Comments:

1	This is a very stressful environment, seems like more work keeps getting assigned but more restraints are being added (no comp/flex, having to use (flex) in a certain time) to get work done. Nursing and direct care staff are tired from working so much overtime so they are leaving to find other jobs. Seems like when there is a problem nothing is done about it.
2	I do not feel safe as an employee and do not believe we are doing all we can to keep our patients safe: Staff do not get properly searched before entering the facility; we don't have enough staff; we don't fire staff who engage in improper conduct; staff are not providing a therapeutic environment for patients. We have communication problems (several months when phone, paging and internet were down) and security problems (cameras not working/staff not being kept up to date on the status of the cameras). The safety is alarming, concerning and appalling. We need help and intervention for safety. We lack the resources to do our job. Staff consistently report feeling burned out, are held over and expected to produce without support and resources from the administration. Administration does not follow policy. We do not properly vet new staff. New staff are either not properly trained or proper procedures are not enforced.
3	Incidents are not reported. Follow up to incidents and preventative/corrective action is not reported. There are insufficient staff to prevent and monitor for safety concerns, or report/document them. Staff are not sufficiently trained to promote safety/incident prevention. Contraband is permitted in the facility (security does not check for contraband-glancing in bags and a metal detector that does not work are not sufficient and there is insufficient staffing to properly check for these items). There are staff assigned to prevent/monitor for safety concerns who are 1) overworked 2) not sleeping, so they are sleeping on the job 3) cannot perform their job (to read/write notes on behaviors and incident reports). Management does not appear to enforce consequences to behavior that threatens staff/patient safety (staff bringing personal items on the units, staff are permitted to keep working after clear violations: abuse, even physical abuse). The facility and units are not designed to house max security patients (e.g. the furniture, lights, trash cans, utensils, writing instuments, etc.). Video surveillance cannot be adequately monitored in real time and often does not work. There is insufficient accountabillity for items given to patients (e.g. utensils, paper, phone cards, etc.). The movies and books shown to patients are rated R and promote violence including: physical violence, rape, child sexual offending, kidnapping, etc. Facility is currently operating under a culture of blame/reactive stance which puts people on the offensive /defensive rather than reporting problems and working together to fix them.
4	There appears to be a lot of dysfunctional relationships here at this facility. Staff who are not receptable (receptive) or accepting of change. These individuals continue to do underminding things to hinder the progress of the facility. Many people continues to ignore or turn their head from these individuals. This is Toxic and unsafe behavior, causing an unsafe environment. These individuals don't get reprimanded or discipline at all making others resent and feel uncomfortable working with them: They are not held accountable for their TOXIC behavior. If the goal is progress, change and move forward how is this possible with this type of individuals a part of this agency. It is time for mose major changes in order for progress to happen!!!
5	Too much is swept under the rug-particularly regarding patient safety
6	This place is becoming very dangerous to work at. Seems like no one is trying to help manage this issue
7	Why don't we work with Bryce to get help with nursing staff or schedule contract RN's to fill in scheduling gaps?
8	Not adequate staff to fully implement safety measures

Comments:

