KANSAS LEGISLATIVE
DIVISION *of*
POST AUDIT

A Performance Audit Report Presented to the Legislative Post Audit Committee

Evaluating Staff Safety at Osawatomie State Hospital

December 2024

Report Number: R-24-017

Introduction

Representative Samantha Poetter Parshall, Senator Caryn Tyson, Representative Carrie Barth, Representative Fred Gardner, and Senator Molly Baumgardner requested this audit, which was authorized by the Legislative Post Audit Committee at its April 24, 2024 meeting.

Objectives, Scope, & Methodology

Our audit objective was to answer the following question:

1. Does Osawatomie State Hospital adequately ensure the safety and security of its staff?

To answer this question, we surveyed staff to better understand their opinions on the safety, culture, and environment at Osawatomie State Hospital (OSH). We visited the facility and reviewed policies and procedures and documentation of physical security measures. We then reviewed personnel and training data to determine whether staffing levels and training were adequate to ensure staff safety. We reviewed policies and procedures as well as documentation of safety processes to ensure that policies and procedures were adequate to ensure staff safety and there was evidence that those policies and procedures were being followed. Finally, we reviewed documentation of incident reports and staff complaints as well as investigations and disciplinary action taken by management to evaluate management's role in cultivating a culture that promotes staff safety and compliance with policies and procedures. In this audit, we relied on samples of documentation and data from January 2022 – September 2024 where possible. However, in some cases data was unavailable for the entire time. We have noted where time reviewed is different where applicable in this report.

More specific details about the scope of our work and the methods we used are included throughout the report as appropriate.

We communicated in a separate letter a concern to Osawatomie State Hospital about documentation of risk of violence assessments and observational statuses for new patients.

Important Disclosures

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. Overall, we believe the evidence obtained provides a reasonable basis for our findings and conclusions based on those audit objectives.

Audit standards require us to report our work on internal controls relevant to our audit objectives. They also require us to report deficiencies we identified through this work. In this audit, we reviewed internal controls in place at OSH to ensure staff safety. This included the hospital's policies, training, and physical security controls for things like keys and perimeter checks. We also reviewed management's oversight and communication. We found deficiencies in most of these areas as described later in this report.

Our audit reports and podcasts are available on our website (www.kslpa.gov).

Osawatomie State Hospital does not adequately ensure the safety and security of its staff.

Background

Osawatomie State Hospital (OSH) is a state psychiatric facility with 2 independently operating hospitals.

- The Legislature established OSH in 1863 in Miami County. It is a state-run facility that provides inpatient psychiatric and mental health services to adults 18 years and older. There are 2 state-run facilities that provide these services in Kansas. Larned State Hospital also provides these services.

- The OSH campus encompasses 2 independently operating hospitals: OSH and Adair Acute Care (AAC).

    - OSH provides treatment for people with acute and chronic mental health disorders but currently is not certified by the federal Centers for Medicare and Medicaid Services (CMS). This means that OSH does not receive federal funding and is instead fully state funded. OSH has capacity for 116 patients and offers general psychiatric care as well as competency evaluations for those awaiting trial. As of August 2024, OSH facilities housed 108 patients. A small number have been voluntarily admitted, but the vast majority have been involuntarily committed for short or long-term care by court order.

    - AAC is CMS certified and receives federal funding. AAC provides treatment for people who are in crisis or need short-term hospitalization. While AAC is separate from OSH, it receives central services like facilities and security services from OSH through a Memorandum of Understanding. As of August 2024, AAC housed 39 patients, but can accommodate 60 patients.

- OSH receives most of its funding from the state general fund. In fiscal year 2024, OSH's base budget, including AAC, was $59.6 million. $48.2 million (80%) came from the state general fund. Other funds, such as federal Medicare funds to the AAC, made up the remaining $11.5 million of the fiscal year 2023 budget.

- The OSH campus also includes the MiCo House, which is a Larned State Hospital program housed at OSH.

    - The MiCo House is part of the sexual predator treatment program at Larned State Hospital. It is the final step in the program, completion of any criminal sentence and program requirements at Larned State Hospital. In August 2024, the MiCo House had 7 residents, but can accommodate 16.

    - The MiCo House follows Larned State Hospital policies and is significantly different from the other 2 hospitals on OSH's campus. Residents can hold

jobs in the community and leave campus for their jobs or for leisure. In this audit, we reviewed processes at OSH and AAC, not MiCo House.

Several state and federal entities oversee OSH.

- The Kansas Department for Aging and Disability Services (KDADS) oversees OSH, including AAC. In addition to regulatory and budgetary oversight, KDADS provides human resources staff for state hospitals including OSH.

