

PERFORMANCE AUDIT REPORT

Client Abuse Reporting System At Winfield State Hospital

**A Report to the Legislative Post Audit Committee
By the Legislative Division of Post Audit
State of Kansas
March 1987**

Legislative Post Audit Committee

Legislative Division of Post Audit

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PERFORMANCE AUDIT REPORT

CLIENT ABUSE REPORTING SYSTEM AT WINFIELD STATE HOSPITAL

OBTAINING AUDIT INFORMATION

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THE CLIENT ABUSE REPORTING SYSTEM AT WINFIELD STATE HOSPITAL

Summary of Legislative Post Audit's Findings

What protections were supposed to be provided by the client abuse reporting system at Winfield State Hospital? The client abuse reporting system was supposed to ensure that suspected abuse or neglect of residents was promptly reported and investigated, that employees who abused residents were disciplined appropriately, that agencies outside the Hospital were notified, and that confidentiality was provided for employees who reported abuse or neglect.

Why did this client abuse reporting system apparently fail to protect clients from abuse or alert officials as to the nature and extent of the abuse? The auditors found that the system apparently failed because many incidents of abuse or neglect were never reported, and others were stopped at intermediate points within the reporting hierarchy. Some incidents of abuse were handled outside the system altogether. Alleged incidents of abuse that reached the Hospital's officially designated Abuse Committee were not always thoroughly investigated, and appropriate punishments were not consistently meted out. Internal and external monitoring efforts were inadequate to detect unreported abuse or to alert State officials to the severity of the problem. A variety of other factors may have contributed to the failure of the client abuse reporting system, and to other problems within the Hospital.

What improvements have been made in the client abuse reporting system, and what further changes are needed to ensure that the system is adequate to fulfill its purpose in the future? The Department of Social and Rehabilitation Services has taken a number of steps to address problems that have been identified with the client abuse reporting system, but additional improvements need to be initiated. The audit recommends establishing a new independent, full-time Abuse Investigation Committee that reports directly to the Department, taking strong measures to ensure that clients are protected from harm, clarifying or strengthening laws relating to client abuse and neglect, and solving other administrative and procedural problems within the system.



THE CLIENT ABUSE REPORTING SYSTEM AT WINFIELD STATE HOSPITAL

Federal inspectors withdrew Winfield State Hospital's federal certification on February 18, 1987, following a series of events that included the reporting and confirmation of cases of client abuse. One of the inspectors' findings related to the Hospital's abuse reporting system. To determine how the resident abuse reporting system contributed to recent problems at the institution, the Legislative Post Audit Committee directed the Legislative Division of Post Audit to examine several aspects of that system. This audit addresses three specific questions:

- 1. What protections were supposed to be provided by the client abuse reporting system at Winfield State Hospital?**
- 2. Why did this client abuse reporting system apparently fail to protect clients from abuse or alert officials as to the nature and extent of the abuse?**
- 3. What improvements have been made in the client abuse reporting system, and what further changes are needed to ensure that the system is adequate to fulfill its purpose in the future?**

To answer those questions, the auditors reviewed the system for reporting client abuse that was in place at Winfield State Hospital before February 5, 1987, and changes that have been made to the system since then. They reviewed case summaries and correspondence, and interviewed agency officials to determine how the system had operated and what results it produced. They also reviewed reports and correspondence regarding monitoring efforts by the central office of the Department of Social and Rehabilitation Services' Division of Mental Health and Retardation Services, the Kansas Department of Health and Environment, and the federal Health Care Financing Administration. In addition, the auditors surveyed Winfield State Hospital employees about their experience with the abuse reporting system and its operation. Finally, they interviewed a number of employees about more specific aspects of their experiences.

The auditors found the client abuse reporting system was supposed to ensure that suspected abuse or neglect of residents was promptly reported and investigated, and that employees who abused residents were disciplined appropriately. It apparently failed in both areas. Many incidents of abuse or neglect were unreported. Others were stopped at intermediate points within the reporting hierarchy or were handled outside the system altogether. Alleged incidents of abuse that reached the Hospital's officially designated Abuse Committee were not always thoroughly investigated, and appropriate punishments were not consistently meted out. A variety of other factors may have contributed to the failure of the client abuse reporting system, and to other problems within the Hospital. The Department has taken a number of steps to address problems that have been identified with the client abuse reporting system, but additional improvements need to be initiated. These findings are described more fully in later sections of the report, following a brief overview of Winfield State Hospital and recent problems there.

Overview of Winfield State Hospital and Recent Problems There

Winfield State Hospital and Training Center is located on a campus of 422 acres in the city of Winfield. The oldest and largest State facility for the care and training of mentally retarded Kansans,

Winfield State Hospital has a budget of \$19.9 million and 853 full-time equivalent positions for fiscal year 1987. The Hospital provides care, training, and developmental services to a residential population of severely and multiply-handicapped individuals for whom alternative services are not readily available in the communities. It serves a diverse population, which averaged 485 residents during fiscal year 1986. (The accompanying box describes the residents' characteristics more fully.)

Characteristics of the Clients

Winfield State Hospital's resident population is a diverse and demanding one. In interviews with the auditors, several individuals who have broad experience with institutions for the mentally retarded characterized the Hospital's population as one of the most intensely demanding groups of residents they have seen. On March 3, 1987, the Hospital housed 468 clients. They ranged in age from less than one year to more than 60 years, with 72 percent between the ages of 22 and 60. Ninety percent were profoundly retarded. According to the agency's budget materials and other information, approximately 60 percent of the clients cannot walk without assistance, and 60 to 80 percent are not toilet-trained. Most of the residents do not communicate verbally. Seventy-six percent of the residents have at least two other handicapping conditions in addition to mental retardation, and many require continuous medical attention.

Characteristics of the Hospital's Staffing

Winfield State Hospital is divided into six separate living units. A unit houses about 80-100 clients. Within each unit, the clients are further divided into smaller groups, called "families," of about 10 clients each. Members of the unit staff are assigned responsibility for one or more families. The unit staff includes a unit director, three to five qualified mental retardation professionals who are responsible for two or three families each, and a number of licensed mental health technicians, psychiatric aides, health service workers, and hospital attendants. The numbers of each kind of staff varies from unit to unit and shift to shift, but generally direct care for a family of 8-10 is provided by two aides or health service workers per shift, supervised and occasionally supplemented by the higher-level staff.

Administratively, Winfield State Hospital is divided into six program areas: general administration, habilitation (training for daily living activities) and treatment, staff education and research, ancillary services, medical and surgical services, and physical plant and central services. The habilitation and treatment program is the central program of the Hospital, and is responsible for providing treatment and training designed to meet each resident's needs. The Hospital is organized into six residential units: four for adults, one for children and adolescents, and one for residents with acute medical needs.

At both the federal and the State level, recent emphasis has been placed on providing active treatment for clients of intermediate care facilities for the mentally retarded. Active treatment is a program to enable each resident to progress and develop. For clients at Winfield State Hospital, these treatment plans focus on such areas as self-help skills, physical development, communication training, special education, social skills, and vocational training. A staff team is assigned to each unit, and that team is responsible for developing individualized plans for each resident. The team implements the plan, then periodically reviews the client's progress and makes necessary changes. A qualified mental

retardation professional is assigned to coordinate planning and service delivery for each client. The primary responsibility for carrying out treatment programs rests with licensed mental health technicians acting as surrogate parents ("family leaders") for small groups of residents ("families").

**Federal and State Surveys in 1985 and 1986
Cited Numerous Deficiencies at Winfield State Hospital,
Some of Which Related to the Client Abuse Reporting System**

Winfield State Hospital, as well as the other three State mental retardation institutions, receives federal Medicaid funding for services provided to eligible clients. Medicaid reimbursement accounted for approximately 40 percent of those institutions' budgets in fiscal year 1986. To receive Medicaid funding, institutions must provide certain minimum levels of service and comply with federal regulations. Each state designates a survey agency to inspect facilities annually and to ensure that federal standards are met. In Kansas, the survey agency is the Department of Health and Environment.

At the federal level, two regulatory investigators from the Health Care Financing Administration of the Department of Health and Human Services are assigned to Region VII, which includes Kansas, Nebraska, Iowa, and Missouri. Federal surveyors do not conduct certification reviews; that is the responsibility of the Department of Health and Environment. Federal surveyors conduct "look-behind" surveys, comprehensive reviews of facilities' compliance with standards that have already been addressed by the Department of Health and Environment.

These federal officials conducted their first survey at Winfield State Hospital in April 1985, and cited deficiencies in the areas of active treatment and protection from harm for the residents. That review indicated many residents were incurring harm from self-abusive behavior and client abuse of other clients, and that staff abuse of clients was occurring as well. The 1985 Legislature authorized 102 additional positions for Winfield State Hospital to address these cited deficiencies. The Hospital was recertified for receipt of federal Medicaid funds by the Health Care Financing Administration in September 1985. The 1986 Legislature authorized an additional 20 new positions for fiscal year 1987.

The next certification survey at Winfield State Hospital was conducted in May 1986 by the Department of Health and Environment. The hospital was again cited for deficiencies in a number of areas, including active treatment, staff training, the provision of specialized and professional services, not following dental orders, and inadequate infection control. No deficiencies were noted in the client abuse reporting system. The Department provided the required plan of correction, and had apparently completed its corrective actions when the hospital was re-evaluated during the first week of December 1986.

**An Employee's Allegations of Client Abuse Led To
A Series of State Investigations in Late 1986 and Early 1987,
Which Eventually Substantiated Abuse Problems**

During the week of December 11, 1986, Health Care Financing Administration officials informed the Department of Social and Rehabilitation Services that an employee of Winfield State Hospital had contacted them, alleging that clients at the facility were being abused. The Department requested a report

from the Hospital. At the same time, the regional office also asked the Department of Health and Environment to investigate the same allegation.

On December 17, 1986, Winfield State Hospital reported to the Department of Social and Rehabilitation Services that its staff had investigated the allegations of staff abuse of clients but was unable to substantiate them. The report was forwarded to the Health Care Financing Administration. On December 19, the investigating team from the Department of Health and Environment reported to their administrator that they had partially substantiated the issues of the same complaint. During their visit to the Hospital, Health and Environment staff witnessed an incident of resident abuse by a staff member. They cited the institution for five deficiencies, one of which was that "residents were not free from mental and physical abuse as evidenced by the substantiated complaint and observations." The Division of Mental Health and Retardation Services responded with a plan of corrective action on January 23, 1987.

Early in January 1987, the Department of Social and Rehabilitation Services was again notified by Health Care Financing Administration officials of continued

**Examples of Client Abuse
Reported at Winfield State Hospital**

According to the Department of Social and Rehabilitation Services, physical or mental abuse or neglect means the infliction of physical or mental injury or the causing of deterioration of a client and includes failing to maintain reasonable care and treatment, sexual abuse, negligent treatment, or maltreatment or exploiting a client to such an extent that the client's health, morals, or emotional well-being is in danger.

Examples of alleged abuse or neglect reported in 1986 included:

- an employee was observed yanking a client's head backward and forward by the hair
- an employee was seen shaking a client by the arm and pulling the client's head back and forth
- an employee was accused of not completing assigned tasks and of neglecting three clients who needed their soiled clothing changed
- an employee slapped a client on the back, pushed, shoved, and grabbed the client during shower procedure
- an employee slapped a client's hand
- an employee pushed a client down in a chair, shook his fist at the client, and yelled at the client

Examples of alleged abuse or neglect reported in 1987 included:

- employees forced a client to put on and wear urine-soaked clothes for about 1.5 hours
- an employee ate clients' pizza
- an employee was found asleep while on duty
- an employee struck a client in the stomach with his closed fist
- employees left a client in bed all day without clothes
- an employee hit a client and told other clients "what rights do you have to live"
- an employee gave clients cold showers
- an employee called a client lazy
- an employee pulled a client across the floor by his overall straps and then kicked the client

complaints of client abuse at Winfield State Hospital. The Department initiated a new investigation at the facility on January 6, conducted by legal, security, and investigative professionals from the central office of the Division of Mental Health and Retardation Services. This investigation substantiated numerous instances of abuse at the Hospital and has resulted in a series of employee terminations, suspensions, and legal actions.

State Investigations Helped Federal Officials Identify Problems During a Later Federal Review That Resulted in a Recommendation for Decertification

The Health Care Financing Administration's survey team returned to Winfield State Hospital on January 26, 1987, to conduct a second comprehensive review. During the February 6 exit conference, Health Care Financing Administration officials recommended decertification because of "...conditions of immediate and serious threat to the health and safety of residents at Winfield State Hospital and Training Center..." In a letter dated February 12, Health Care Financial Administration officials cited the following conditions:

- failure to thoroughly investigate and effectively resolve instances of staff abuse of residents
- failure to protect residents from harm and provide for their basic needs
- failure to monitor resident harm reports
- failure to train direct-care staff charged with implementing restrictive procedures
- failure to staff and organize dining hall areas to assure basic protection of the health and safety of residents
- failure to protect residents from infectious disease
- failure of the medical and nursing staff to assess and monitor the health status of residents
- failure to provide and maintain the dental health of residents
- failure to meet general sanitation requirements
- failure to maintain sanitary standards in kitchen, food preparation, food serving, dining, and utensil and dishware washing areas

Winfield State Hospital was given until midnight February 18 to correct these conditions. Department correspondence indicates the facility began to take corrective actions immediately. The Health Care Financing Administration returned to the Hospital on February 16, and conducted another exit conference February 18. The review team concluded that, although extensive improvements had been made, clients were not free from staff abuse, and employees were not sufficiently trained to change practices regarding use of restrictive procedures. Winfield State Hospital was terminated from federal financial participation in the Medicaid program effective midnight February 18. Federal funds will continue during a 30-day grace period, after which the Hospital will lose approximately \$700,000 per month in federal Medicaid funds.

To be recertified for Medicaid, the hospital has to meet all 693 certification standards for intermediate care facilities for the mentally retarded. The Department hopes to accomplish this goal by March 20, 1987. A team of professional consultants was brought in to review the Hospital and the Department's proposed

corrective measures on March 4 and 5. The results of their review were included in a memorandum from the Commissioner of Mental Health and Retardation Services to the Health Care Financing Administration's regional office on March 12, 1987.

What Protections Were Supposed to Be Provided By the Client Abuse Reporting System In Place at Winfield State Hospital?

