

P U L S E F O R G O O D

# Inpatient & Residential

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## Behavioral Health Feedback Toolkit

### **Safely Gather Feedback from Clients in Controlled Environments**

*“Feedback without coercion or fear of retaliation.”*

A specialized toolkit for collecting anonymous feedback in inpatient psychiatric, residential treatment, crisis stabilization, and other locked or controlled behavioral health environments. Contains 10 ready-to-use documents addressing the unique power dynamics, physical constraints, and ethical complexities of feedback collection where clients cannot freely leave.

### **10 Inpatient-Specific Documents**

Power Dynamics • Unit Deployment • Timing • Privacy • Discharge Loop-Closure

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# Toolkit Contents

Inpatient and residential behavioral health settings are the environments where feedback is both most needed and most difficult to collect ethically. Clients cannot leave. Staff control their daily schedule, medication, privileges, and discharge date. In this context, asking someone for “honest feedback” is an act loaded with power dynamics that outpatient settings do not face. This toolkit addresses every dimension of that challenge.

**Document 1: Power-Dynamics Risk Checklist** — Identifying and mitigating the coercive forces unique to controlled environments

**Document 2: Unit-Based Feedback Deployment Guide** — Adapting feedback systems to different inpatient unit types

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**Document 10: Discharge Loop-Closure Templates** — Ensuring clients who leave know their voice was heard

## DOCUMENT 1

# Power-Dynamics Risk Checklist

*Identifying and mitigating the coercive forces unique to controlled environments*

**INSTRUCTIONS:** *In outpatient settings, a client who is unhappy can leave. In inpatient and residential settings, they cannot. This single fact transforms every interaction — including feedback collection — into a power-laden event. This checklist identifies the specific power dynamics at play in your setting and verifies that your feedback system mitigates each one.*

## The Fundamental Power Asymmetry

### Why Inpatient Feedback Is Different From Every Other Setting

In a controlled environment, staff have authority over:

- When the client wakes up, eats, sleeps, and moves between spaces
- Whether the client receives privileges (phone calls, visitors, outdoor time)
- What medications the client takes and when
- Whether the client is placed in seclusion or restraint
- When the client is discharged
- What is documented in the client's chart — which may follow them for years

A client who is asked to “give honest feedback” in this context will rationally assume that negative feedback could affect any of these. Your feedback system must be designed so thoroughly that this assumption is wrong — and so transparently that the client believes it is wrong.

## Power-Dynamics Risk Assessment

RISK	DESCRIPTION	YOUR STATUS	MITIGATION
Privilege connection	Client believes feedback could affect privileges (phone, visitors, outings)	<input type="checkbox"/> Mitigated	Consent script explicitly states: “This will not affect your privileges.” Privileges are never modified after feedback collection.
Discharge influence	Client believes positive feedback could accelerate discharge or negative feedback could delay it	<input type="checkbox"/> Mitigated	Consent script states: “This has no connection to your discharge date.” Discharge decisions are documented independently.

Staff retaliation	Client believes staff will treat them differently if they give negative feedback	<input type="checkbox"/> Mitigated	Anonymity is absolute. Staff cannot access individual responses. Staff training explicitly prohibits inquiry about feedback.
Medication connection	Client believes feedback could influence medication decisions	<input type="checkbox"/> Mitigated	Medication decisions are clinical and documented separately. Feedback system has no link to clinical systems.
Seclusion / restraint fear	Client fears that expressing anger or dissatisfaction could be interpreted as agitation and lead to restrictive intervention	<input type="checkbox"/> Mitigated	Feedback is anonymous and asynchronous. It is not observable by staff in real time. No real-time alerts go to unit staff.
Chart documentation	Client fears that feedback content will appear in their medical record	<input type="checkbox"/> Mitigated	Feedback data is stored in a separate, non-clinical system. Nothing from the feedback kiosk enters the clinical record.
Legal / court influence	Court-ordered clients fear feedback could be shared with the court	<input type="checkbox"/> Mitigated	Feedback data is anonymous and is never shared with courts, probation, or any external party. Consent script states this.
Peer pressure	Other clients may see who uses the kiosk, creating social dynamics	<input type="checkbox"/> Mitigated	Kiosk is in a semi-private location. Use is not observed or tracked. No group activity involves the kiosk.