- The Kansas Department of Health and Environment (KDHE) also provides oversight of OSH, including AAC, and other state hospitals. As part of this, it conducts inspections of hospitals to ensure their compliance with health and safety regulations.

- Finally, CMS provides federal oversight of the AAC portion of OSH. This means that AAC must meet certain federal requirements set by the Medicare Conditions of Participation. AAC must also pass inspections to ensure compliance with these regulations to receive federal Medicaid and Medicare funding.

OSH is a large campus that has many departments and staffing needs.

- The OSH campus has around 25 buildings that it uses for a variety of purposes. As of September 2024, OSH used all but a handful of the buildings for things like housing, physical exercise and activities, administration, and necessary services like laundry and facilities. OSH has 4 patient housing units in 2 buildings, while AAC has 2 housing units in 1 building. These units include areas like patient rooms, a dayroom, treatment rooms, and offices for staff.

- The OSH campus has 533 total authorized positions in fiscal year 2024 to staff these buildings and provide the necessary services. This includes both FTE (full-time equivalent) and part-time positions.

- The OSH superintendent oversees both OSH and AAC, but each has independent administrative staff. These staff include fiscal staff, training and development staff, and facilities and maintenance staff. As of September 2024, there were 117 total administrative staff.

- The OSH campus has dedicated security staff. These staff conduct patrols of the campus during non-working hours, respond to security incidents involving patients and staff, and respond to fire emergencies on the campus grounds. As of September 2024, there were 28 security staff.

- The campus also has facilities staff that respond to work orders and oversee tasks like distributing keys for the facility. As of September 2024, there were 38 facilities staff.

- Finally, OSH and AAC have medical, nursing, and risk management staff that deal most closely with patients. Medical staff includes positions like psychiatrists and medical doctors. Nursing staff includes positions like registered nurses (RN), licensed practical nurses (LPN), and mental health technicians (MHT). OSH and AAC utilize both state and contracted staff in these nursing areas. As of September 2024, there were 156 state staff and 128 contracted staff working in this category.

- State staff are staff hired through the state hospital. These staff are state employees. Contracted staff work for non-state nursing agencies. Nursing agencies are independent agencies that employ nurses contracted for short periods of time, usually in 3-month contracts.

OSH has a history of safety and security issues.

- In 2015, OSH lost CMS certification due to repeated safety deficiencies. These deficiencies included insufficient nursing staff to perform necessary patient status checks and security staff not performing security checks. Further, a staff member was sexually assaulted by a patient in late 2015, which staff alleged was possibly due to lack of staff.

- OSH's plan to resolve the issues in 2015 included assessing patients' risk of violence toward others, increased training, reminding staff to use and respond to personal safety alarms, and ensuring that staffing levels were adequate.

- Federal inspectors required renovations to address safety issues for patients at risk of suicide prior to resuming federal funding. For instance, light fixtures, door handles, and windows should not physically allow for something to attach or hang from them.

- These types of renovations required extensive work for the facility. The hospital split into 2 separate hospitals, OSH and AAC, under the supervision of the OSH superintendent. AAC was renovated to meet the required safety measures and federal Medicare funding resumed in 2017 for AAC only.

State law and CMS regulations require that OSH and AAC provide services to patients in the "least restrictive manner".

- K.S.A. 39-1603(g) & (i) require that the 2 hospitals on the OSH campus provide services in the least restrictive ways possible. K.S.A. 59-2961 requires that a mental health professional at the hospital must examine and provide their opinion as to the least restrictive treatment. Treatment should protect the patient and others and allow for the patient's improvement.

- State law doesn't define terms like "least restrictive manner" or "least restrictive treatment." However, K.S.A. 59-2977 only allows OSH to use restraints or seclusion to "prevent immediate substantial bodily injury to the patient or others," and requires that such techniques are the least restrictive

necessary and are not used as punishments. Federal regulations applicable to AAC as a CMS certified hospital generally say the same.

- During a tour, we observed OSH and AAC patient rooms are not locked. Patients can generally enter and exit their rooms and the rooms of other patients. Patients may also have permissions based on level of risk. For instance, some patients may leave their building for activities or outside walks typically with a staff escort.

- We also observed there is no physical barrier or fencing encompassing the campus. There are no security checks at the campus entrance or on campus roadways. There are cameras throughout the facility, but these cameras are not monitored in real-time. Rather cameras are used retroactively to review specific incidents when necessary. Further, security staff do not use or carry lethal or non-lethal weapons or other defensive items such as batons, tasers, or pepper spray.

OSH faces some unique challenges for staff safety and security because of these environmental requirements and the population it serves.

- As a psychiatric and mental health facility, patients can behave in ways that are sometimes unpredictable, aggressive, or violent. For example, we reviewed camera footage from a few incidents where patients attacked staff members suddenly and without warning.