9	Patient safety and care continue to decline as concerns related to work environment and staff shortages continue to increase without any form of intervention. Because of staff shortages and immense workloads, staff are having to work long hours and do jobs of multiple people. Therefore, issues fall between the cracks. In addition, the amount of hours that staff are required to work impede their ability to be proactive and handle safety issues appropriately. In my opinion, patient safety only becomes a priority when negative attention has been brought to ADMH or THSMF administration. Patient safety is usually an afterthought, a technicality, and we approach the subject of patient safety ina reactive rather than proactive manner.
10	Patient safety is definitely at risk, as well as staff safety! Due to excessive work hours (mandatory overtime) required by staff it has gotten to a critical point. It has been declining (number of staff for patient areas) and no one has done anything abotu it. Very poor leadership and lack of concern for patient and staff safety is obvious.
11	Patient care has gotten so bad in this facility I am ashamed to say that I work here.
12	Patient safety is overlooked at this facility. FTs are on units sleeping instead of watching patients. The morale is horrible because no one is held accountable for their actions. No one takes their job seriously. We have FTs getting chased into parking lots and arrested with illegal drugs and come back to work the next day and take care of patients. Doesn't sound safe to me.
13	If staff do a good job they receive more responsibility or have higher expectations placed on them. For those who do not perform at a higher level, less expectation and less work (transferred) happens. There seems to be little accountablility for those who do not do their job. When one member/group is not performing it impacts All groups. Stress levels are very high. Frustration is high. All of this can impact work with patients and the overall quality and accuracy of work done.
14	Understaffing is a serious issue at this facility and upper management does not care!!! We are alone. Exhausted people make errors and we are all exhausted (the people that are in direct care). There are nurses that have cute little offices up front that should be ashamed of themselves because they could help but never do.
15	I have Never worked in a hospital (including Ers, ICUs, Dialysis units) where Management is allowed to manage from offices in such critical nurse staffing shortages…with an RN III begging, pleading, consistently attempting to notify management (Nurses that have 1st in their credentials the Responsibility as RN then RN Manager or Director of Nursing or Director). I've worked in nursing shortages much like this one we're experiencing now and managers, directors, department heads put lab coats on, stethoscopes etc and came to the units!!! They did not have the luxury to simply look at the text or screen the call then look away. Karma? Not unless you believe in Hinduism and Buddism. I, like many of my co-workers, am Christian are we live by His word and some of His work says: To whom much is given, from him much is expected (exact quote from Luke 12:48-For unto whomsoever much is given, of him shall be much required). He is going to straighten this proverbial "crooked road." I serve a just God. I'm leaving "management" and their lack of it in His hands. I forgive them, He tells me to, and judgement is not mine...just answering the survey.

Comments:

16	This facility is terribly understaffed and they are steadily firing staff behind one patient, when the staff should just be moved to another unit.
17	No teamwork. For safety purposes on DREAM the doors should have windows so staff can see in the room before entering, especially at night when the rooms are very dark. Staff feel like mistakes are held against them most of the time, they are even possibly terminiated. Mistakes have staff scared to do their jobs/assignments due to fear of losing their job. No matter what you do it's not good enough. I would like to see all staff work together as a team and try to accomplish one goal and that is to work together to come up with the best solutions and ideas to help the patients instead of staff throwing eachother under the bus and rather than using job titles to determine how much work we do and how much we care.
18	Secure Facility is a loose term here. There is no secure with the half fast security measures. Restrictions on searches, etc. The constant hiring of young males with criminal records to sit with patients. The fact that administrators, nurses and social workers call them patients instead of inmates or prisoners is part of the problem. We first have to acknowledge they are felons and they realize the security that needs to be in place to prevent drugs, tobacco and weapons from entering the facility.
19	Shortage of nursing staff has crippled this facility and caused hazard unnecessarily due to manditory work policy. This policy makes a full time staff position unbearable to qualified personnel. It also jeapardizes quality of care each time a worker is forced to stay an extra 8 hours when their scheduled 8 hours are over. This happens weekly and sometimes twice a week to nurses and Forensic Technicians. When an employee sees how little their personal well-being means to this facility, they look for a better opportunity.
20	We work in a very unsafe climate because of staff shortages, staff not getting along (some bullies and some passive-aggressiveness), discrimination based on race (both ways), gender, and education level; an administration that obviously does not care about staff or patients (administrators who run departments and those departments are crumbling need to be fired). Administrators try to cover up incidents and accidents and put on a show for commissioner and/or surveyors. This place is full of errors, accidents, etc that are waiting to happen because morale is at an all time low. And when morale is low, it means people don't care. And when people don't care, our patients aren't safe. Period.
21	While staff may feel like they are being written up, rather than the incident being written up when an event is reported the process is a discrete and improving process. We may use more agency/temp staff than is ideal, but the alternative would be doing with even less staff which would definitely be dangerous for the patients. Patient safety problems on the units are inherent to patient volitility on admission. Our procedures and systems are good at preventing errors from happening as evidenced by reduction in med errors.
22	It is my impression that safety is a top priority and changes to policy/procesdure are made in response to events. I know that several education classes are developed and taught every year to prevent events/incidents from re-occurring.
23	Poor facility patient safety. Poor incident reporting and decision making amongst key administration staff.
24	Way underpaid, understaffed, unappreciated, and disrespected. No days to properly rest. Cannot request time off for a mental break.
25	We are already working 16 hour days be being mandated-just make it two 12 hour shifts. More money would definitely keep workers, especially the ones that are already here.
26	I am really pleased with Dr. Glen-her thoughtfulness and hard work. Ms. Jackson is doing an excellent job with all the changes.