Federal regulations require that each resident of an intermediate care facility for the mentally retarded must be free from mental and physical abuse. To achieve

Federal Regulations for Resident Abuse Reporting Systems

42 CFR 442:430 makes the following requirements for staff treatment of residents in Intermediate Care Facilities for the Mentally Retarded:

- (a) The facility must have written policies that prohibit mistreatment, neglect, or abuse of a resident by an employee.
- (b) The facility must insure that all alleged violations of these policies are reported immediately.
- (c) The facility must have evidence that:
 - 1. All violations are investigated thoroughly;
 - 2. The results of the investigation are reported to the chief executive or his designated representative within 24 hours of the report of the incident; and
 - 3. If the alleged violation is verified, the chief executive officer imposes an appropriate penalty.

this standard, the Department of Social and Rehabilitation Services has set protection from harm as each institution's top priority. In a December 1986 letter, the Commissioner of Mental Health and Retardation Services listed the four major areas of program expectations for its Mental Retardation Hospitals as protection from harm, quality of life, active treatment, and appropriate placement.

The Commissioner's letter gave the following definition of protection from harm:

Protection from harm means that each client of a state mental retardation institution shall be safe from harmful acts committed by themselves, by other clients, by staff, and by people from outside the institution; be safe from harmful conditions of the physical environment; and be safe from malpractice.

The client abuse reporting system is one aspect of each institution's responsibility to protect clients from harm. The auditors found that the abuse reporting system was supposed to ensure that all instances of abuse or neglect were promptly reported and investigated, that appropriate disciplinary actions were taken, that outside agencies were notified as required, and that reports of suspected abuse or neglect would be kept confidential. These protections are explained in the following sections.

The Client Abuse Reporting System Was Supposed to Ensure That All Instances of Suspected Abuse or Neglect Were Promptly Reported and Investigated, and That Appropriate Disciplinary Actions Were Taken

Both State statutes and Department policies provide requirements for reporting suspected incidents of resident abuse or neglect at State institutions. State laws require that suspected abuse or neglect be reported and investigated. However, the Department of Social and Rehabilitation Services' has delegated the

responsibility for investigating allegations of resident abuse to the institutions themselves. Winfield State Hospital's client abuse reporting system before February 1987 did not fully comply with the Department's policies. These findings are summarized in the sections that follow, and a chronological summary of the legislation and Department policies that are discussed is presented in Appendix A.

State laws require that suspected abuse or neglect of residents be reported and investigated. The 1980 Kansas Legislature passed legislation (K.S.A. 39-1401 et seq.) requiring medical and administrative officers to report to the Department of Social and Rehabilitation Services whenever they had reasonable cause to believe that a resident of a medical facility had been abused or neglected. The law defined abuse to mean neglect, willful infliction of physical or mental injury or willful deprivation by a caretaker of services that are necessary to maintain physical or mental health. The law defined neglect to mean the failure of a caretaker to maintain reasonable care and treatment to such an extent that the resident's health or emotional well-being is injured.

Upon receiving a report of suspected abuse or neglect, the law requires the Department to investigate and prepare written findings of whether abuse or neglect of a resident occurred. The law also requires the Department to maintain a Statewide register of the reports received, the findings, and the actions recommended.

In 1982, the Legislature enacted legislation (K.S.A. 38-1521 et seq.) requiring the reporting of suspected child abuse or neglect to the Department. This law requires that suspected child abuse or neglect by persons employed by the Department should be investigated by the appropriate law enforcement agency, not by the Department.

The Department delegated the responsibility for investigating allegations of resident abuse to the institutions. In January 1980, the Secretary of the Department of Social and Rehabilitation Services issued a letter to all Department employees clearly stating that abuse or neglect of clients would not be tolerated. The letter required any employee witnessing such a violation to report immediately to his or her supervisor. The letter also required each State hospital to maintain a chronological log of all incidents that were reported.

In February 1983, the Department issued a policy letter on reporting suspected child abuse or neglect in an institutional setting. The letter required employees to report immediately to the Superintendent, who was to immediately report verbally to the appropriate law enforcement agency.

In August 1985, the Department issued a comprehensive policy on unacceptable behavior by its employees, including client abuse or neglect. The policy required all employees of institutions operated by the Department to report all instances of suspected abuse or neglect immediately to the institution's superintendent. This policy is included in the handbook distributed to all employees of Winfield State Hospital. Individuals the auditors interviewed indicated that abuse complaints from outside parties regarding both adults and children residing in State institutions were channeled through the regular reporting channels within the Department to the institution for investigation.

The Department's personnel manual provides that employees who are suspected of client abuse shall be relieved of all duties involving contact with clients, pending investigation of the incident. If abuse or neglect by an employee is confirmed, the superintendent of the institution can impose such disciplinary actions as dismissal, demotion, or suspension.

Winfield State Hospital's client abuse reporting system before February 1987 appeared to comply with most, but not all, of the Department's policies. In December 1980, the Superintendent of Winfield State Hospital delegated the responsibility for investigating alleged resident abuse to the Hospital's director of social services. This person also chaired the Hospital's five-person Abuse Investigation Committee until February 1987. In addition to the chairperson, the Abuse Committee's other members included a social worker, a registered nurse, and a licensed mental health technician. All members of the Committee had other full-time positions within the Hospital. According to the Hospital's written policy, the purpose of the Abuse Committee was to investigate reported incidents of resident abuse or neglect by employees and to report the results of the investigation to the Hospital Superintendent. The Committee met only as needed to investigate reports of abuse or neglect.

The flowchart on page nine shows that the system provided for suspected abuse or neglect to be reported, for reports to be investigated by the Abuse Committee, and for disciplinary actions to be taken against persons found to have abused or neglected a client. Two aspects of the Hospital's system did not comply with Department policies. First, the procedure requiring that reports be made through the Hospital's chain of command made it difficult, if not impossible, to comply with the Department's policy that the chief administrative officer on duty be notified not more than two hours after the incident was witnessed. Second, the Hospital's procedures did not ensure that parents or guardians were notified that a report of abuse or neglect had been made until after the investigation was completed. Department policies require that the parents or guardians be notified when the report is first referred for investigation.

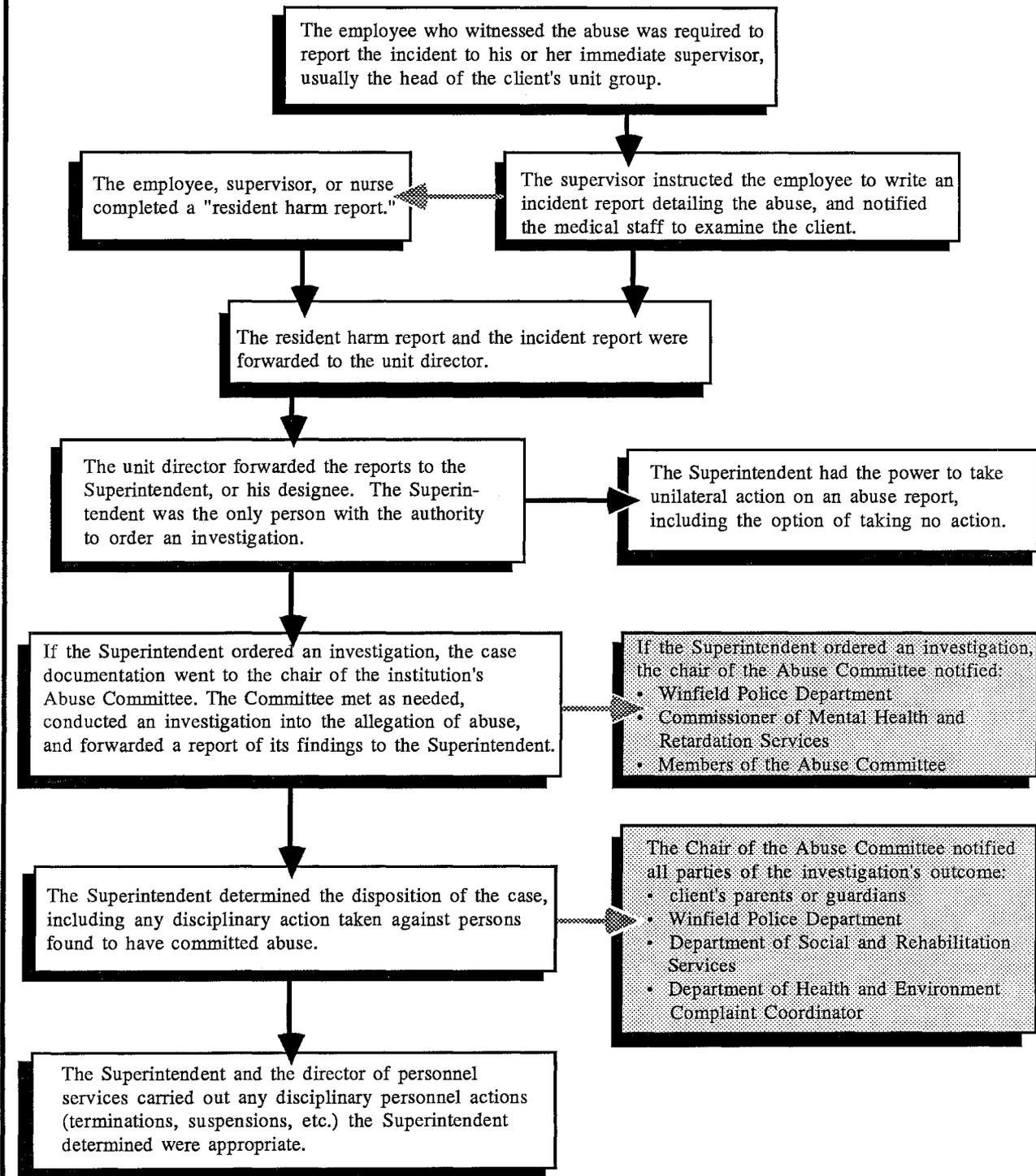
As the flowchart shows, the system in place before February 1987 required an employee who witnessed abuse or neglect of a client to report the incident to his or her supervisor, who in turn forwarded the report to the unit director. (The report also might have passed through intermediate levels of supervision within the unit.) From the unit director, the report went to the Superintendent or his designee. The Superintendent was the only one in the institution with the authority to order an investigation into an abuse or neglect allegation. He was also responsible for determining the final disposition of the case, including disciplinary action against any employee found to have committed abuse or neglect.

The Client Abuse Reporting System Was Supposed To Ensure That Persons and Agencies Outside the Institution Were Notified of All Instances of Suspected Abuse or Neglect

State law and Department and Hospital policies require that certain outside entities be notified when an abuse report is made.

K.S.A. 38-1522a requires that reports of child abuse or neglect be made to the Department, and that any reports of child abuse or neglect by Department employees be made to an appropriate law enforcement agency as well. K.S.A. 38-

Winfield State Hospital's Client Abuse Reporting System Before February 1987



The system of abuse or neglect report investigations in effect at Winfield State Hospital before February 1987 relied on reports being passed along from the employee making the report through his or her immediate supervisor, the shift supervisor, the unit director, and the Superintendent, before being directed to the Abuse Committee for investigation. At any point in the process, a supervisor or administrator could elect to resolve the report informally or even ignore it, rather than pass it along to the next level of review. In 1986, the Abuse Committee received and investigated a total of 13 complaints of client abuse or neglect.

1523 requires that any allegation of child abuse or neglect made against Department employees be investigated by an appropriate law enforcement agency at the direction of the county or district attorney, rather than by Department officials. K.S.A. 39-1404 requires the Department of Social and Rehabilitation Services to notify the Department of Health and Environment of any report of abuse or neglect of a State hospital resident.

In addition, K.S.A. 21-3425 makes mistreatment of a confined person a Class A misdemeanor. Any such act of mistreatment should be reported to a law enforcement agency for possible prosecution.

Department policy states that, in addition to notifying local law enforcement agencies, the superintendent or his designee shall notify the client's parents or guardians of the alleged abuse. The policy also states that an investigation shall be conducted, and that the parents or guardians shall be kept informed of the initiation and outcome of that investigation. These requirements are consistent with federal regulations that require intermediate care facilities for the mentally retarded to inform residents' families or legal guardians of resident activities that may be of interest to them, or of significant changes in residents' condition.

Department policy also directs that a copy of the written report to local law enforcement be forwarded to the Department's Commissioners of Youth Services and Mental Health and Retardation Services. At Winfield State Hospital, the responsibility for sending these notices was delegated to the chairperson of the Abuse Committee.

The requirement that outside parties be notified of alleged abuse was apparently intended to protect clients by encouraging Hospital officials to follow through with investigation and disposition of allegations, and by permitting an outside review of those officials' performance.

The Client Abuse Reporting System Was Supposed To Provide Confidentiality for Employees Who Reported Instances of Suspected Client Abuse or Neglect

Winfield State Hospital's policy on mandatory reporting of adult abuse says that the name of the person reporting abuse or neglect of a resident will not be disclosed unless the person agrees in writing to such disclosure or unless a judicial proceeding results. The Hospital's policy on mandatory reporting of child abuse does not include this statement.

The Department's personnel manual says that every effort will be made to keep incident reports confidential so that the alleged violators will not necessarily learn of the identity of persons reporting. The apparent purpose of this policy was to encourage the reporting of suspected abuse or neglect of clients, and to reduce the possibility of retaliation against the person who submitted the report.

Why Did The Client Abuse Reporting System Apparently Fail To Protect Clients from Abuse or Alert Officials as to The Nature and Extent of the Abuse?

To answer this question, the auditors reviewed State law and Department policies applicable to Winfield State Hospital. They interviewed officials of the Department, the Hospital, and the employees' union, and reviewed correspondence,

memoranda, and other Hospital documents relating to the client abuse reporting system. Finally, the auditors administered a survey to a total of 864 of the Hospital's 981 employees concerning the client abuse reporting system in place at Winfield State Hospital in 1986. Appendix B contains a copy of the survey materials given to each employee, and Appendix C contains a complete summary of the survey responses.

In general, the auditors identified a number of serious problems with the abuse reporting system that prevented it from effectively protecting Hospital clients from abuse. First, partly because of intimidation and fear of retaliation, employees apparently did not report all instances of client abuse or neglect by other employees. Second, many of the reports that were filed did not reach the Abuse Committee or were apparently handled outside the official system. In fact, at any point in the reporting process, a supervisor or administrator could elect to resolve the report informally or even ignore it.

Third, when reports did make it through the appropriate channels of the reporting system, they were not always handled properly. The investigations that were conducted were not professional, thorough, or aggressive, and the established procedures for investigating reports of abuse were not sufficiently independent. When abuse was verified, the Hospital did not always take appropriate disciplinary actions. Fourth, monitoring efforts both within the Hospital and by other State agencies were inadequate to detect unreported abuse or neglect or the severity of the abuse problem. These and other findings are discussed in the following sections.

