring for special risks	2.9	7	9.3	12	16.0	32	42.7	24	32.0
Therapeutic Groups	2.9	4	6.0	13	19.4	31	46.3	19	28.4
Overall Effectiveness of current practices	2.9	7	9.5	11	14.9	40	54.1	16	21.6
Recovery Planning special risks, treatment obj., interventions	2.9	4	5.8	15	21.7	37	53.6	13	18.8
Morning Report with both treatment teams represented	2.8	9	14.5	5	8.1	36	58.1	12	19.4

Assessments by PCS and Inpatient MD/PhD of special risks	2.8	8	11.4	12	17.1	35	50.0	15	21.4
Patient Education on sexual contact policy	2.8	4	5.7	15	21.4	42	60.0	9	12.9
Electronic Video Monitoring of unit	2.7	10	18.9	10	18.9	20	37.7	13	24.5

*Instructions for this survey question directed respondents to leave blank any items for which they did not have experience. Total number of respondents for each item was between 53 and 75 (total surveys received = 82).

** Response Scale: 1 = very ineffective / 2 = somewhat ineffective
3 = somewhat effective / 4 = very effective

For current practices rated as ineffective, staff was asked for recommendations to improve them (see Appendix B for complete list). Staff suggested that the unit zone surveillance was a very good idea and would work even better if staffed adequately and with better monitoring of CNA performance. Patient education on the no sexual contact policy, though well intended, was often inconsistent and of little benefit for patients with impulse control issues. Some staff commented that higher risk patients seem to get around unit safety nets.

In addition to the current safety practices, staff was asked for any other suggestions to improve the sexual safety of men and women residing on the same unit (see Table 9).

Table 9. *Staff Suggestions to Improve Sexual Safety*

3. WHAT OTHER SUGGESTIONS DO YOU HAVE TO IMPROVE THE SEXUAL SAFETY OF MEN AND WOMEN RESIDING ON THE SAME UNIT?		
Suggestion Category	N	%
Staffing pattern (e.g. adequacy & composition of staff for monitoring & duties)	26	31.7
Staff performance (e.g. staff supervision, training, and teamwork)	20	24.4
Hospital configuration for patient mix (e.g. based on gender, risk, acuity, etc.)	15	18.3
Clinical interventions (i.e. clinical strategies for intervening with patients)	11	13.4
Unit environment modification (i.e. modifications to existing unit physical environment and practices)	10	12.2
Total	82	100.0

Nearly one-third (32%) of suggestions from staff indicated that an improved staffing pattern (e.g. adequacy and composition of staff for monitoring duties) would contribute to the sexual safety of men and women residing on the same unit. Nearly another quarter (24%) suggested better supervision and training of staff and better teamwork would improve the sexual safety of men and women residing on the same unit. Additional staff respondent suggestions for improving sexual safety included the hospital configuration for the mix of patients; increasing the use of clinical intervention strategies regarding sexual issues and behavior; and modifying the existing unit physical environment.

Attitudes and Preferences for Single-Gender Units. Table 10 presents staff opinions on the helpfulness for managing sexual safety for BHD to develop plans for an all-women's unit.

Table 10. *Staff Opinions about an All-Women's Unit*

4. HOW HELPFUL DO YOU THINK IT WOULD BE FOR MANAGING SEXUAL SAFETY ON THE UNITS FOR BHD TO DEVELOP PLANS FOR AN ALL-WOMEN'S UNIT?		
	N	%
Not at all helpful	10	12.5
Not very helpful	10	12.5
Neutral / Unsure	22	27.5
Somewhat helpful	15	18.8
Very helpful	23	28.8
Total	80	100.0

Nearly half (48%) of staff respondents thought it would be somewhat or very helpful for managing sexual safety on the units for BHD to develop plans for an all-women's unit. These respondents thought that this would promote the women on the unit feeling safer and reduce or eliminate sexual harassment and contact. Staff also thought an all-women unit could better serve the subset of women with sexual abuse and trauma issues. Slightly more than a quarter (28%) of staff were neutral or unsure whether an all-women's unit would be helpful primarily due to not being able to control or prevent all sexual contact, including same-gender activity. Additionally, staff cited the benefit of patients being able to interact and learn from the opposite sex on mixed-gender units. Another quarter of staff respondents thought that an all-women's unit would be not very or not at all helpful due to the possibility of same-gender sexual activity and that patients need to function in a normalizing environment similar to the community.

Table 11 presents staff opinions on the helpfulness of BHD developing plans for an all-men's unit. Nearly half (49%) of staff respondents thought it would be somewhat or very helpful for

Table 11. *Staff Opinions about an All-Men's Unit*

5. HOW HELPFUL DO YOU THINK IT WOULD BE FOR MANAGING SEXUAL SAFETY ON THE UNITS FOR BHD TO DEVELOP PLANS FOR AN ALL-MEN'S UNIT?		
	N	%
Not at all helpful	12	15.2
Not very helpful	8	10.1
Neutral / Unsure	20	25.3
Somewhat helpful	14	17.7
Very helpful	25	31.6
Total	79	100.0

managing sexual safety on the units for BHD to develop plans for an all-men's unit. Respondents thought that this could help particularly high-risk men from taking advantage of vulnerable females and provide a safer, less violent environment for the rest of the patient population. Those staff respondents who were unsure (25%) cited concerns that this might shift the risk of sexual behavior toward vulnerable male patients, and that an all-male unit may be more violent than a mixed-gender unit. Another quarter of respondents thought that an all-men's unit would not be very or at all helpful, and also cited concerns about same-gender sexual behavior and the abuse of vulnerable males.

Preference for Unit Work Assignment. Most staff respondents would not prefer or were neutral or unsure about working on a single-gender unit if BHD had one, with more staff respondents preferring to work on an all-men's unit rather than an all-women's unit (See Tables 12 and 13). Nearly half (48%) of staff respondents would not prefer to work on an all-women's

Table 12. *Staff Preferences to Work on All-Women's Unit*

6. WOULD YOU PREFER TO WORK ON AN ALL-WOMEN'S UNIT, IF BHD HAD ONE?		
	N	%
No	37	48.1
Neutral / Unsure	29	37.7
Yes	11	14.3
Total	77	100.0

unit if BHD developed one. Their reasons were primarily concerned with the stressful demands and problems they would have to deal with from hostile, moody, and threatening women. They also cited the benefits of the current mixed-gender recovery environment that reflects the community to which patients will return. Male staff respondents were also concerned about the potential for false accusations of sexual advances. Almost 38% of staff respondents were neutral or unsure about working on an all-women's unit. The few reasons provided by the 14% of staff respondents who preferred to work on an all women's unit referenced wanting to feel safe and to be there for all patients.

Table 13. *Staff Preferences to Work on an All-Men's Unit*

7. WOULD YOU PREFER TO WORK ON AN ALL-MEN'S UNIT, IF BHD HAD ONE?		
	N	%
No	33	42.9
Neutral / Unsure	26	33.8
Yes	18	23.4
Total	77	100.0

Most staff respondents did not prefer (43%) or were neutral or unsure (34%) about working on an all-men's unit. The primary reasons cited were concerns about anger and the potential for aggression and violence. They also cited the benefits of the current mixed-gender recovery environment that reflects the community to which patients will return. Nearly a quarter (23%) of staff respondents would prefer to work on an all-men's unit due to either their personal preference or their belief that men are easier to handle and deal with.

Table 14. *Staff Preferences to Work on Mixed-Gender Unit*

8. WOULD YOU PREFER TO WORK ON A MIXED-GENDER UNIT (MEN & WOMEN), LIKE BHD HAS NOW?		
	N	%
No	5	6.6
Neutral / Unsure	28	36.8
Yes	43	56.6
Total	76	100.0

Most (57%) staff respondents preferred to work on a mixed-gender unit like BHD has now (see Table 14). Most reasons for this preference had to do with the variety of patient needs and

personalities of this arrangement, and the benefits of the current mixed-gender recovery environment that reflects the community to which patients will return. Approximately 37% of respondents were neutral or unsure but cited the benefits of the current mixed-gender recovery environment for interpersonal interactions.

Attitude on Single-Gender Lounges. Most staff respondents were unsure or did not think that having single-gender lounges on mixed-gender units would improve sexual safety (Tables 15, 16). Approximately 40% of staff respondents did not think that having a women-only patient

Table 15. *Staff Attitude about Women-Only Patient Lounge*

9. DO YOU THINK THAT HAVING A WOMEN-ONLY PATIENT LOUNGE ON A MIXED-GENDER UNIT WOULD IMPROVE SEXUAL SAFETY?		
	N	%
No	31	39.7
Neutral / Unsure	26	33.3
Yes	21	26.9
Total	78	100.0

lounge on a mixed-gender unit would improve sexual safety. Another third of respondents were neutral or unsure. The primary reasons why these two groups of respondents did not think it would improve sexual safety were focused on their observation that inappropriate sexual behavior occurs in places other than lounge areas, and that the area would require close monitoring by staff. Slightly more than a quarter of staff respondents were in favor of a women-only lounge as a safe and secure place for women to go to when feeling threatened.

With respect to a men-only patient lounge, approximately 45% of staff respondents did not think

Table 16. *Staff Attitude about Men-Only Lounge*

10. DO YOU THINK THAT HAVING A MEN-ONLY PATIENT LOUNGE ON A MIXED-GENDER UNIT WOULD IMPROVE SEXUAL SAFETY?		
	N	%
No	35	44.9
Neutral / Unsure	27	34.6
Yes	16	20.5
Total	78	100.0

that having a men-only patient lounge on a mixed-gender unit would improve sexual safety. Approximately another third of respondents were neutral or unsure. The primary reasons why these two groups of respondents did not think it would improve sexual safety were focused on their observation that inappropriate sexual behavior occurs in places other than lounge areas, and that the area would require close monitoring by staff. Only 20% of respondents were in favor of a men-only lounge and provided few reasons.

Public Psychiatric Hospital Findings.

Ten of the 24 public psychiatric hospitals that were contacted responded to the email inquiry. Of the 10 replies, all but 1 have civil acute units at their facility; the civil units at the 1 other facility that replied has an average length of stay of 5 years and, therefore, cannot be considered to be

acute. Of the 9 public hospital respondents, none of them have single-gender civil acute units and most stated that their units have been coed for as long as they can remember. Of the hospitals that also have formally-designated state forensic units, some of these units are single-gender, some all-male and some all-female. Some of the hospitals shared that patients identified at increased risk for dangerous behaviors are on a heightened level of observation and monitoring to reduce opportunity for acting out. Some of the hospitals operate a psychiatric intensive care unit to manage particularly violent or high-risk patients that, though not intended or designated as such, tends to be predominantly male.

Community Stakeholder Input

Characteristics of Respondents. Input was obtained from community stakeholders regarding the practice of having male and female patients residing on the same acute adult inpatient units, as well as thoughts about having patients reside on all-male and all-female acute inpatient units. Input was received from 216 respondents. The self-identified breakdown was: Consumer 112 (51.9%), Family 8 (3.7%), Provider 35 (16.2%), Advocate 37 (17.1%) and Other (e.g., human service, corrections, law enforcement) 24 (11.1%). Some individuals checked more than 1 box. The reply was counted in the order of respondent type above to try to reflect those respondent types more likely to have had direct experience with acute psychiatric inpatient services and operations. Because this respondent classification is approximate, findings are summarized for the total group of respondents, with any trend differences between respondent types informally noted.

Content Analysis and Main Categories. The responses to each of the two questions posed were sorted into those citing primarily advantages of mixed and single-gender unit arrangements, and those citing primarily disadvantages. The advantage and disadvantage groups of comments were then further divided into major content categories based on the main ideas expressed in those comments. Included in the content tables are responses illustrating those main ideas. The questions asked for respondents' thoughts about, not necessarily mutually exclusive preference for, the two types of gender-unit accommodations. Indeed, a number of respondents who offered positive comments about single-gender accommodation also offered positive comments about mixed-gender accommodation. It is important to interpret the summary of opinions with caution due to limitations associated with the collecting of this input. The information was obtained through an open invitation for input, not based on systematic sampling procedures.

Opinions about Mixed-Gender Units. With respect to the first question on men and women patients residing on the same acute inpatient units, approximately 47% of respondents cited predominantly advantages, and approximately 53% cited predominantly disadvantages. The respondents who were noted to emphasize more advantages over disadvantages of mixed-gender units tended to be consumers and families. Advocates and other respondents were more skewed in their focus on disadvantages as compared to advantages.

Comments citing advantages of mixed-gender units fell into the two main categories of *Therapeutic Recovery Environment* and *Quality of Care & Patient-Centered Treatment*. A third category was comprised of *Nonspecific* positive comments. The categories and illustrative responses are summarized in Table 17 below.

Table 17. *Community Input on Advantages of Mixed-Gender Units*

THERAPEUTIC RECOVERY ENVIRONMENT ❖ Quality of interpersonal interactions ❖ Impact on overall treatment milieu ❖ Practice standards and availability	QUALITY OF CARE & PATIENT-CENTERED TREATMENT ❖ Focus on safety and quality of care ❖ Role of staff, supervision and training ❖ Screening and treatment for vulnerability/risk
• Healthy environment realistic to everyday interaction; should be reflective of society; hospital experiences should mimic the community and help patients cope with the real world they will return to • Should have opportunity to learn from men and women, share experiences; healthier and promotes recovery • Adults who are not a threat should have access to the least restrictive and most integrated treatment environment; been on coed inpatient units before and had no problems as long as there is supervision • Better to be in a natural setting, not prison-like, when in a crisis • Standard of care for most hospitals as long as adequate supervision; realistic approach with screening and monitoring processes; refer to best practices for guidance and determining beds for inpatient facilities	• Question whether mixed gender is really the core cause of problems vs. interrelated issues of adequate staffing, skills and prevention of violence in general; violence is usually related to staffing, observation of and interaction with patients and absence of a recovery focus; main concern is safety and gender mix doesn't matter – people can be violent against their same sex, too • Segregation by gender doesn't fix the problem or promote resilience – the problem is staffing, supervision, programming; better and easier as long as enough trained staff to oversee the unit; with proper supervision, the practice is quite acceptable as long as potential for violence is not high – anyone displaying questionable behavior toward others is removed or closely supervised • If use trauma-informed care as a standard, it won't matter how we house patients – needs of patients should be indicators of units to be placed on, no one size fits all in recovery; appropriately assign patients to units for benefit of treatment, not just restriction of freedom
NONSPECIFIC ❖ Brief, general comments	• Issue is not gender but protecting people who are vulnerable or have aggressive behavior that hampers safety or recovery; need better screening and keeping more vulnerable or potentially dangerous patients under closer care; more appropriate to place by acuity; patients should be housed by severity of behavior – men assault men and women, women; put people who are scaring others in their own unit and help them get better • Don't base decisions on people's opinions but on research, site data and careful analysis – treatment of people with mental illness is not any less worthy

Comments citing disadvantages of mixed-gender units fell into two main categories of *Therapeutic Recovery Environment* and *Vulnerability, Trauma and Patient Mix*. A third category was comprised of *Nonspecific* negative comments. These categories and illustrative responses are summarized in Table 18 below.