Comments:

27	We are working too short of staff too many hours for the safety of patietns and co-workers. Staff is never praised for a job well done. Professional staff never listen to the staff htat work hands on with the patients daily. Staff fear reporting things for fear of losing theri jobs or being wrote up. No respect is given to direct care staff. Hiring too many young staff. Nurses downgrade the FTs often. This place has gone to the dogs.
28	We do not have enough staff to handle the workload. Staff work longer hours than what is best for patients-16 hours 2 days straight or back to back 12 hour shifts. We never do things to improve patient safety because we are understaffed. We need more agency/temp staff. We work in crisis mode all the time and no one up front comes down and helps answer the door/phone. We are in a dangerous situation now with work getting done. My supervisor doesn't consider staff suggestions, just delegates more work. My supervisor wants us to work faster, even if it means taking more shortcuts all of the time. My supervisor doesn't care about patient safety problems. Not everything gets reported because not enough staff to report everything that happens with the patients. Management doesn't care. Actions of management DO NOT show that patietn safety is a priority. Something needs to be done around here before we all walk out of this place and management up front will be on the floor working with these patients. Tired of long hours. We have no time with our families or our kids and we continuously work the overtime then get punished for sleeping or for forgetting to do something. Time for a change around here.
29	Mental Health Workers are underpaid and we work entirely too much overtime.
30	Working on CARE with only one nurse is very unsafe when we are having to answer phones, doors, do FT's work along with pulling meds. Then we have one patient over there that needs our one-on-one attention, not fair to other patients and they tell us that we are showing favoritism to him. But when he starts acting up the whole program starts getting disruptive. We need more nurses and FT's. We are working very unsafe. I have been hit by this patient as well.
31	I think we should have a time clock so all staff can keep up with his or her hours worked. I also think we should be paid be the hour and have rotating shifts for example: one week you work 12 hours all week and the next week you work 16 hours all week. Therefore you will know the hours you have to do before doing them. I also feel in my opinion that control should help us out in the Dining Room whenever a unit goes to eat, at least one person from control would help make things go a little more smoother.
32	*Forensic Techs are *Under-Paid* *Forensic Techs are *Under-Paid* *Under-Paid* *Under-Paid* *Under-Paid* *Under-Paid* *Under-Paid* This facility is understaffed. The staff is overworked and any little think or mistake that is made by a FT is always under investigation that could cost us our job or moved off programs. Our FT's have no say so in anything that goes on in this facility. We are be-littled and talked down on. Our FT's are under paid, but we have the toughest job.
33	State needs to pay more for FTs. You will hire good people and keep them.
34	We are very short of staff which is not safe for the patients or staff and it's like if you make a mistake your job is on the line.
35	The RN III does a good job, she gives positive feedback.We are short staffed. Safety is being jeapordized due to staff exhaustion. Patients are not being held accountable for program violations and behavior-It's out of control.
36	Everyone should not be able to access every door in clinical services, unless they are the clinical director.

2018 Culture of Safety Survey

Attached please find the results of the 2018 Culture of Safety Survey. This survey was conducted in April 2018. There were 82 responses for a 43% participation rate, which is an increase from the 27% last year and 40% the year before.

An ADMH approved tool from the Agency for Healthcare Research and Quality (AHRQ) website was used to conduct the survey. It is considered valid and reliable.

FINDINGS:

Patient Safety Grade:

2018	2017	2016	2015
A: 10% Excellent	10% Excellent	14% Excellent	13.6% Excellent
B: 16% Very Good	27% Very Good	39% Very Good	34.6% Very Good
C: 28% Acceptable	38% Acceptable	36% Acceptable	35.3% Acceptable
D: 23% Poor	21% Poor	9% Poor	12.2% Poor
F: 20% Failing	0% Failing	0% Failing	2.7% Failing

Five participants chose not to respond to this section of the survey. Positive responses (excellent and very good) have continued their downward trend with 26% this year compared to 38% in 2017, 53% in 2016 and 48.2% in 2015. The majority of the respondents (54%) gave their work area a patient safety grade of "Acceptable" or higher.

