

STATE OF WEST VIRGINIA
THIRTEENTH JUDICIAL CIRCUIT
OFFICE OF THE COURT MONITOR



A Review of
Over-bedding at

William R. Sharpe Jr.
Hospital
and
Formal Recommendations

September 17, 2010

INTRODUCTION

In June, July and August of 2010 several complaints were filed in the Office of the Court Monitor regarding the over-bedding at William R. Sharpe Jr. Hospital, hereinafter referred to as “Sharpe Hospital”. Many of the complaints were filed by staff of the hospital, a state-operated psychiatric facility.

The Court Monitor has been involved in several meetings with management staff of the Department of Health and Human Resources (DHHR) to discuss the increasing demand for inpatient psychiatric treatment and rehabilitation of individuals who are determined to be incompetent to stand trial or Not Guilty By Reason of Mental Illness (NGRMI) by the Court. This population is generally known as the “forensic population”. The forensic population has increased from a relatively small number of individuals in the early 1990’s to a total today of over 120 patients, many of whom occupy a substantial portion of the beds available at Sharpe Hospital. This significantly reduces the hospital’s ability to focus on its original mission of provision of acute psychiatric care. In fact, the Court Monitor in his role as Behavioral Health Ombudsman produced a report to the Court and Parties in 2005 addressing the issue of capacity at Sharpe Hospital with regard to the forensic population. Because of the many forensic patients, Sharpe has operated over the hospital’s licensed capacity by as many as 20 patients at a time for the last several months.

The Court Monitor is aware that the DHHR has conducted a bed analysis study in an attempt to review the present population and project the future demand for residential treatment capacity for both the acute care and forensic populations. The Office recognizes that the DHHR is working with several providers to design intermediate and long-term solutions to the ever-increasing need for forensic treatment capacity.

In order to identify first-hand the many challenges posed by the hospital's being forced to operate beyond its licensed capacity (in other words, "overbedding"), the Court Monitor scheduled an on-site visit to Sharpe Hospital on August 30th, 31st, and September 01st, 2010. The Monitor interviewed patients and staff and also observed environmental conditions in order to determine whether patient treatment is being compromised and whether basic patient care is able to occur when the Hospital operates over its 150-bed licensed capacity. The Court Monitor conducted forty (40) interviews; 12 with patients and 28 with staff. The interviews included a cross section of professional disciplines (health service workers, nurses, mid level management, psychiatrists, social workers, security guards and housekeeping staff). The patient interviews were also from a cross section of individuals with varying lengths of stays, i.e., twenty-five years, six months, two weeks, and three days. All disability groups were represented, including some forensic patients.

This report will address the observations and findings made during the review and investigation. Formal Recommendations will be proposed at the conclusion.

FINDINGS

The following are observations made at the time of the investigation and concerns that were articulated by patients and staff who were interviewed:

- The census at the time of the review was 164 patients on August 30th, 167 patients on August 31st and 170 patients on September 01st. The hospital is running an average daily census of 17 patients over its licensed capacity.

- According to staff interviewed, overbedding has been an episodic problem for about five years but has been consistently occurring for the past six months.

- When over-bedding occurs, the seclusion room and the visitor's room are being utilized on the units as patient bedrooms. These rooms do not comply with the square footage required by licensing standards. In addition, patients in those rooms do not have access to their own bathroom or shower. Staff must make arrangements for patients in the non-traditional rooms to bathe, and bathrooms in

the rooms of other patients often must be utilized. At times, according to staff and patients interviewed, this can and does cause confusion, anxiety and tension between patients.

- Patients complained that the noise level on the units is extreme when over-bedding occurs at the hospital.

- Patients feel that there is not sufficient privacy to make personal phone calls. They also complained that the phones do not work consistently. In fact, during the visit a sign was observed hanging next to the patient phone stating “*Attention: this phone only works some of the time. Please be patient and considerate of your peers needing to use one phone*”. This practice is in violation of §64 CSR 59 12.3.1 and 12.3.3.

- It was observed during the visit that all patient closets were locked in the bedrooms. This does not afford patients easy and ready access to their clothing and personal items. All patients must approach a staff person when they want access to their possessions and clothing. Staff indicated that this practice was put in place to prevent theft, and for security reasons. The Court Monitor is aware that in the recent past a patient committed suicide by hanging in one of these closets.

Nonetheless, a patient should have the right of ready access to their personal clothing and possessions. This is particularly troublesome for patients in the non-traditional bedrooms and during times of high patient volume when staff is otherwise occupied and too busy to unlock closets at a time convenient for patients.

- Several patients interviewed complained of the quality of the food, which they eloquently described as “*it sucks*”. The same was said of the quality of the treatment, although it seemed that the complaint addressed concerns that there was too much unstructured time due to the fact that staff is not available to escort patients to the library, outdoors to play basketball, or to the music room or gym. At least one patient indicated that they were frightened during the night when they were unable to find staff.

- One staff interviewed said that patients occasionally urinate on the floor because they don’t have access to a bathroom when over-bedding occurs.