Table 18. *Community Input on Disadvantages of Mixed-Gender Units*

THERAPEUTIC RECOVERY ENVIRONMENT ❖ Quality of interpersonal interactions ❖ Impact on overall treatment milieu ❖ Practice standards and availability	VULNERABILITY, TRAUMA & PATIENT MIX ❖ Impact on overall experience of safety ❖ Potential for harassment, abuse and victimization of women ❖ Patient mix of vulnerable and dangerous
• Can focus on recovery more; coed atmosphere counterproductive due to distractions of the opposite sex ; focus should be on behavioral issues not socialization during hospital stay; causes problems relationship-wise • Opposite sex can add stress to a difficult situation; people need to be away from opposite sex to heal • Possible fears of opposite sex that would affect rehabilitation, competition for attention and detract from treatment; would reduce further anxiety at a time of crisis and limit potential for manipulation; puts patients in uncomfortable position not conducive to recovery • Taking individuals with mental illness and putting them with dangerous people creates tension and hostility; interferes with sense of privacy, security and therapeutic outcomes • Behavior may be improved on mixed-wards but staff needs to help individuals make competent choices among treatment alternatives	• Too much risk of inappropriate behavior; patients of opposite sex may lack appropriate boundaries or are not supervised closely enough and adds to stress and possible sexual contact or abuse; patients will feel safer; dangerous situation; so no one gets hurt; potential for manipulation and intimidation by opposite sex; bad idea safety-wise • Experiencing mental illness is difficult enough, why add element of sexuality to the mix, tempt individuals with little impulse control over behavior and make work of staff more difficult; too much access to inappropriate behavior regardless of how well supervised • Unsafe/uncalming environment for those already in vulnerable state, especially females; women more vulnerable and at increased risk of harm from harassment, discomfort, abuse, assault; men give the women reason to feel unsafe • Patients are very sick and many women are already traumatized; higher proportion of females who have been physically or sexually assaulted by men and they should feel secure to facilitate treatment; could be possible with enough staff to supervise but reservation mixing vulnerable people and women with issues of past abuse who could be victimized by men on the same unit
NONSPECIFIC ❖ Brief, general comments	
• Bad idea, oppose/no; should be separate; trouble waiting to happen	• Shouldn't put dangerous patients together with vulnerable of both genders – creates environment likely to result in sexual and physical assaults; females and vulnerable males feel safer in less triggering environment – separate hypersexual males from both sexes; women may be victims of sexual abuse or domestic violence and can be uncomfortable - men with histories of these crimes need to be separated

Opinions about Single-Gender Units. With respect to the second question on having patients reside on all-male or all-female units, approximately 66% of respondents cited predominantly advantages, and approximately 34% cited predominantly disadvantages. Comments citing advantages of single-gender units fell into the two main categories of *Therapeutic Recovery Environment* and *Vulnerability, Trauma and Patient Mix*. A third category was comprised of *Nonspecific positive* comments. The categories and illustrative responses are summarized in Table 19 below.

Table 19. *Community Input on Advantages of Single-Gender Units*

THERAPEUTIC RECOVERY ENVIRONMENT ❖ Quality of interpersonal interactions ❖ Impact on overall treatment milieu ❖ Practice standards and availability	VULNERABILITY, TRAUMA & PATIENT MIX ❖ Impact on overall experience of safety ❖ Potential for harassment, abuse and victimization of women Patient mix of vulnerable and dangerous
• Though isn't normal to segregate sexes during the recovery process, seems safe and smart; fine, if helps individuals focus on their recovery; less distraction; less stressful for healing; men and women will feel more comfortable and the recovery process more successful; should be working on their issues, getting well; less interference with therapy • May find it easier to relate to same sex; so women won't have their therapy interrupted by men; decreased anxiety and some women may not be comfortable residing with the opposite sex due to privacy and space • Could be beneficial and offered as an option based on patient preference and staff to create sense of security and patient-centered care; wouldn't have an issue with them but should be based on consumer preference then staff; some patients do fine on mixed units and some better on single-gender -- ideally hospital could maybe have both types to give patients and caregivers options; mixed gender not an issue but some clients are easily manipulated or intimidated by opposite sex and may have better therapeutic stay on separate units	• Much safer; safest situation for women; protects patients and staff more effectively; female clients will feel safer with all women and have less paranoia about men • Avoids vulnerable people being taken advantage of; decreases potential for victimization between residents; segregation eliminates possibility of male on female sexual assaults • Some have been abused by opposite sex and have triggers; men won't be tempted; would make men and women who have been harassed by opposite sex feel safer; because of trauma, important for women who feel safer on all-female unit • Fine if facility can't have good screening system; first choice but problem is with severity and sufficient staff; may be circumstances that warrant mixed units though at times same-sex facilities must be mandated by staff for good of patient; hopefully, safer treatment option for men and women who are vulnerable and limited in judgment and impulse control • For particular patients whose history makes it unsafe for them to be in an environment with the opposite sex, placement on a same-gender unit may be indicated based on professional evaluation; violent patients should be kept as separate as possible from all other patients
NONSPECIFIC ❖ Brief, general comments	
• Makes sense; if feasible, better option; would be fine, too; would be a good change	

Comments citing disadvantages of single-gender units fell into two main categories of *Therapeutic Recovery Environment* and *Patient-Centered Treatment*. A third category was comprised of *Nonspecific* negative comments. These categories and illustrative responses are summarized in Table 20 below.

Table 20. *Community Input on Disadvantages of Single-Gender Units*

THERAPEUTIC RECOVERY ENVIRONMENT ❖ Quality of interpersonal interactions ❖ Impact on overall treatment milieu ❖ Practice standards and availability	QUALITY OF CARE & PATIENT-CENTERED TREATMENT ❖ Focus on safety and quality of care ❖ Role of staff, supervision and training ❖ Screening and treatment for vulnerability/risk
• Provides degree of safety while under care but doesn't reflect society and may create false security; limits experiences to share with each other and should only be by choice; can be therapeutic for men and women to be with each other; makes little sense to restrict sexes from learning from one another if goal is to reintegrate back into society; we're grown adults and should be with other people, male or female; while such units may put people at ease over safety concerns, they will tend to increase tension and hostility less prevalent on mixed units and can be counterproductive • Makes mental health recovery place more like a jail, prison-like setting; can be viewed as a move to corrections approach versus focusing more on person-centered, trauma-informed care • Archaic, based on other hospitals familiar with and where coed works out fine • Not conducive to reducing stigma; should be based on competent research and data informed judgments, not on what's popular with the public or press; problems are likely not related to gender issue – though makes for great media and political scrutiny • Not necessary for the general population – violence can occur on same-sex units as well and having a recovery focus would contribute more to a healing, safe environment in the long run than segregation	• Wouldn't focus on gender segregation – create a respectful environment, segregate troublemakers; problem isn't mixing patients of different gender but quality of care- that should come first • Issue isn't keeping people separate but supervision, trained staff and better screening to keep vulnerable/potentially dangerous people under closer care; staff need to care more and walk around to see what's going on • Treat people for their problems, not demographics, and if people can't behave acceptably among peers, they should be treated on separate units with staff to meet their special needs; no segregation of men and women – find a place for people who are most destructive instead; important to do what's best for individualized patients – one may be comfortable on mixed unit and would be nice if another with trauma had a choice • More appropriate response is to isolate high risk male patients from women rather than remove women to separate unit – conveys that sexual aggression is related to individual high-risk men and reduces stigma of being on a women-only unit; gender mix doesn't matter, male to male and female to female can be just as unsafe or violent • This approach can be used for setting up units with increased supervision of patients at greater risk for violence; better to segregate patients by degree of potential for violence with increased supervision; segregation of all patients is not needed; don't see this as an issue of male-female but rather as predatory and vulnerable, regardless of sex
NONSPECIFIC ❖ Brief, general comments	
• Not good idea; like coed better but would be fine; not much benefit; fine but not necessary	

DISCUSSION

The purpose of this study was to conduct a detailed evaluation of the current practice of mixed-gender units at BHD, specifically in the context of patient sexual safety. To this aim, the study assessed BHD inpatient perceptions of safety on the current mixed units as well as preferences for single-gender units; examined BHD staff perceptions of patient sexual safety on the inpatient units, effectiveness of current safety practices and attitudes toward gender unit options; communicated with other public psychiatric hospitals regarding the gender configuration of their acute adult units; and obtained input from community stakeholders on male and female patients residing on the same and single-gender units, and recommendations to improve quality of care in the acute hospital.

BHD Patient Perceptions

Most of both male and female patient respondents reported feeling somewhat or very safe on a mixed-gender unit. The majority of them explained that their feeling safe related to positive interpersonal interactions and denial of concerns about aggression. Almost 88% of all patient respondents reported that they felt somewhat or very safe with men and women patients on the same unit. More than 90% of male patient respondents felt somewhat or very safe with males and females on the same unit. Nearly 84% of women felt somewhat or very safe with male and female patients on the same unit. The predominant explanation provided by male respondents for feeling safe centered on potentially beneficial interpersonal interactions and denying aggression was a concern, although some respondents did fear there would be more fights on an all-male unit. They also cited that unit and security staff and their own self-advocacy contributed to their feeling safe. The predominant explanation provided by female respondents feeling safe focused on the positive interpersonal interactions of having male patients on the unit and feelings of being safe from aggression. These women also cited that unit and security staff and their own self-advocacy contributed to their feeling of being safe on the unit. The small percentage of men and women patients who felt unsafe on a mixed-gender unit was concerned about safety from aggression.

Respondents indicated that they would feel safer on a mixed-gender unit with improved interpersonal interactions and with unit and security staff presence, behavior and monitoring. For male patient respondents, most indicated that what would make them feel safer was concerned with unit and security staff presence, behavior and monitoring. For women patient respondents, most indicated what would make them feel safer were improvements in overall interpersonal interactions and unit and security staff presence, behavior and monitoring.

Almost 50% of male and female patient respondents did not prefer to be on a same-gender unit. The primary reason cited for this finding was the perceived value of interpersonal interactions between patients and the negative impact a single gender unit would have on these interactions. A secondary, less predominant, reason was the potential for more aggression on an all-male or all-female unit. Only 15% of male patient and 29% of female patient respondents indicated that they would prefer a same-gender unit if it were available. The women who did prefer an all-female unit cited the positive impact of female-to-female interpersonal interactions, and did cite concerns about male aggression on a mixed-gender unit. Thirty percent of both male and female respondents were unsure of their preference for a same-gender unit. Of note, however, were

their explanatory comments that cited mainly positive features of interpersonal interactions with both men and women on a unit.

Only one-quarter of the total of male and female patient respondents indicated that they would feel safer on a same-gender unit. A higher percentage of men would feel less safe (38%) than more safe (23%) on an all-male unit. The men who said they would feel less safe on a same-gender unit were mostly focused on the potential for aggression. Male respondents who gave reasons for feeling safer on a same-gender unit cited interpersonal benefits. A slightly higher percentage of women responded that they would feel less safe (32%) than more safe (29%) on an all-female unit. Women who said they would feel less safe on a same-gender unit were mostly focused on the potential for interpersonal conflict between women. Those who responded that they would feel safer on a same-gender unit cited safety from aggression and expected improvements in interpersonal interactions.

Women did not express a definitive preference for a women's-only lounge to be made available on the unit. Of the women who were opposed (39%) to a women's-only lounge, the majority of their reasons cited an expected negative impact on interpersonal interactions. The remainder of their comments cited expected verbal and physical aggression between women. Of the women who would prefer (32%) that there be a women's-only lounge on the unit, most reasons centered on an expected benefit in their interpersonal interactions and shared communication with other women. Only a few comments referenced a vague feeling that they would feel safer. The comments by the unsure or neutral group (29%) of women emphasized no problems with the current arrangement of a shared lounge with men on the unit.

BHD Inpatient Staff Perceptions

Most staff respondents thought that men and women patients are somewhat or very sexually safe residing on the same unit. More than 60% of staff responding to the survey thinks that men and women patients are somewhat (52%) or very (9%) sexually safe residing on the same unit. Nearly 40% of staff respondents think that men and women patients are somewhat (27%) or very (12%) sexually unsafe residing on the same unit. Staff respondents' sexual safety concerns for both men and women residing on the same unit were related to the individual's vulnerability to sexual harassment, intimidation, exploitation and/or abuse, and the unit configuration, staffing pattern, and patient mix. Staff respondents indicated that most (53%) of their concerns for women patients' sexual safety were related to the women's vulnerability to sexual harassment, intimidation, exploitation and/or abuse. Staff also noted that the unit configuration, staffing pattern, and patient mix contributed to their sexual safety concerns for women on the unit, and identified concerns about women initiating or provoking sexual activity. Staff respondents indicated that most (46%) of their concerns for men patients' sexual safety were related to some men being vulnerable to sexual harassment, intimidation, exploitation and/or abuse. Staff also noted that the unit configuration, staffing pattern, and patient mix contributed to their sexual safety concerns for men on the unit, and identified concerns about men initiating or provoking sexual activity. Staff respondents identified that both men and women raised sexual safety concerns about vulnerability to sexual harassment and intimidation; being concerned about personal boundary violations; and general (nonsexual) safety concerns. Nearly half of staff respondents said that men usually expressed no sexual safety concerns, and nearly one-quarter said women did not raise any sexual safety concerns.