## Power-Dynamics Self-Test

Answer each question honestly. If any answer is “no,” the risk has not been mitigated:

<input type="checkbox"/>	Could a client give the most negative possible feedback without any change to their treatment, privileges, or discharge timeline?
<input type="checkbox"/>	Could a client refuse to use the kiosk with zero consequence — no notation in their chart, no comment from staff, no change in how they are treated?
<input type="checkbox"/>	Is it physically impossible for staff to see what a client types on the kiosk while the client is using it?
<input type="checkbox"/>	Is it technically impossible for anyone to link a specific response to a specific client?
<input type="checkbox"/>	Has every staff member on the unit been trained on non-interference with feedback collection?
<input type="checkbox"/>	Has the feedback system been reviewed by a client rights advocate or patient advocate?
<input type="checkbox"/>	Would a client who has been restrained, secluded, or involuntarily committed feel safe using this system?
<input type="checkbox"/>	Would a court-ordered client feel confident that their feedback cannot reach the

	judge?
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## DOCUMENT 2

# Unit-Based Feedback Deployment Guide

*Adapting feedback collection to different inpatient and residential unit types*

**INSTRUCTIONS:** *Not all inpatient units are the same. An acute psychiatric stabilization unit has different dynamics than a 90-day residential SUD program. This guide provides unit-specific deployment recommendations based on acuity, average length of stay, population, and physical layout.*

## Unit Type Profiles

UNIT TYPE	ACUITY	AVG LOS	FEEDBACK APPROACH	SPECIAL CONSIDERATIONS
Acute Psychiatric Stabilization	High	3-7 days	Minimal: 3 questions max, available after 48 hours. Kiosk passively available, never prompted.	Clients may be psychotic, manic, severely depressed. Cognitive capacity varies widely. Do NOT collect during acute phase.
Crisis Stabilization (CSU)	High	1-5 days	Minimal: 3 questions, available after 24 hours. Focus on safety and dignity only.	Very short stay. Feedback captures only the most basic experience. Consider discharge-only collection.
Inpatient Psychiatric (Subacute)	Medium	7-30 days	Standard: 5-7 questions, available after day 5. Mid-stay and discharge collection.	Clients are stabilizing. Can engage more meaningfully. Include treatment plan and staff respect questions.
Residential SUD Treatment	Medium	28-90 days	Full: Complete survey set, available after week 2. Mid-stay, monthly, and discharge collection.	Longest stay. Richest feedback opportunity. Use recovery-stage questions from SUD Toolkit.
Residential Mental Health (Long-Term)	Low-Medium	3-12 months	Full: Complete survey, monthly collection. Include community and autonomy questions.	Clients are living here. Feedback should include quality-of-life dimensions: food, environment, personal space, autonomy.
Forensic / Court-Ordered	Variable	Variable	Modified: Must address court-sharing fears explicitly. 42 CFR Part 2 protections. Consent script must be	Clients may believe feedback goes to the court. Must repeatedly clarify that feedback is anonymous and non-judicial.

			forensic-specific.	
Adolescent / Youth	Variable	Variable	Modified: Age-appropriate language, simpler scales, parental notification considerations. Reviewed by youth advisory.	Mandatory reporting obligations are heightened. Staff training must address minor-specific disclosure protocols.

## Deployment Decision Matrix

Use this to determine the right configuration for each unit:

DECISION	IF YES	IF NO
Average LOS > 7 days?	Mid-stay + discharge collection. Full survey.	Discharge-only or minimal (3 questions). Passive availability only.
Clients are generally cognitively stable?	Standard or full survey deployment.	Minimal survey. Delay availability until clinical team confirms capacity.
Unit has >20 active clients?	Aggregate data is meaningful at the unit level.	Roll data up to program level to protect anonymity.
Unit has court-ordered clients?	Add forensic-specific consent language. Never share data externally.	Standard consent is sufficient.
Unit has minors?	Age-appropriate language review. Mandatory reporting training. Parental considerations.	Standard adult survey.
Unit uses seclusion / restraint?	Add questions about feeling safe during interventions. Heightened anonymity.	Standard safety questions are sufficient.