Some Hospital Employees Did Not Report Instances of Client Abuse or Neglect By Other Employees

In their survey, the auditors questioned employees about the Hospital's atmosphere and employees' support for reporting instances of abuse. Employees involved in the direct care of mentally retarded clients--those who would be among the most likely to witness and report client abuse--said they generally were encouraged to report client abuse or neglect. For example, nearly 85 percent said that their supervisor would encourage or strongly encourage them to report client abuse or neglect. Smaller majorities said that their co-workers would encourage or strongly encourage them to report (64.5 percent), or that the Hospital's general atmosphere encouraged or strongly encouraged reporting of abuse or neglect (63 percent). Only six percent of the direct-care staff responding said that the Hospital's atmosphere discouraged or strongly discouraged reporting.

Despite these generally favorable comments, employees' responses to another survey question, federal findings, and the auditors' interviews with other employees showed that employees were

Most Winfield Employees Participated in the Survey

The auditors administered a survey to Winfield State Hospital employees on March 4, 5, and 6, 1987 to find out about their experiences with the 1986 client abuse reporting system. Of the 981 persons employed at the time of the survey, 864 completed and returned the survey, for a response rate of 88.1 percent. Of those responding, 428 (49.5 percent) were direct-care staff: aides, licensed mental health technicians, and the like. Another 124 (14.4 percent) were professional staff, including physicians, psychologists, social workers, and those with similar occupations. The remaining 312 survey respondents (36.1 percent) were classified as support staff, administrative or clerical staff, or foster grandparents. Among the direct-care staff, 182 (42.5 percent) supervised at least one other person. For all employees, 320 (37.0 percent) were supervisors.

not always reporting instances of abuse, as required by law or Department policy. At least some were not doing so because of intimidation or fears of retaliation..

More than one-fourth of the direct-care and medical and professional employees responding to the survey said they had seen client abuse or neglect in 1986 but had not reported it. In all, 26 percent of the direct-care staff responding to the survey (111 employees) and 29 percent of the professional and medical staff responding (36 employees) said they had seen abuse or neglect of a Hospital client in 1986 but did not report it. By law, any person licensed to practice any branch of the healing arts is required to report incidents of patient abuse or neglect to the Department. Department policy also requires all employees to report such abuse or neglect.

The survey asked respondents to pick from a group of possible reasons why they did not report abuse, or to list their own reasons. They chose the following four reasons most often:

<u>Reason for not reporting witnessed abuse</u>	<u>% of direct-care respondents who gave a reason</u>	<u>% of professional or medical staff who gave a reason</u>
• I thought the problem could be resolved informally within my work unit.	39.6%	47.2%
• The incident was too minor to report.	34.2	61.1
• I thought that no action would be taken even if I reported the incident.	32.4	11.1
• I thought other members of the staff would retaliate against me if I reported it.	30.6	11.1

As the table shows, the most common reason for not reporting incidents of client abuse or neglect was different for the two groups of employees. Almost 40 percent of the direct-care staff thought the problems they had witnessed could be resolved informally. About 61 percent of the professional and medical staff said they thought the incidents of abuse or neglect they had seen were too minor to report.

Federal findings indicated that some administrators apparently discouraged employees from filing abuse reports, and that the Hospital did not act to investigate possible incidents of retaliation. In a detailed listing of all deficiencies at Winfield State Hospital dated March 5, 1987, federal surveyors indicated that, in some instances, employees who had reported abuse claimed that Hospital administrators made them feel as if they "were doing something wrong," or tried to talk them out of filing allegations against other employees. Other employees who had reported abuse told surveyors they often felt intimidated by administrators and supervisors, or thought their allegations were greeted with disbelief by senior Hospital administrators.

The federal report also indicated that the Hospital failed to take strong action to protect employees from retaliation for reporting client abuse or neglect. Specifically, Hospital officials did not investigate several instances of damage to employees' cars, nor did they investigate an alleged threat by one employee against another.

Interviews with employees tended to support both the federal findings and the employee survey results. The auditors interviewed three groups of employees: 15 Hospital administrators, 18 employees who had been involved in reporting abuse, and 12 employees who requested to be contacted when they completed the survey. Five of the 15 administrators interviewed said that Hospital employees did not always report cases of abuse. Three of them thought intimidation and fear of retaliation kept employees from reporting abuse. Two of them thought some employees were covering up for employees they worked with.

Two of the employees who had filed abuse complaints told the auditors they were threatened with retaliation. Two others said they were aware of client abuse, but did not report it because they were afraid they would lose their jobs. Employees who requested interviews as part of the survey made similar comments. One indicated that a member of the Abuse Committee had told aides on the employee's ward not to report abuse. Another said that a unit director had encouraged unit staff not to report abuse. Other employees said they were fearful of retaliation by other staff if they reported abuse. That retaliation was sometimes indirect; for example, employees who reported abuse may find that no other employee would be "available" to help them handle a difficult client. Other employees expressed concern about the confidentiality of abuse reports, saying that more employees might be willing to report abuse or neglect if they had reasonable assurances that their names would not be revealed unnecessarily.

Reprimanding an Employee Who Reported Neglect

The auditors spoke with one employee who said that three of her co-workers had made a neglect report against an aide on one of the units. The complaint alleged that the aide had left a client who was confined to a wheelchair alone in a room for several hours. The auditors reviewed the files of the persons involved, and found that although the worker who left the client alone was reprimanded, at least one of the workers who made the report also received a letter of reprimand.

The letter said in part: "Your initial statement was dated the day after the occurrence and was not received by the unit director, or the Superintendent until three days later...There is also a serious question about the motives of those of you reporting the episode...During the course of the investigation, it became apparent that the motives of those of you reporting the incident had much to do with inter-personal differences between some of you working on the unit and underlying feuding over these differences."

The result of this series of events appears to have been that an employee reporting neglect was reprimanded for making a report incorrectly, and the employee's motives for reporting were called into question. The person interviewed by the auditors said that such occurrences discourage other employees from reporting abuse or neglect.

Most of the Incidents of Abuse That Were Reported Apparently Never Reached the Abuse Committee for Investigation

In the survey of Hospital staff, 151 employees indicated that they had reported an incident of client abuse or neglect during 1986. This number contrasts sharply with the 13 reports of client abuse or neglect that reached the Abuse Committee for investigation between January 1986 and January 1987.

Under the reporting system's established procedures, the Superintendent or his designee was required to keep logs of all reported incidents of abuse. The

auditors were unable to find any of the required records or logs. As result, they could not substantiate the reporting figures provided on the survey.

Federal surveyors were able to substantiate an incident on one residential unit in which Hospital administrators did not act for weeks to investigate an abuse allegation. The allegation was eventually substantiated. Several employees the auditors interviewed also related their own experiences with having complaints blocked. In one case, the worker said he had reported to his supervisor the discovery of a large bruise on the buttock of a client confined to a wheelchair. His supervisor said it would be taken care of. The worker said no further action was ever taken on his report. Another employee told the auditors that a complaint the employee filed in November 1986 did not reach the Abuse Committee until February 1987. Finally, one of the employees surveyed responded that "one of my employees reported to me [that] a direct-care employee had abused a client . . . we didn't hear anything more. This happened twice in our department."

One of the problems inherent in the client abuse reporting system was that, at any point in the reporting process, a supervisor or administrator could elect to

**Abuse Handled Outside
the Abuse Reporting System**

In late 1985, a probationary employee was dismissed from Winfield State Hospital. The abuse was not referred to the Abuse Committee for investigation. The Superintendent's letter informed the employee that the dismissal was the result of the following:

- Throwing ice at a resident trying to hit the client's mouth; when asked to stop by another employee, another piece of ice was thrown at the employee
- On the same day, the employee was seen lifting a resident's sore leg to watch the resident jump as the leg came down
- Later, that same day, the employee was seen dunking a resident in the swimming area, causing the resident to gasp for air

Because the abuse complaint was handled outside the formal reporting system, there was no record of an investigation. There was also no record that the residents were physically examined, or that these instances of abuse were reported to a law enforcement agency, the central office, or the residents' parents.

resolve a report informally or even ignore it, rather than pass it along to the next level of review. It would appear that this "stoppage" happened frequently at Winfield State Hospital. But because no records or logs were kept, the auditors could not determine at what point within the Hospital these reports of abuse were stopped from going to the Abuse Committee. Some of the Hospital administrators the auditors interviewed said complaints were blocked at the unit level, and others said complaints were diverted at higher levels within the Hospital's administration, including the Superintendent.

The Superintendent acted to discipline some employees for alleged client abuse or neglect without passing the reports of abuse on to the Abuse Committee or the central office. Under the old abuse reporting system, the Superintendent or his designee saw all complaints before they were referred to the Abuse Committee, giving them an opportunity to take unilateral administrative action. The Superintendent's designee was the chairperson of the Committee, who referred

all reported incidents of abuse to the Superintendent for possible action before referring them to the Committee as a whole. The chairperson kept a log only for the reports of abuse that the Superintendent requested be referred to the Abuse Committee for investigation. And only those reports of abuse or neglect that reached the Abuse Committee were reported to the central office.

In reviewing employee personnel records for fiscal years 1986 and 1987 to date, the auditors found that a total of 28 employees had been disciplined for resident abuse or neglect. However, 15 of those incidents were not included in the Abuse Committee files and were apparently handled without formal investigation. The auditors examined those 15 cases to determine whether they differed from cases that had been referred to the Abuse Committee.

In three cases, disciplinary action was taken for neglect that resulted from employees sleeping on the job, but the rest covered a wide variety of abusive or neglectful activities involving both permanent and probationary employees. The auditors also found that the investigations of these cases appeared to be less thorough than those investigated by the Abuse Committee. The documentation in these employees' personnel files generally included memos alleging abuse and memos from supervisors, unit directors, or higher-level administrative staff recommending disciplinary action. No documentation was present in the files to indicate that any organized investigation had taken place, nor was there any reference to medical evidence.

It is not possible to determine conclusively why these cases were handled outside the reporting system, but one distinguishing characteristic was that seven of the 15 cases originated from the residential units where some of the most serious problems with resident abuse were later identified. This may indicate an attempt to downplay the extent of the abuse problem in that area.

The auditors also reviewed the actions taken against the employees involved in these 15 cases. Six probationary employees were dismissed and two were suspended. Permanent employees received lesser disciplinary actions. None were dismissed, four were suspended, one was demoted, and two received official reprimands.

Reports of Client Abuse or Neglect That Reached the Abuse Committee Were Not Always Handled Properly

Based on their examination of the 13 reports of client abuse that were submitted to the Abuse Committee during 1986, federal surveyors concluded that the subsequent investigations lacked professionalism, thoroughness, and aggressiveness. The auditors determined that the established procedures for investigating reports of abuse were not sufficiently independent. And when abuse was verified, the Hospital did not always take appropriate disciplinary actions. These and other findings are discussed in more detail in the following sections.

Federal surveyors concluded that the abuse investigations conducted in 1986 lacked professionalism, thoroughness, and aggressiveness. The Hospital's Abuse Committee investigated 13 allegations of abuse over the 13 months from January 1986 to January 1987. In their March 5, 1987, listing of detailed deficiencies, federal officials indicated that the Hospital's abuse investigations of these 13 cases were narrow in scope and lacked an attitude of advocacy aimed at protecting both staff and residents. Most of the investigations failed to follow up on even basic leads. Present and former staff were almost never questioned as part of a normal investigation.

As part of their audit fieldwork, the auditors also reviewed the timeliness of these 13 investigations and determined whether outside officials had been notified

**Not All Alleged Abuse Complaints
Can Be Substantiated**

Three of the 13 complaints handled by the Abuse Committee in 1986 were not substantiated. Twenty-six of the 62 complaints investigated under the new system between February 5 and March 3, 1987, could not be substantiated as well. The following are examples of allegations that could not be substantiated.

1986 Complaints:

An employee was reported to have slapped a resident on the neck and jerked the resident through a hallway. The Abuse Committee determined that there was insufficient evidence to verify abuse.

An employee was reported to have slapped a resident in the face. Following an investigation, the Abuse Committee could not confirm that abuse of a resident had occurred.

1987 Complaints:

An employee was reported to have improperly administered an injection to a resident. The Abuse Committee determined that this was not a case of resident abuse.

A resident was found to have the blood flow into his hands cut off by physical restraints. Following an investigation, the Abuse Committee found that no obvious neglect or abuse had occurred.

procedures. Many said that the Hospital's follow-up on their reports was inappropriate or insufficient. One worker wrote: "I was never asked what happened, why I wrote the memo, anything. No one from [the] abuse committee talked to me at all. Nothing was said or asked of me till I received a reprimand for not reporting soon enough." On the other hand, two persons who filed abuse reports told the auditors that a member of the Abuse Committee questioned and interrogated them in a way that made them feel as if they were the abusers. They said this treatment could affect their decisions about initiating future abuse complaints.

In interviews with the auditors, two administrators indicated that the Abuse Committee was not properly trained to conduct abuse investigations. The chief of security for the Department of Social and Rehabilitation Services said that the Abuse Committee should conduct only the preliminary investigation. If that preliminary investigation confirms that abuse has occurred, he said, the investigation should be turned over to Department security officers or the appropriate law enforcement agency for formal investigation.

The system for investigating reports of client abuse or neglect was not sufficiently independent. Under the old reporting system, if the Superintendent ordered an investigation into a report of client abuse or neglect, the case documentation went to the chairperson of the Abuse Committee. The Com-

as required. In general, they found that reports were made the same day the incident occurred. However, notice of these 13 reported incidents of abuse did not reach the Abuse Committee within a day or two. The Committee's final action on these cases was completed anywhere from one day to seven days after the date of the reported abuse incident. (Federal regulations require that initial investigations should be completed for 24 hours.)

The chairperson of the Abuse Committee notified local law enforcement officials and Department of Social and Rehabilitation officials the same day the Committee received the complaint. In 1986 cases, parents or guardians were not usually notified of the complaint until after the investigation was completed, although Hospital and Department policies required that parents and guardians be notified prior to the investigation.

More than one-fourth of the direct-care staff who said on the survey form that they had filed an abuse report said they thought their reports were not handled properly and in accordance with the Hospital's policies and

procedures. Many said that the Hospital's follow-up on their reports was inappropriate or insufficient. One worker wrote: "I was never asked what happened, why I wrote the memo, anything. No one from [the] abuse committee talked to me at all. Nothing was said or asked of me till I received a reprimand for not reporting soon enough." On the other hand, two persons who filed abuse reports told the auditors that a member of the Abuse Committee questioned and interrogated them in a way that made them feel as if they were the abusers. They said this treatment could affect their decisions about initiating future abuse complaints.

mittee met as needed to conduct an investigation into the allegation of abuse, then forwarded a report of its findings back to the Superintendent.

This Committee comprised employees who had other full-time jobs within the Hospital, and who reported directly or indirectly to the Superintendent. Given the sensitive nature of reports of client abuse or neglect, and the fact that many members of the Committee were friends and colleagues of the employees they were investigating, the investigation process cannot be viewed as independent. One employee who responded to the survey said that the incident in which the employee had been involved "...was handled well within the unit, but I don't believe the superintendent should have turned it back over to the unit to investigate--an outside investigation should have been done."