Current practices were predominantly rated by staff respondents as being somewhat effective for ensuring the sexual safety of patients on the unit. Locked community bathrooms and the unit zone surveillance system were the highest rated practices with more than 40% of staff respondents rating them as very effective. Cross shift communication of special risk patients, the separation of bedroom hallways for men and women, and behavior observation for special risks were other practices rated by about one-third of staff as being very effective. In regard to other suggestions to improve sexual safety on the mixed-gender units, the largest percentage (32%) of staff respondents suggested an improved staffing pattern. Additional suggestions included better supervision and training of staff, better teamwork and hospital configuration of patient mix.

Nearly half of staff respondents thought it would be somewhat or very helpful for managing sexual safety on the units for BHD to develop plans for an all-women's unit. This group of respondents thought that this would reduce or eliminate sexual harassment and contact and could better serve the subset of women with sexual abuse and trauma issues. Unsure or neutral respondents cited the benefit of patients being able to interact and learn from the opposite sex on mixed-gender units and were concerned about not being able to control or prevent all sexual contact, including same-gender activity. Those not viewing the unit as being helpful were also concerned about same-gender sexual activity and felt that patients need to function in a normalizing environment similar to the community. Nearly half of staff respondents thought it would be somewhat or very helpful for managing sexual safety on the units for BHD to develop plans for an all-men's unit. Respondents thought that this could particularly help high-risk men from taking advantage of vulnerable females and provide a safer, less violent environment for the rest of the patient population. Those respondents that were unsure or not in favor of an all-men's unit cited concerns about the unit being more violent than a mixed-gender unit, that vulnerable males may be abused, and same-gender sexual behavior.

Only about one-quarter of staff respondents were in favor of a women-only lounge, citing it as a safe and secure place for women to go to when feeling threatened. Those staff respondents not in favor or unsure indicated that inappropriate sexual behavior occurs in places other than lounge areas, and that the area would require close monitoring by staff. Most staff respondents were unsure or did not think that having a men-only lounge on a mixed-gender unit would improve sexual safety. They indicated that inappropriate sexual behavior occurs in places other than lounge areas, and the area would require close monitoring by staff. Only one-fifth of staff respondents were in favor of a men-only lounge.

As for staff preference for type of unit work assignment, nearly half of staff respondents would not prefer to work on an all-women's unit. Primarily this was due to their concerns about having to deal with stressful demands, and secondarily their viewing the benefits of a mixed-gender recovery environment that reflects the community to which patients will return. Similarly, most staff respondents did not prefer or were neutral or unsure about working on an all-men's unit due to the potential for aggression and violence. Most staff respondents preferred to work on a mixed-gender unit due to the variety of patient needs and personalities of this arrangement, and the benefits of the current mixed-gender recovery environment that reflects the community.

Public Psychiatric Hospital Practices

Information from 9 Midwest public psychiatric hospitals with civil acute units revealed that none of them have single-gender civil acute units and most stated that their units have been coed for as long as they can remember. Of the hospitals that also have formally-designated state forensic units, some of these units are single-gender, some all-male and some all-female. Practices some hospitals use for patients identified at increased risk for dangerous behaviors include heightened levels of observation and monitoring to reduce opportunity for acting out, as well as a psychiatric intensive care unit to manage particularly violent or high-risk patients.

Community Stakeholder Input

Community stakeholders shared a variety of responses about having male and female patients residing on the same acute adult inpatient units, as well as thoughts about having patients reside on all-male and all-female acute inpatient units. This wide range of opinions is to be expected as some respondents are more likely to have direct experience with BHD acute inpatient services and/or acute hospital operations, whereas those groups of respondents extending further into the community have more an indirect and varied information base. Nearly half of respondents offered comments citing advantages of mixed-gender units, and slightly more than a half cited reasons against such an arrangements. Consumers and families tended to be more favorable in their opinions of men and women on the same units, whereas advocates and "other" type respondents were more skewed in their focus on disadvantages as compared to advantages. The advantages of mixed-gender units fell into the two main content categories of *Therapeutic Recovery Environment* (beneficial effect on interpersonal interactions and treatment milieu, and practice standards) and *Quality of Care & Patient-Centered Treatment* (core issues of quality of care, staffing/supervision and screening/treating of most dangerous/vulnerable). Disadvantages of mixed-gender units fell into two main categories of *Therapeutic Recovery Environment* (negative impact on interpersonal interactions and treatment milieu) and *Vulnerability, Trauma and Patient Mix* (impact on safety, potential for harassment, abuse and re-traumatization of women and patient mix of vulnerable and dangerous).

With respect to having patients reside on all-male or all-female units, approximately two-thirds of respondents shared benefits of gender segregation and one-third focused predominantly on disadvantages. The advantages of single-gender units fell into the same two main categories, described above, as did the disadvantages of mixed units: *Therapeutic Recovery Environment* and *Vulnerability, Trauma and Patient Mix*. Likewise, responses focusing on disadvantages of single-gender units fell into the same two main categories, described above, as did the advantages of mixed units: *Therapeutic Recovery Environment* and *Patient-Centered Treatment*. Of interest is that a number of respondents, including consumers, regardless of their opinions about unit gender mix, argued that gender should not be the primary factor taken into consideration in determining placement, and that quality of care and recovery focus will not be adequately addressed by resort to single-sex segregation. Other factors, such as severity of illness and risk of violence, are equally if not more important in creating a safe and therapeutic environment.

LIMITATIONS

This study is limited by the sample of respondents who participated in the various phases. BHD inpatients were sampled over a restricted period of one month and were self-selected. Their opinions may not be necessarily representative of all BHD acute inpatients. Participants may have felt unwilling to appear critical of care while in the hospital. BHD staff respondents were self-selecting and the generalizability of their opinions is limited by the overall response rate. In addition, participants might have had particular concerns around issues of patient sexual safety and gender configuration of acute units. The findings on single-gender units at public psychiatric hospitals represent the practices of those facilities that responded. It is unknown if those who did not respond failed to do so because they had no experience with single-gender units to share, or due to other customary reasons. The process of obtaining input from community stakeholders was an open request for opinions and was not based on systematic sampling procedures. As such, the opinions only represent those individuals who chose to respond and may not be representative of community stakeholders in Milwaukee County as a whole. Additionally, it is unknown to what extent those who provided opinions have knowledge of the operation of the BHD acute inpatient units, or psychiatric inpatient units in general, and whether they have more or less favorable perceptions of the services provided on these units. For example, some comments indicated that the respondent had erroneous assumptions about the acute inpatient units (e.g., units could be single-gender and patients meet in a coed TV room and dining room; male and female patients shouldn't live together but have opportunity to interact at coed social and recreational activities).

RECOMMENDATIONS

Based on this extensive study, The Gender Unit Work Group recommends a configuration of the 4 Acute Adult Inpatient Units that would create a 12-bed *Intensive Treatment Unit (ITU)* that is expected to be predominantly male, a combined *Women's-Option/Med-Psych Treatment Unit*, and 2 remaining mixed-gender units designated as *General Acute Treatment Units*. The new configuration of the Acute Adult Inpatient units and bed capacity would be as follows:

ACUTE ADULT UNIT CONFIGURATION	
• Intensive Treatment Unit (ITU)	12 beds
• Women's-Option/Med-Psych Treatment Unit	24 beds
• General Acute Treatment Unit	24 beds
• General Acute Treatment Unit	24 beds
<u>NEW CAPACITY</u>	84 beds

Unit Configuration Model

The *Intensive Treatment Unit* would be designated for patients with high risk for aggression and violence, including sexual acting out. The ITU can be presumed to be predominantly, if not

always, all male. Most women with elevated risk of violence can usually be managed in the general population with enhanced monitoring. Though the ITU concept will need to be further developed, the Work Group is firm in its stand that the unit not be considered nor referred to as a "secure" unit [all BHD acute units are secure and locked], a "forensic" unit [BHD has no formally designated forensic services or specialty nor is it in a position to add such] or a "detention" unit [BHD is not a correctional facility]. The ITU must have reduced beds, as is the practice in other hospitals with such units. We recommend the ITU have a capacity of 12 beds. The implication is that BHD would have to be prepared to reduce its overall Acute Adult Inpatient bed capacity by 12 beds to a total of 84 beds. The benefit of the ITU is that it achieves separation, from the general acute patients, of predominantly those male patients with higher violence potential. This separation addresses the main safety concerns of staff and patients, especially vulnerable male patients and most female patients.

The needs of women patients, however, are more complex due to higher rates of trauma and may not be fully resolved by segregation of high-risk men. For this reason, the Work Group recommends that one unit be designated as a combined *Women's-Option/Med-Psych Treatment Unit*. One of the current adult units has historically been partly dedicated to treating geropsychiatric patients and younger patients with complex medical-psychiatric disorders. BHD Acute Adult Inpatient admission data from 2009 – 2010 YTD were reviewed using an age cut-off of 60 and older (though not "geriatric" it errs on side of caution to allow for younger med-psych patients). At any given time, there are approximately 9 "geriatric/med-psych" patients on this unit. Per BHD current acute inpatient gender breakdown (59.8% male and 40.2% female), this equates to 5-6 men and 3-4 women. With a unit capacity of 24, this leaves 15 beds that are anticipated to be available as Women's-Option beds. These beds would be prioritized for female patients at heightened risk of vulnerability to inappropriate sexual behavior, abuse and violence. Assignment would be based on medical staff assessment or patient choice, depending on clinical safety needs and bed availability. Though there will be a minority of generally older male patients on this unit, the anticipated risk is lower and can be planned for. With a new overall bed capacity of 84 beds, the female beds on this unit (Women's-Option plus Med-Psych beds) would equate to more than half of the total estimated adult female inpatient beds.

The remaining two units would be mixed-gender *General Adult Treatment Units*, with separate bedroom hallways for male and female patients as is currently the case. The separation of those patients with highest potential risks of both violence and vulnerability would, hopefully, allow these units to better serve the general patient population in a normalizing, therapeutically focused milieu which many patients value.

Rationale

Segregation and mixing of genders is not an all or nothing approach. It is not about one answer. It is a process. There are reasons for and reasons against each option. To some, segregation by gender of all of the units seems to be the obvious choice. However, the Work Group was unanimous in its conclusion that, though appearing progressive on the face of it, this approach is compartmentalized and rigid. The proposed configuration offers a blended model that covers the main bases in a thoughtful, flexible and pragmatic way. It is not one-size-fits-all. It offers a more individualized, needs-based, trauma informed care approach than simple division by gender. A strong impression was given by a number of patients and consumers that a recovery focused, destigmatizing and normalizing treatment environment is desirable to them. The model addresses many of the concerns of BHD staff, patients, community consumers, and stakeholders and

coheres with accepted practices of public psychiatric hospitals. Other than requiring a 12-bed reduction in overall Acute Adult Inpatient capacity, the recommendation is feasible and offers flexibility with census management. It acknowledges gender-based safety concerns while affirming the current improvement practices already being implemented.

Next Steps and Implications

The recommendation of the Gender Unit Work Group is advisory to the BHD Administrator. Should it receive endorsement, the proposal will need to be presented to the full BHD clinical and administrative-finance leadership teams. Then a detailed planning process will need to be undertaken, addressing considerations in three main domains:

1. Human Resource – Determination of staffing composition and pattern of the ITU; staff selection (preference is for selection by skill versus seniority) and labor union issues; Medical Staff recruitment to fill vacant acute inpatient positions
2. Program Development – Development of model for ITU and Women's-Option units, admission/transfer criteria, programming needs, staff training
3. Physical Environment/Operations – Plans for reduction in bed capacity and census management, physical environment audit of proposed ITU unit location and completion of any necessary environmental modifications

To allow for the planning required, the estimated timeline for implementation of the unit configuration recommendation is during the Quarter 3 of 2011 (July to September). Regardless of the final decision, BHD shall continue the current practices, policies and guidelines in place to maintain a safe, therapeutic unit environment. Patient risk assessment, interdisciplinary treatment planning and effective patient monitoring processes are essential components. Staff supervision and active patient intervention are recognized as factors that can contribute to reduction of violence of all types. Peer specialists and client rights specialists provide essential advocacy services to help represent patient interests and support dignity, respect and autonomy.

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APPENDIX A

Contents

- I. BHD Acute Inpatient Questionnaire – *Acute Adult Inpatient Gender Unit Preference Survey*
- II. Content Analysis of Male and Female Patient Responses to Open-Ended Items

ACUTE ADULT INPATIENT GENDER UNIT PREFERENCE SURVEY

We would like to know your opinion about men and women being on the same unit here. Your answers are confidential and will not influence the services you receive.

Date of Survey: ____/____/2010	Date of Admission: ____/____/2010
Gender: ____ Male ____ Female	Race/Ethnicity (check one):
Age: ____ years	____ African American ____ White/Caucasian
Acute Unit ____ 43A ____ 43B	____ Hispanic/Latino ____ Native American
____ 43C ____ 43D	____ Asian/Pacific Islander ____ Other

		NO	UNSURE/ DOESN'T MATTER	YES
1.	Would you prefer to be on an [say same gender as pt.] all-men's/all-women's unit if it were available?	1	2	3

➤ 1a. Explain why.

		VERY UNSAFE	SOMEWHAT UNSAFE	SOMEWHAT SAFE	VERY SAFE
2.	How do you feel with men and women patients on the same unit?	1	2	3	4

➤ 2a. Explain why.

- 2b. What would make you feel safer?

		LESS SAFE	NO DIFFERENCE	MORE SAFE
3.	How would you feel if there were all [<i>say same gender as pt.</i>] men/women patients on the unit?	1	2	3

- 3 a. Explain why.