- Throughout this audit, staff also consistently reported that patients are one of the biggest reasons they sometimes feel unsafe. Staff reported being verbally and physically harassed and physically assaulted by patients.

- The type of patients they serve and regulations requiring a least restrictive environment are not things OSH management can change. Further, the OSH superintendent told us they have limited options for handling especially violent patients. She said OSH can transfer aggressive males to a behavioral unit at Larned State Hospital or they can have law enforcement arrest violent patients. However, both are only temporary ways of managing the situation, with patients often returning to OSH after Larned or law enforcement's involvement.

- However, OSH management can develop policies and processes to manage the risk of patient aggression. Further, management can create a culture of staff safety and security by having good controls, reviewing data, and responding appropriately to incidents.

We surveyed hospital staff and reviewed processes in 3 main areas to determine whether OSH adequately ensures the safety and security of its staff.

- We defined staff safety and security as processes that protect and minimize hospital employees (both state and contracted) from verbal, physical, or

sexual harassment or assault related to their work. Staff safety is related to, but separate from, patient safety. The scope of this audit focuses only on staff safety and security.

- To evaluate whether OSH is adequately ensuring staff safety and security, we surveyed state and contract staff who worked at OSH in fiscal years 2020 through 2024. We used the survey to gauge staff opinions on safety and security-related issues, and to identify and describe specific staff safety incidents that we could investigate.

- Staff provided their opinions, but did not identify specific safety incidents for us to review. Therefore, we took a broad approach to assessing key processes within 3 main areas that we identified as critical to staff safety:

    - Physical security: This work focuses on processes OSH management uses to manage risks in the physical environment. This includes risks to buildings' physical security (e.g., door locks, keys, and perimeter checks) and staff's physical safety (e.g., audible security alarms). These processes are important to staff safety because they ensure only authorized people have access to the facility and that staff can call for and receive assistance when necessary.

    - Personnel: This work focuses on processes OSH management uses to manage risks related to having enough knowledgeable staff to provide the necessary services (e.g., staffing ratios, turnover and vacancy rates, salaries, overtime, and training). These processes are important to staff safety because they ensure shifts have enough staff to monitor, treat, and respond to patients and that those staff are competent.

    - Management culture: This work focuses on processes OSH management uses to establish a culture that prioritizes staff safety (e.g., policies and procedures, communication, and responsiveness to reported incidents). These processes are important to staff safety because they ensure staff know what to do when incidents occur, staff report all known issues to management, and management corrects systemic issues.

- The survey results will be discussed throughout the report, but complete responses to all questions can be found in **Appendix A.**

Physical Security

OSH does not have adequate processes to ensure physical security.

- OSH is a psychiatric hospital that houses and treats adults with acute and chronic mental health disorders on a large and dispersed physical campus. Because the hospital serves a high-risk, vulnerable population and involves large numbers of both staff and patients, it's important for staff to ensure the grounds and buildings are physically secure.

- To determine whether OSH adequately ensures the physical security of the campus, we looked at its processes in 5 areas. There are minimal clear standards for physical security measures in regulation, statute, federal code, or best practices to use as benchmarks. Therefore, we used our professional judgment to select these areas based on their relevance to physical security. We also focused on these areas because OSH policies generally suggested there would be documentation we could review. The 5 areas we reviewed were:
    - Whether security staff patrol the campus to ensure buildings are secure in the evenings, overnight, and on weekends.
    - Whether each security staff shift has enough staff trained to respond to fires.
    - Whether security and other OSH staff ensure that staff who work with patients have personal security alarms they can activate in emergencies.
    - Whether facilities staff oversee the keys each staff member has. This includes recording what keys staff members have and ensuring staff return keys when they stop working at OSH. It also includes ensuring staff have management approval for certain high-access keys.
    - Whether management monitors for and follows up on safety risks and noncompliance with hospital policies.
- To evaluate OSH's processes in these 5 areas, we reviewed policy and interviewed staff to determine what OSH staff should do. Then, we visited OSH and reviewed documentation to determine whether OSH staff were following policies and procedures. We also considered whether what we saw indicated security problems, regardless of what OSH policy said.
- Overall, we found OSH’s processes in each area were inadequate or unimplemented for the samples and time periods we reviewed. We discuss the issues we identified in more detail in the following sections.

Security staff patrols of the OSH campus are incomplete and inadequate.

- Security staff are responsible for checking non-patient building exterior doors like the laundry, administrative, and power plant buildings to ensure they’re locked during non-working hours.
- Security staff should complete 64 campus patrols per week.
    - There are 3 8-hour security shifts per day. Each shift does patrols except for the 5 weekday daytime shifts. OSH officials told us that's because those shifts overlap with standard working hours. During that time, non-patient buildings are occupied by staff and don't need to be locked. So, 16 of the 21 weekly shifts should do campus patrols.