In addition, although complaints of abuse that come from outside the Hospital are referred to the Department of Social and Rehabilitation Services as the agency responsible for investigating abuse within State institutions, the Department has delegated this responsibility to the institutions themselves. Thus, outside complaints of abuse or neglect against employees at Winfield State Hospital would be referred to Hospital administrators or the Abuse Committee for investigation and response.

When the Abuse Committee verified that client abuse had occurred, the Hospital failed to impose appropriate disciplinary actions in some cases. Federal surveyors indicated that, for the 13 formal reports of client abuse the Abuse Committee investigated over the past year, Winfield State Hospital failed to impose appropriate penalties when abuse was verified. The failure of the Hospital and the State system to deal effectively and decisively in instances of substantiated abuse led to a tacit condoning of staff abuse of residents.

As part of their audit fieldwork, the auditors also reviewed the results of these 13 investigations. The Committee's investigation did not substantiate that abuse had occurred in three cases. In three other cases, the Committee apparently found that the alleged incident had occurred and that the employees' behavior was inappropriate, but that the incidents did not constitute abuse or neglect. The Committee recommended that two of these three employees be counseled, and that the third employee be transferred to a different unit and supervised more closely.

Employees Disciplined for Abuse and Neglect

In 1986, a probationary health service worker was dismissed for resident abuse at Winfield State Hospital. A letter from the Superintendent stated that the dismissal was the result of:

- Verbal abuse to residents by saying they are ugly and nasty
- Physical abuse to a resident by pushing the resident against a wall
- Pilfering food off of a resident's tray
- General neglect of residents

Each of the incidents was alleged to have occurred on the same day.

A Winfield State Hospital permanent employee was demoted in 1986 for neglecting residents. The reasons for the demotion included an unattended client being found away from the family group "gobbling" food in an aide station. The resident apparently began to choke, and the employee who found the resident had to perform the Heimlich maneuver on him. The following day another resident for whom the same employee was responsible was found to have been left unattended on a toilet for 20-30 minutes. Ten months earlier, the same employee had received a reprimand for resident neglect.

Both cases were handled outside the abuse reporting system, and were not reviewed or investigated by the Abuse Committee.

Client abuse or neglect was substantiated in seven of the 13 investigations. Four employees involved were dismissed immediately, one was suspended, and one was suspended then dismissed. In the seventh confirmed case, the Committee recommended that "appropriate disciplinary action" be taken against the employee, and that the employee's supervisor be officially reprimanded for not taking immediate action or reporting the incident.

In their review of Hospital personnel records, the auditors found no evidence to suggest that the disciplinary actions recommended in the seventh confirmed case were ever carried out. They also found that in the case where the employee was suspended before being dismissed, the suspension was initially ordered despite direction from the Department's central office to immediately dismiss confirmed client abusers.

In their review of the disciplinary actions taken in these and other reported cases, the auditors noted a tendency for probationary employees to be disciplined more harshly than permanent employees. They found five occasions in which proposed disciplinary actions were lessened for employees who appeared before the Superintendent or provided a written justification for their actions. In addition, they found that the dismissals of two employees at Winfield State Hospital for substantiated client abuse were overturned by the Civil Service Board in 1985, and that the employees had been reinstated. The Department of Social and Rehabilitation Services did not appeal the Board's decisions.

Department officials the auditors interviewed indicated that it may be legitimate to discipline probationary employees more harshly than permanent employees; for example, to terminate them for the first offense rather than providing an initial suspension. Probationary employees have a right to appear before the disciplining administrator, but have no right to appeal to the Civil Service Board. Those officials also indicated that it can be difficult to defend disciplinary actions that are based on the testimony of one employee versus another, without the benefit of physical evidence or corroborating statements by the client. Such actions may be overturned if they are appealed to the Civil Service Board, and it is almost impossible to discipline reinstated employees. Those officials also indicated that local law enforcement agencies' willingness to pursue cases of abuse apparently varied from institution to institution.

**Monitoring Efforts Were Inadequate
To Detect Unreported Abuse
Or to Alert Officials
To the Severity of the Abuse Problem**

The auditors determined that Winfield State Hospital's safeguards for ensuring that client abuse or neglect was being reported and investigated were ineffective. Records of client injuries were not always maintained as required, those that were kept were not monitored systematically to identify potential patterns of abuse, and clients were not examined on a regular basis to help detect potentially unreported abuse or neglect. Further, external monitoring of the Hospital's reported incidents of client abuse or neglect by both the Department of Social and Rehabilitation Services and the Department of Health and Environment were inadequate as well. These findings are discussed in more detail in the following sections.

Within the Hospital, records of client injuries were not always maintained as required, and those that were kept were not monitored systematically to identify potential patterns of abuse. One way to ensure that client abuse or neglect within an institution is being reported and investigated is to require other forms of documentation of client injuries, no matter what the cause of those injuries, and to monitor them to detect patterns in the occurrence of injuries, particularly those of "unknown origin." Such forms of documentation can include logs and notes maintained on the residential units, as well as "resident harm" reports.

Winfield State Hospital developed forms and procedures for reporting any physical harm to residents in 1985, after the first federal survey discovered that more than one-third of the 499 clients had injuries they received from other residents, from their own self-injurious behavior, or from isolated incidents of employee abuse. The purpose of the harm-reporting process was to ensure consistent documentation and review of any harmful incidents so that corrective action could be taken. The Hospital also designated a Protection from Harm Committee, and assigned individual members to monitor resident harm reports from various living units. Questionable incidents were to be referred to the Abuse Committee for investigation.

The auditors found that these procedures and the formation of the Protection from Harm Committee did little to help identify resident abuse patterns or ensure that such abuse was being reported. Several staff members the auditors interviewed said they had understood that a memo was the preferred documentation in cases of alleged client abuse, not a resident harm report. Thus, for some cases of alleged abuse no resident harm report was ever written. In addition, the Protection from Harm Committee apparently met only as necessary, and did not document its monitoring activities.

In addition, Hospital administrators apparently did not review or monitor the reports and logs that were available to them in any systematic way, nor did they investigate any such patterns they identified. For example, in the deficiency listing of March 5, 1987, federal officials stated that the Hospital failed to aggressively investigate a pattern of abuse allegations coming from a particular residential area, even though there were numerous indications (abuse allegations, harm reports, patterns of resident injuries with unknown origin) that problems existed in the area from at least October

**Resident Neglect Can Occur
If Staff Fails to Recognize
Clients' Needs**

During 1986, 14 residents had teeth extracted at the dental clinic. Of these, two had five teeth extracted and several others had two or more teeth extracted. The only pain medication ordered for any of these residents was Tylenol. Three of the residents were given no pain medication.

A federal review team reported that they observed a resident banging his head, and were told by Hospital staff that this was not normal behavior for this resident. Upon investigation, the federal team discovered that this resident had five teeth extracted six hours earlier. The area medication aide indicated that Tylenol was ordered to be given, as needed, but had not yet been given. This same aide admitted that the resident was unable to verbalize pain.

The federal review team reported that another resident had extensive dental infections and extractions in December 1986. In the two-week period beginning December 5, 1986, which coincided with the discovery of the residents dental abscess, the resident was placed in restrictive mechanical restraints for "self-injurious behavior." Only one dose of Tylenol was given to the resident during this period.

1986. As a result, federal surveyors noted, a daily pattern of verbal, mental, and physical abuse of 20 residents continued unabated in the area for months until uncovered by the federal survey and the State investigation.

Within the Hospital, clients were not examined on a regular basis to help identify injuries potentially caused by abuse or neglect. Another way to detect injuries and determine whether incidents of abuse or neglect are being reported is to physically examine the clients. The auditors found that, until March 1987, Winfield State Hospital had no program for daily physical checks of residents. Such examinations can be important for a client population that is predominantly nonverbal, although the disadvantages of such a procedure are that it tends to diminish residents' independence and privacy and can be very time-consuming for residents and staff alike.

External monitoring by the Department of Social and Rehabilitation Services was inadequate to detect the extent and severity of the client abuse problem at Winfield State Hospital. The auditors interviewed administrators of the Department of Social and Rehabilitation Services' Division of Mental Health and Retardation Services to determine what central systems were in place to monitor activities relating to resident abuse at Winfield State Hospital. They found that no one within the central office was responsible for monitoring the incidence of client abuse or neglect reports, for following up on their resolution, or for comparing the frequency of the reports over time or between institutions.

In addition, the auditors reviewed correspondence relating to an internal professional review of the Hospital in the fall of 1986 conducted by central office staff. That review identified a number of problems at the Hospital, including the problem with residents' protection from harm. The correspondence they reviewed appeared to focus on the problems' implications for decertification, rather than on the potential for harm to the residents or on how those issues were being handled administratively within the Hospital.

External monitoring of the Hospital by the Department of Health and Environment was also inadequate. To meet Medicaid funding requirements, Kansas has designated the Department of Health and Environment as the agency responsible for annually inspecting State institutions to ensure that they provide certain minimum levels of service and comply with federal regulations.

Department of Health and Environment surveyors reviewed Winfield State Hospital during 1986 as part of a certification survey. Their review failed to detect the magnitude of the problems with the reporting of resident abuse that were identified by the federal surveyors from the Health Care Financing Administration in 1985 and again in 1987. Both State and federal survey administrators indicated that this oversight may have occurred because of differences in the way the two survey teams conduct their reviews. Both State and federal surveyors examine elements of the reporting system itself, and review a sample of investigations conducted by the Hospital's Abuse Committee. However, federal surveyors go beyond this point, examining other records and interviewing former and current employees in an effort to detect unreported incidents of resident abuse.

Finally, State law requires that any reports of client abuse or neglect must be forwarded to the Department of Health and Environment's complaint coordinator.

However, the Department indicated that reports on abuse investigations were not generally received until about three months after the incidents occurred, and that there was no way of knowing whether copies of all investigations had been forwarded. Nonetheless, the complaint coordinator does keep track of how many complaints are received and where they come from, and apparently attempts to notice when anything unusual occurs. For example, in June 1986 the coordinator wrote to the Division of Adult Services about the results of eight complaints of client abuse the coordinator had received from Winfield State Hospital. These complaints, which had been referred to the Hospital for investigation and resolution, did not state how the complaints were resolved. That memo was routed from the Division of Adult Services to the Hospital Superintendent, who wrote to the complaint coordinator about the disposition of each case.

A Number of Other Factors May Have Contributed To Client Abuse and to Some Employees' Reluctance to Report It

Through their reviews of written documents, employee surveys and interviews, and interviews with experts in the field, the auditors identified a number of other factors that may have contributed to the occurrence of abuse at Winfield State Hospital and to some employees' failure to report such occurrences. Those factors include the difficult resident population, inadequate training of direct-care staff, inadequate staffing ratios, and the Hospital's physical environment.

Experts the auditors interviewed indicated the population of residents at Winfield State Hospital was a particularly difficult one. Sixty percent of the residents are unable to walk, which makes them physically taxing to care for. Many of the ambulatory residents are aggressive adults. In the employee survey, for example, 9.3 percent of the direct-care staff who provided written comments said that they or other employees were sometimes injured by the clients they cared for.

Training of direct-care staff was not always adequate. The employee survey asked employees to rate the training they had received on how to recognize client abuse or neglect and on how to report it. The majority of the direct-care staff responding rated their training in both areas as good or very good. However, about five percent said they had received no training in how to recognize abuse, and another five percent said they had received such training but rated it as poor. Only two percent of these respondents said they had not been trained in how to correctly report client abuse or neglect, and five percent said the reporting training they had received was poor.

On the survey form, 27 of 205 people who made written comments (13.2 percent) said that the direct-care staff needed more or better training. For example, one worker wrote that "...new employees, untrained, with no experience in the field of retardation, should not have been in the units with the abusive and aggressive clients. A new employee is only as good as his training." Another worker said that some of the direct-care workers had very poor parenting skills and little or no training. A third respondent suggested that new staff members could be paired with experienced workers, and that all staff needed to be monitored more frequently and closely.

Individuals the auditors interviewed indicated that as many as 200 of the direct-care staff at Winfield State Hospital were largely untrained. The Hospital had scheduled a full-scale training program for the spring of 1986, but cancelled it for financial reasons. In December 1986, the Hospital started a one-week orientation program for new employees.

Experts the auditors interviewed indicated that the staffing ratios are still far below what is needed to provide adequate care and active treatment. The Hospital's current staffing ratio is one staff member for every six residents. As a result, for nearly two and one-half hours during each eight-hour shift, one staff person has sole responsibility for 12 residents while his or her co-worker is at lunch or on break. If supervisory staff fill-in during these periods for the two or three units they are responsible for, they have no time for supervision or training. If a staff member does not report for duty as scheduled, clients may be unable to participate in their scheduled activities.

These individuals recommended staffing ratios as low as one employee for every two or three residents during the day shift on the units with aggressive adult residents. Their recommendations ranged upwards to one employee for every six to eight residents on other units at other times of day.

On the survey form, 18 of 205 people who made written comments (8.8 percent) said that the Hospital needed more direct-care staff. One of the workers surveyed wrote that "it was unclear at the time and continues to be unclear how neglect that is the direct result of insufficient staff on duty is to be handled." Further, a number of employees the auditors interviewed said that the units at the Hospital did not have enough staff to properly meet the needs of the clients.

Federal surveyors cited numerous deficiencies relating to the Hospital's physical environment. Their report notes that the living units within the Hospital are not designed for maintaining or promoting an active and normal environment. There is little privacy. Bedding is sometimes inadequate. Some residents do not have their own chest of drawers or access to their own clothing. Bathrooms and showers seem designed to accommodate mass toileting and showering of clients. One concern expressed to the auditors is that these aspects of the Hospital's facilities may lead staff to see residents as less than human, and may make treating them harshly seem excusable.