## DOCUMENT 3

# Timing Rules: Admission, Mid-Stay, Discharge

*When to collect, when to wait, and when to never ask*

**INSTRUCTIONS:** *Timing in inpatient settings is not just a logistical question — it is an ethical one. A client who arrived 4 hours ago in psychosis cannot give meaningful feedback. A client being discharged in 30 minutes may feel pressured to be positive. This document establishes timing rules that protect both the client and the data.*

## The Three Collection Windows

WINDOW	WHEN	PURPOSE	QUESTIONS	CAUTIONS
Admission Exclusion	First 48-72 hours	DO NOT collect feedback. Client is orienting, stabilizing, and processing admission. Any request feels institutional.	None.	The kiosk may be visible but should not be introduced. Staff should not mention it.
Mid-Stay	After day 5 (short stay) or week 2 (residential)	Capture the lived experience while the client is still immersed in the environment. Most honest window.	Full survey (5-7 questions for short stay; complete set for residential).	Avoid days when treatment team meetings, court dates, or family visits occur — client is emotionally activated.
Discharge	24-48 hours before planned discharge	Capture the retrospective experience before the client leaves. Do NOT collect on discharge day itself.	Modified: include “What did we do well?” and “What would you change?” retrospective questions.	NEVER require or prompt as part of the discharge process. Kiosk should be passively available. No “check-out” framing.

## Timing Exclusions

**⚠ NEVER Collect Feedback During or Immediately After These Events**

✘ Within 24 hours of an involuntary admission or commitment hearing

- ✗ Within 24 hours of a seclusion or restraint episode
- ✗ During or within 2 hours of a psychiatric emergency or behavioral crisis
- ✗ While a client is in active withdrawal (SUD settings)
- ✗ During the actual discharge process (paperwork, transition planning meeting)
- ✗ During or immediately after a medication change that affects cognition or mood
- ✗ While a client is under 1:1 or close observation (staff proximity makes anonymity impossible)
- ✗ During a legal proceeding or immediately after court contact

## Timing Decision Aid

Use this quick-reference when unsure whether it is appropriate to have the kiosk available:

QUESTION	IF YES	IF NO
Has it been at least 48 hours since admission?	Kiosk can be available.	Do not mention or draw attention to the kiosk.
Is the client medically and psychiatrically stable enough to engage?	Standard availability.	Delay. Clinical team determines when client has capacity.
Has the client experienced a restrictive intervention in the last 24 hours?	Do NOT prompt. Kiosk remains passively available but staff do not mention it.	Standard availability.
Is the client being discharged today?	Do NOT introduce or prompt the kiosk. If client approaches on their own, that is fine.	Standard availability.
Is the client under 1:1 observation?	Kiosk is not appropriate. Staff proximity prevents anonymity.	Standard availability.

## DOCUMENT 4

## Staff Presence vs. Privacy Guidance

*The line between availability and surveillance in controlled environments*

**INSTRUCTIONS:** *In inpatient settings, staff are always nearby. Clients are accustomed to being observed. This creates a unique challenge: the kiosk must be accessible but not monitored, available but not supervised. Staff must be present enough to respond if a client is distressed but distant enough that the client feels private. This document defines the boundary.*

### The Paradox of Inpatient Privacy

#### **Clients Are Always Being Watched. The Kiosk Must Be the Exception.**

In a controlled environment, clients have almost no moments of unobserved autonomy. The feedback kiosk should be one of the rare exceptions — a space where the client is genuinely, observably, and credibly NOT being watched.

This is not just a design preference. It is a prerequisite for honest feedback. If a client believes — for any reason — that their kiosk interaction is being monitored, the data is compromised and the system fails.