THE NEXT QUESTION IS FOR WOMEN ONLY:

		NO	UNSURE/ DOESN'T MATTER	YES
4.	Would you prefer there to be a <u>women-only</u> patient lounge available on the unit?	1	2	3

- 4a. Explain why.

THANK YOU FOR COMPLETING THIS SURVEY!

Question 1. Would you prefer to be on an all-men's unit if it were available? (1a.) Explain why.

NO

UNSURE/DOESN'T MATTER

YES

SAFETY FROM AGGRESSION

- Less fights if mixed – 2
- M would kill and fight each other – 2
- Some M are homosexual so would not make us safe
- Don't feel comfortable around a lot of guys

- W touching other people too much
- Could be sedated and clothes half off and lead to charges of indecent exposure
- M trying to mess with the girls
- Because what's going on in the media, pt had sex with a W and had a baby
- Staff should be watching what's going on so pts are safe

INTERPERSONAL INTERACTION

- Want to be around M and W – 7
- W give a different point of view, can learn from them – 3
- In real world, have to deal with multiple genders – 2
- Integration of M and W facilitates healing
- Meet new people, socialization – 5
- Different people to talk to – 5
- Like to see variety of people on unit – 3
- W have soft touch, more understanding
- Like to see a smiling face
- Get along better with W
- Pts need help
- Keep to myself
- M are rude
- Pick up bad habits
- Don't want to look at all M all day
- Boring

- Nice to have a mix of cultures
- Like to be around different people
- Nice to see a pretty face – 2
- People need to get along – 2
- W are trouble - 2

- Everyone would have their own space
- Don't feel appreciated

OTHER

- Get mixed emotions
- Poison in food

Question 1. Would you prefer to be on an all-women's unit if it were available? (1a.) Explain why.

NO

UNSURE/DOESN'T MATTER

YES

SAFETY FROM AGGRESSION

- There haven't been any problems sexually with M and W on the unit
- W would just fight
- Because W are always arguing over hair products

- M are not going into W's rooms, so I don't have fears about my safety

- Men try to intimidate W
- Sometime I feel safer when I'm around all W
- Because you have to watch what you're wearing with all M around
- M act out more – I was called a derogatory name this morning by a M
- M might swear at us or hurt us
- Because M might want to have sex, sometimes it makes me nervous to be around M
- Lot of interactions between the sexes, at times disruptive to safety and treatment

INTERPERSONAL INTERACTION

- Good to meet new, different people, I like a variety of people – 5
- Would like to meet M and W, prefer M and W, been with M and W all my life – 7
- Like having input/talking to both genders, hearing M talk and interacting with them – 4
- You need to talk to M and give each other feedback, can teach each other lessons – 2
- Don't get along with W very often, W can't get along with each other – 3
- W are catty, get into "he said she said" kind of talk, are too bitchy when they get together as a group, are not as nice to each other as they should be, would nag at each other and try to control – 5
- They think they know everything and talk too much
- W like to form cliques

- I like to see different people very day, like to see a mixture of people – 2
- We're all human and should be around each other and get along, as along as we all get along – 2
- We're all treated the same and here for the same reason
- I can get along with anybody, I'm flexible – 2
- I don't let M bother me most of the time
- I haven't had any problem with anyone here
- Doesn't matter, I'm a little old lady
- W are louder than M
- All the hospitals I've been in have M and W on the same unit so I can't compare to anything else

- Feels better with all W, personally like W better than M – 2
- Get along better with W than M – 3
- W are easier going, fun – 2
- W have a lot in common, could talk about our children and women's issues
- More privacy with just W
- Lot of interaction between the sexes, at times it's healthy
- M are devils

OTHER

- Cause M and W wouldn't get along

- Because I can change without M being around
- Neither, I'd like to go home

Question 2. How do you feel with men and women patients on the same unit? (2a.) Explain why.

VERY UNSAFE/SOMEWHAT UNSAFE

SOMEWHAT SAFE/VERY SAFE

SAFETY FROM AGGRESSION

- Would be a fight – 3
- Some W touching people all the time
- Other people can get into arguments
- Pts sometimes pour coffee on another pt

- Some M make me feel safe
- No one gets hurt, no fighting or killing
- W usually not violent, though some can be
- Never know when someone's going to snap – 2
- Would be lots of fights with all M, More M will be trouble other pts try to start fights – 3
- Pt threw coffee on me

INTERPERSONAL INTERACTION

- M and W get along, communicate – 6
- We can talk it out – 3
- + Here to get help, focus
- W tell what they see
- Depends on people on the unit and attitudes
- Both M and W can be moody
- W over-exaggerate more than M, like to fuss – 2
- Some W approach you
- Some W have a bad attitude

UNIT AND SECURITY STAFF

- Because of social worker and nurses
- Staff watch people
- Feel protected by CNAs
- Security on unit
- Staff and security act fast if pts get aggressive and loud; staff able to handle any problems – 2
- Staff are busy and sometimes can't get to us right away
- Staff tease pts too much

SELF ADVOCACY

- I walk away, don't argue with people
- I know how to separate myself from people - 2
- I'm a huge guy

Question 2. How do you feel with men and women patients on the same unit? (2a.) Explain why.

VERY UNSAFE/SOMEWHAT UNSAFE

SOMEWHAT SAFE/VERY SAFE

SAFETY FROM AGGRESSION

- When it's all girls, I feel safer
- M and W like to fight each other
- M are devils
- Besides being called a name this morning, some of the M try to go down the W's hallway
- Because people are yelling for help at night and I don't know what's happening to them
- There's people here doing things to me that make me feel like they don't want to be around me – both pts and staff

- M don't try to do anything to the W on the unit; don't have problems with the M, haven't shown themselves to be predators towards me; no one tried to come in my room and there's a no-touch policy – 3
- No one would touch me, no pt would touch each other
- I haven't seen any violence since I've been here; no one has tried to do anything bad – 2
- M would take notice if a W was being mistreated and would do something about it; the M will defend us W, being around M makes me feel safe – 3
- Because when W try to get in a fight, the M pts will try to help break it up
- A W could punch me for no reason as could a M
- I feel threatened by some of the M – 2
- Sometime, depending on the person there's been sexual contact in the past
- Some of the W make me feel unsafe also, if they are aggressive or intimidating
- I get scared sometime
- Depending on their illness, all W on the unit would make me feel safe
- The W would protect me

INTERPERSONAL INTERACTION

- Because of different age groups; young people should be together and old people with each other because young try to get you caught up in their issues or to do things for them

- M and W need to get along with each other – 2
- M and W get along better
- Used to being around M and W – 2
- We should have different kind of people from all over, never know how they will respond to you – 2
- The M don't bother me, they are not mean, I don't have any problems, M are nicer to W here than on the street – 5
- M will watch over W, we have each other's back – 2
- M always like to talk to the W, we can work together – 2
- Don't know the other people very well, matter of meeting them, talking and making friends
- I get along with anyone but need younger pts on unit
- Sometime think people are my friend but they're not, so feel somewhat safe

UNIT AND SECURITY STAFF

- If you have a problem, you can tell the nurse and they take of it
- Staff manages behavior by redirecting people as needed
- Staff have everything under control and there's security staff to help if necessary
- It's improved since CNAs are sitting in different areas of the
- Pts who need to be watched are supervised more carefully
- People are always walking around

SELF ADVOCACY

- I feel safe with anyone – 2
- I will stand up for my rights

OTHER

- I don't like being here – 2

Question 2. How do you feel with men and women patients on the same unit? (2b.) What would make you feel safer?

VERY UNSAFE/SOMEWHAT UNSAFE

SOMEWHAT SAFE/VERY SAFE

UNIT AND SECURITY STAFF

- Security
- Nobody make me feel safer

- Security – 19
- Staff – 11
- The Zone – 3
- Staff need to get their act together, do their jobs – 6
- Don't trust security – 2

INTERPERSONAL INTERACTION

- More M - 2

- Respect and boundaries, caring, if patients could get along – 2
- Family and friends - 3
- No threats
- If people wouldn't steal

SELF ADVOCACY

- I will make myself feel safe

- I know how to protect myself – 3
- Myself - 2
- I feel safe already – 2

OTHER

- Sheriff
- No poison

- In my own house, not in hospital with strangers – 2
- Access to personal belongings, music
- Good environment
- Sheriff
- God
- Contact with Social Security Office because of concern about my benefits

Question 2. How do you feel with men and women patients on the same unit? (2b.) What would make you feel safer?

VERY UNSAFE/SOMEWHAT UNSAFE

SOMEWHAT SAFE/VERY SAFE

UNIT AND SECURITY STAFF

- Security
- Staff could help people get along

- Staff, my nurse, doctors – 12
- Security – 12
- CNA
- Should have more than 1 CNA on each unit per shift to take care of the M
- Make certain staff give me the right medication so I can get well
- Staff should pay more attention to the pts, people who are more sick – 2
- I'd feel better if they'd control the noise; I feel threatened when people yell, staff should have them in their room
- If staff would treat us the way they want to be treated, with more respect
- Sometime staff makes us feel invisible when we go to the desk, they ignore us when we have important questions

INTERPERSONAL INTERACTION

- If people wouldn't get angry and swear
- People respecting their elders
- If M and W have separate units; that M are out of my life – 2
- More people who are here to get professional help
- Curtains dividing the rooms so no one is watching you and you have some privacy to heal
- I couldn't get out of my room this morning and that makes me uncomfortable

- No issue with the M
- I need to get to know people better
- Family - 2
- W friends
- Mixing of genders is an issue at times
- The M, not staff; Feel the pts will help me instead of staff - 2

SELF ADVOCACY

- Myself – 2
- Take my medications on time – 2
- They can talk to me but not touch me, touching my hand would be OK
- Mind my own business

OTHER

- Sheriff and police

- Cops - 2
- I feel safe now - 3
- A cleaner environment
- God
- Nothing – 3

Question 3. How would you feel if there were all men patients on the unit? (3a.) Explain why.

LESS SAFE	NO DIFFERENCE	MORE SAFE
SAFETY FROM AGGRESSION		
- Fights, someone will get killed – 18 - Sexual assaults, M get “funny” ideas— 3 - M like to start trouble	- I wouldn’t feel threatened - 3 - Mixed feeling – men carry weapons	- No one would touch you - I can defend myself - M don’t start arguments like W
INTERPERSONAL INTERACTION		
- Enjoy W’s company; wouldn’t have emotional help from W, more compassionate – 2 - M have hidden agendas, don’t trust them - I have nothing to offer a M - Would feel like prison - Would need more activities to keep M calm	- I get along with everyone – 4 - Both M and W can get along – 2 - I walk away from drama - 2 - Everyone’s docile - What matters is if someone cares - All are strangers anyway	- More comfortable - Could get to know each other and do things together - M are more reliable - M are more protective - Women are nosy, they watch everything that goes on - Prefer M and W
OTHER		
		No poison

Question 3. How would you feel if there were all women patients on the unit? (3a.) Explain why.

LESS SAFE	NO DIFFERENCE	MORE SAFE
SAFETY FROM AGGRESSION		
• They like to fight and scream at each other; lot of W get into cat brawls; there'd be a lot of bruises on me – 6 • When I get around a lot of W, they threaten to hurt me	• M on this unit have not been harmful in any way; I don't feel threatened – 2 • We all need help and unit staff or security will intervene if needed – 2 • Anyone can have an acting out behavior problem • If a W attacked me, I could handle her • I don't argue with people • Staff knows what they're doing; if anyone acts out they intervene	• W don't fight; not as aggressive as the M; may form cliques but usually don't get violent – 3 • No M could hurt me; don't want any M making advances toward me – 2 • Don't feel afraid but feels like all W unit would be safer • W protect each other
INTERPERSONAL INTERACTION		
• Need mixed gender, need the openness of both M and W, all our peers – 2 • More tension with all W, too many W get on my nerves, W don't get along very well, they talk about each other or gossip, too many young women get upset about too many things, like doing things better than them – 5 • Don't like to be around all W, don't get along with W like I do M – 2 • W get bitchy when they get their period – 2 • W can be loud and domineering; having M around keeps them somewhat under control – 2 • Have less privacy with W around and boundary issues, they think they have the right to invade your personal space	• Wouldn't mind, I like W also – 5 • W should participate more, we should stick together but we don't • I don't have to worry about them • M and W are good together; both friendly with me – 2 • Some of the M are enjoyable	• All W stick together, we can watch one another – 2 • I can try to trust W, it's harder to trust M • Has to do with wearing appropriate clothing when M are around • I keep to myself • Depends on type of illness W has, some are more serious
OTHER		
• Men are like animals • I will not like it on unit if we share with M		

Question 4. Would you prefer there to be a women-only patient lounge available on the unit? (4a.)
Explain why.

NO	UNSURE/DOESN'T MATTER	YES
SAFETY FROM AGGRESSION		
• W like to argue and M don't • W like to fight; catty girls would get in a fight and staff couldn't get to us to intervene - 2 • W are jealous of each other an they want what you've got and they'll try to get it • M might try to protect us from others who try to hurt us	• Don't want to go in any room with someone alone, M or F	• Feel safer with all W in the room; would make me feel more safe; safer if I could go in a room without M and watch TV - 4
INTERPERSONAL INTERACTION		
• Need a mixture of M and W; still want to have a conversation with both M and W pts; like to meet different people - 5 • Don't like all W; not all W like other W; W don't get along well - 5 • Both genders are people; M and W should like each other and be together; OK the way it is - 4 • Feels more normal to have M and W around - keep it real, like in the community; healthier environment, like the rest of society and the world; M like to watch TV with us - 3 • Most of the M mind their own business • Stupid idea, only so much room on the unit, we should just all get along • If staff is watching the pts, there shouldn't be need for a separate lounge	• I will talk to all W • Works fine the way it is, don't care if M and W are in the same room - I'll talk to either; extra lounge would be a waste of money - 3 • Haven't had a problem with any of the M, people have been respectful; There are some nice and interesting M we like to talk to - 2	• W have more in common and could talk about things that don't concern M; we could talk about different issues, problems with just W; can talk about things that I can not tell M; can talk about personal business - 6 • I get along better with W, like to hang out with W better, W are friends - 4 • W might want to be alone with no M around - 2 • I trust W more than M • Good idea, by trying it they could observe if W liked it
OTHER		

APPENDIX B

Contents

- I. *BHD Acute Adult Inpatient Staff Survey: Patient Sexual Safety*
- II. Content Analysis of Staff Responses to Open-Ended Items

ACUTE ADULT INPATIENT STAFF SURVEY: *PATIENT SEXUAL SAFETY*

The BHD Gender Unit Work Group would like to know your opinions about the *sexual safety* of men and women patients residing on the same Acute Inpatient Units here. For the purposes of this survey, **SEXUAL SAFETY** refers to preventing and managing sexual behavior between patients – including sexual contact, harassment, exploitation, intimidation and assault.