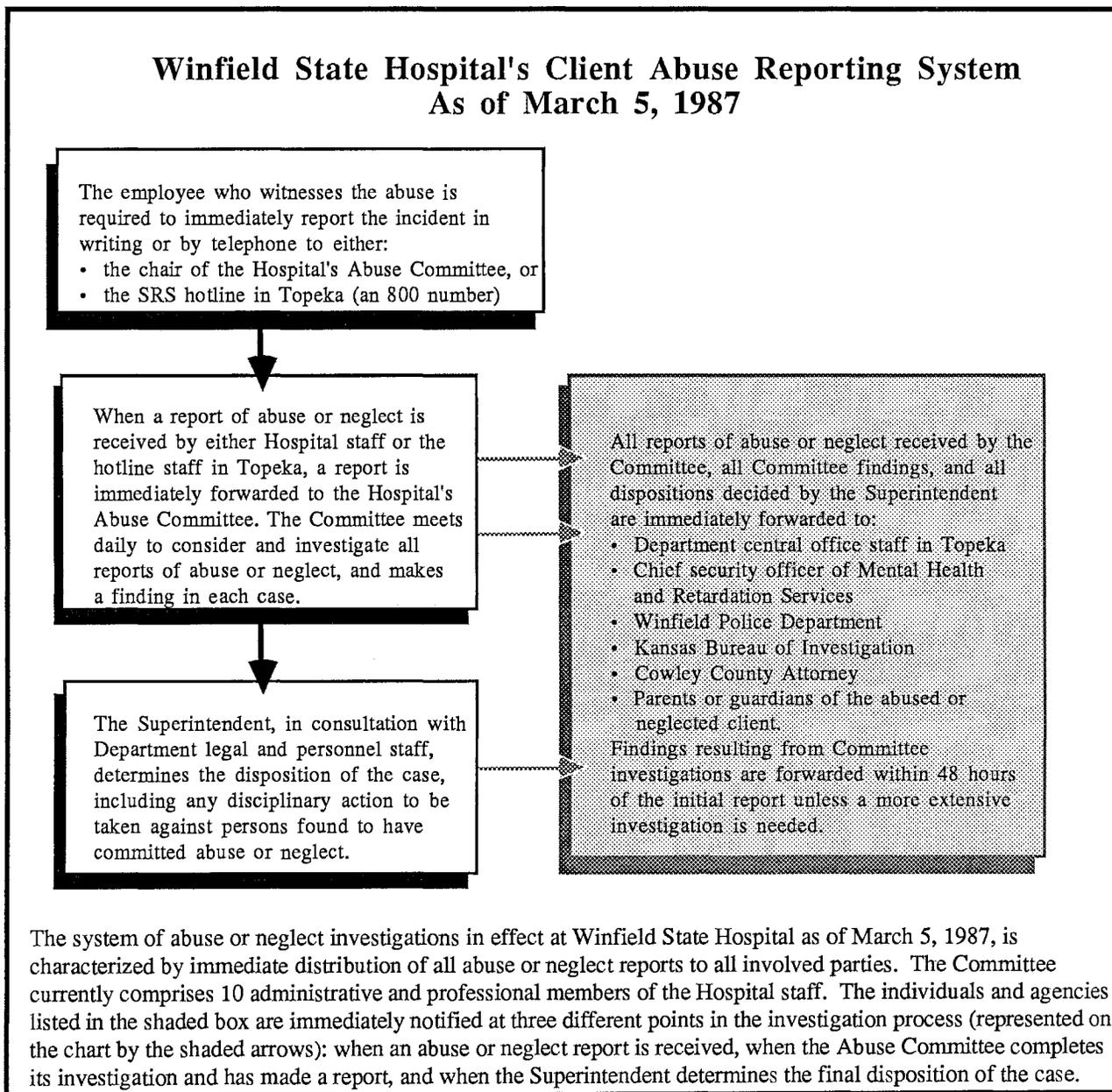
What Improvements Have Been Made In the Client Abuse Reporting System, and What Further Improvements Are Needed To Ensure That the System Is Adequate To Fulfill its Purpose in the Future?

As part of its plan to reapply for federal certification of Winfield State Hospital, the Department of Social and Rehabilitation Services has made or is instituting a number of changes in the Hospital's operations. These changes fall into two main areas: changes in the Hospital's abuse reporting system and other procedures for ensuring that clients are protected from harm, and changes in the recruitment, training, and discipline of the personnel who carry out that system. These changes, although necessary, are not sufficient. This audit recommends that further improvements be made in the reporting system and protection-from-harm procedures, personnel matters, changes in State law and administrative oversight, and other aspects of Hospital operations to ensure protection of the clients and

compliance with all laws and regulations. The changes that have been made and those that are still needed are discussed in the sections that follow.

The Department and Hospital Have Taken Steps Recently To Improve the Client Abuse Reporting System and Other Procedures for Protecting Clients From Harm

The client abuse reporting system at Winfield State Hospital underwent a series of changes following the recent federal and State investigations and reports about client abuse. The latest abuse reporting system for Winfield State Hospital was issued on March 5, 1987. The key elements of that system are depicted in the flowchart below.



The most significant change in the new system is that the previous requirement for reporting incidents of client abuse up the Hospital's chain of command has been removed. Under the previous reporting system, abuse reports were first made to an employee's immediate supervisor, and could be blocked or diverted by administrators at any level, rather than being investigated through the Hospital's established procedures. Under the new reporting system, reports of suspected client abuse or neglect are now to be made either directly to the chairperson of the Abuse Committee or to a hotline the Department established in its central offices in Topeka. This improvement is highlighted on page 25.

As the chart shows, the new reporting system gives the Abuse Committee more independent and complete authority to conduct all investigations, and allows it to determine whether to contact the personnel department immediately to relieve the alleged abuser from duty. Under the previous reporting system, the Hospital Superintendent had sole authority to order the alleged abuser to be relieved from duty.

The Hospital has taken several steps to encourage employees to report possible cases of client abuse or neglect. Eliminating the administrative reporting levels in the previous reporting system may encourage Hospital employees to report incidents of abuse. As further encouragement, the Hospital provided stickers for employees to put on their nametags showing the chairperson's office telephone number. Establishing a hotline provides a way for employees to report client abuse totally outside the Hospital's structure, as well as anonymously. This hotline, established February 21, is answered by Department staff during regular office hours, and by an answering machine at all other times. Since February 5, the Abuse Committee has received 62 cases of suspected abuse or neglect of residents, compared with only 13 cases in all of 1986.

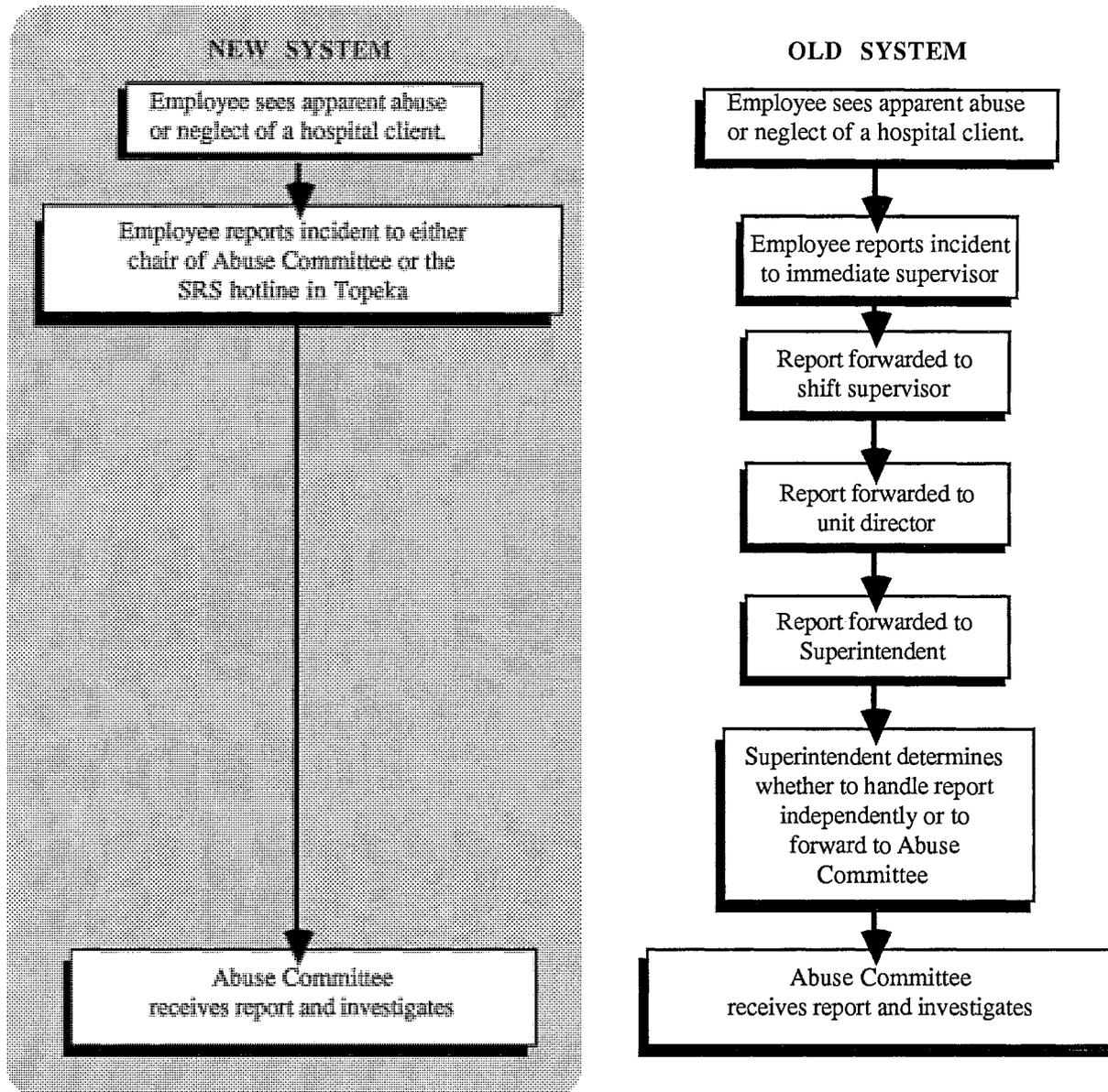
The reporting system has been changed to provide for more timely investigations and for a better-trained Abuse Committee. Since February 4, the Abuse Committee has been expanded from five members to eight members, then to 10 members, and a new chairperson was named. The new Committee chairperson is the Hospital's director of institutional research and training. The other nine members of the Committee include three registered nurses, two licensed mental health technicians, two social workers, one psychiatric aide, and one music therapist.

Reports of client abuse or neglect that are received on the Department's abuse hotline are now sent to the chairperson of the Abuse Committee by electronic mail, which can make reporting more immediate. And beginning February 5, the Committee started to meet daily Monday-Friday, instead of on an as-needed basis, to review all abuse reports and resident-harm reports.

To help ensure that the Committee's investigations would be more thorough and professional, the Department's chief of security has held training sessions with the Committee. This training has covered the preservation of medical and physical evidence of abuse or neglect, techniques for interviewing employees, and the need to contact law enforcement agencies.

The Hospital has taken steps to actively monitor each client's physical condition. In the past, Hospital clients were not regularly checked for physical evidence of abuse or neglect. Hospital personnel who saw a client injured

**Winfield State Hospital's Client Abuse Reporting System:
Principal Changes in the Flow of Abuse Or Neglect Reports
As of March 5, 1987**



As this comparison chart shows, the principal difference between the old client abuse reporting system and the new one is that the old system passed abuse or neglect reports through several administrative levels. At any of those levels, the supervisor or administrator could elect to either pass the report on or deal with it at that level. One weakness of the old system was that abuse or neglect reports were vulnerable to being blocked or diverted, rather than being investigated through the institution's established procedures. Under the new plan, all reports to either the hotline or the chair of the Abuse Committee are relayed directly to the Committee for investigation.

Important Considerations for Client Abuse Reporting Systems

The auditors interviewed federal officials, representatives of state institutions in New York and Nebraska, and a representative of the Accreditation Council on Services for People with Developmental Disabilities to determine what factors should be present in a good system for reporting and investigating client abuse in residential settings. Those individuals indicated the following considerations were important in developing a system that worked well:

- * in their initial training, employees must learn what abuse or neglect is, what reporting procedures to follow, and that failure to follow those procedures in a timely manner will result in disciplinary action
- * when abuse or neglect is suspected, complaints must go to the head of the institution or a designee quickly, with few intermediate steps
- * immediate action must be taken to protect the resident, if appropriate, including removing the alleged perpetrator from the residential unit
- * an external investigating organization should be used, if at all possible
- * if an in-house investigating committee is used in addition to or instead of an external agency, the members of that committee should be strong client advocates, and they should be adequately trained
- * if investigations cannot be completed within 24 hours as federal regulations require (and most cannot,) the investigation should be continued and the reasons for its continuance should be documented
- * employees who willfully inflict bodily harm on residents should be terminated. Those who commit lesser offenses should be suspended and re-educated. Although due process requirements must be met, disciplinary actions should be defended aggressively if necessary.
- * employees who intervene in and report incidents of resident abuse or neglect should receive positive recognition for having done so
- * the system should be supplemented by a proactive incident reporting process, and subject to external monitoring and reporting requirements

or who saw physical evidence of abuse or neglect were required to fill out a resident-harm report, although the auditors found that such reports were not always filled out.

Starting March 3, 1987, all clients are being checked twice daily for any physical signs of injury. These checks are done each morning and at bedtime--the times most residents would normally be undressed. If a client has a scratch, bruise, or other evidence of injury, the employee is required to notify medical staff and fill out a resident-harm report. These reports are to be forwarded directly to the Abuse Committee for investigation or for referral to the Protection from Harm Committee. The latter Committee is to look for trends or patterns in the occurrence of client injuries within the Hospital.

The Department and the Hospital have taken other steps to increase Hospital clients' protection from harm. The Hospital has begun to increase staff training in the areas of client abuse or neglect. The Abuse Committee has prepared a videotape for direct-care staff to help them identify client abuse or neglect and the appropriate actions for reporting abuse.

The Department is seeking to establish a client ombudsman at Winfield State Hospital. The ombudsman would be available to discuss client-related problems with employees or with clients' parents or guardians. The ombudsman would also provide oversight for the clients' welfare, and would report directly to the senior legal counsel of the Division of Mental Health and Retardation Services.

The Department and Hospital Have Made a Number of Changes In the Hospital's Personnel and Personnel-Related Procedures

On February 26, 1987, the Department of Social and Rehabilitation Services dismissed the Winfield State

Hospital Superintendent. It appointed the Department's director of institutional programs as the Hospital's Acting Superintendent. At his direction, the Hospital is being reorganized into three distinct organizations: one for medically fragile residents, one for nonambulatory residents, and one for aggressive residents. Employees are being reassigned according to the various needs within those units.

Under the direction of the Acting Superintendent and the Department's Commissioner of Mental Health and Retardation Services, the Hospital has taken disciplinary action against a significant number of employees whose abuse or neglect of clients was confirmed. Between February 5 and March 3, 1987, the Abuse Committee recommended that 14 employees be dismissed and that 12 receive other disciplinary action. Of the 14 employees recommended for dismissal, 11 have been dismissed following confirmation of client abuse, one quit before being dismissed, and two were suspended instead of being dismissed. Criminal prosecution is being considered against several employees accused of willfully abusing Hospital clients.

Also, in mid-February 1987 the Hospital improved its form for security clearance of new employees. The revised form asks applicants whether they have been convicted of certain crimes, and informs them that their criminal records will be checked. Previously, federal surveyors had discovered that some Hospital employees had criminal records when they were hired. The Department is also seeking to increase the number and role of security officers at the Hospital.