- Each of the 16 shifts that do patrols should patrol each of the north and south parts of the campus. OSH officials told us those shifts should also patrol each area twice. So, security staff should complete 64 patrols per week: 32 for the north part of campus and 32 for the south part.

- Security staff should check whether the buildings and areas they patrol are secure and record the times of their checks on a checklist.

  - The chief of security told us staff should physically test doors to ensure they're locked for the first patrol of each shift. The chief told us the second patrol may be done as a visual assessment of buildings for issues. Staff may do these visual assessments from patrol vehicles.

  - During each patrol, staff should complete a checklist to record the times they checked each building or area and to identify any issues they encountered (e.g., unlocked doors). There are 12 buildings or areas in each of the north and south parts of campus (i.e., 24 buildings or areas across the whole campus). Buildings generally have multiple exterior doors staff should check. However, there are a couple areas staff check that don't have buildings (e.g., the main entry gates).

- Security staff generally appeared to conduct patrols and document them. We reviewed documentation for 1 week of patrols from September 14-20, 2024, and found that security staff conducted and documented 61 patrols out of the 64 patrols they should have completed.

- However, the patrols we reviewed were frequently incomplete. Security staff on 3 shifts conducted only 1 patrol instead of 2. Further, in 56% of the patrols we reviewed, security staff did not record checks for all 12 buildings or areas in the part of campus they patrolled. In these incomplete patrols, staff didn’t record the times they checked between 1 and 4 of the 12 buildings in their area. For example, for 1 evening shift we reviewed, staff recorded checking 8 buildings on the south part of campus between 5:20 p.m. and 5:29 p.m. But they didn’t record checks for the 4 remaining buildings in the area: the power plant, 2 staff office buildings, and a vacant building.

- Additionally, we questioned the quality of many patrols based on the length of time security staff reported it took to complete them. In the 61 patrols we reviewed, 48% appeared to be implausible or questionable based on how long they took to complete. Officers reported taking between 8 and 75 minutes to conduct their first patrols, which should have included physically verifying doors were secure. This suggests that quality of patrol checks varies widely. Further, during a mock patrol security staff performed for us, staff estimated it would take about 30 minutes for 1 officer to do an adequate patrol of 1 part of campus. While up to 3 officers participated in each patrol, we found some of the reported patrol times were unrealistic.

Security staff do not have enough fire-trained staff to respond to campus fires because they haven't conducted fire training since March 2024.

- At the time of our review, OSH policy stated security staff provide fire protection of patients, staff, and visitors. Such protection included things like evacuation, rescue, and fire control. Agency officials confirmed that no policy exists describing fire training requirements for security staff.

- OSH should regularly provide fire training to security staff. We think doing so would be prudent given the inherent danger associated with fires. Additionally, based on records we reviewed from 2023, OSH generally used to conduct fire trainings multiple times each month.

- OSH hasn't conducted any fire training for security staff since March 2024. We reviewed firefighter training records for security staff at OSH for 2023 and 2024. We found OSH's last fire training was in March 2024. There have been no firefighter trainings since then. But in that time, OSH has hired 10 new security staff. This means 37% of security staff employed at OSH as of September 2024 hadn't received any fire training.

- OSH has sent staff with no or limited training to respond to potential fire situations. Based on dispatch records from 2024, 3 staff with no fire training responded to 5 fire alarms. Those staff were accompanied by staff who had received training in the past. Further, 1 staff member with only 2 hours of training checked active burn piles. That staff member wasn't accompanied by any better-trained staff on 1 of those checks. Having untrained or under-trained staff respond to potentially serious situations puts those staff, and potentially others, at risk.

- In late October 2024, OSH officials decided to stop responding to fire situations with its security staff. Officials told us they plan to rely on the City of Osawatomie's fire department for fire services. They further said they'd focus any future training on evacuating staff and patients from buildings in the event of a fire emergency.

OSH doesn't ensure staff carry required personal safety alarms and doesn't check if staff respond to alarms timely.

- Hospital policy requires all staff who work near patients to wear personal safety alarms. This includes administrative or facilities staff when they are working on the patient units. These alarms make a loud noise when staff press a button. These alarms alert other staff that a staff member needs assistance (e.g., because a patient attacked them). Hospital policy also requires that staff respond immediately when they hear an alarm.

- Hospital policy says security staff should randomly check to ensure staff have their personal alarms. Policy also says security staff should test how long it takes for other staff to respond to hearing a personal alarm.