Number of Events Reported:
Seventy-three percent of respondents completed at least one incident report over the past 12 months. Twenty percent indicated that they have not completed any incident reports with thin the last 12 months. Seven percent of the respondents chose to leave this section blank. Fifty percent of the respondents indicate that they have reported between 1-10 incidents, with 3-5 incidents being the most frequent response (20%).

ITEM-LEVEL RESULTS
There are twelve (12) patient safety culture composites. All twelve (12) patient safety culture composites scores for THSMF were below the AHRQ scores. When determining percentages of positive responses for positively worded statements those who responded "Strongly Agree," or "Agree" are calculated. Whereas, when calculating the percentage of positive responses for negatively worded items (*), the percentage is based on those who responded "Strongly Disagree", or "Disagree".

Using the 5% point difference as a rule of thumb when comparing THSMF's results with the AHRQ database averages revealed the following:

- There were no items with 5 percentage points greater than the database average that would be considered "better" than the AHRQ database average.
- The following composite scores were more than 5% below the database average:

- *Overall Perceptions of Patient Safety (-45)*
- *Organizational Learning- Continuous Improvement (-43)*
- *Management Support for Patient Safety (-41)*
- *Communication Openness (-36)*
- *Nonpunitive Response to Error (-32)*
- *Staffing (-32)*
- *Feedback & Communication about Error (-30)*
- *Teamwork Within Unit (-28)*
- *Teamwork Across Units (-23)*
- *Supervisor/Manager Expectations & Actions Promoting Patient Safety (-23)*
- *Frequency of Events Reported (-19)*
- *Handoff & Transition (-19)*

Using the 5% point difference as a rule of thumb when comparing THSMF's results with THSMF's averages from 2017 revealed the following:

- There were no items with 5 percentage points greater, which would be considered "better" than THSMF's 2017 data.
- The following composite scores were more than 5% below the database average:
  - *Organizational Learning- Continuous Improvement (-24)*
  - *Overall Perceptions of Patient Safety (-20)*
  - *Teamwork Within Unit (-18)*
  - *Management Support for Patient Safety (-17)*
  - *Nonpunitive Response to Error (-14)*
  - *Communication Openness (-13)*
  - *Supervisor/Manager Expectations & Actions Promoting Patient Safety (-13)*
  - *Teamwork Across Units (-12)*
  - *Feedback & Communication about Error (-11)*
- The following items did not show a significant change based on comparison to THSMF's 2017 data
  - *Frequency of Events Reported (0)*
  - *Handoff & Transition (1)*
  - *Staffing (-3)*

The areas or the composites with the highest average of percent positive responses were:

- ***Supervisor/Manager Expectations and Actions Promoting Patient Safety*** *(55% positive)*
  - My supervisor says a good word when he/she sees a job done according to established patient safety procedures (59% positive)
  - My supervisor seriously considers staff suggestions for improving patient safety (45% positive)
  - *Whenever pressure builds up, my supervisor wants us to work faster, even if it means taking shortcuts (54% positive)

  - *My supervisor overlooks patient safety problems that happen over and over (61% positive)
- ***Teamwork Within Units*** *(54% positive)*
  - People support one another in this unit (60% positive)
  - When a lot of work needs to be done quickly, we work together as a team to get the work done (59% positive)
  - In this unit, people treat each other with respect (60% positive)
  - When one area in this unit gets really busy, others help out (37% positive)

The areas or the composites with the <u>lowest average</u> percent of positive responses were:

- ***Nonpunitive Response to Error*** (13% positive)
  - *Staff feel like their mistakes are held against them (11% positive)
  - *When an event is reported, it feels like the person is being written up, not the problem (17% positive)
  - *Staff worry that mistakes they make are kept in their personnel file (10% positive)
- ***Overall Perception of Patient Safety*** (21% positive)
  - *It is just by chance that more serious mistakes don't happen around here (19% positive)
  - Patient safety is never sacrificed to get more work done (23% positive)
  - *We have patient safety problems in this unit (23% positive)
  - Our procedures and systems are good at preventing errors from happening (18% positive)
- ***Staffing*** (22% positive)
  - We have enough staff to handle the workload (11% positive)
  - *Staff in this unit work longer hours than is best for patient care (25% positive)
  - *We use more agency/temporary staff than is best for patient care (40% positive)
  - *We work in "crisis mode" trying to do too much, too quickly (12% positive)

The areas with the <u>most significant change</u> from 2017 to 2018:

- *Organizational Learning- Continuous Improvement- 30%, which is a decrease of 24*
  - We are actively doing things to improve patient safety (36% positive)
  - Mistakes have led to positive changes here (20% positive)
  - After we make changes to improve patient safety, we evaluate their effectiveness (35% positive)
- *Overall Perceptions of Patient Safety- 21%, which is a decrease of 20*
  - *It is just by chance that more serious mistakes don't happen around here (19% positive)
  - Patient safety is never sacrificed to get more work done (23% positive)
  - *We have patient safety problems in this unit (23% positive)

  - Our procedures and systems are good at preventing errors from happening (18% positive)
- *Teamwork Within Unit- 54%, which is a decrease of 18*
  - People support one another in this unit (60% positive)
  - When a lot of work needs to be done quickly, we work together as a team to get the work done (59% positive)
  - In this unit, people treat each other with respect (60% positive)
  - When one area in this unit gets really busy, others help out (37% positive)
- *Management Support for Patient Safety-31%, which is a decrease of 17*
  - Hospital management provides a work climate that promotes patient safety (33% positive)
  - The actions of hospital management show that patient safety is a top priority (38% positive)
  - *Hospital management seems interested in patient safety only after an adverse event happens (23% positive)

PARTICIPANT COMMENTS:
There were 36 surveys with comments written on the survey forms. Issues noted have been broken into two main categories: staffing/employee morale and safety concerns.

Staffing/Employee Morale:
1. This is a very stressful environment, seems like more work keeps getting assigned but more restraints are being added (no comp/flex, having to use (flex) in a certain time) to get work done. Nursing and direct care staff are tired from working so much overtime so they are leaving to find other jobs. Seems like when there is a problem nothing is done about it.
2. If staff do a good job they receive more responsibility or have higher expectations placed on them. For those who do not perform at a higher level, less expectation and less work (transferred) happens. There seems to be little accountability for those who do not do their job. When one member/group is not performing it impacts ALL groups. Stress levels are very high. Frustration is high. All of this can impact work with patients and the overall quality and accuracy of work done.
3. Understaffing is a serious issue at this facility and upper management does not care!!! We are alone. Exhausted people make errors and we are all exhausted (the people that are in direct care). There are nurses that have cute little offices up front that should be ashamed of themselves because they could help but never do.
4. I have Never worked in a hospital (including ERs, ICUs, Dialysis units) where Management is allowed to manage from offices in such critical nurse staffing shortages…with an RN III begging, pleading, consistently attempting to notify management (Nurses that have 1st in their credentials the Responsibility as RN then RN Manager or Director of Nursing or Director). I've worked in nursing shortages much like this one we're experiencing now and managers, directors, department heads put lab coats on, stethoscopes etc. and came to the units!!! They did not have the luxury to simply look at the text or screen the call then look away. Karma? Not unless you believe in Hinduism and Buddhism. I, like many of my co-workers, am Christian. We live by His word and some of His work says: To whom much is given,

from him much is expected (exact quote from Luke 12:48-For unto whomsoever much is given, of him shall be much required). He is going to straighten this proverbial "crooked road." I serve a just God. I'm leaving "management" and their lack of it in His hands. I forgive them, He tells me to, and judgement is not mine...just answering the survey.