The Hospital Has Begun To Address Some of the Deficiencies Cited By Federal Reviewers Following Their February 16-18 Inspection

The Health Care Financing Administration visit on February 16-18 resulted in the decision to decertify Winfield State Hospital from Medicaid certification. Following that visit, the federal review team issued a written report of deficiencies. Deficiencies cited in the client abuse reporting system included the following:

- There was no effective system of thoroughly investigating and effectively resolving allegations of abuse.
- Reports were not being investigated and closed within 48 hours as required by Hospital policy.
- Information on the new abuse reporting system had not been disseminated to all direct-care workers.
- The Hospital had failed to define in concrete terms what behavior constituted abuse.
- Members of the expanded Abuse Committee were poorly equipped to handle the large number of abuse or neglect reports. Members had received little or no training on how to investigate reports.
- Abuse Committee members held other full-time positions which made it impossible to effectively resolve reports in a timely way.
- Because the Committee could not keep up with the mounting workload, reports were referred to unit directors who were also untrained to investigate abuse allegations.
- Hospital officials had failed to use resident harm reports to identify other possible incidents of client abuse or neglect.
- Hospital officials had overlooked staffing patterns and accident reports that indicated areas of concern.

- The facility lacked a central point of coordination for investigating abuse and neglect.
- The Hospital was not following its own disciplinary procedures for employees who abused or neglected Hospital residents.

Since this federal report was written, Winfield State Hospital has worked to correct some of the deficiencies cited. For example, it enlarged the Abuse Committee to 10 members and gave the members some training in how to conduct investigations. In addition, the Hospital circulated its revised abuse reporting policy to all employees on March 5-6. This policy states that the Abuse Committee chairperson will act as the central coordinator for reporting and investigating reports of client abuse and neglect.

Further Improvements Are Needed in the Abuse Reporting System to Ensure Clients' Protection And Compliance with All Laws and Regulations

The Department of Social and Rehabilitation Services and Winfield State Hospital have made major strides to correct the problems that had caused the client abuse reporting system to fail. Because reports go directly to the Abuse Committee, the revised system is much more likely to result in prompt investigation of all reports. However, further improvements are needed.

Some of the deficiencies raised by the federal reviewers have not been fully addressed. The auditors noted additional problems during the course of this audit. The recommendations presented in this report are made with the primary emphasis on protecting clients at Winfield State Hospital. In view of the serious problems of client abuse noted by federal and State officials, the legal and ethical responsibilities for the Department to care for the Hospital clients, and the financial implications of the recent decertification of the Hospital, both the Department and the Hospital must act immediately to solve the remaining problems.

To further improve the client abuse reporting system and to ensure compliance with all laws and regulations, the audit recommends that changes be made in the following areas: establishing a new, independent Abuse Investigation Committee at Winfield State Hospital that is adequately and appropriately staffed, taking stronger measures for ensuring that clients are protected from harm, improving oversight and inspections of Winfield State Hospital by other State agencies, seeking statutory changes related to client abuse and neglect, and making other administrative or recordkeeping changes. These recommendations are presented below.

1. **The Department of Social and Rehabilitation Services should establish a new, independent Abuse Investigation Committee at Winfield State Hospital that is adequately and appropriately staffed, as follows:**
 - a. **The Department should establish a new, full-time Abuse Committee at Winfield State Hospital that reports directly to the Department.** To be considered fully independent from influence by Hospital administrators and staff, Committee members should have no other responsibilities at the Hospital and should report to the Commissioner of Mental Health and Retardation Services or to a designated person in the

Department's Topeka office. Committee members should also be strong client advocates, and could serve the Hospital's residents in an ombudsman's capacity. The Committee should formalize procedures that specifically state how reports of abuse will be handled and how investigations will be conducted. Committee members would be responsible for investigating allegations of client abuse or neglect, but serious allegations of willful abuse or neglect should also be investigated by State or local law enforcement agencies. Any confirmed allegations of client abuse or neglect should continue to be referred to the Hospital Superintendent for appropriate disciplinary action.

- b. **The Department should ensure that the Abuse Committee has adequate and appropriate resources to effectively carry out its responsibilities on a timely basis.** This new, full-time Abuse Committee should comprise at least one medically trained person and at least one person trained as an investigator. If these full-time Committee members need additional help to conduct timely investigations of abuse or neglect reports--as required by federal regulations and Department policies--they should be authorized to call on other staff resources within the Department.
2. **The Department of Social and Rehabilitation Services should take strong measures to ensure that clients at Winfield State Hospital are protected from harm, as follows:**
 - a. **When not investigating reports of client abuse or neglect, Abuse Committee members should act in a quality control capacity to monitor the Hospital's system for protecting clients from harm.** Monitoring activities could include walking through Hospital units on an unannounced basis, observing or verifying the twice-daily physical checks, and monitoring resident-harm reports from each unit for trends or patterns of abuse. Such quality-control measures should provide for the integrity and accuracy of the Hospital's system for protecting clients from harm.
 - b. **The Department should ensure that a procedure is in place for handling serious abuse or neglect reports 24 hours a day, seven days a week.** Under current procedures, reports of suspected client abuse or neglect are to be made directly to the Abuse Committee chairperson or to the abuse hotline in Topeka. However, the Abuse Committee currently has a five-day workweek, and the hotline is staffed only during the regular 40-hour workweek. (Hotline calls are answered on an answering machine the rest of the time.) The Hospital's written policies do not specify what actions should be taken to begin addressing a reported incident of abuse when the Abuse Committee chairperson is unavailable or when a call comes into the abuse hotline outside the regular workweek. In addition, outside the regular workweek there is no mechanism to immediately relieve the alleged abuser from duty, as required in the Department's personnel manual. The Department should develop reporting and response procedures that cover 24 hours a day, seven days a week, and those procedures should be clearly communicated to Hospital employees and the Abuse Committee.

3. **State agencies responsible for oversight of Winfield State Hospital should take stronger steps to ensure that clients are free from abuse or neglect, as follows:**
 - a. **The Department of Social and Rehabilitation Services should actively monitor the number, severity, and resolution of all client abuse and neglect cases reported at Winfield State Hospital.** The Department should compare the Winfield State Hospital information with similar information for other State mental retardation hospitals. Over a period of time, the Department should determine a "normal" range in the number of abuse reports being received, confirmed, and unconfirmed at each institution. The Department should also investigate any marked deviations from the norm, either low or high.
 - b. **The Department of Social and Rehabilitation Services should provide guidance and support for consistent, appropriate disciplinary action in cases of willful abuse or neglect.** The Department should issue written guidelines to State hospital superintendents who are responsible for taking disciplinary actions against their employees. These guidelines should generally indicate what types of evidence would support the dismissal, demotion, or suspension of an employee whose client abuse or neglect was confirmed. The guidelines should also indicate that the Department will aggressively pursue the disciplinary actions it deems appropriate, even when those actions are contested.
 - c. **In the future, the Department of Health and Environment should be more aggressive and attentive when it surveys Winfield State Hospital for client abuse or neglect.** Department staff assigned to conduct certification reviews at Winfield State Hospital should make special efforts to review the degree to which clients at the Hospital are free from physical or mental abuse. If possible, these efforts should include unannounced visits to selected areas of the Hospital.
4. **The Department of Social and Rehabilitation Services should seek the following legislative changes to clarify or strengthen the laws relating to client abuse and neglect:**
 - a. **The Department should seek legislation to clarify who should investigate allegations of child abuse or neglect.** K.S.A. 39-1404 requires the Department to investigate all reports that a State hospital resident is being, or has been, abused or neglected. On the other hand, K.S.A. 38-1523 requires that suspected child abuse or neglect by Department employees shall be investigated by the appropriate law enforcement agency under the direction of a county or district attorney, and not by the Department. If the latter statute applies to Winfield State Hospital, then suspected abuse or neglect of residents under 18 could not legally be investigated by the Hospital's Abuse Committee.
 - b. **The Department should seek legislation to ensure that intentional abuse or neglect of a mentally retarded person can be prosecuted as a crime.** K.S.A. 21-3425 makes mistreatment of a confined person a Class A misdemeanor. This statute applies only to the intentional abuse, neglect, or ill-treatment of a person "who is physically

disabled or mentally ill or whose detention or confinement is involuntary." To aid in the prosecution of future cases, the Department should seek legislation to add the mentally retarded to the list of persons covered by this law.

5. **The Department of Social and Rehabilitation Services and Winfield State Hospital should resolve other administrative and procedural problems related to the effectiveness of the client abuse reporting system, as follows:**
 - a. **The Department and the Hospital should resolve conflicts between the Department's personnel manual and the Hospital's revised abuse reporting system.** The Department's personnel manual says that any employee who witnesses unacceptable behavior by another employee must report such violations immediately to his or her supervisor, who must immediately forward the report to the Hospital Superintendent. As of March 5, the revised client abuse reporting system does not require employees to report to their supervisor, and does not require that the Superintendent be notified until the Abuse Committee investigation is completed. These conflicts should be resolved to avoid any confusion about Hospital employees' duties to report instances of suspected abuse or neglect.
 - b. **The Hospital should continue its efforts to train employees in how to recognize abuse or neglect of clients, and how to report any apparent instances.** Training sessions for Hospital employees should emphasize that obvious and "borderline" abuse or neglect should be reported, that failure to report will result in disciplinary action, and that failure to cooperate with the Abuse Committee will also result in disciplinary action. Better training should foster a Hospitalwide attitude that abuse or neglect of clients will not be tolerated.
 - c. **The Hospital should provide better feedback to persons who report suspected abuse or neglect of clients.** Within applicable legal restrictions, the Hospital should keep the employee who reports an incident of abuse informed about the resolution of the report filed. This feedback should be accompanied by a commendation for the reporting employee and a request that any actual or threatened retaliation should also be reported to the Abuse Committee.
 - d. **The Hospital should maintain a chronological log of all abuse and neglect incidents reported, as well as a permanent file containing written reports, letters, and memoranda pertaining to each incident.** This documentation, which is already required by the Department's personnel manual, would provide a formal, chronological log of all reported incidents of abuse, thus reducing the chance that such incidents are not reported. The required documentation would also give outside reviewing agencies another method for reviewing the Hospital's investigation and resolution of client abuse reports. The Abuse Committee would continue to be responsible for notifying clients' parents or guardians, local law enforcement agencies, and State agencies as required by law and Department policy. Documentation of these notices should be placed in the permanent file for each incident.

Conclusion

Winfield State Hospital's client abuse reporting system has been significantly revised and improved over the past two months. If the recommendations in the previous section are addressed, the Hospital's abuse reporting system will have greater independence, credibility, and responsiveness to the needs of its clients. However, even if all these recommendations are implemented, additional steps will be required to address some of the underlying problems that led to a conducive atmosphere for client abuse or neglect. Some of those additional steps have cost and staff resource implications. The Hospital must be adequately staffed in all areas to provide protection from harm and active treatment of its clients, as required by federal regulations. Hospital employees must be adequately trained to give care and treatment to clients, without unintentionally abusing or neglecting them. The commitment to protecting clients from harm must be shared by the Legislature, the Departments of Social and Rehabilitation Services and Health and Environment, and the entire staff of Winfield State Hospital.

APPENDIX A

Historical Development of State Laws and Departmental Policies on Reporting Abuse and Neglect

<u>Date</u>	<u>Law or Policy</u>	<u>Requirements</u>
Jan. 1980	Secretary's letter L-294	Any SRS employee must immediately report any abuse or neglect orally, followed by a written report to his/her supervisor. The appointing authority must maintain a chronological log of all incidents. The appointing authority must also maintain a permanent file of all written reports.
1980	KSA 39-1401 39-1410	If there is reasonable cause to believe that a State Hospital resident has been abused or neglected, it must be reported to the Department of Social and Rehabilitation Services. The Department must initiate an investigation within 48 hours. The Department must maintain a Statewide register of the reports received, the findings, evaluations, the actions recommended.
Dec. 1980	Superintendent by letter	The responsibility for investigating alleged resident abuse at Winfield State Hospital was assigned to the Director of Social Services.
Feb. 1981	Superintendent by letter	The Superintendent appointed a committee to investigate and recommend action to the Superintendent on cases of resident abuse.
Dec. 1981	Winfield State Hospital Policy G.I. 603.05	Incidents of reported resident abuse or neglect should be investigated as soon as possible. The committee is to investigate the report, determine if abuse or neglect has occurred, and report to the Superintendent.
1982	KSA 38-1522a to 38-1523	Persons having reason to suspect that a child has been injured as a result of physical, mental, or emotional abuse or neglect shall report the matter promptly to the Department of Social and Rehabilitation Services. Suspected child abuse by Department employees shall be investigated by a law enforcement agency, not by the Department.
Feb. 1983	Secretary's letter L-388	The Department requires that employees of institutions must report immediately to the superintendent of the institution or his/her designee, all instances of suspected child abuse or neglect occurring within the institution. Upon receipt of such a report, the superintendent must immediately report verbally all available information to the appropriate law enforcement agency.

<u>Date</u>	<u>Policy</u>	<u>Requirements</u>
Mar. 1983	Winfield State Hospital Policy G.I. 103.03	The Department requires that employees of institutions must report immediately to the Superintendent of the institution or his/her designee, all instances of suspected child abuse or neglect occurring within the institution. Upon receipt of such a report, the Superintendent must immediately report verbally all available information to the appropriate law enforcement agency.
Mar. 1983	Winfield State Hospital Policy G.I. 103.04	A report must be made immediately to the Superintendent by employees when they have reason to suspect that adult resident abuse or neglect has occurred. Upon receipt of a suspected abuse or neglect report, the Superintendent or designee will investigate the alleged incident of abuse or neglect.
Aug. 1985	Department's Personnel Manual, Chapter X	All employees of institutions and facilities operated by the Department are required to report all instances of suspected abuse or neglect immediately. Any employee who witnesses violations relating to unacceptable behavior has a responsibility to report such violations to his/her supervisor. A chronological log of all incidents shall be maintained in the office of the appointing authority. The appointing authority must maintain a permanent file of all written reports, letters, and memoranda pertaining to each reported incident.

APPENDIX B

Survey Materials Distributed to Winfield State Hospital Employees

This survey material was administered to 864 Hospital employees on March 4, 5, and 6, 1987.



Legislative Division of Post Audit

**MEMO TO: All Winfield State Hospital Employees
March 1987**

109 WEST 9TH, SUITE 301
MILLS BUILDING
TOPEKA, KANSAS 66612-1285
(913) 296-3792

The Kansas Legislature is interested in your opinions about the client abuse reporting system that was in place at Winfield State Hospital in 1986. As the Legislature's independent audit agency, we have been directed to evaluate that reporting system and to answer the following specific questions: What protections are supposed to be provided by the client abuse reporting system in place at Winfield State Hospital? Why did this client abuse reporting system apparently fail to protect clients from abuse or alert officials as to the nature and extent of that abuse? And how can that system be improved to ensure that such protection is provided in the future?