PLEASE RETURN SURVEY TO DR. MARY KAY LUZI -CENTRAL ADMINISTRATION BY SEPTEMBER 30, 2010 via Inter-Office Mail or Placement in Locked Mail Box Outside Administration Suite 1046. Your answers are confidential. Only original printed surveys are to be used. Thank you for your time and participation. We value your input.

Gender: ☐ Male ☐ Female	Position : ☐ Medical Staff (MD/PhD/APNP)
	☐ Social Work/Rehab Services
Years of Employment at BHD: Years	☐ Registered Nurse
	☐ Certified Nursing Assistant
Years of Employment in Acute Adult Inpatient: Years	☐ Peer Specialists
	☐ Other (e.g., Dietician, Chaplain)

CIRCLE THE NUMBER IN THE BOX THAT BEST DESCRIBES YOUR ANSWER

		VERY UNSAFE	SOMEWHAT UNSAFE	SOMEWHAT SAFE	VERY SAFE
1.	How sexually safe do you think men and women patients are residing on the same unit in our hospital?	1	2	3	4

➤ 1a. What sexual safety concerns do you have for women patients on the unit?

➤ 1b. What sexual safety concerns do you have for men patients on the unit?

➤ 1c. What sexual safety concerns have women patients raised?

➤ 1d. What sexual safety concerns have men patients raised?

**** IF YOU HAVE NO EXPERIENCE WITH AN ITEM, LEAVE IT BLANK.**

2.	How would you rate the effectiveness of these <u>current</u> practices for ensuring the sexual safety of patients on the unit?	VERY INEFFECTIVE	SOMEWHAT INEFFECTIVE	SOMEWHAT EFFECTIVE	VERY EFFECTIVE
2a.	<u>Assessments</u> by PCS & Inpatient MD/PhD of special risks	1	2	3	4
2b.	<u>Recovery Planning</u> special risks treatment objectives & interventions	1	2	3	4
2c.	<u>Patient Education</u> on sexual contact policy	1	2	3	4
2d.	<u>Unit Zone Surveillance</u> system	1	2	3	4
2e.	<u>Morning Report</u> with both treatment teams represented	1	2	3	4
2f.	Cross Shift communication of special risk patients	1	2	3	4
2g.	<u>Behavior Observation</u> monitoring for special risks	1	2	3	4
2h.	<u>Bedroom Hallways</u> separate for men & women; no bed assignment beyond fire doors for women	1	2	3	4
2i.	<u>Locked Community Bathroom</u>	1	2	3	4
2j.	<u>Therapeutic Groups</u>	1	2	3	4
2k.	<u>Electronic Video Monitoring</u> of unit	1	2	3	4
2l.	<u>OVERALL EFFECTIVENESS</u> of current practices	1	2	3	4

- 2 m. For any current practice you rated as ineffective (1 or 2), explain why and your recommendation for improving it. (please list by item #)

3.	What other suggestions do you have to improve the sexual safety of men and women residing on the same units?
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	NOT AT ALL HELPFUL	NOT VERY HELPFUL	NEUTRAL/ UNSURE	SOMEWHAT HELPFUL	VERY HELPFUL
4. How helpful do you think it would be for managing sexual safety on the units for BHD to develop plans for an <u>All-Women's Unit</u> ?	1	2	3	4	5

➤ 4a. Explain why.

	NOT AT ALL HELPFUL	NOT VERY HELPFUL	NEUTRAL/ UNSURE	SOMEWHAT HELPFUL	VERY HELPFUL
5. How helpful do you think it would be for managing sexual safety on the units for BHD to develop plans for an <u>All-Men's Unit</u> ?	1	2	3	4	5

➤ 5a. Explain why.

		NO	NEUTRAL/ UNSURE	YES
6.	Would you <u>prefer</u> to work on an All-Women's Unit, if BHD had one?	1	2	3

➤ 6a. Explain why.

		NO	NEUTRAL/ UNSURE	YES
7.	Would you <u>prefer</u> to work on an All-Men's Unit, if BHD had one?	1	2	3

➤ 7a. Explain why.

		NO	NEUTRAL/ UNSURE	YES
8.	Would you <u>prefer</u> to work on a Mixed-Gender Unit (men & women), like BHD has now?	1	2	3

➤ 8a. Explain why.

		NO	NEUTRAL/ UNSURE	YES
9.	Do you think that having a <u>Women-Only Patient Lounge</u> on a Mixed-Gender Unit would improve sexual safety?	1	2	3

➤ 9a. Explain why.

		NO	NEUTRAL/ UNSURE	YES
10.	Do you think that having a <u>Men-Only Patient Lounge</u> on a Mixed-Gender Unit would improve sexual safety?	1	2	3

➤ 10a. Explain why.

**PLEASE RETURN SURVEY TO: DR. MARY KAY LUZI – CENTRAL ADMINISTRATION
BY SEPTEMBER 30, 2010. THANK YOU AGAIN FOR YOUR PARTICIPATION!**

1a. What sexual safety concerns do you have for women patients on the unit? (92 comments)

Vulnerability to Sexual Harassment, Intimidation, Exploitation, Abuse (53.3%)

- Being approached by others making sexual advances, being propositioned, verbally harassed, intimidated (7)
- W who are mentally retarded/cognitive impaired are vulnerable, lack capacity to say no (6) – (e.g., slower functioning W taken advantage of for cigarettes, food, provisions; vulnerable to sexually aggressive M)
- MI/psychotic state who otherwise wouldn't consent in normal state of mind (8) – (e.g., acute psychiatric pts, esp. manic, can be very unpredictable and impulsive and harassment esp. is difficult to prevent; due to mental illness, sexually preoccupied; afraid of the M and might consent to sex from fear of harm)
- W with trauma histories are very vulnerable to sexual predators and those sexually inappropriate due to power issues with M (3)
- Potential for sexual assault (5)
- Potential for sexual abuse (2)
- Being inappropriately touched (3) (e.g. unwanted touching difficult to stop in common areas of unit)
- Sexually inappropriate behavior (4)
- Sexually explicit comments
- Being victimized
- Inability to effectively manage hypersexual males with history of violence
- Exploitation by some M
- Violent M seducing W for sex, preying on the vulnerable ones (2)
- Sexually aggressive M pursuing pt on unit and trying to get contact information after discharge
- Being trapped in room with sexually aggressive M
- Not being assertive or able to advocate for self
- STDs, pregnancy, birth control
- Age and physical limitations (e.g., elderly, dementia)

Propensity to Initiate or Provoke Sexual Behavior (8.7%)

- Due to decompensation, sexually provocative behaviors themselves, can be sly in hiding actions (2)
- They get too close to the M and incidences do occur
- Not always the M – some W tell me he looks so fine, I can just grab him and hold him forever
- Roommates with bisexual W
- W who prey on both sexes
- W sought out by M pts more often than not are active willing participants and will take steps to set up meetings together
- When M and W are hypersexual, they look for partners and find many willing ones; rape is one thing but keeping people from being sexual when they're impulsive and sexually charged is different

Hospital Unit Configuration and Patient Mix (18.5%)

- M sexual predators routinely housed on same unit in close proximity to vulnerable F pts (6)
- When sexual predator/violent pt on unit, need extra milieu management to keep genders separate; though q 15 beh checks, takes only 1 minute to abuse someone (3)
- Keeping W on their side of the unit (2)
- Putting W in the M hall unless on 1:1 (2)
- Pts being placed in M hallway due to no female hall beds (2)
- M pts wandering into W room to use bathroom and W are exposed, vulnerable
- In rooms by self at night

Staffing Pattern (9.8%) (Adequacy and composition of staff for monitoring & duties) • Inadequate staffing – short staffing, decreased ability to monitor all pts (8) • Units are safe with the zones, but only if there is staff to do it
Staff Performance (3.3%) (Team work, staff supervision and training) • Verbally redirecting W pt who's sexually inappropriate and ask for help from RN and nothing's done • Staff not paying attention or believing it's happening • Knowing pt's history and potential to engage in sexual behaviors
Minimal to No Problems (6.5%) • None to little (4) • I feel W are now safe on the unit • OK with proper supervision & security

1b. What sexual safety concerns do you have for men patients on the unit? (84 comments)

Vulnerability to Sexual Harassment, Intimidation, Exploitation, Abuse (46.4%) • Sexual predator s may focus on vulnerable M, psychotic M (4) • Mixing developmentally disabled with general population (4) (e.g., cognitive or emotionally impaired M with sexually aggressive M) • M & W can be abused the same way because of mental illness (3) • Vulnerable M being targeted for physical abuse by aggressive M (4) • Being approached by M & F making sexual advances, propositioning, harassing (4) • Exploitation by some M & F (2) • Sexual assault (4) • Being sexually touched by M pts (2) • Being sexually touched by F pts • Being victimized • M with trauma histories who will not receive care they need if there are sexual predators on the unit (2) • At disadvantage because often neglected fact that they may fall victim to other M and are unlikely to report or protect self (2) • Acute psychiatric pts, esp. manic can be very unpredictable and impulsive, and harassment difficult to prevent • If put in room with M who's sexually active that could cause problems even with 15 min checks (2) • Often accused of sexual advances that may or may not be true due to manipulative W • Age and physical limitation differences • STDs

Propensity to Initiate or Provoke Sexual Behavior (11.9%)

- Sexually enticing W (3)
- Due to decompensation, engaging in sexually provocative behaviors themselves
- M who prey on both sexes (2) – (e.g., many M have potential for soliciting sex from other M as well as W)
- Sexually inappropriate behaviors (2)
- Some talk sexual and I tell them this is a hospital and is not tolerated here
- M get too close to the W and incidents occur

Hospital Unit Configuration and Patient Mix (11.9%)

- Keep M on one side of the unit (2)
- When M are in the F hall unless on 1:1
- If they are roommates with bisexual M or sexually aggressive M (2)
- W wandering in M's rooms
- Even large M complain of safety concerns when violent pts on the unit – assaultive/repeat antisocial pts shouldn't mix with regular population (2)
- Predatory clients can be identified and should be segregated on a special unit
- Prison separation causes same sex sex

Staffing Pattern (13.1%)

(Adequacy and composition of staff for monitoring & duties)

- Inadequate staff, short staffing for monitoring (6)
- Less need for monitoring because no risk of pregnancy
- Residents are monitored much much more and units are truly safer – if had staff for zones, will work perfect (2)
- Need more security on units
- Psych techs

Staff Performance (2.4%)

(Team work, staff supervision and training)

- Assessment of M behaviors/indicators during peer contacts so not “lost in crowd”
- That rounds are done

Minimal to No Problems (14.3%)

- None (12)

1c. What sexual safety concerns have women patients raised? (87 comments)

General Safety Concerns (11.5%)
• Personal safety, keeping them safe (3) • Feeling unsafe with M pts on unit (2) • Feeling unsafe at night in their rooms • Some concerned with loud, chaotic ward (2) • Asking to have door locked at night • General safety concerns by vulnerable F
Personal Boundary Violations (28.7%)
• Room intrusions (9) – (e.g., M coming into their bedrooms when they are asleep or in shower) • Inappropriate, unwanted touching (4) • They flirt (2) • M following them (3) (e.g., talking, smiling, asking for phone numbers) • Personal space violations (4) (e.g., M getting too close to them and brushing up against them) • “stalking” on unit – no private space to go, don’t feel safe in room (2) • Not liking the way M or W talk or look at them
Sexual Harassment, Intimidation, Exploitation, Behavior, Contact (33.3%)
• M harassing them, intimidating (6) • Trying to solicit sex (5) • Sexual remarks from M (3) (e.g., take your shirt off) • Alleging sexual assault (rarely) or nonconsensual sex (3) • M showing unwanted sexual interest in them (2) • Hypersexual roommates (2) • Being vulnerable to abuse and sexual behavior • M flashing genitals and suggestive language (2) • Fear of hypersexual M who are also violent • Concerns come up after the fact is done • Some W tell me how they’ve been sexually molested by family and when a M comes up and starts talking, the F freaks out and says he wants to have sex and I have to explain that he does not want to harm you • Fear or rape concerns – all have been product of psychosis • Propositioning by W
Hospital Unit Configuration and Patient Mix (4.6%)
• Keep W on one side of unit • Wandering to M’s side when not watched closely • Don’t want to be in M hallway when no bed in F hall • Some don’t care and some want to be on F side only and their own room
Minimal to No Problems (21.8%)
• None (18) • They don’t talk about it

1d. What sexual safety concerns have men patients raised? (76 comments)

General Safety Concerns (9.2%)
• Fear of peer, reported threats (2) • Fear of violent M (2) • Don't feel safe on unit • Noise on the unit • Not liking the way M or W look at them or talk to them
Personal Boundary Violations (11.8%)
• Afraid of certain M peers coming in their room (3) • W wandering in their room (2) • W following them around the unit • Intrusiveness of other pts • They flirt • On 3rd shift, some say this W came into my room and I couldn't get her out, she wouldn't leave
Sexual Harassment, Intimidation, Exploitation, Behavior, Contact (30.3%)
• Complaints about M peer making sexual comments or advances to them (5) • Extremely rarely have M made allegation of sexual assault by another M (3) • Sexually preoccupied with aggressive M peers • Unwanted touching by M (2) • Propositioned by F peers (2) • Being harassed, targeted (2) • Afraid of peers they perceive as gay, bisexual (2) • Being touched by W • Being recipient unwanted sexual advances and feeling unsafe • When they have sexual behavior issues • They sometimes expose self • Being accused • Concerns come up after the fact is done
Hospital Unit Configuration and Patient Mix (2.6%)
• Wander to F side when not watched closely • Keep M on one side of the unit
Minimal to No Problems (46.0%)
• None, usually no complaint (34) • They don't talk about it

2m. For any current practice you rated as ineffective, explain why and your recommendation for improving it.