- OSH officials told us security staff have neither checked staff for their alarms nor tested alarm response times since late 2021. Officials couldn't tell us why these checks stopped, but they speculated it may have been because of turnover in the chief operating officer position around that time. This means OSH hasn't done anything recently to ensure staff respond timely to personal alarms. If staff don't respond timely to hearing an alarm, they put the staff using their alarm at risk.

- Instead, OSH officials told us OSH's safety coordinator began quarterly checks in July 2022. These quarterly checks included reviewing whether staff had their personal alarms, but didn't include checking staff response times to alarms. We reviewed 7 quarterly checks from fiscal years 2023 and 2024 (there was no check in the third quarter of fiscal year 2024) to see how many staff had working alarms. In fiscal year 2023, 19 (22%) of the 85 staff OSH checked didn't have working alarms. Similarly, in fiscal year 2024, 23 (36%) of the 64 staff OSH checked didn't have working alarms. When staff don't have working alarms, they're at risk of being unable to call for help in emergency situations.

- OSH officials did not appear to do anything with the results of these quarterly reviews. OSH officials told us they weren't aware of staff receiving discipline because the safety coordinator found they didn't have a working alarm. They said some staff may have received a written warning from their supervisors.

Facilities' staff key tracking does not include a complete and accurate accounting of all keys, many of which are missing.

- The OSH campus has around 25 buildings, and most have physical key access. There are also physical keys for specific areas or functions in buildings such as patient units, offices, cabinets, and alarms. Grand master keys access multiple or all areas. Hospital policy states that facilities staff should assign staff only the keys they need to do their job. Facilities staff are then responsible for tracking who has what keys through a system of written key agreements and an electronic key database. Further, the hospital should retrieve keys from departing staff.

- Hospital policy requires managers or supervisors to complete a work order to obtain the keys their staff need to do their jobs. The work order should include the name of the key recipient and the key(s) the recipient requires. This policy states that the AAC chief operating officer or OSH superintendent must approve requests for grand master keys. Policy also requires employees to sign key agreements when they pick up their keys.

- We reviewed a judgmental selection of 9 work orders from 2023 and 2024. Because this was a judgmental selection, the results are not projectable. We found issues with 6 of the 9 work orders we reviewed. For instance, 3 work orders did not specify who should receive keys and 3 other work orders did not specify which keys were being ordered. Further, facilities staff told us that key requests sometimes come via email instead of through the work order process outlined in policy.

- We also looked at key agreements for a judgmentally selected sample of 10 current and former staff members. For this selection, we targeted staff who had grand master keys (among others). We chose this selection because of the high-risk nature of those keys. Policy requires employees to sign key agreements when they pick up their keys. 4 of the 10 staff we reviewed either didn't have a key agreement, grand master key approval, or both. For example, facilities staff did not have key agreements for 3 of the staff members. Further, officials couldn't show that the appropriate official approved 2 of 8 staff having grand master keys. 1 of the staff who didn't receive approval for a grand master key also didn't have a key agreement. This means some staff may have keys, including grand master keys, they don't need or weren't authorized for.

- We also noticed OSH identified at least 56 keys as stolen, including keys that grant access to patient units. OSH identified many other keys, including 8 grand master keys, as lost. We can't say how many lost keys there are in total because of the format of the data OSH provided us. These issues mean there's a risk someone could gain unauthorized access to OSH buildings, or a patient could find keys and escape. We haven't seen any evidence of these things happening, but we did review a few incidents in which staff or patients found misplaced keys.

OSH has a process to monitor for safety risks and noncompliance with policies, but management hasn't followed the process.

- Hospital policies require the Environment of Care Committee to assess the hospital and its occupants to evaluate staff knowledge and compliance with hospital procedures and to identify safety risks. According to policy, the committee should assess OSH at least annually and AAC at least twice annually. The committee should share the results of these assessments with other oversight committees.

    - The OSH Environment of Care Committee helps monitor the effectiveness of the hospital's safety and security management plan. This means the committee should do things like evaluate whether the hospital is a safe environment for patients and staff. For example, according to policy, the committee should routinely assess the hospital for safety risks. The Environment of Care Committee has 15 members and includes individuals like the hospital superintendent, the director of operations, the chief of security, and the safety coordinator. AAC doesn't have an Environment of Care Committee because it receives services from OSH through a memorandum of understanding.

    - The hospital also has 3 other related oversight committees: the OSH administrative executive committee, the AAC compliance committee, and the AAC leadership team.

    - The OSH administrative executive committee receives and approves recommendations from the Environment of Care Committee and safety coordinator. It has 13 members, 5 of whom are also part of the Environment of Care Committee. The 13 members hold director-level positions or higher.

    - The AAC compliance committee receives presentations from the OSH safety coordinator and makes recommendations on issues. It has 17 members, many of whom are director-level or higher.