### Staff Behavior Rules Near the Kiosk

RULE	RATIONALE	VIOLATION EXAMPLE
No staff member positions themselves within direct line of sight of the kiosk screen	Client must be confident no one can read their responses	Staff member standing at the nurses' station that faces the kiosk screen
No staff member approaches a client while they are using the kiosk	Interruption signals monitoring	Staff member walking over to "check on" a client at the kiosk
No staff member comments on kiosk use ("I see you used the kiosk!")	Acknowledgment implies tracking	"Did you use the feedback thing? Good for you!"
No staff member asks about kiosk content ("What did	Direct breach of anonymity	Even if asked casually or with good intentions

you write?”)		
No staff member adjusts a client’s schedule to “make time” for the kiosk	Creates implicit obligation	Moving a client’s group time so they can “do the survey first”
Staff are available if a client becomes distressed near the kiosk but do not hover	Presence for safety, not surveillance	Staff member standing nearby “just in case” while the client uses the kiosk
Overnight / low-staff shifts do not restrict kiosk access	Restricting access to high-staff times implies monitoring is necessary	Turning off the kiosk at night “for safety”

## Privacy Zones

ZONE	DESCRIPTION	ACCEPTABLE?
Zone A: Full Privacy	Kiosk in a dedicated alcove, private nook, or room with a closeable (not lockable) door. Staff cannot see screen or client interaction.	✓ Ideal
Zone B: Visual Privacy	Kiosk positioned so screen faces a wall or corner. Staff can see that someone is at the kiosk but cannot see the screen.	✓ Acceptable
Zone C: Minimal Privacy	Kiosk in common area with screen partially visible from staff areas. Staff would need to approach to read the screen.	△ Marginal — add a privacy screen
Zone D: No Privacy	Kiosk at or near the nurses’ station, in a hallway with camera coverage, or in a room where 1:1 observation occurs.	✗ Unacceptable

## Security Camera Guidance

### △ Cameras and Kiosks Cannot Coexist

If a security camera captures the kiosk area, clients will rationally assume their interaction is being recorded. Even if the camera is positioned to not capture the screen, the perception of surveillance eliminates trust.

- Remove cameras from the kiosk area, OR
- Relocate the kiosk to an area without camera coverage, OR
- Post clear signage: “This area is not monitored by camera. Your feedback is private.”

AND verify with your security team that the camera does not capture the kiosk area.

## DOCUMENT 5

## Client Explanation Scripts

*What to say so inpatient clients believe feedback is truly safe*

 **INSTRUCTIONS:** *In controlled environments, the consent and explanation scripts carry more weight than in any other setting. Clients have been told many things that turned out not to be true: “This conversation is confidential.” “Your treatment won’t be affected.” “You can leave whenever you want.” Your explanation must overcome this history of institutional betrayal.*

### Kiosk Welcome Screen (Inpatient-Specific)

#### Welcome Screen Text

We want to hear from you.

This is a short, anonymous survey about your experience here — how you’re being treated, whether you feel safe, and whether we’re doing a good job.

- It is completely anonymous. No one will know what you wrote.
- It takes about 2 minutes. You can skip any question.
- Nothing you say will affect your treatment, your privileges, or your discharge.
- Your feedback will NEVER be shared with the court, your PO, or anyone outside this program.
- Staff cannot see what you type.

You can stop at any time. There are no wrong answers.

[BEGIN]      [NO THANKS]

### Verbal Introduction Script (Staff to Client)

#### **SITUATION: Staff introduces the kiosk to an inpatient client**

STAFF: “Hey [name], I wanted to let you know about this. It’s a feedback kiosk — a way for you to tell us how things are going here. It’s anonymous. Nobody sees your name, and nobody knows what you wrote.”

“I know you might be thinking, ‘Yeah right.’ I get it. But this really is separate from your treatment. Nothing you say on here changes anything about your care, your

discharge, or your privileges. It's for us to get better, not to track you."

"Using it is completely up to you. If you never touch it, that's fine. If you use it every day, that's fine too. No one is watching and no one will ask."

## Addressing Specific Client Concerns

CLIENT SAYS	STAFF RESPONDS
"Yeah, but you'll read it and know it's me."	"The system doesn't collect names, room numbers, or any identifying information. Even I can't connect a response to a person. The results go out as numbers and themes — not individual answers."
"What if I say something bad about staff?"	"That's exactly what the kiosk is for. If something isn't right, we want to know. And because it's anonymous, you can say it without worrying about how anyone will react."
"Will this go to my lawyer / PO / judge?"	"No. This is completely internal and anonymous. It is never shared with courts, attorneys, probation, or any outside party. That's a firm policy."
"Will this affect when I get out?"	"No. Your discharge is a clinical decision made by your treatment team. The feedback system is separate from clinical decisions. It has no connection to your chart."
"I don't trust anything in this place."	"I hear you. You don't have to use it. But it's here if you ever want to. Sometimes it helps to have a way to say something without someone looking at you."