2a. <u>Assessments by PCS & Inpatient MD/PhD of special risks</u>	2b. <u>Recovery Planning special risks treatment objectives & interventions</u>
• PCS MDs go overboard in initial monitoring orders; assessment of sexual risks done improperly and not relevant per pt (2) • Unit Drs go a little overboard with monitoring ½ pts on unit without any history • PCS not aware of case mix on unit • Don't think Drs listen enough to RN/CNA and try to appease pt without taking violence risk into account • CNAs not notified immediately of behavior risks of pts • Screen out criminals that belong in jail (Pers. D.O. & malingerers vs. true MI) • Background checks should be done on pts to identify sexual offenders	• Interventions not always followed (2) • CNAs don't read the charts • Team doesn't seem to meet with pts as they should • Useless, record not pt-oriented • Need to implement Trauma Informed Care
2c. <u>Patient Education on sexual contact policy</u>	2d. <u>Unit Zone Surveillance system</u>
• Inconsistent and of questionable benefit (10) – e.g., inconsistent, pts are very impulsive and not sure RN really goes over orientation material; only few pts are capable of benefiting; don't believe has any effect with main perpetrators (manic pts); doesn't mean pts will listen if they have sexual issues; pts will still do what they want if not monitored; pts don't retain the unit policy info given them. • Better sexual education & consequences of sexual attachment	• Would work/be very effective if staffed (5) – e.g., zones will work if each unit has enough staff; frequently understaffed and CNAs pulled; RNs have to fill in and it's a lot of work; if short-staffed, RNs won't help CNAs • Very good idea but issues with staff performance (7) – e.g., staff is reading, texting, listening to ipods; staff sit at beginning of hallway not halfway down so can see rooms better; staff sit in chairs, sit together and talk; staff not always in zone areas & don't know where pts actually are; with increased CNA expectation could be very effective; if short, RNs won't help CNAs with some duties so they have to leave zones • Very positive step
2e. <u>Morning Report with both treatment teams represented</u>	2f. <u>Cross Shift communication of special risk patients</u>
• Don't follow through, both teams are never together (2) • CNAs not involved in morning report; were told at least 1 CNA would be but never happened (2) • Different on each unit – touch & go	

2m. For any current practice you rated as ineffective, explain why and your recommendation for improving it.

2g. <u>Behavior Observation</u> monitoring for special risks	2h. <u>Bedroom Hallways</u> separate for M&W; no bed assignment beyond fire doors for W
• So many pts on behavior checks the importance is diminished, so go to 15 minute rounds (6) – e.g., every pt should be on Q 15 minute checks; not done consistently because not taken seriously – everyone’s on them; almost everyone’s on 15 min checks for vulnerability and difficult to manage, cumbersome • Staff don’t always know where pts are so can’t monitor; CNAs sitting & talking, need to walk more (4) • Useless, double CNAs and put security in place	• Halls should be single sex only (3) • If beds are tight, have to go beyond fire doors – 3/room is too crowded • Pts find ways to engage in sexual contact despite
2i. <u>Locked Community Bathroom</u>	2j. <u>Therapeutic Groups</u>
• Shouldn’t be necessary with the Zone • CNAs don’t always lock or pts shut the door • A pt found a way to unlock it • Lack of privacy and M peeing on the toilet would make me crazy	• Many pts don’t attend • No groups on evenings & weekends • Nursing groups ineffective • No groups to teach pts how to change their behavior • Other hospitals have good groups, like coping skills, not “coloring” • More training for groups from Education Dept
2k. <u>Electronic Video Monitoring</u> of unit	2l. <u>Overall Effectiveness</u> of current practices
• Who does this and how is it implemented? (2) • 1 security officer w/o knowledge of pts and risks monitoring multiple units not as effective as staff stationed in various places on unit who know pts and risks • Not noticed effective use or communication with staff; never seen security guard come during emergency situation that could have been seen on camera – we always call for help (2) • Physical appearance of security would be money better spent • Not in every place – limited space • Electronic ankle monitor for high risk pts from entering designated areas (2)	• Wards frequently understaffed to put these practices in use, incl. Lunch coverage for CNAs (5) • Need correct staff- 4 RNS and psych techs who constantly rove/monitor, not just sit • Many CNAs don’t watch – chat on cell phones & travel the building • “Secure unit” for violent/sexually predatory pts (3) • Pts with sexual abuse hx may be predatory and find ways to get around safety nets • Present mix of pts on a given unit can be scary • Focus on very effective practices – separate M&F units (2) • If everyone on all 3 shifts would be on their watch, could prevent most • Staff remains in nursing station for lengthy periods of time

3. What other suggestions do you have to improve the sexual safety of men and women residing on the same units? (82 comments)

STAFFING PATTERN (31.7%) • Adequacy of staff • Composition of staff for monitoring & duties
• Units fully staffed & consistent monitoring (9) • Unit Zone Surveillance is adequate for monitoring sex (2) • Properly man the zones and will be most effective tool for sexual safety (2) • More CNAs (2) • Better way to measure acuity & ensure correct coverage (2) • More RNs (4) – e.g., 4 RNs for 6 pts each more manageable esp. to cover Zone 2 and CNA breaks, RNs doing CNA work, not job hired to do so they could talk to pts more • More security visible (4) - e.g., to deal with behavior issues therapeutic staff can't monitor while doing other cares • Manager has to be on the unit to make sure CNAs are rounding, not sitting
STAFF PERFORMANCE (24.4%) • Team Work • Staff Supervision • Training
• Better CNA supervision and training on Zones (5) – e.g., enforce zone supervision; make sure CNAs are doing job and roving, not talking on phone, doing word searches; not allowing CNAs on break to visit other units • Increase RN involvement with CNAs (2) – e.g., help CNA when pts need redirecting • Increased supervision of staff (3) – e.g., each staff person doing their job • Close proximity of staff to pts (close monitoring) (2) • Enhance execution of current safeguards (2) • Give all staff immediate report of pt sexual behavior issues • More team work • MDs need to listen to RNs (too permissive and prescribed Viagra in past) • Increase training of staff (2) – e.g., rights of pts to a recovery environment; sexual safety policies • Welcoming attitude and take seriously pts bringing sexual safety concerns to staff
CLINICAL INTERVENTIONS (13.4%) • Clinical strategies for intervening with patients
• Increase unit groups & activities (3) – e.g., to decrease boredom; better teaching groups geared to unit population; group and individual therapy to discuss sexual abuse and vulnerability • 1:1s at least until meds in system (2) • RNs to intervene when pts are being sexually inappropriate • Ensure pts know to inform staff if they feel threatened • Remind pts each shift about no sexual contact • Pass restrictions for those with sexual assault histories • Give something to lower libido • Discharge sooner

UNIT ENVIRONMENT MODIFICATION (12.2%)

- **Modification to existing unit physical environment and practices**

- Separate M-only & F-only hallways (3) – e.g., no exceptions, no 3/room
- Door/wall to separate M & F on same unit, with coed groups, meals and supervised social areas (3)
- Allowing bedroom door to be locked upon request (2)
- Separate lounges
- Separate M & F bathrooms

HOSPITAL RECONFIGURATION OF PATIENT MIX (18.3%)

- **Reconfiguration of patient mix on units based on such variables as gender, risk, acuity, etc.**

- All M and all F units (5)
- Separate unit for high risk males
- Segregate pts with sexual, criminal, antisocial history, violent behavior
- “Forensic” unit (2) – e.g., dangerous pts found incompetent to stand trial; should be a hospital & prison
- Special unit for dangerous pts (more than average) (3) – e.g., esp. physical assault, but ending coed units not the answer; don’t put predators on mixed gender unit
- Acute mixed unit for decompensated pts at higher risk
- Separate by acuity: MI vs. personality disorder
- Segregating sexes not the answer – can still assault same sex

4. How helpful do you think it would be for managing sexual safety on the units for BHD to develop plans for an All-Women's Unit?

NOT AT ALL HELPFUL/NOT VERY HELPFUL
• Can still have W to W sex (6) • Pts. Need to function in a normal setting, community environment (3) • W are hypersexual (when noncompliant with meds) and separating units won't help (2) • Anything can happen no matter what and if employees don't do their job • Staff need to carry out plans • More violent environment for pts and staff • Only need all M unit for criminals, sexual offenders, history of assaultive behavior • Opposite sex caregiver could be falsely accused of inappropriate behavior at increased rate
NEUTRAL/UNSURE
• Sexual acts can occur between same sexes (5) • Would prevent some, not all, contact • Life interactions involve M&W; won't give pts chance to interact and learn from opposite sex (2) • Don't believe sexual contact can be controlled in any setting • If aggressive M are on all M unit, can monitor W more easily & not have availability of highly sexualized M • Hypersexuality is dangerous, whether M or F • Fully staffed • Increased security time on units • Trauma informed care is the solution
SOMEWHAT HELPFUL/VERY HELPFUL
• W to W sex still possible, but W would feel safer (5) • Answer to many problems coming up – vulnerable W mixed with M, limits exposure of W to predatory aggressive M (4) • Would reduce/remove M-F contact, assault, harassment (3) • Potential for harassment from those who prefer same sex (2) • Some W have fear of M due to past trauma • W with trauma history are retraumatized as solicited by M for sex • Still sexual issues but no pregnancies • Allow for stabilization in a manic state until less sexually preoccupied • Remove temptation with no M around • Prevents M from undetected access to W • Subset of population (gender identity, sexual abuse) better served by same-sex unit • Effective, easier fewer incidents • Caring staff can better understand and care for gender • Potential problem of W vying for attention, getting restless with each other (2) • But staff can become inattentive in monitoring • Won't need zones but zones are working well • But best to address safety in general

5. How helpful do you think it would be for managing sexual safety on the units for BHD to develop plans for an All-Men's Unit? Explain why.

NOT AT ALL HELPFUL/NOT VERY HELPFUL
• M to M sex can still be a problem; vulnerable M can still be abused by M (12) • Concern about increased fighting, safety concerns, violence potential (2) • Need a community environment (2) • Many nurses are small W and may be at increased risk for victimization • Only if staffed with all M • Anything can happen if employees don't do their jobs • Need to monitor all pts. • Not enough CNAs to cover zones
NEUTRAL/UNSURE
• M could sexually assault each other unsure if would shift risk to same sex behavior, vulnerable M could be a target (9) • May be more violent/aggressive than on a coed unit (2) • All pts who are hypersexual are dangerous • Life interactions involve M & F • Staff may be less willing to work there, if mixed with violent pts, could be safety issue for staff (2) • Some M pts. Would still be on units with F pts. • Don't believe sexual contact can be entirely controlled in any setting
SOMEWHAT HELPFUL/VERY HELPFUL
• To separate perpetrators from general pop, from predatory/violent men from preying on vulnerable (5) • Eliminates M-F assault, W would be safer, protects most vulnerable W (3) • Eliminates pregnancy concern (2) • Some M like M, can have sex with each other (2) • Stop the sexual tension between the genders; reduces temptation (2) • But need to focus on <u>overall</u> safety – violence and sexual safety (2) • Zone & monitoring makes M to M sexual contact unlikely • With caring team could better understand needs of that gender • Would require significant staff engagement and use of therapeutic technique • Secure unit for violent high risk men would be safer environment for rest of population • High risk unit with strict behavioral guidelines to protect other pts • Forensic unit for chronic offender • Especially antisocial and sexual predator • Only for violent pts with criminal records and history of violence <u>of any kind</u> • But need to separate violent M and W from general population • Must be highly secure for violence as well as sexual contact – security on unit all times, adequate RN/CNA staff • Send criminals to jail, prosecute when they attack staff and pts.