    - Finally, the AAC leadership team is AAC's analogue to OSH's administrative executive committee. It receives and approves recommendations from the AAC compliance committee. It has 7 members, all of whom are also on the AAC compliance committee.

- We reviewed Environment of Care Committee assessments from fiscal years 2023 and 2024. These assessments included the checks for personal alarms we discussed previously. The assessments happened in all but 1 quarter during this time. This is more often than required by policy. However, officials told us they haven't responded to results of the assessments beyond entering work orders (i.e., requesting fixes to specific, discrete problems). This suggests hospital management isn't addressing the root causes of the problems assessments identify (e.g., that staff don't always have their alarms or that patient units need repairs).

- Further, officials told us the Environment of Care Committee hasn't communicated assessment results with the hospital's other oversight committees, as policy says should be happening. These issues are likely due to the hospital's confusing and overlapping oversight committees and because, according to hospital officials, hospital policies don't reflect current practices. That, in turn, suggests OSH management isn't doing a good job ensuring policies are up to date.

Management lacks effective policies over these physical security measures, and staff have allowed issues to persist.

- OSH does not have policies or is missing documentation for a couple of the physical security processes we reviewed.

    - Security staff lack documented policies for how campus patrols should be documented and how many hours and what types of training security staff are expected to receive.

    - The hospital doesn't have a documented process for retrieving keys from departing staff. The hospital also lacks a complete inventory of which keys open which doors.

- In other instances, OSH lacks adequate oversight to ensure that staff follow policies.

    - For instance, the chief of security told us that he does not review documentation for security patrols. He also told us he has not provided training on how to conduct patrols or complete documentation since he took over the position in November 2023. He told us that he relies on lieutenants to review documentation and train new staff. However, our review showed documentation was inconsistent, incomplete, or questionable, which suggests lieutenants are not providing adequate oversight, either.

    - OSH management has known about issues with missing or stolen facility keys since at least April 2023 and hadn't taken substantive action to secure the campus as of October 2024. Officials told us the issues we saw with staff not signing key agreements occurred under a prior hospital administration and that an ex-staff member did not perform their job appropriately.

    - Staff reportedly go undisciplined when the safety coordinator finds they don't have their alarms.

- Part of hospital management's job should be to promote an environment that protects both staff and patients. To do this, management needs to establish clear policies, train and monitor staff for compliance, discipline staff for noncompliance, and generally oversee hospital processes to make sure they're working as intended. These issues lead to confusing situations where hospital policies don't align with hospital practices. Staff may not know what to do or may perceive rules to be inconsistently enforced. These issues fail to promote the importance of safety and may leave staff with the impression that safety isn't a priority.

Personnel

OSH and AAC had enough nursing staff on patient units to meet their minimum staffing requirements during the 4 weeks we reviewed.

- Adequate staffing is important to ensure the safety of OSH staff and patients. This includes having enough staff to supervise and treat patients. It also includes having knowledgeable staff who can provide quality services. There are minimal clear standards for personnel in regulation, statute, federal code, or best practices to use as benchmarks. Therefore, we used our professional judgement to select topics to review. We compared OSH statistics to similar facilities when possible. To determine whether OSH is adequately staffed, we reviewed:

- Staffing ratios for each of OSH and AAC's patient units. Staffing ratios show the number of nursing staff per patient and are an indicator of whether the facility has enough staff.

- Training records for a sample of OSH and AAC staff on select topics. Training is an indicator of whether staff are prepared to do their jobs and respond to emergency situations.

- Turnover rates. This shows the percentage of the hospital's total staff who left the facility during the year. It is an indicator of staffing stability. High turnover can lead to increased inconsistencies and inexperience among staff.

- Vacancy rates. This shows the percentage of the hospital's total positions that are unfilled. It is an indicator of how well the hospital is hiring and retaining employees. High job vacancies can lead to increased costs and inefficiencies.

- Overtime. This is an indicator of whether the facility has enough staff. Large amounts of overtime can lead to increased costs and employee stress and decreased service quality.

- Each of OSH's patient units must have 1 registered nurse, 1 licensed practical nurse, and 3 mental health technicians on staff for each shift. AAC's chief nursing officer told us each patient unit must have a minimum of 2 registered nurses, 1 licensed practical nurse, and 4 mental health technicians on staff for each shift. However, when fewer than 15 patients are in the unit, AAC requires fewer staff.

- We reviewed staff schedules and timesheets for 2 separate 2-week periods in August 2023 and August 2024 for each of OSH's 4 patient units and AAC's 2 patient units. We chose this sample to cover time periods from before and after this audit was requested. Each unit has daytime and nighttime shifts, so our analysis covered 336 total shifts across the weeks, units, and shifts we reviewed.