- Staff said that they were concerned about their safety when the hospital is over its licensed capacity. The Office of the Court Monitor is aware that in the past year incidents of violence have actually decreased according to Bureau data,

however, staff perception is that staff and vulnerable patients are in danger in conditions of overcrowding and noise/chaos.

- Several staff interviewed believe that training for health service workers, particularly temporary workers, is inadequate. Behavior management techniques and other more advanced and specialized training is neglected. New staff is not given adequate time to “shadow” more experienced staff for mentoring in order to receive “hands on” training and observation time for acquiring those skills that cannot be taught in a classroom. More training supplies are needed.

- At least one staff person expressed the concern that department heads do not communicate well.

- Staff argue that “forensic patients do not belong at Sharpe Hospital”. Many believe that they are not properly trained to work with forensic patients.

- Staff believe that they are not adequately compensated, particularly relative to the private health care market. Nurses, Health Service Workers, security guards, staff from housekeeping and mid-management staff all voiced their concerns with

this issue. Some staff indicated that they were planning on retiring because of the stress of the job in comparison to the salary paid in the nursing department.

■ Many staff interviewed were frustrated with the practice of **mandatory over-time** required by management at Sharpe Hospital. Staff believes that there is no exception to this policy and that they are unable to refuse to work a double shift at very short notice as this would be considered “*Patient abandonment*” according to management. Some staff has been fired for not working a double shift and many staff believe that disciplinary action will be taken against any employee who refuses to comply with mandatory over-time. The Monitor has discussed this situation with Bureau staff on other occasions. Bureau staff confirms that mandatory overtime is a policy in place. Management indicates that the practice is only used in emergency and staff who volunteer for the overtime are given first preference. The practice of overbedding and the recent influx of aggressive or medically compromised patients have increased the need for one to one supervision by health service workers which subsequently decreases the number of staff available for routine duties.

■ Some staff interviewed believe that management at Sharpe Hospital are helpful in dealing with the daily stresses and anxiety that staff are experiencing

because of over-bedding but believe that an inappropriate number of decisions are being made in Charleston. Some felt that “micro-managing” by Charleston Bureau staff make the situation at Sharpe more difficult to manage flexibly.

■ Patients and staff interviewed describe the cots being used for bedding when the hospital is overly full as uncomfortable for patients. The Court Monitor can confirm this personally as he tried out one of the cots during the visit/investigation and found them to be very flimsy and uncomfortable. He also sat on the bed being used for patients in the seclusion room. This bed is extremely uncomfortable and would be comparable to sleeping on a “slab of concrete”.

■ Staff believe that mixing the disability populations at Sharpe Hospital makes it difficult to provide adequate treatment and sometimes compromises treatment to patients. For example, if the unit designated for forensic patients is full, forensic patients are blended into the general patient population. Substance abuse patients are often placed on the same unit as individuals with intellectual disabilities and severe psychiatric illness. Behavior management programs are impossible to operate with consistency. Staff cannot create a therapeutic environment for patients because of the constant needs of the unusual mixture and number of patients on the units. When the hospital is overcrowded

there is no room available on the units to provide group therapy to patients. The physical environment created as a result of over-bedding is considered to “devalue patients” and “interferes in the delivery of care and treatment”. Many patients do not feel safe, which was reported in both staff and patient interview. Staff believes that the hospital is responsible for producing a therapeutic atmosphere where patients feel safe and comfortable with their treatment, a responsibility which it is failing to meet.

- It was reported that the advocates from Legal Aid located at the hospital deal in only “*peon stuff*”. Staff recommended that the advocates get more involved in the transfer of patients from unit to unit when the hospital is over-bedded. Staff stated it is like “playing musical chairs the way they move patients around from between units and between hospitals no matter what the age or disability”.

- All staff interviewed believe that the portable nursing stations that exist on all the units are unsafe and create a real safety risk for personnel working at them. The nurse’s stations were observed during the investigation to be flimsy and conducive to a potential assault on staff by patients.

■ Staff interviewed believe that temporary staff hired is not adequately trained before starting their jobs on the units. Although they receive basic passive restraints and First Aid, as mandated by policy, they are functionally unprepared to enter the unit environment and to deal with the demands of an acute psychiatric population.

■ It was apparent during the visit and interviews that there is an unreasonable amount of unrest among dietary staff. The problem appears to result from individual conflicts based on the perception that favoritism is being exhibited towards certain staff. This problem was brought to the attention of the acting CEO before the completion of the investigation.

■ It was reported by staff that over-bedding of the hospital interferes with community integration and other treatment programs for patients, i.e., doctor appointments, shopping downtown, eating in the community, etc. When the hospital is over census it affects the availability of staff on the units and makes implementing community integration programs very difficult, if not impossible to implement.

■ Staff interviewed were upset about a recent change in policy 2991, which allowed the State to reimburse staff for personal property such as eye glasses destroyed by aggressive patients. According to the Deputy Commissioner of Operations, the practice is not supported by West Virginia Code and therefore there is no mechanism to reimburse staff for their loss. Currently staff whose personal property is destroyed because of an altercation with a patient must bear the cost of replacement of destroyed personal items on their own. These changes only magnify the hostile working environment that some staff perceive as existing.