You can help us answer these questions by filling out the accompanying survey form. The survey you have received is designed to let you tell us about the experiences or problems you have had with the system for reporting client abuse. **THE PURPOSE OF THIS AUDIT IS NOT TO IDENTIFY HOSPITAL STAFF WHO MAY HAVE ABUSED HOSPITAL CLIENTS, NOR TO GATHER INFORMATION ABOUT ANY ABUSE THAT MAY HAVE OCCURRED.** If you have any information to report about client abuse or neglect, call the Department of Social and Rehabilitation Services' Hotline number (1-800-221-7973) or the Cowley County Attorney (221-4066). Any information the auditors receive regarding alleged abuse would have to be turned over to these sources as well.

Please take 10-15 minutes to fill out the survey form and return it to the auditors. The survey is designed so that you cannot be personally identified. If you do not want your identity to be known, please do not include any information in your survey responses that could identify you.

If you would like to talk with the auditors about your experiences or problems with the client abuse reporting system, you can do so in one of two ways. First, if you provide your name and phone number on the last page of the survey, a member of the audit staff will call you back. The last page of every survey will be detached from the survey form so that your name will not be associated with your survey responses. Second, if you would rather call us, you can do so any time through Wednesday, March 11, between the hours of 7:30 a.m. and 5:30 p.m. The numbers to call are as follows:

**KANS-A-N Number: 561-3792
OR Call Collect: (913) 296-3792**

PLEASE KEEP THIS MEMO FOR FUTURE REFERENCE.

Thank you for your help.

Meredith Williams
Legislative Post Auditor

**Legislative Post Audit Survey of Winfield State Hospital Employees
Client Abuse Reporting System**

This survey pertains to the client abuse reporting system in use at Winfield State Hospital during calendar year 1986. The survey is designed so that you cannot be personally identified. If you do not want your identity to be known, do not include any information in your responses to the survey questions that could identify you. **DO NOT USE** this survey to provide information about client abuse or neglect. That information should be reported to the Department of Social and Rehabilitation Services or to the Cowley County Attorney. Thank you for your help.

Part I: General Information About You

1. What is your position or role at Winfield State Hospital?
 Administrative or clerical staff
 Direct client care staff
 Professional or medical staff (social workers, psychologists, therapists, doctors, nurses)
 Support services--dietary, physical plant, laundry, or other support staff

2. Do you supervise at least one other employee?
 Yes No

Part II: Your General Perceptions About the Hospital's Training and Support for the 1986 Client Abuse Reporting System

3. How would you rate the training you received on how to recognize abuse or neglect of a client?
 (If you received no training, please check here: , and skip to the next question)
 Poor Fair Adequate Good Very Good

4. How would you rate the training you received on the procedures for reporting abuse or neglect of a client?
 (If you received no training, please check here: , and skip to the next question)
 Poor Fair Adequate Good Very Good

5. During 1986, did you receive or have easy access to information about the client abuse reporting system (policies, procedures, forms, and the like)?
 Yes Not sure No

6. For 1986, which of the following best describes the overall atmosphere at Winfield State Hospital for reporting instances of client abuse or neglect?
 Reporting Strongly Discouraged Reporting Discouraged Reporting neither Discouraged nor Encouraged Reporting Encouraged Reporting Strongly Encouraged Don't Know

7. To what extent do you think your supervisor would encourage you to report potential client abuse?
 Strongly Encourage Encourage Neither encourage nor discourage Discourage Strongly Discourage Don't Know

8. To what extent do you think your co-workers would encourage you to report potential client abuse?
 Strongly Encourage Encourage Neither encourage nor discourage Discourage Strongly Discourage Don't Know

Part III: Your Own Experiences With the Client Abuse Reporting System

9. If you reported any incident(s) of client abuse or neglect in 1986, do you think your reports were generally handled properly and according to the policies and procedures that were in place?

(If you did not report any client abuse in 1986, check here [], and skip to the next question)

- Yes
- Not sure or don't know
- No. If no, please explain why: _____

10. If you saw what you considered to be incidents of client abuse or neglect during 1986 but did not formally report them, why didn't you report them? (Check all that apply. If you check more than one, please circle what you consider to be the main reason or reasons.)

(If you did not see any client abuse in 1986, check here [], and skip to the next question)

- The incident was too minor to report.
- I thought the problem could be resolved informally within my work unit.
- My supervisor convinced me that the incident was not abuse or neglect.
- My supervisor suggested that I should not report the incident.
- I thought I might lose my job if I reported the incident.
- I thought other members of the staff would retaliate against me if I reported it.
- I thought my supervisor would retaliate against me if I reported it.
- I did not know who to report the incident to.
- I thought that no action would be taken even if I reported the incident.
- I did not think I was responsible for reporting the incident.
- Other _____
- Other _____
- Other _____

11. If you have any other comments or opinions on the client abuse reporting system, including ways to improve the system, please use this space. **DO NOT USE** this space to provide information about client abuse or neglect.

THIS PAGE WILL BE DETACHED FROM THE SURVEY WHEN YOU TURN IT IN

If you would like to talk to one of the auditors from Legislative Post Audit about problems you have had with the client abuse reporting system, you can do so in one of the following ways:

1. **Provide the information requested below and a member of the audit staff will contact you:**

Name _____

Phone Number _____

Time when you are generally available at that number: _____

An auditor will call you back to interview you by telephone. A personal interview can be arranged, if needed. If you would like, that personal interview can be conducted off the Hospital grounds at a place designated by the auditors. **Please note:** The last day for scheduled interviews will be Friday, March 13.

2. **Call the Legislative Division of Post Audit between the hours of 7:30 a.m. to 5:30 p.m., through Wednesday, March 11.**

An auditor will be available to interview you by telephone. The numbers to call are listed on the memo you received with this survey form.

The confidentiality of all voluntary interviews will be maintained. However, any allegations concerning specific instances of client abuse or neglect will be turned over to the Department of Social and Rehabilitation Services or to the Cowley County Attorney, along with the name of the person who made the allegations.

APPENDIX C

Winfield State Hospital Client Abuse Or Neglect Reporting System Survey Results

The auditors surveyed employees of Winfield State Hospital about their experiences with the client abuse and neglect reporting system. All 981 were given the opportunity to fill out a survey and 864 took advantage of that opportunity.



Legislative Post Audit Survey of Winfield State Hospital Employees Client Abuse Reporting System

This survey pertains to the client abuse reporting system in use at Winfield State Hospital during calendar year 1986. The survey is designed so that you cannot be personally identified. If you do not want your identity to be known, do not include any information in your responses to the survey questions that could identify you. **DO NOT USE** this survey to provide information about client abuse or neglect. That information should be reported to the Department of Social and Rehabilitation Services or to the Cowley County Attorney. Thank you for your help.

Part I: General Information About You

(Percentages are based on the total number of survey respondents.)

1. What is your position or role at Winfield State Hospital?

Direct client care staff	49.5 %
Professional or Medical staff (social workers, psychologists, doctors, nurses)	14.4
Administrative or clerical staff	8.0
Support services (dietary, physical plant, laundry, or other support staff)	21.7
Foster Grandparents	4.1
No Response	<u>2.3</u>
	100.0%

(For the purpose of reporting results, the categories of administrative or clerical staff, support services, and foster grandparents have been combined into a category called other.)

2. Do you supervise at least one other employee?

Yes

Direct client care staff	21.1 %
Professional or Medical staff	8.3
Other	7.6

No

Direct client care staff	27.2 %
Professional or Medical staff	5.7
Other	26.4

No Response

3.7
100.0 %

Part II: Your General Perceptions About the Hospital's Training and Support for the 1986 Client Abuse Reporting System

(Percentages are based on the number of respondents in each category.)

3. How would you rate the training you received on how to recognize abuse or neglect of a client?
(If you received no training, please check here: [], and skip to the next question)

	<u>Direct Client Care Staff</u>	<u>Professional or Medical Staff</u>	<u>Other</u>
No Training	5.1 %	21.0 %	49.7 %
Poor	4.7	4.8	3.5
Fair	9.4	17.7	6.1
Adequate	23.6	21.8	13.1
Good	38.1	26.6	13.8
Very Good	18.9	7.3	9.6
No Response	<u>.2</u>	<u>.8</u>	<u>4.2</u>
	100.0 %	100.0 %	100.0 %

4. How would you rate the training you received on the procedures for reporting abuse or neglect of a client?
(If you received no training, please check here: [], and skip to the next question)

	<u>Direct Client Care Staff</u>	<u>Professional or Medical Staff</u>	<u>Other</u>
No Training	2.1 %	16.9 %	40.7%
Poor	5.1	8.1	3.5
Fair	12.6	15.3	8.0
Adequate	22.7	26.6	17.3
Good	36.7	21.8	13.5
Very Good	18.5	10.5	7.7
No Response	<u>2.3</u>	<u>0.8</u>	<u>9.3</u>
	100.0 %	100.0 %	100.0 %

5. During 1986, did you receive or have easy access to information about the client abuse reporting system (policies, procedures, forms, and the like)?

	<u>Direct Client Care Staff</u>	<u>Professional or Medical Staff</u>	<u>Other</u>
Yes	63.8 %	63.7 %	38.8 %
Not Sure	17.0	14.5	17.6
No	17.3	21.0	40.4
No Response	<u>1.9</u>	<u>0.8</u>	<u>3.2</u>
	100.0 %	100.0 %	100.0 %

6. For 1986, which of the following best describes the overall atmosphere at Winfield State Hospital for reporting instances of client abuse or neglect?

	<u>Direct Client Care Staff</u>	<u>Professional or Medical Staff</u>	<u>Other</u>
Reporting Strongly Discouraged	1.2 %	4.0 %	1.3 %
Reporting Discouraged	5.1	5.7	2.6
Neither Discouraged nor Encouraged	18.9	29.0	16.3
Reporting Encouraged	36.7	40.3	30.1
Reporting Strongly Encouraged	25.9	10.5	12.2
Don't Know	10.8	8.9	34.0
No Response	<u>1.4</u>	<u>1.6</u>	<u>3.5</u>
	100.0 %	100.0 %	100.0 %

7. To what extent do you think your supervisor would encourage you to report potential client abuse?

	<u>Direct Client Care Staff</u>	<u>Professional or Medical Staff</u>	<u>Other</u>
Reporting Strongly Encouraged	57.5 %	58.9 %	45.5 %
Reporting Encouraged	27.1	25.8	28.2
Neither Discouraged nor Encouraged	7.2	11.3	7.1
Reporting Discouraged	2.4	0.8	0.0
Reporting Strongly Discouraged	2.8	0.0	0.6
Don't Know	2.8	3.2	16.7
No Response	<u>0.2</u>	<u>0.0</u>	<u>1.9</u>
	100.0 %	100.0 %	100.0 %

8. To what extent do you think your co-workers would encourage you to report potential client abuse?

	<u>Direct Client Care Staff</u>	<u>Professional or Medical Staff</u>	<u>Other</u>
Reporting Strongly Encouraged	25.5 %	29.8 %	27.9 %
Reporting Encouraged	39.0	34.7	40.4
Neither Discouraged nor Encouraged	21.0	22.6	9.6
Reporting Discouraged	5.4	4.9	0.9
Reporting Strongly Discouraged	2.3	2.4	1.3
Don't Know	6.6	4.0	18.3
No Response	<u>0.2</u>	<u>1.6</u>	<u>1.6</u>
	100.0 %	100.0 %	100.0 %

Part III: Your Own Experiences With the Client Abuse Reporting System

9. If you reported any incident(s) of client abuse or neglect in 1986, do you think your reports were generally handled properly and according to the policies and procedures that were in place?
(if you did not report any client abuse in 1986, check here [], and skip to the next question)

(Percentages are based on the number of respondents in each category.)

	<u>Direct Client Care Staff</u>	<u>Professional or Medical Staff</u>	<u>Other</u>
Did not report abuse	74.8%	67.7%	83.0%
No Response to question 9	5.4	5.7	6.4
Yes	9.1	14.5	4.5
Not sure or don't know	5.1	5.7	3.9
No. If no, please explain why:	<u>5.6</u>	<u>6.5</u>	<u>2.2</u>
	100.0 %	100.0 %	100.0 %

(Following is a summary of comments supplied by the survey respondents. Percentages are based on the number respondents in each category who said that their report was not handled correctly. The following percentages do not sum to 100 because respondents often made more than one comment.)

	<u>Direct Client Care Staff</u>	<u>Professional or Medical Staff</u>	<u>Other</u>
Reports were blocked, lost, or sidetracked	16.7 %	37.5 %	57.1 %
No action taken on reports filed	8.3	0.0	0.0
Administrator or supervisors showed favoritism or inconsistency in discipline	16.7	62.5	14.3
Abuse reporting procedures unclear	0.0	0.0	14.3
Followup is inappropriate or insufficient	50.0	37.5	42.9
No feedback to unit supervisors or staff on the outcome of the investigation	8.3	0.0	14.3
Reports not kept confidential	4.2	0.0	14.3
Respondent feared, witnessed, or experienced retaliation by staff or supervisors	4.2	0.0	0.0
Other	16.7	12.5	42.9

10. If you saw what you considered to be incidents of client abuse or neglect during 1986 but did not formally report them, why didn't you report them? **(Check all that apply.)**
 (If you did not see any client abuse in 1986, check here [], and skip to the next question)

(Percentages are based on the number of respondents in each category)

	<u>Direct Client Care Staff</u>	<u>Professional or Medical Staff</u>	<u>Other</u>
Did not see abuse	60.5 %	56.5 %	71.5 %
No response to question 10	13.5	14.5	19.2
Saw Abuse and Did Not Report It - (Comments below)	<u>26.0</u>	<u>29.0</u>	<u>9.3</u>
	100.0 %	100.0 %	100.0 %

(Percentages are based on the number of respondents in each category who saw abuse and did not report it. The following percentages do not sum to 100 because respondents often made more than one comment.)

	<u>Direct Client Care Staff</u>	<u>Professional or Medical Staff</u>	<u>Other</u>
The incident was too minor to report.	34.2 %	61.1 %	24.1 %
I thought the problem could be resolved informally within my unit.	39.6	47.2	31.0
My supervisor convinced me that the incident was not abuse or neglect.	4.5	2.8	3.5
My supervisor suggested that I should not report the incident.	3.6	2.8	0.0
I thought I might lose my job if I reported the incident.	11.7	0.0	6.9
I thought other members of the staff would retaliate against me if I reported it.	30.6	11.1	17.2
I thought my supervisor would retaliate against me if I reported it.	9.0	0.0	6.9
I did not know who to report the incident to.	3.6	2.8	24.1
I thought that no action would be taken even if I reported the incident.	32.4	11.1	31.0
I did not think I was responsible for reporting the incident.	3.6	5.6	13.8

(Summary of comments supplied by the survey respondents.)