## What Staff Should NEVER Say

### Prohibited Phrases in Inpatient Feedback Introduction

- ✘ "We'd really appreciate it if you'd fill this out." (creates obligation)
- ✘ "Everyone on the unit is doing it." (social pressure)
- ✘ "It will help your treatment team understand you better." (implies clinical connection)
- ✘ "We need you to do this before discharge." (coercion)
- ✘ "Just be honest." (implies there's a risk to honesty that needs encouragement)
- ✘ "Your counselor asked me to mention it." (treatment team connection)

## DOCUMENT 6

# Anonymity Protection Strategies

*Technical and operational protections unique to inpatient and residential settings*

**INSTRUCTIONS:** *Anonymity is harder to protect in controlled environments than in open ones. Client populations are smaller, stays overlap, and staff have deep familiarity with individual clients. A response that says “the guy in room 204 yelled at me” may not include a name but functionally identifies both the reporter and the accused. This document addresses the specific anonymity threats unique to inpatient settings.*

## Inpatient-Specific Anonymity Threats

THREAT	DESCRIPTION	MITIGATION
Small census	On a 12-bed unit, demographic disaggregation can identify individuals	Data suppression: never publish subgroup data when $N < 10$ . On small units, report only at the program or site level.
Known schedules	Staff know who was on the unit at what time. Timestamps could narrow the respondent pool.	System does not log timestamps visible to staff. If timestamps are stored for data purposes, they are accessible only to the system administrator.
Identifying details in open-ended responses	Clients may describe specific events, rooms, or people that make their identity obvious	Review all open-ended responses before sharing. Redact identifying details. If the response remains identifiable after redaction, suppress it entirely.
Staff familiarity	In small residential settings, staff may recognize a client’s writing style or concerns	Share only thematic summaries to staff, not verbatim quotes, for units with $< 15$ clients.
Physical observation	In controlled environments, staff or cameras may see who approaches the kiosk	Privacy zone requirements (Document 4). No cameras covering the kiosk area. Staff behavioral rules.
Timing correlation	If only one client was in the common area at 2 AM, a timestamped response could identify them	Remove or obscure timestamps in all reports shared with unit-level staff.
Involuntary hold status	A client on a 72-hour hold is a very small subgroup. Any data disaggregation that includes hold status could identify them.	Never disaggregate by legal hold status. Never ask about involuntary status on the survey.

## Anonymity Protection Checklist

<input type="checkbox"/>	No timestamps are visible in any report shared with unit staff
<input type="checkbox"/>	Open-ended responses are reviewed for identifying details before any staff access
<input type="checkbox"/>	Data is suppressed or aggregated upward when unit census is below 10
<input type="checkbox"/>	No survey question asks about legal hold status, room number, or admission date
<input type="checkbox"/>	Staff have signed agreements acknowledging they will not attempt to identify respondents
<input type="checkbox"/>	The kiosk does not require login, name entry, or any identifier to begin the survey
<input type="checkbox"/>	The kiosk screen resets to the welcome page immediately after submission (no previous responses visible)
<input type="checkbox"/>	The feedback platform has been reviewed by IT for any metadata that could identify users (device ID, network logs)
<input type="checkbox"/>	Physical privacy protections are in place per Document 4 and Document 7
<input type="checkbox"/>	A client rights advocate has reviewed the anonymity protections and confirmed they are adequate

## DOCUMENT 7

## Environmental Placement Checklist

Where to put the kiosk when every space in the building is controlled

**INSTRUCTIONS:** In inpatient and residential settings, there are no truly “public” spaces. Every area is managed, monitored, and regulated. The kiosk must be placed in a location that is accessible to clients during their normal routine, private enough for honest feedback, and safe for both the equipment and the person using it.