6. Would you prefer to work on an All-Women's Unit, if BHD had one? Explain why.

NO
• Don't believe in its principles – to a pt's mental health benefit to be on a mixed unit, current recovery environment more accurately reflects community to which pts will return (4) • Concern about false accusation of sexual advances toward me and other M staff (3) • W can be just as loud, hostile aggressive, threaten other W; worse than M; W can be nasty, lie; cattier and sneakier; too moody (8) • More personality disorders without enough staff to meet needs; too demanding (2) • Not a fan of too many manic W • More problems, too stressful (2) • Array of problems – what if % M vs. F is skewed and single gender units are full? • I enjoy M & F mix and different issues
NEUTRAL/UNSURE
• As M RN would rather not, but would if had to • I have concerns about being falsely accused of abuse • Only if a F older population • Cat fights, more discord between pts per staff who have worked on all F units
Yes
• Because I'm a W, and want to feel safe (2) • I'm here for all pts. • Won't be concerns about sexually inappropriate behavior, though it's not happening now because zones are in place

7. Would you prefer to work on an All-Men's Unit, if BHD had one? Explain why.

NO
• Don't believe in its principles, to a pt's mental health benefit to be on a mixed unit, more accurately reflects the community to which pts return (4) • I'm a W – too dangerous, I'm too small to protect myself (3) • Too much anger/aggression potential, too violent, danger of violence to staff would be higher (4) • Too little variety (2) • Not if a young M population • Because of my own trauma history • Not much tolerance for sexual comments toward me • Nice way BHD is set up, just need more supervision and training
NEUTRAL/UNSURE
• M might try sexual behavior on F staff • I'm a M RN • They can be mean • Many M pts are protective of F staff • Will have a wide array of problems
Yes
• M are easier to handle and control (3) • Personal preference (2) • Less manic behavior and M seem more respectful to F • Less moody, demanding • Less drama and likelihood of allegation if someone touched me • Better control of unit population to focus on treatment and not policing • As a F, I can talk better to M, reason with them and have them tell me their problems • With the correct staffing and security presence, it would be improved • I'm here for all pts • If you start a high risk unit, I'll work on it

8. Would you prefer to work on a Mixed-Gender Unit, like BHD has now? Explain why.

NO
• Unsafe
NEUTRAL/UNSURE
• Flexible, I'll work anywhere (2) • System has worked for a long time though has some flaws • Think pts communicate better with mixed genders • Do value interactions between M & W as reflection of "real life" • OK for me, not as safe for pts • Only if trauma informed care is implemented • If predators are separated from the general population
Yes
• Variety (personalities, needs, issues) (7) • Current recovery environment more accurately reflects the environment to which pts will return (4) • Never worked on an inpatient unit with sex segregation – will be like jail, it's about how you monitor • I'm here for all pts • I'm a people person and understand both M & W • Only if properly staffed • To pts mental health benefit to be on mixed unit • Was working until secure M unit closed and violent sociopathic M were integrated onto general units • Would get burned out on all-M or all-F unit • Zones are working • Believe staff is able to manage/separate/protect pts, need to enforce our policies • Easier to work with • Less pt discord • Would work with elderly pts • I like where I am now • OK other than some comments, hand kissing, butt grabbing

9. Do you think having a Women-Only Lounge on a Mixed-Gender Unit would improve sexual safety? Explain why.

NO
• Most inappropriate sexual behavior occurs in places other than lounge areas, day and night, not just leisure time (4) • If they want to have sex, they'll find a way to do it – they watch staff to find opportunity (3) • M would be jealous, angry and see it as unfair (3) • Sounds discriminating (3) • Lack of space (3) • W have sex with W (2) • Would only increase sexual curiosity toward one another, been seen as another challenge by M pts (2) • Modulating, moderating effect on behavior & emotions with mingling genders • Sexual safety not determined because you have a same sex group • When they decide to get to the other sex, they can be very dangerous • Would still need to monitor • Adequate staff to monitor pts based on acuity • W many times won't use it – sexually preoccupied and want to be near M • Problem is sexual interaction (willing/unwilling) on a mixed unit and it won't solve that • Would help tiny bit but not big difference • Don't need a lounge to hold a gender-specific group • Living quarters separate, common areas mixed • Feel strongly about F-only unit
NEUTRAL/UNSURE
• Would be difficult to keep people separated, would have to closely monitor (3) • Most sexual contact without consent occurs away from lounge • Another thing staff would have to police • Would increase need for more staff • May increase stalking • Not sure if pts would find a way to get away with things • Space concerns • Staff address harassment when it occurs, lounge may help with prevention • Not sure what goal would be • Too isolating for some pts • Not sure would increase safety but would give W sense of comfort and place to relax • Would be a therapeutic benefit • If aggressive M are on their own unit; lounges are in view of staff & pts need to learn to interact in healthy ways
Yes
• Offer W safe place to be on unit when feel threatened (3) • Improve sense of safety, security, place to go and sit (2) • Supplement with a women's group and different trauma topics (2) • Limits sexual contact, innuendo. Flirting between opposite sex pts (2) • Lot of inappropriate behavior happens in the community room • Unstructured time on second shift is higher risk • Zones are working good • May be hard to enforce • May decrease temptations

10. Do you think having a Men-Only Lounge on a Mixed-Gender Unit would improve sexual safety? Explain why.

NO
• If they want to have sex, they'll find a way to do it, they watch staff to look for opportunity, can be very dangerous (5) • Lack of space (4) • Most inappropriate sexual behavior occurs in places other than lounge areas (2) • Potential sexual predators could bond/plan offenses without W present, and see which peers are weaker (2) • Sounds discriminating (2) • Have M that have sex with M, can prey on other M as well (3) • When you restrict something, they work harder to obtain it; Prefer staff to monitor mixed=gender lounge and be alert to developing relationships • Would only increase sexual curiosity toward one another • Moderating, modulating effect on behavior, emotions with mingling of genders • Adequate staff to monitor pts based on acuity. • Sexual safety is not determined because you have a same sex group • Our job is to monitor changes in inappropriate behavior to return pt to community • Help a tiny bit but not make a big difference • Don't need a lounge to hold a gender-specific group • Would cause anger and hostility with M • Important for pts to interact with both genders as must do in community • Feel strongly about F only unit • Living quarters separate; common areas mixed
NEUTRAL/UNSURE
• Staff addresses harrassment when it occurs; lounge may help with prevention • Another thing staff will have to police • M seem prone to take other means because they're insecure in their sexual identity • Not sure would increase safety but would give M a sense of comfort and place to relax. • Need better staff training to improve safety • Not sure if pts would be determined to find a way to get away with things • Would have to monitor closely so W wouldn't enter M lounge (2) • Most sexual contact without consent occurs away from lounge • Too isolating for some pts • If aggressive M are on their own unit; lounges are more in view of staff & pts need to learn to interact in healthy ways
Yes
• Limits sexual contact, innuendoes, flirting between pts of opposite sex (2) • May be hard to enforce • Unstructured time on second shift is higher risk • Zones are working good

**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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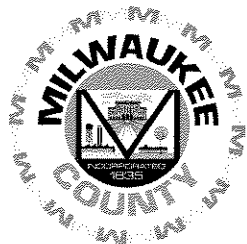
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Department of Audit

Milwaukee County

Jerome J. Heer

• Director of Audits

Douglas C. Jenkins

• Deputy Director of Audits

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.

A handwritten signature in black ink, appearing to read "Jerome J. Heer".

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
Steven Kreklow, Fiscal and Budget Director, DAS
Steve Cady, Fiscal and Budget Analyst, County Board Staff
Carol Mueller, Chief Committee Clerk, County Board Staff

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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				
	<u>2008</u> <u>Actual</u>	<u>2009</u> <u>Budget</u>	<u>2010</u> <u>Budget</u>	<u>2009/2010</u> <u>Change</u>
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.

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

- **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.

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

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 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:

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

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

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

- o 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.**
 - o Treatment Plans were individualized for patients with risk for sexual behavior to address specific problems, treatment objectives and methods.
 - o 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.
 - o 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.
 - o Off Ward Privilege assessment procedures were modified to ensure persons at risk remain on the inpatient unit.
 - o Treatment Team Reports and Nursing Cross Shift Reports were revised to ensure communication of patient behaviors between treatment teams and across changes in shifts.

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

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

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

- **Increased Environmental Surveillance.**

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

- o 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.
- o 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).
- o 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.

- o 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 all cases of known or suspected patient sexual contact to the Sheriff's Office.

- **Compliance Plan.**

- o 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

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

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.

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

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

Behavior Observation Flow Sheet Signatures

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 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 <u>Lines</u>	% Total Signature <u>Lines</u>
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 than 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

	<u>2007</u>	<u>2008</u>	<u>2009</u>
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			
	<u>2007</u>	<u>2008</u>	<u>2009</u>
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.

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

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):

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

<u>Year</u>	<u>Month</u>	<u>Hours</u>	<u>FTE*</u>
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.

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.

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 February 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.

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

<u>Incidents</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010**</u>
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.

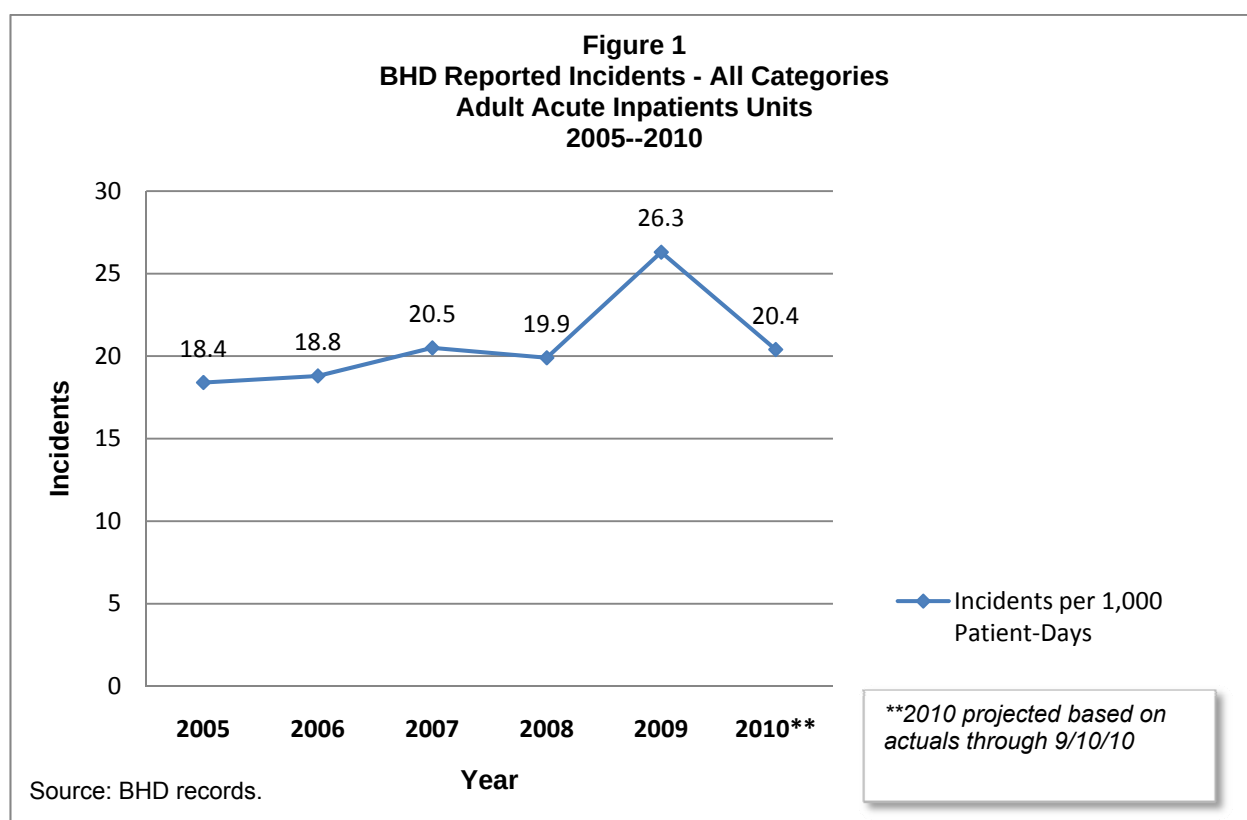
*** 2010 Projected based on actuals through 9/10/10.

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.



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

<u>Incidents</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010**</u>
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.

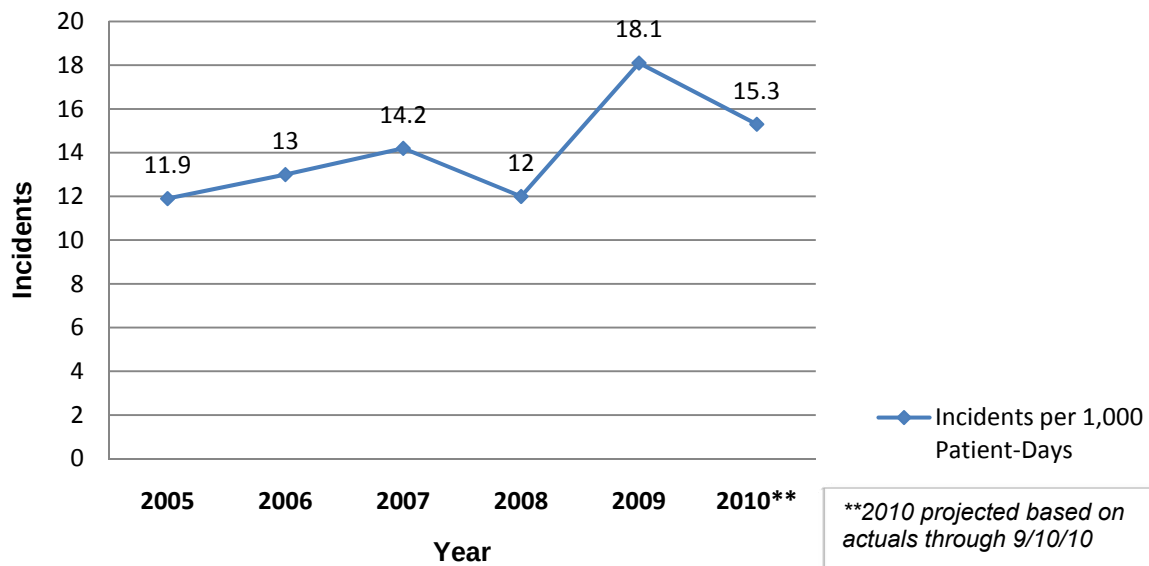
Source: BHD records.

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

<u>Incidents</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010*</u>
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.

