

A Review of
**Over-Bedding at
Mildred
Mitchell-Bateman
Hospital**

And
Recommended Order

July 3, 2008



The Office of the
Ombudsman for Behavioral Health

INTRODUCTION

In April, May and June of 2008 several complaints were filed in the Office of the Ombudsman for Behavioral Health regarding the over-bedding at Mildred Mitchell-Bateman Hospital herein referred to as "Bateman Hospital". The complaints were filed by patients and staff at Bateman Hospital and numerous advocate agencies.

As Ombudsman, I have been involved in several meetings with advocates and representatives from DHHR on this matter. In order to better comprehend the many issues surrounding this over-bedding, I scheduled an on-site visit to Bateman Hospital on June 4th and 10th 2008, for the purpose of interviewing patients and staff. I also wanted to observe first hand the environmental conditions, determine if treatment is being compromised, and whether basic patient care is being provided when Bateman Hospital is over its census. I conducted twenty-one (21) interviews of which 6 were with patients and 15 were with staff. The interviews with staff included a cross section of professional disciplines (health service workers, nurses, management and doctors). The patient interviews were also from a cross section of individuals with varying lengths of stays, i.e., eight years, five years, two months, two weeks and two days. In addition one interview with a family whose adult child had been placed at Bateman Hospital also was conducted.

This review will address the grievances being voiced and some of my discoveries/observations made during my visit. In an attempt to provide resolution to the many grievances reported, I am issuing this review/report and *Recommended Order* for consideration by DHHR.

FINDINGS

The following are observations made at the time of my visit and grievances/concerns that were expressed by patients and staff who were interviewed:

■ The overall staff morale across all employees appeared extremely low and fatalistic. Everyone interviewed seemed powerless to change the conditions in which they find themselves. This was also directly communicated to me.

■ According to staff interviewed, the problem with over-bedding has been occurring for the last four years.

■ There were 117 patients at Bateman Hospital on the day of my visit. Several patients were located in rooms without a bathroom and the bathroom that was made available to these patients is locked and has to be opened by a staff person. Privacy is most certainly compromised in these situations which I witnessed during my visit. (A patient had a toileting accident and the event unfolded in clear view of patients and staff, as there were no curtains on the huge window to his make shift room). Eventually staff threw a blanket over the windows to attempt to provide some privacy.

■ Patients indicated that their rooms were hot and complained that they could not secure a second pillow. They also indicated that the beds (cots) being used were extremely uncomfortable. A patient pointed out for me the

metal rod that protrudes from the middle of the cot. These cots are approximately eight inches off of the floor.

- All patients interviewed complained about falling over the cots when there are three patients to one room. This happens when over-bedding occurs at Bateman Hospital.

- Patients in room 209 complained that the sink is not located in the bathroom. It is situated in the bedroom area of the room. They said that this offers absolutely no privacy during usage.

- One patient interviewed complained that she could not use the privacy curtain in her bedroom as the third bed in the room is directly situated over the curtain. This allows her no privacy and she has been at Bateman Hospital for three years. This is true in every room observed where there is a third bed being added as a result of over-bedding.

- Staff indicated that the diversionary hospitals will not take patients who are showing aggression at the time of admission. They said that this places a “great deal of burden” and hardship on the staff at the hospital and that they do not know on a day-to-day basis how many diversionary beds are available in the system and that it varies. It was said that there is no magic number when admissions would cease at Bateman Hospital. It is my opinion that the diversionary hospitals for Bateman are, for some unknown reason, allowed to "cherry pick" their patients. This opinion is shared by many of the staff I interviewed. Staff believe that changes should be made in the community with the crisis bed units because, as of now, they only accept patients who have Medicaid. They went on to say that diversionary hospitals

should have trained staff to deal with patients who are aggressive. In addition they said they would like to have back the twenty beds that have been set aside for forensic patients.

■ Staff interviewed said that they have very limited time just to complete the basic patient care activities required and some patients told me that they would like to have a shower every day but that it is impossible. Male patients complained that they could not shave on a daily basis. In my observation of patients it was evident in their appearances that basic daily living skills are not being met for many patients on all three units.

■ Staff indicated that over-bedding compromises the amount of time you can spend with your patients. One staff said that there was a bad mix of patients on their unit and that “people are just on top of each other”. Staff said there was an increase in patient to patient incidents and patient to staff incidents. I witnessed one of these incidents on my June 10 visit, where a patient attacked a female staff, two other staff intervened to assist and the outcome was that all three staff including the patient plunged to the floor. This resulted in the patient being chemically restrained. I inquired as to why the patient was upset and was told that the patient was agitated because he did not have any space to put his personal belongings.

■ Staff indicated that many times, especially on the weekends, there are not enough staff to accompany the patients to the dining room for meals. This results in the patients eating their meals on the unit. This creates many problems and, as I observed, there are not enough chairs in any of the dining rooms on the units for the patients to sit down and eat. During my visit I discovered that on unit two there were 20 chairs for 40 patients, on unit

three there were 21 chairs for 37 patients and on unit four there were 17 chairs for 40 patients.

- Staff did not think it was fair to patients to mix the populations especially the nursing home patients with dementia (forensic, mental health, MR/DD, nursing home, substance abuse).

- Staff voiced concerns regarding a practice called "FREEZING", this is activated when there is not enough staff for a particular shift. Staff are required to pull another eight hour shift on top of the eight hour shift they have just completed. This is mandatory for staff and they stated that if they refused to follow this practice they would receive a written notice (reprimand) and it would be filed in their personnel file. Staff find this requirement very demanding and it is very hard on those employees with families. They believe this lowers staff morale and only adds to the frustrations that currently exist on the units because of over-bedding. It was stated that some staff have been asked to pull another shift at least two times a week.