- All but 1 of the 336 shifts we reviewed met the minimum staffing requirements. That shift had 1 fewer mental health technician than required but only for part of the shift. However, to meet the minimum staffing ratios, OSH and AAC frequently used registered nurses to make up for a shortage of mental health technicians and licensed practical nurses. For example, 90 of the 336 shifts we reviewed did not have enough mental health technicians or licensed practical nurses. Additional registered nursing staff covered the shortages on 46 of those shifts. Registered nurses have higher certifications than other nursing staff, they also are more expensive.

- OSH and AAC's patient-to-staff ratios are somewhat similar to the other 2 Kansas facilities we compared them to. For the sample of shifts we reviewed,

we saw an average of 1 nursing staff member to 3.3 patients in 2023 and 1 nursing staff member to 3.5 patients in 2024. We also compared the ratio of total staff to total patients based on data that hospitals report annually to KDADS. Using total staff and patients, OSH has 1 staff member for every 2.8 patients. Larned State Hospital, which is the other state psychiatric hospital, and Parsons State Hospital, a state hospital serving individuals with intellectual disabilities, had ratios of 1 staff member to 1.4 patients and 1 staff to 2.9 patients, respectively. We can't say whether OSH's staffing ratio is enough to ensure safety because there are no best practices or policies that specify a safe ratio.

A sample of OSH and AAC staff generally received training on the select topics we reviewed in 2022-2024.

- OSH and AAC require staff to receive periodic training on specific topics. The requirements vary based on the type of staff and their interaction with patients. They do not require staff to receive a certain number of training hours each year. For example, OSH and AAC require all staff to receive training on topics like crisis intervention and personal protective equipment annually and topics like CPR every 2 years. They require nursing staff to receive additional training on topics like the use of physical interventions and restraints annually.

- We compared OSH and AAC's requirements for training related to patient interactions and safety risks (e.g., CPR, first aid, crisis intervention, physical interventions) to training requirements at Larned and Parsons State Hospitals and the Kansas Department of Corrections. OSH and AAC generally had similar requirements to these other facilities.

- We also randomly selected a sample of 30 nursing staff and 30 general staff and reviewed transcripts and rosters from 2022-2024 for 5 training topics, including crisis intervention, physical interventions, restraints, CPR, and personal protective equipment. 57 of the 60 staff (95%) met training requirements during the 3-year period we reviewed. The remaining 3 staff members didn't receive training on either crisis intervention or physical interventions in 2022. Staff in OSH's training department told us this happened because of a mistake in their records about who needed to receive training. All 3 staff received the required training in 2023 and 2024.

However, the facility depends on large numbers of contract nursing staff and overtime to meet minimum staffing requirements due to high turnover and vacancy rates.

- Turnover rates and vacancy rates are separate, but related measures. The turnover rate measures how many staff left the hospital during the year, whereas the vacancy rate measures how many positions remained unfilled during the year. The measures are related because vacancies are the result of

staff turnover. OSH and AAC rely on a combination of state staff and contract staff to fill their total positions.

- OSH and AAC's turnover rates and vacancy rates for state staff were high in the 2 to 3 years we reviewed. We reviewed annual turnover data for state employees for September 2021 through September 2024 and monthly vacancy data for January 2023 through August 2024.

    - The turnover rate for state staff averaged 37% annually over those 3 years. All agencies experience some turnover. But OSH's turnover rate is significantly higher than the turnover reported in a Kansas Hospital Association survey of 110 Kansas hospitals. That survey showed the average turnover rate for Kansas hospitals was 16-30% in 2023.

    - For comparison against other state hospitals, we looked at the vacancy rate for 2 points in time in 2023 and 2024. The vacancy rate for state staff was about 43% on September 1, 2023, and 39% on September 1, 2024. This was similar to the vacancy rate the Department for Aging and Disability Services reported for Larned State Hospital (45%), but much higher than Parsons State Hospital (24%).