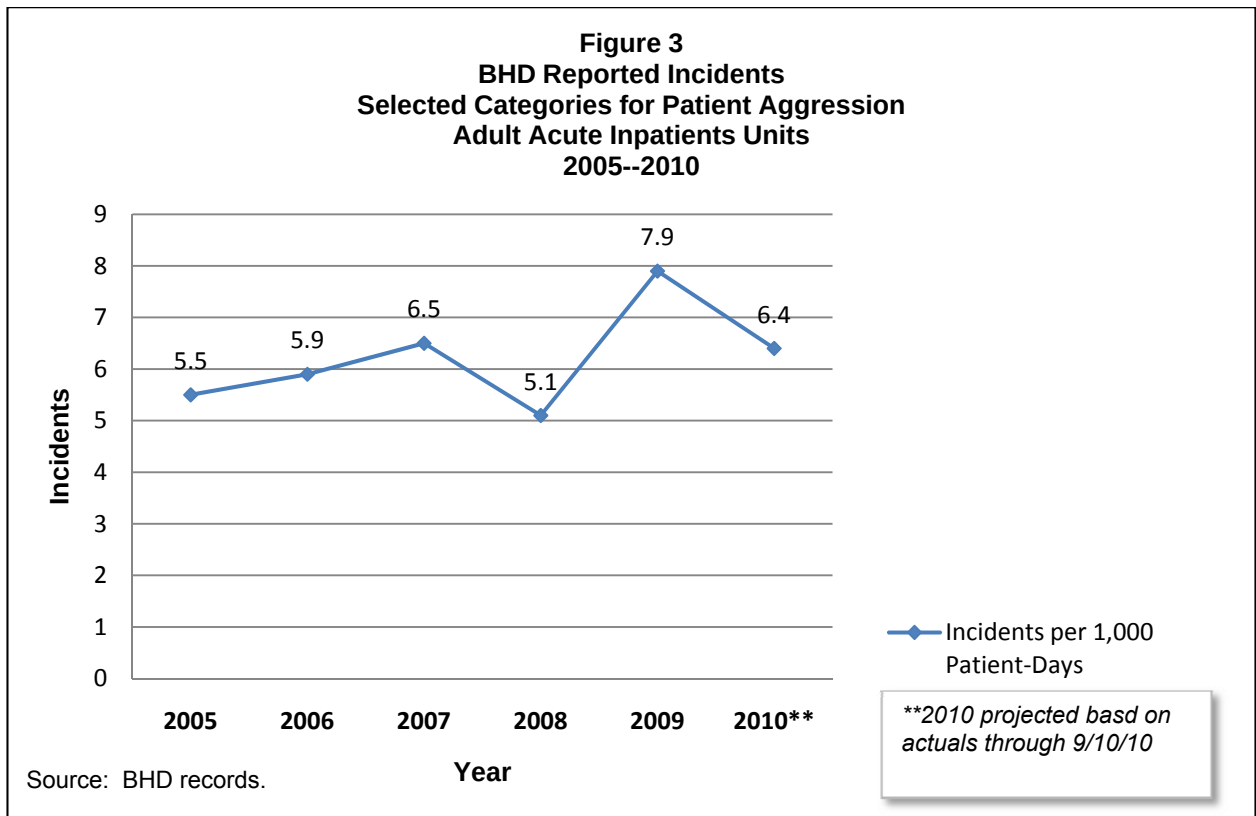
*** 2010 Projected based o actuals through 9/10/10.

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.



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.

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.

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.

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

	<u>1st Shift</u>	<u>2nd Shift</u>	<u>3rd Shift</u>
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

<u>Month</u>	<u>Shifts with Incident Report</u>	<u>Shifts with Unsafe Staffing Forms</u>	<u>Match</u>
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

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.

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.

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

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.

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.

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

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.

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

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. 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 not 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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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

<u>Prefix Tag</u>	<u>Date</u>	<u>Patient #</u>	<u>Sexual Contact?</u>	<u>Description (Excerpted and Paraphrased from Survey Comments)</u>
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 Jeopardy 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 inappropriate 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 Privileges (OWP) were discontinued.

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 medical 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 interview 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 Psychiatric 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 reflect 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 sexual 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 clinical 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 inappropriately--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. <i>Note: These appear to be notes of generalized observations; no specific incident cited.</i>
9/23/2009	14 & 15	Alleged	10:45 AM Pt. #14 alleges that his roommate, Pt. 315, sexually assaulted 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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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		INITIALS/ SIGNATURE* (see back)	TIME	Monitored Behaviors		INITIALS/ SIGNATURE* (see back)	TIME	Monitored Behaviors		INITIALS/ SIGNATURE* (see back)
	Attempted				Attempted				Attempted		
	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

CHW&MILWAUKEE COUNTY Behavioral Health Division Form #309-R3 12/14/14

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

On:\NrsAdmin\NA\FORMS\2004\Behavior Observation Flow Sheet 6-12-04.doc

Form #309-R3

Quality Management No.
SEE INSTRUCTIONS ON BACK OF LAST PAGE

10. DESCRIBE IMMEDIATE ACTION TAKEN13. REPORT COMPLETED BY

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

PLEASE PRINT all information being described/identified on this form.

DO NOT put a copy of the Incident/Risk Management Report in the patient/resident's medical record.

COMPLETE 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.

COMPLETE 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.

DO NOT complete this form for allegations of workplace violence or sexual harassment. Consult Milwaukee county policies for reporting procedure.

SPECIFIC INSTRUCTIONS FOR EACH ITEM

1: Print the date of incident.

2: Print the time incident occurred, use military (24-hour) time.

3a: Print the location of the incident, indicate program and unit.

3b: Record room, area or any other location.

4: 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.

5: Check if patient/resident (P), employee (E), visitor (V), security or contract personnel(S/C), student(Stdnt), or volunteer involved in the incident.

6: If a patient was involved, the medical record number must be listed.

7: 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 HIPAA 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.

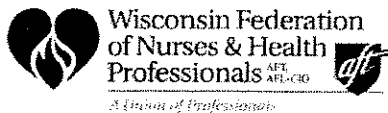
Signature(s): _____ Date: _____

_____ Date: _____

Top copy to supervision

2nd copy to WFNHP

3rd copy to member



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 alternative 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:

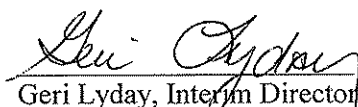
- Check in with nursing staff regarding any "potential hot spots/areas;"
- Walk down both hallways;
- Check that the community bathroom is locked along with other required locked doors;
- Observe the environment for any concerns and stand by while nursing staff assess the situation and take action as 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

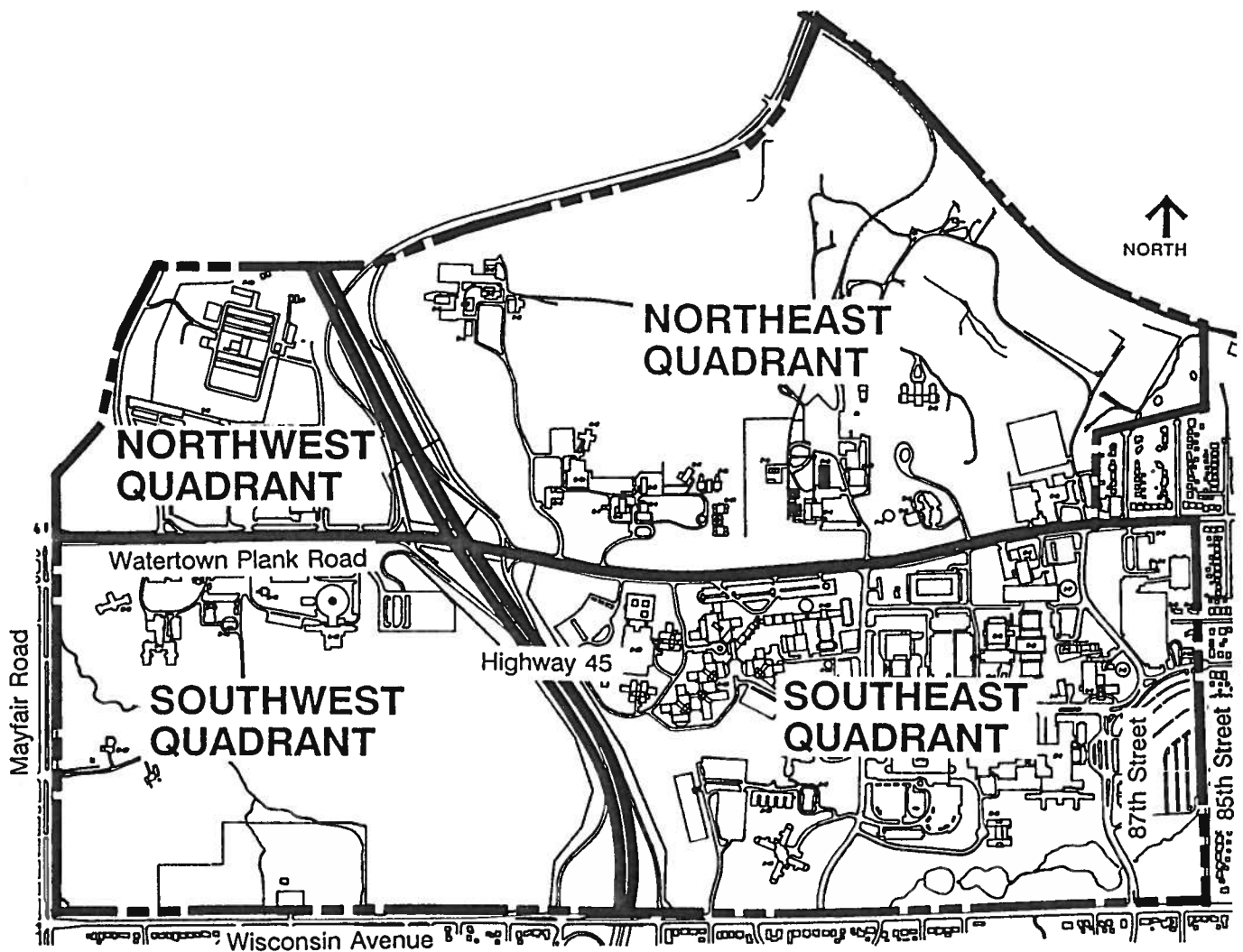
BHD would like to thank the Department of Audit for their work on this extensive project.

Respectfully submitted,


Geri Lyday, Interim Director

LAND USE PLAN**PLANNING AREA**

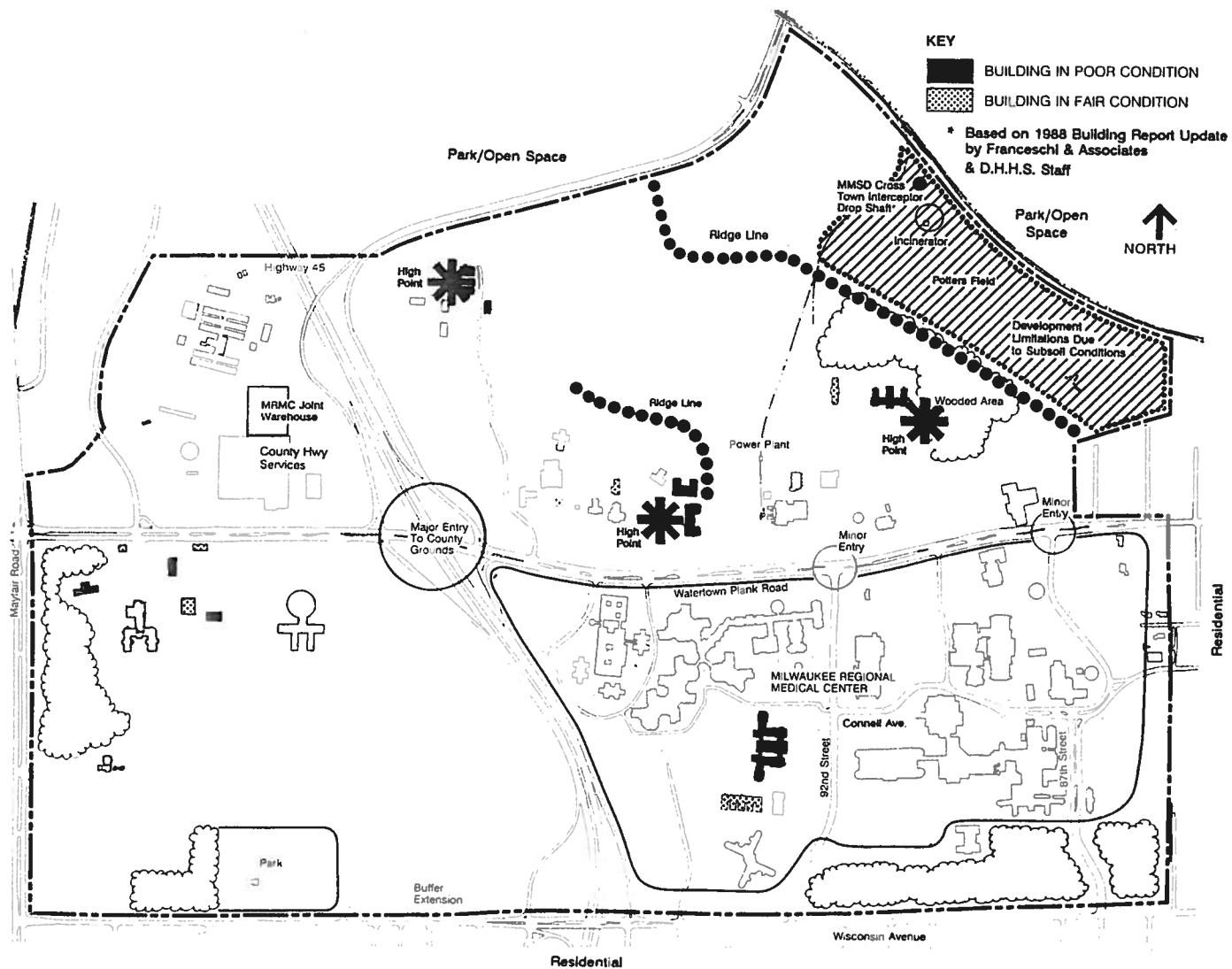
The planning area is shown on the map below. The three exhibit photos that follow provide a visual overview of the primary sections of the study area.

PLANNING AREA

Grounds is highly visible from the neighborhoods east and north of the Grounds. In general, the Milwaukee County Grounds has few development limitations because of soils, slope or subsurface conditions.

The Physical Characteristics map identifies buildings that are in poor or fair condition for adaptive reuse. The building evaluations were made as

PHYSICAL CHARACTERISTICS



NORTHEAST QUADRANT

The maps and text on the following pages provide the summary description of the Land Use Plan for the Northeast Quadrant of the Milwaukee County Grounds. The Land Use Plan defines the land use patterns, traffic circulation concepts and development intensity standards.

**LAND USE PLAN FOR
NORTHEAST QUADRANT****LAND USE KEY**

	Institutional MRMC		Commercial
	Residential		Utility/Service
	Wellness/Recreation		Power Plant
	Woodland/Openspace		Interchange Expansion