5. This facility is terribly understaffed and they are steadily firing staff behind one patient, when the staff should just be moved to another unit.
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7. Shortage of nursing staff has crippled this facility and caused hazard unnecessarily due to mandatory work policy. This policy makes a full time staff position unbearable to qualified personnel. It also jeopardizes quality of care each time a worker is forced to stay an extra 8 hours when their scheduled 8 hours are over. This happens weekly and sometimes twice a week to nurses and Forensic Technicians. When an employee sees how little their personal well-being means to this facility, they look for a better opportunity.
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19. Everyone should not be able to access every door in clinical services, unless they are the clinical director.

Safety Concerns:

1. I do not feel safe as an employee and do not believe we are doing all we can to keep our patients safe: Staff do not get properly searched before entering the facility; we don't have enough staff; we don't fire staff who engage in improper conduct; staff are not providing a therapeutic environment for patients. We have communication problems (several months when phone, paging and internet were down) and security problems (cameras not working/staff not being kept up to date on the status of the cameras). The safety is alarming, concerning and appalling. We need help and intervention for safety. We lack the resources to do our job. Staff consistently report feeling burned out, are held over and expected to produce without support and resources from the administration. Administration does not follow policy. We do not properly vet new staff. New staff are either not properly trained or proper procedures are not enforced.
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sufficient and there is insufficient staffing to properly check for these items). There are staff assigned to prevent/monitor for safety concerns who are 1) overworked 2) not sleeping, so they are sleeping on the job 3) cannot perform their job (to read/write notes on behaviors and incident reports). Management does not appear to enforce consequences to behavior that threatens staff/patient safety (staff bringing personal items on the units, staff are permitted to keep working after clear violations: abuse, even physical abuse). The facility and units are not designed to house max security patients (e.g. the furniture, lights, trash cans, utensils, writing instruments, etc.). Video surveillance cannot be adequately monitored in real time and often does not work. There is insufficient accountability for items given to patients (e.g. utensils, paper, phone cards, etc.). The movies and books shown to patients are rated R and promote violence including: physical violence, rape, child sexual offending, kidnapping, etc. Facility is currently operating under a culture of blame/reactive stance which puts people on the offensive /defensive rather than reporting problems and working together to fix them.

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actions. No one takes their job seriously. We have FTs getting chased into parking lots and arrested with illegal drugs and come back to work the next day and take care of patients. Doesn't sound safe to me.

12. Secure Facility is a loose term here. There is no secure with the half fast security measures. Restrictions on searches, etc. The constant hiring of young males with criminal records to sit with patients. The fact that administrators, nurses and social workers call them patients instead of inmates or prisoners is part of the problem. We first have to acknowledge they are felons and they realize the security that needs to be in place to prevent drugs, tobacco and weapons from entering the facility.
13. We work in a very unsafe climate because of staff shortages, staff not getting along (some bullies and some passive-aggressiveness), discrimination based on race (both ways), gender, and education level; an administration that obviously does not care about staff or patients (administrators who run departments and those departments are crumbling need to be fired). Administrators try to cover up incidents and accidents and put on a show for commissioner and/or surveyors. This place is full of errors, accidents, etc. that are waiting to happen because morale is at an all-time low. And when morale is low, it means people don't care. And when people don't care, our patients aren't safe. Period.
14. Poor facility patient safety. Poor incident reporting and decision making amongst key administration staff.
15. Working on CARE with only one nurse is very unsafe when we are having to answer phones, doors, do FT's work along with pulling meds. Then we have one patient over there that needs our one-on-one attention, not fair to other patients and they tell us that we are showing favoritism to him. But when he starts acting up the whole program starts getting disruptive. We need more nurses and FT's. We are working very unsafe. I have been hit by this patient as well.
16. While staff may feel like they are being written up, rather than the incident being written up when an event is reported the process is a discrete and improving process. We may use more agency/temp staff than is ideal, but the alternative would be doing with even less staff which would definitely be dangerous for the patients. Patient safety problems on the units are inherent to patient volatility on admission. Our procedures and systems are good at preventing errors from happening as evidenced by reduction in med errors.
17. It is my impression that safety is a top priority and changes to policy/procedure are made in response to events. I know that several education classes are developed and taught every year to prevent events/incidents from re-occurring.

RECOMMENDATIONS/ACTIONS:

- Review by Facility Leadership to develop a plan of action to address findings