Definition of abuse/neglect not clear	4.5	11.1	10.3
Experienced or witnessed retaliation	0.9	0.0	3.5
Followup to abuse/neglect reports inappropriate or insufficient	1.8	2.8	6.9
I knew that the incident had been reported by others	3.6	0.0	0.0
Punishment of abusers is inconsistent or arbitrary	0.0	2.8	0.0
Other/non-germane/illegible	7.2	8.3	6.9

11. If you have any other comments or opinions on the client abuse reporting system, including ways to improve the system, please use this space. **DO NOT USE** this space to provide information about client abuse or neglect.

Responding to question 11	23.7 %
No Comment	<u>76.3</u>
	100.0 %

(Following is a summary of comments supplied by the survey respondents. Percentages are based on the number of survey respondents who made a comment. The following percentages do not sum to 100 because respondents often made more than one comment.)

Institutional Concerns

Abuse/neglect and/or the reporting system is not a problem at Winfield State Hospital	12.2 %
Abuse/neglect problems have been blown out of proportion	8.8
Employees need better guidelines and definitions about what constitutes abuse/neglect	16.1
Employees need more and better training	13.2
The institution needs more staff or more participation in direct client care by the current staff	8.8
The institution needs higher quality staff	3.9
Staff are abused or injured by clients	6.3
Respondent is afraid of, witnessed, or experienced retaliation by staff or supervisors	5.9
Clients are difficult to handle	.5
Institution is top-heavy with administration	1.0
Punishment for abuse is inconsistent/arbitrary	4.9
Staff fearful of abuse charges being filed against them	6.3
Hospital administration is poor, abusive, or unresponsive	4.4

Concerns with the Abuse/Neglect Reporting System

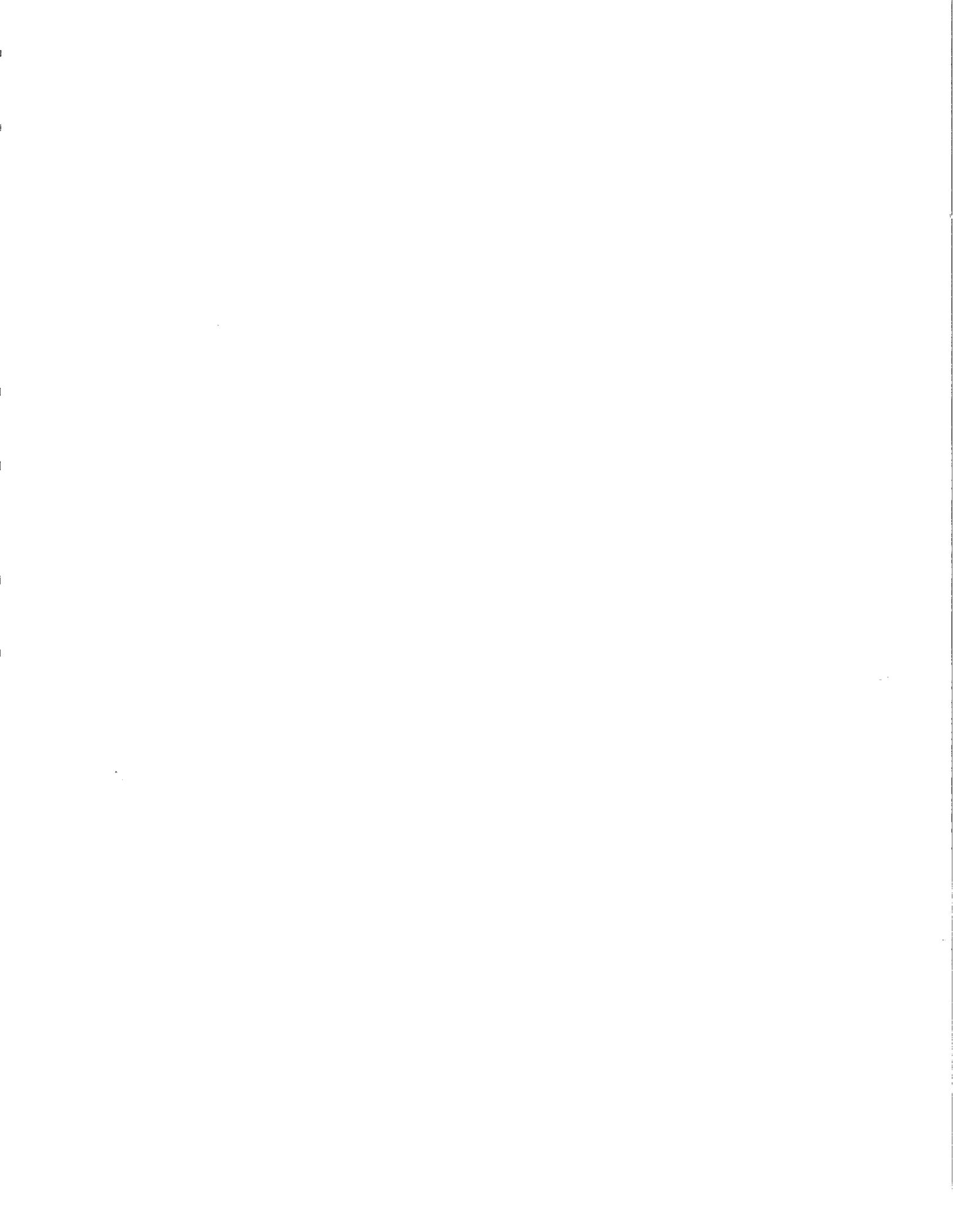
Abuse/neglect reports are not kept confidential	4.4 %
No action or insufficient action taken on abuse/neglect reports filed	2.4
Resolution of abuse/neglect reports not communicated to supervisors/unit staff	3.9
False/inaccurate reports may have been filed by some members of the hospital staff	9.3
Report processing/investigating time is too long	2.9
Proven abusers should be fired	1.0
Institution's atmosphere discourages abuse/neglect reporting	6.3
Abuse/neglect reports vulnerable to being sidetracked or blocked	5.4
Abuse/neglect system need better investigations and/or investigators	10.7
The new reporting system is an improvement	4.9
System needs to protect innocent staff and those reporting abuse/neglect	4.4
Other/non-germane/illegible	16.6

Excerpts of Comments Supplied By the Survey Respondents

Question 11 of the survey asked the employees of Winfield State Hospital for other comments they wanted to make about the client abuse reporting system. Following is a sample of those comments.

- "All the things that are termed 'abuse' are much too broad to be applicable. All the staff that has worked any length of time are guilty of perhaps raising their voice. We push the clients to assist them – when does pushing become abuse? Our clients are not steady on their feet. No matter how or whether they are pushed or pulled they fall. So there are degrees...and who decides the degree?"
- *"Right now everyone seems to be confused as to what is considered abuse...it seems our jobs are hanging by a fine thread and we could lose them...because someone decides they want to get rid of us and report us for something we didn't do. Even if found innocent the trauma we'd be put through would be shattering."*
- "There are instances where something is definitely abuse – i.e., slapping, kicking [a] client, but there are also more undefined circumstances – holding a client's hands to wash his face; assisting clients to walk in ways that could look like pushing...the major feeling here at this time seems to be a fear to deal with clients for fear of doing something that could be considered abuse."
- *"Better pay might help if you expect to get better employees."*
- "I feel that when struggling with an aggressive client, or stopping them from abusing other clients, sometimes staff will use excessive restraints, especially if they are not familiar with the client. I am very hesitant (more so than in 1986) in turning someone in for abuse...because I am convinced that the alleged abuser will probably be fired – due to the witch hunt mentality of the present abuse reporting system."
- *"You also have to get the [Licensed Mental Health Technicians and Qualified Mental Retardation Professionals] out of their offices to get them to observe and to help where abuse is caused by shortage of staff."*
- "Although I wasn't personally involved it was common knowledge that abuse committee recommendations for disciplinary action were sometimes overturned by the administration. Direct care staff often joked about this fact. If staff inquired as to why no action was taken they were sometimes threatened by the administration. I heard more than one person comment after such an experience 'that's the last time I'll report abuse.' Some persons have attempted to communicate with SRS officials in Topeka about these problems – these communications were not kept confidential from our administration and the staff who had written or phoned were often threatened by the superintendent."
- *"During the last six months of 1986 and the first month of 1987, the attitude of staff...was 'go ahead and report abuse but don't expect any action from the superintendent.' Our unit saw [at least three cases] of staff who were investigated for abuse... In one case, suspension had been recommended by the Center Abuse Committee, and in the other two the staff were recommended for termination by their supervisors. All were overruled."*

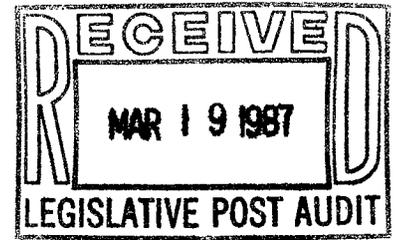
- "Present system much better – the problem in the past has been that those reporting the abuse/neglect have usually undergone as much distress as those they reported..."
- *"1) Retain the hotline... 2) Review applicants...for employment closely; 3) [Keep] [Licensed Mental Health Technicians and Qualified Mental Retardation Professionals] in area of client activity more and assist direct care staff whenever needed... 4) Allow employment of more direct care staff... 5) create simple reporting forms and have followup... 6) Allow physicians and nurses time to plan and supervise the medical and nursing care of our clients."*
- "...under the current reporting procedures, care must be taken that the reporter is reporting an actual incident of abuse, rather than carrying on a vendetta against another employee. Because of the atmosphere here...some of us are concerned about any action taken with a client to the point where we aren't providing the best of care."
- *"Some abuse/neglect could certainly be avoided through better staffing of direct care or 'hands on' staff. It's very frustrating to have several clients...by yourself and try to control several [self-injurious behaviors], make sure all are clean and are changed as soon as they become soiled. Soon the demands increase so rapidly that it all becomes overwhelming and most of the time there is no one to call for relief or you can't find them. I feel that the [Licensed Mental Health Technicians and Qualified Mental Retardation Professionals] spend too much time pushing a pen and paper...as long as the data come in OK they think things are all right..."*
- "The abuse I have heard and read about does not occur. I would strongly suggest you investigate your informant before you take action against anyone. Please investigate the abuse staff receives from clients. This is widespread."
- *"The only abuse I have seen is from resident to staff; they have been kicked, scratched, pushed, spit on, and still did not abuse resident."*
- "The hospital has a lot of good aides and I think they're being punished from the people [the hospital has] brought in that are not used to working with clients of this kind."
- *"I see a very dedicated staff, doing a very difficult job and doing it very well. [Direct care] staff have been driven to do so much stuff that good patient care almost becomes a thing of the past."*
- "Provide special screening, training, etc. for staff being hired for 'high-stress' areas."
- *"The people investigating (abuse committee) should be thoroughly objective and above suspicion themselves rather than being chosen to serve on the committee because they are non-essential. They need to be trained in appropriate investigative techniques and confidentiality...attempts at harassment must be dealt with swiftly and decisively."*
- "I feel that as much as we protect the clients' privacy, respect, dignity, health, and personal feelings we must in the same way protect our staff. If a person is accused of abuse of whatever type this information should be kept confidential. Gossip and unproven rumors will only hurt this hospital, its clients, and staff."



APPENDIX D

Agency Responses

On March 18, 1987, copies of the draft audit report were sent to the Departments of Social and Rehabilitation Services and Health and Environment. Their responses are included in this appendix.



STATE OF KANSAS

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

ROBERT C. HARDER, SECRETARY

STATE OFFICE BUILDING
TOPEKA, KANSAS 66612-1570

March 19, 1987

Meredith Williams
Legislative Post Auditor
Legislative Division of Post Audit
109 West 9th, Suite 301
Mills Building
Topeka, KS 66612-1285

Dear Mr. Williams:

I want to thank you and the members of your staff for the professional and helpful work they did in relation to reporting patient abuse at Winfield State Hospital.

We are at work on the recommendations of the Legislative Post Audit staff.

They recommended that we establish staff at WSH whose responsibility it is to investigate abuse and neglect reports and to provide for quality control through the hospital. We are presently working to establish such positions.

The recent re-design of reporting and investigating procedures is aimed at assuring greater protection from harm. We plan to expand our training capabilities. The Central Office will monitor the reporting and investigating to insure that the work is being done appropriately and in a timely way.

Our staff attorney is reviewing the laws mentioned in the report. We may be asking the Legislature to act in this area before the session is over.

We plan to follow through on the report and implement the recommendations as proposed by Legislative Post Audit staff.

We are committed to protecting the residents from harm. We are committed to providing the best services we can within available resources.

Sincerely yours,

A handwritten signature in cursive script that reads "Robert C. Harder".

Robert C. Harder
Secretary

RCH:mo

MIKE HAYDEN
Governor
JACK D. WALKER, M.D.
Secretary

STATE OF KANSAS

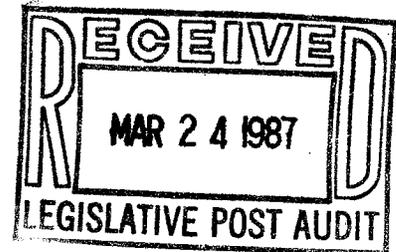


Forbes Field
Topeka, KS 66620-0001
(913) 862-9360

DEPARTMENT OF HEALTH AND ENVIRONMENT

March 23, 1987

Meredith Williams, Legislative Post Auditor
Legislative Division of Post Audit
Mills Building, Suite 301
109 West 9th Street
Topeka, Kansas 66612-1285



Dear Mr. Williams:

Thank you for the opportunity to comment on the audit report "The Client Abuse Reporting System at Winfield State Hospital."

The department's survey staff certainly will make special efforts to review the degree to which clients are free from abuse at Winfield State Hospital and other intermediate care facilities for the mentally retarded. To the extent possible, the survey staff will continue to make unannounced visits to selected areas of the hospital. It was on such a visit during the late evening hours that the staff observed an abusive incident at Winfield in December 1986.

However, it must be noted that limited staff resources impact the department's ability to aggressively enforce all the state and federal standards for these facilities. At present there is only one team (consisting of a qualified mental retardation professional and two registered nurses) to conduct all inspections and investigations in 27 facilities with 2,402 beds. Without additional staff, we are limited in our ability to improve the present enforcement process.

Sincerely,

A handwritten signature in cursive script, appearing to read "Jack D. Walker".

Jack D. Walker, MD
Acting Secretary

P
cc: Patricia Schloesser, MD
Richard Morrissey