### Placement Evaluation Matrix

POTENTIAL LOCATION	PRIVACY	ACCESSIBILITY	SAFETY	VERDICT
Common area / day room	⚠ Other clients nearby	✓ High traffic, clients here daily	✓ Low damage risk	✓ Acceptable with privacy screen and wall-facing orientation
Hallway alcove or nook	✓ Good natural privacy	✓ Accessible during movement between spaces	✓ Low risk	✓ Often the best option in inpatient settings
Near dining / break area	⚠ Moderate — mealtimes busy	✓ Clients pass through regularly	✓ Low risk	✓ Good if positioned away from seating areas
Nurses' station area	✗ Staff proximity too high	✓ High traffic	✓ Safe	✗ Unacceptable — perceived surveillance
Therapy room / clinical office	✗ Clinical association	⚠ Requires appointment or access	✓ Private	✗ Unacceptable — clients will associate feedback with treatment
Client bedroom / dormitory	⚠ Private but raises peer concerns	⚠ Other clients may see use	⚠ Damage risk higher	✗ Generally unacceptable — too personal and too risky
Visitor area / lobby	✓ Semi-private	⚠ Only accessible during visits	✓ Low risk	⚠ Marginal — only works if open to clients outside visit hours
Outdoor area / courtyard	✓ Good privacy if away from	⚠ Weather-dependent, may be	⚠ Equipment exposure	⚠ Consider only for enclosed, covered outdoor spaces

	windows	locked at times	risk	
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## Inpatient-Specific Placement Requirements

<input type="checkbox"/>	Kiosk is bolted or secured to prevent removal, damage, or use as a projectile (in high-acuity units)
<input type="checkbox"/>	Kiosk cord is secured and tamper-resistant (no ligature risk)
<input type="checkbox"/>	Screen faces a wall or corner (not toward staff areas, hallways, or cameras)
<input type="checkbox"/>	Kiosk is at a height accessible to seated clients (wheelchair, fatigue, medication effects)
<input type="checkbox"/>	Kiosk area has adequate lighting for reading but is not spotlighted
<input type="checkbox"/>	A chair or bench is available near (not blocking) the kiosk for clients who need to sit
<input type="checkbox"/>	Signage near the kiosk states: "Anonymous. Voluntary. Private. Your feedback will not affect your treatment."
<input type="checkbox"/>	Grounding resources and crisis line (988) are posted near the kiosk
<input type="checkbox"/>	The kiosk location has been approved by the unit's safety committee or environment-of-care team
<input type="checkbox"/>	A client advisory group or peer specialist has reviewed the location and confirmed it feels safe

## Ligature Risk Assessment

### Critical Safety Requirement for Inpatient Settings

Any equipment introduced to an inpatient psychiatric unit must be assessed for ligature risk. This includes the feedback kiosk, its mounting, its cord, and any accessories.

- Cord must be breakaway or internal (no external cords that could be wrapped)
- Mount must be flush to the wall or recessed (no protruding hardware)
- If free-standing, the unit must be too heavy to lift or must be secured to the floor
- No headphone jacks, USB ports, or other small removable components
- Assessment must be signed off by the unit's environment-of-care / safety officer

## DOCUMENT 8

# Incident Escalation Flowchart

*From feedback to action in high-acuity inpatient environments*

 **INSTRUCTIONS:** *Inpatient settings produce feedback that is both more urgent and more complex than outpatient settings. A client who reports feeling unsafe may be describing a moment that happened 30 minutes ago on a unit where they still live. Escalation must be fast, clinical, and above all, it must not compromise the anonymity that made the disclosure possible.*

## Inpatient Escalation Flowchart

### STEP 1: A safety-related response has been identified in feedback. Is anyone in IMMEDIATE physical danger?

- **YES:** Activate unit emergency protocol (Code, 911, rapid response). Then continue to Step 2.
- **NO / UNKNOWN:** Continue to Step 2.

### STEP 2: Classify the feedback using the BH Red-Flag Thresholds (BH Safety Toolkit, Document 2).

- **LEVEL 1 (suicidal intent, assault, medication error, restraint concern):** Notify charge nurse and clinical supervisor IMMEDIATELY. Go to Step 3.
- **LEVEL 2 (coercion, verbal abuse, substance access, passive ideation):** Notify clinical supervisor within 2 hours. Go to Step 3.
- **LEVEL 3 (discomfort, peer conflict, environment complaints):** Add to unit-level review (Document 9). Go to Step 5.