- Staff declared that the "90 day temp" employee system does not work. Full time equivalent staff end up spending more time shadowing these employees, redirecting them on tasks and interventions and most of them do not get hired on as full time staff once their 90 day period ends. This results in very inexperienced/unqualified staff working with very difficult and at times aggressive and violent patients. It was mentioned, "one 90 day temp was fired for drinking on the job and sometimes staff do not feel safe around them and staff wonder where they find these people".

■ Staff said that on June 03, 2008 the kitchen staff informed all three units that they ran out of milk. No milk was sent to the units on that day.

■ It is very hard for staff to find the time for lunch and break times.

■ One staff interviewed said they haven't seen patient care this bad in 10 years.

■ Staff said that there are not enough wheel chairs for those patients who are non-ambulatory. This problem occurs daily according to the person being interviewed. They also believe that any patient who is wheelchair dependent is at risk in case of a fire emergency.

■ A patient indicated that he was concerned that his bathroom door would not close properly and he was not getting the privacy he needed when using the bathroom. He also stated that he did not have enough storage space for his personal belongings.

■ Staff believe that the hospital, when it is over-bedded, is an accident waiting to happen. There are not enough staff on duty to effectively evacuate all patients in case of a fire emergency. Recently one unit had 10 patients who were dependent on wheelchairs for their mobility. It would take 20 staff or more to safely evacuate these patients, as some fall into the category of obesity. It was stated that on a good day the units have a maximum of 11 staff.

■ Staff believed that closing the volunteer clothing closet was not a wise decision as patients have very limited choices for clothing.

■ In meeting with a patient's family members it was voiced to me that having her son at Bateman was a hardship on her as she lived in Cross Lanes, WV and had to travel to visit her son. The family said they "took their son to Thomas Hospital for help and he ended up here, and we have insurance." She wanted to know, "How does this kind of thing happen?"

■ Staff and patients interviewed were concerned about safety during times of over-bedding. The patient said "there are times when the tension is really high and nerves are on end and the staff appear really tired". He also stated that "I am shocked at the conditions of this hospital; it smells of urine, it's dirty and I haven't shaved in three weeks because I don't want to get an infection on my face". He also didn't feel like he has received any help and stated "they are just warehousing me here".

■ Staff indicated that four things needed to occur, they are the following: no more over-bedding at the facility, new contract arrangements with the diversionary hospitals, no more "cherry picking" of patients by diversionary hospitals, and more resources need to be directed to the community to help with crisis services and residential options for people.

■ Staff said that over-bedding and the conditions that result are a prime reason they are losing professional staff, i.e., doctors, nurses and health service workers.

RECOMMENDED ORDER

After careful review and analysis of the many issues and concerns with over-bedding at Bateman Hospital and in order to properly address them, the Ombudsman is providing the Secretary of Department of Health and Human Resources with the following recommended order, pursuant to E.H., ET AL vs. Matin, ET., AL, Court Order dated December 14, 2001 in CIVIL ACTION NO. 81-MISC-585.

RECOMMENDATION: #1.) DHHR shall discontinue the practice of over-bedding at Bateman Hospital. This facility shall not exceed their 90 licensed bed capacity. A gradual movement/ diversion of patients must be accomplished over the next 90 days to achieve this goal.

RECOMMENDATION: #2.) DHHR shall conduct meetings with the five diversionary hospitals (Thomas Hospital, CAMC, St. Mary's Hospital, Highland Hospital, River Park Hospital and others if necessary) and the Community Providers for the purpose of negotiating contracts that will adequately meet the needs of the patients seeking treatment in this region. The goal is to establish sufficient bed capacity for all populations who are coming into the system for care without over-bedding Bateman Hospital. All hospitals must take on a shared responsibility to take all disability groups including those with aggressive behavior. An evaluation of the resources needed in the community to expand crisis and residential services shall also be examined in this process.

RECOMMENDATION: #3.) DHHR along with the staff and management at Bateman Hospital shall re-evaluate the practice of employing 90 day temp staff. This employment practice according to staff is a real injustice for patients as it truly has a direct effect on the quality of treatment being provided.

RECOMMENDATION: #4.) DHHR along with staff and management at Bateman Hospital shall re-evaluate the practice of FREEZING, determine its effectiveness and weigh the cost as it relates to overall staff morale. Keeping Bateman Hospital at its licensed capacity should eliminate some of the need to implement this procedure.

RECOMMENDATION: #5.) DHHR shall systemically evaluate the forensic patient population and determine if a separate centralized facility (hospital) for this population is warranted at this time in West Virginia.

SUMMARY

I would like to thank the staff and management at Bateman Hospital for their cooperation extended to me during this review. I, along with them, am committed to making the necessary changes needed to forever stop the practice of over-bedding at this hospital. In addition I would like to express my appreciation to the Legal Aid advocate who assisted me throughout this review. It is my opinion and that of many of the staff and patients interviewed that treatment is absolutely compromised at Bateman Hospital at this time. The environmental conditions that exist as a result of over-bedding are also interfering with the staff's ability to provide just the basic care needs

of the patients. Safety of the patients and staff remains my utmost concern until this over-bedding practice is discontinued. I am also somewhat concerned that the fire marshal has never provided this hospital with any citations relative to over-bedding. That remains a mystery to me.

I am available to assist DHHR in working on these recommendations to produce the desired outcome.

The Secretary of DHHR has twenty-days (20) from the date of this order to respond. If she does not concur with the Ombudsman's recommendations, the Respondent Secretary must provide a written rationale as to why such recommendations is not acceptable.

David G. Sudbeck
Ombudsman for Behavioral Health

Date

CC: Honorable Judge Bloom
Dan Hedges, Esq.
John Bianconi, Commissioner, BHHF