■ Two units reviewed did not have adequate seating for patients in the day rooms. There were only 21 seats available for 31 patients on G-2 unit.

■ E-2 conference room has been converted into a permanent bedroom (beds bolted to floor) with no bathroom readily available for these two patients.



FORMAL RECOMMENDATIONS

After careful review and analysis of the many issues and concerns with the over-bedding at Sharpe Hospital, the Court Monitor is providing the Secretary of the Department of Health and Human Resources with the following recommendations:

Recommendation #1.) The DHHR shall discontinue the practice of over-bedding at Sharpe Hospital. This facility shall not exceed its 150 licensed bed capacity. A plan should be developed to begin the process of gradual movement/diversion of patients. This shall be accomplished over the next 90 days. The Monitor is aware that as many acute patients as possible are currently being diverted and that many private hospitals used for diversion are full much of the time. The Office offers its cooperation in assisting in the development of alternative placements for new and forensic patients.

Recommendation #2.) The management at Sharpe Hospital shall develop a design plan, with the input of nurses, health service workers and appropriate others, in the construction of more appropriate nurse's stations on all units. The design of the nurse's station shall ensure safety and eliminate the risk of patients assaulting staff

positioned in these areas. The final design plan shall be submitted to the Office of the Court Monitor for review and approval before construction begins.

Recommendation # 3.) DHHR and the management at Sharpe Hospital shall develop a policy that allows for some method of reimbursement when personal belongings of staff are damaged because of a work-related incident with a patient while the staff is employed at the hospital.

Recommendation #4.) DHHR and the management at Sharpe Hospital shall comply with all aspects of §64 CSR 59 as it pertains to Behavioral Health Client Rights. Several violations have been noted throughout this investigation with regard to square footage in non-traditional patient bedrooms, access to bathrooms and showers, and lack of privacy for patients making personal phones calls. Telephones that do not operate at all times need to be repaired.

Recommendation #5.) DHHR and the management at Sharpe Hospital shall re-evaluate the policy and practices of “mandatory over-time”. This study should address amending the policy to allow for some flexibility under certain specific circumstances for staff this affects.

Recommendation #6.) The hospital shall develop a plan which precludes inappropriate mixture of clinical populations. Forensic patients should not be mixed with acute care populations. Individuals with intellectual disabilities should be treated in separate structured units in which behavior management and community integration activities can be provided by appropriately trained staff. Individuals with substance abuse disorders should receive treatment in a self-contained specialty unit similar to that created recently at Bateman Hospital. Since this population is becoming more and more pervasive in admissions, the Bureau needs to expand specialty substance abuse programs in the community, including specialty inpatient treatment as appropriate. The Court Monitor would like to see a comprehensive statewide substance abuse treatment plan designed in collaboration with community providers, including clinical/administrative staff from private diversion facilities, within the next six months (March 2011).

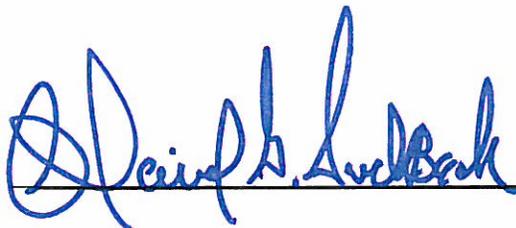
SUMMARY

The Court Monitor would like to thank the staff and management at Sharpe Hospital for their cooperation during this review. The Court Monitor's Office remains committed to assisting the Department and the hospitals to make the changes necessary in order to forever stop the practice of over-bedding at both

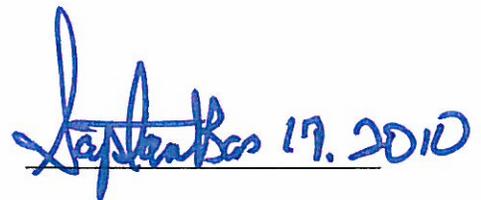
Sharpe and Bateman Hospitals. In addition, the Court Monitor would like to thank Ms. Tami Handley, Legal Aid Advocate, for her assistance throughout this review/investigation.

As a result of the input offered by clinical staff during the investigation, the Monitor must conclude that patient treatment is compromised when over-bedding occurs at Sharpe Hospital. Environmental conditions that exist as a result of over-bedding are also interfering with the staff's ability to address basic care needs of the patients. Safety of patients and staff remain the utmost concern of this Office.

Pursuant to Section 8.02(6)(c) of the West Virginia Behavioral Health Care Delivery System Plan, the Parties may file objections to the Court Monitor's Formal Recommendations within fifteen(15) business days of the date below.

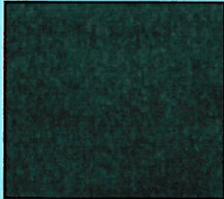


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September 17, 2010

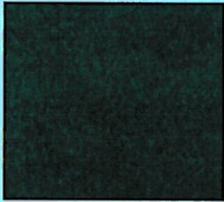
Cc: The Honorable Judge Bloom
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