### STEP 3: Can the client be identified from the feedback content?

- **YES:** Clinical team conducts a welfare check through standard clinical channels. DO NOT reference the kiosk.
- **NO:** Activate ENVIRONMENTAL response: increase milieu monitoring, post crisis resources, brief unit staff on the identified theme without quoting the response.

### STEP 4: Does this trigger a mandatory reporting obligation or regulatory notification?

- **YES:** File mandatory report. Notify compliance officer. Complete incident report. Go to Step 5.
- **NO:** Document per standard protocol. Go to Step 5.
- **UNSURE:** Consult compliance officer same day. When in doubt, report.

### STEP 5: Close the loop.

- Document in Feedback Incident Log (BH Safety Toolkit, Document 5).
- Add to Unit-Level Improvement Tracker (Document 9).
- Notify leadership per the Leadership Briefing process if Level 1 or 2.
- Review at next unit-level team meeting.

## Inpatient-Specific Escalation Contacts

ROLE	NAME	PHONE	HOURS	BACKUP
Charge nurse (unit-level first responder)				
Clinical supervisor				
Medical director / psychiatrist on call				
Patient rights advocate				
Compliance / risk management				
Executive director				
State reporting hotline				N/A

## DOCUMENT 9

# Unit-Level Improvement Tracker

Connecting unit-specific feedback to unit-specific change

 **INSTRUCTIONS:** Different units have different dynamics, staffing patterns, client populations, and physical environments. Aggregate data across the entire facility can mask unit-specific problems. This tracker enables unit-level monitoring so that a safety concern on Unit A does not get diluted in facility-wide averages.

## Unit Scorecard

METRIC	UNIT A	UNIT B	UNIT C	FACILITY AVG
Overall experience (avg, 1-5)				
Staff treat you with respect (% Yes)				
Feel safe — physically and emotionally (% Yes)				
Supported in recovery / treatment (avg, 1-5)				
Treatment plan reflects client goals (% Yes)				
Can speak up without fear (% Yes)				
Red-flag responses this quarter				
Response volume this quarter				
Response rate (if estimable)				

## Unit-Specific Theme Tracker

UNIT	TOP THEME #1	TOP THEME #2	TOP THEME #3	ACTIONS PLANNED
Unit A				
Unit B				
Unit C				

## Unit Comparison Analysis

After each quarterly review, answer these questions:

<input type="checkbox"/>	Are any units consistently scoring lower than the facility average on safety questions?
<input type="checkbox"/>	Are any units producing more red-flag responses than others (adjusting for census)?
<input type="checkbox"/>	Are open-ended themes on one unit significantly different from other units?
<input type="checkbox"/>	Do unit-level differences correlate with staffing patterns (specific shifts, specific staff)?
<input type="checkbox"/>	Has any unit improved significantly after a targeted intervention?
<input type="checkbox"/>	Are there equity dimensions? (Do specific demographic groups report worse experiences on specific units?)
<input type="checkbox"/>	Are court-ordered clients concentrated on one unit, and does that unit have different scores?

## Unit Action Items

UNIT	ISSUE	ACTION	OWNER	DEADLINE	STATUS	OUTCOME MEASURE

## Quarterly Unit Review Meeting Agenda

TIME	SEGMENT	CONTENT
0:00–5:00	Unit scorecard review	Review scores by unit. Identify outliers.
5:00–15:00	Theme comparison	Compare open-ended themes across units. Are problems local or systemic?
15:00–25:00	Red-flag review	Review all Level 1 and 2 escalations by unit this quarter. Were protocols followed?
25:00–40:00	Action item review	Review actions from last quarter. Status update. New actions.
40:00–50:00	Equity check	Are disparities visible across units? By demographics? By legal status?

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50:00-60:00	Next steps	Assign owners. Set deadlines. Identify what staff need to hear.
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## DOCUMENT 10

## Discharge Loop-Closure Templates

*Ensuring clients who leave know their voice was heard and their feedback will drive change*

**INSTRUCTIONS:** *In inpatient settings, clients often leave without knowing whether anyone heard what they said. The feedback loop closes not when leadership reads the data, but when the person who gave the feedback knows it mattered. Because many inpatient clients will not return to the same program, the loop must close BEFORE or DURING discharge.*

### Why Discharge Loop-Closure Matters

#### **The Client Who Leaves in Silence Tells the Next Person Not to Bother**

Inpatient clients talk to each other. In waiting rooms, shelters, recovery meetings, and online forums, they share what programs are really like. A client who feels heard will tell people: “They actually listen there.” A client who feels ignored will say: “Don’t waste your time.”

Closing the loop is not just ethical — it is reputational infrastructure. Every discharged client is an ambassador or a warning.

### Loop-Closure Method 1: Discharge Folder Insert

Include this card in the client’s discharge folder or packet. Do NOT hand it to them separately or call attention to it — it should be one of several items in the folder.

#### **Discharge Card Text**

Thank you for sharing your voice while you were here.

We read every piece of feedback, and we use it to make this place better for the next person. Because of what people like you have told us:

- [Insert 1-2 concrete changes that were made from feedback. Example: “We changed the wake-up time because clients said it was too early.”]
- [Example: “We added more recreational time because clients said the schedule was too rigid.”]

Your experience mattered. We hope you're moving toward something good.

If you ever want to share more, visit [pulseforgood.com](https://pulseforgood.com).

## Loop-Closure Method 2: Unit Poster

Post this on the unit in a common area where current clients can see it. Update quarterly.

### Unit Poster Text

YOU SAID IT. WE DID IT.

People on this unit gave anonymous feedback. Here's what we changed:

- [Change 1 — specific and concrete]
- [Change 2]
- [Change 3]

Your feedback kiosk is [location]. It's anonymous, voluntary, and has nothing to do with your treatment. What you say stays between you and the machine.

Last updated: [date]

## Loop-Closure Method 3: Community Meeting Mention

If your unit holds community meetings (often daily or weekly in residential), the charge nurse or program coordinator can include a brief mention:

### **SITUATION: Community meeting feedback mention (2 minutes max)**

STAFF: "I want to share something quickly. We've been reading the anonymous feedback from the kiosk, and I wanted to tell you what we've heard and what we're doing about it."

"The most common theme this month was [X]. In response, we are [specific action]."

"I'm not going to read any individual responses or try to figure out who wrote what. But I want you to know: we're reading it, and it's making a difference."

“The kiosk is there whenever you want to use it. Or not. Completely your call.”

## Loop-Closure Checklist

<input type="checkbox"/>	Discharge folder includes the loop-closure card with at least 1 concrete change from feedback
<input type="checkbox"/>	Unit poster is updated quarterly with recent feedback-driven changes
<input type="checkbox"/>	Community meeting includes a feedback mention at least monthly
<input type="checkbox"/>	Changes cited in loop-closure materials are REAL — verifiable, completed, and not aspirational
<input type="checkbox"/>	No loop-closure communication identifies or could identify a specific client’s feedback
<input type="checkbox"/>	Loop-closure materials have been reviewed by a client advisory group or peer specialist
<input type="checkbox"/>	Staff understand that loop-closure is about the CLIENT seeing impact, not the organization taking credit

## What NOT to Do at Discharge

### Discharge Feedback Anti-Patterns

- ✘ Handing the client a satisfaction survey to complete during discharge processing (coercive timing, positive bias)
- ✘ Asking the client verbally: “How was your stay?” as a data collection method (social desirability, power dynamics)
- ✘ Making kiosk use part of the discharge checklist (“Before you go, please complete the feedback survey”)
- ✘ Offering a discharge incentive for completing the survey (“Fill this out and you can have an extra snack”)
- ✘ Having the treating clinician ask for feedback during the discharge session
- ✘ Collecting feedback and telling the client “we’ll use this for your aftercare plan” (clinical connection)

## End of Toolkit

*Feedback without coercion or fear of retaliation.*

For implementation support, contact your Pulse For Good account manager or visit [pulseforgood.com](https://pulseforgood.com)

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