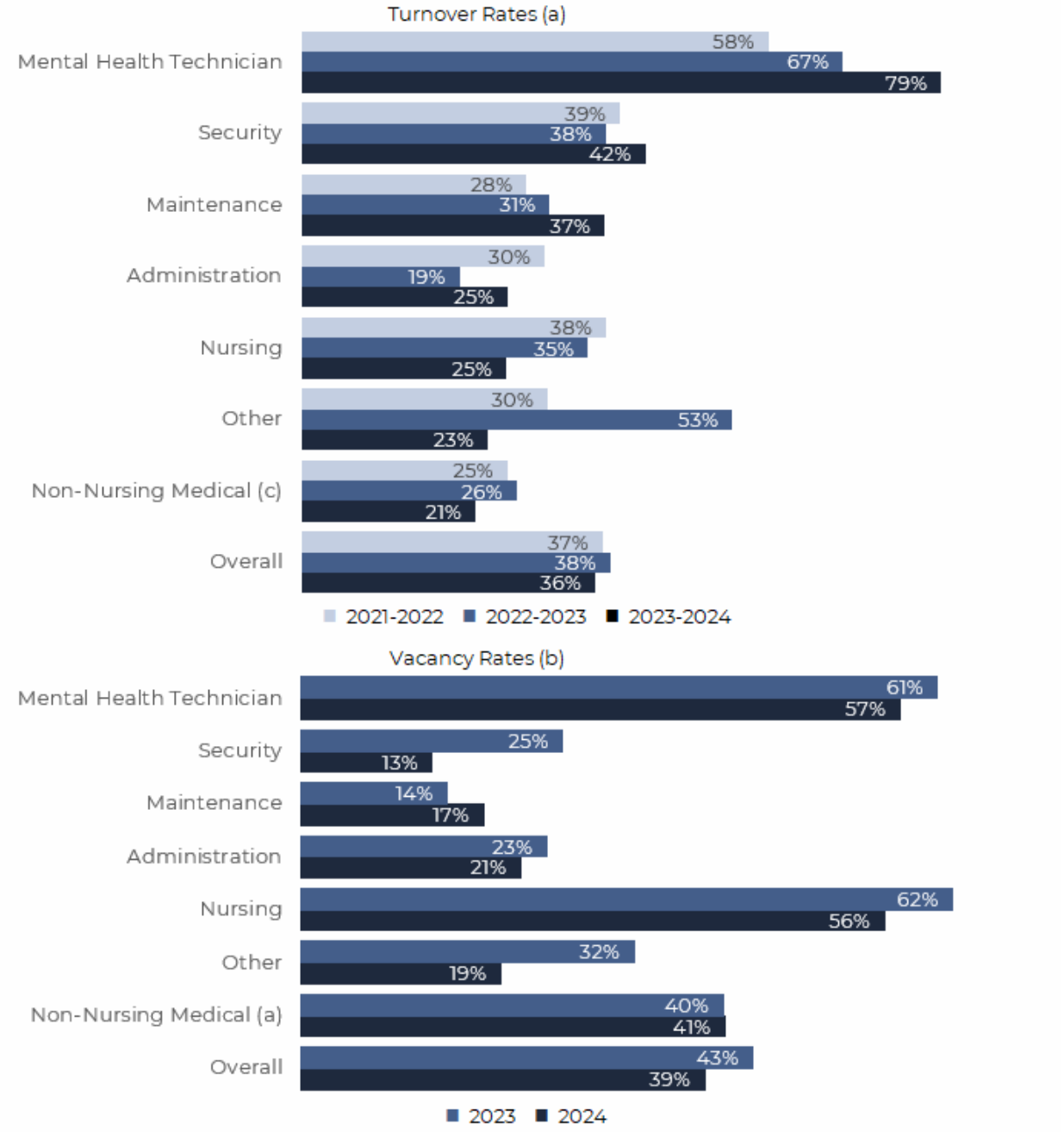
    - **Figure 1** shows the turnover rates and vacancy rates for state staff by position category as of September 1st. As the figure shows, there was significant turnover and vacancies across all categories. Mental health technicians had the highest turnover and vacancy rates of any staffing category in 2024 with 79% turnover and 57% vacancy.

- OSH and AAC's turnover rates for contract staff also were high in the 3 years we reviewed from September 2021 to September 2024.

    - The turnover rate for contract staff at OSH was 54% of all active contracts from September 2023 through August 2024. Some turnover is expected since OSH typically only signs 3-month contracts with contract staff at their facility. Some of these contract staff will have their contracts renewed, but others will not.

    - Vacancy rates are not applicable for contract employees. That's because the hospital plans for positions to be filled by state staff, not contract staff.

Figure 1. Mental Health Technicians had the highest rate of turnover of the state staffing groups we reviewed during the years 2022-2024.



(a) Turnover was calculated annually on September 1st of each year.
(b) Vacancy was calculated as a snapshot in time on September 1st of each year.
(c) Non-Nursing Medical staff include physicians, psychiatrists, etc.
Source: Agency separation data from 2022-2024 (audited).

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- OSH hires contract nursing staff to fill vacant state nurse positions to meet its minimum staffing requirements. However, this is a short-term solution and adds to high turnover because contract staff are on short-term contracts. As of September 2024, 47% of mental health technicians and 50% of nursing positions were filled by contract staff. As the figure shows, without contract staff, mental health technicians have a vacancy rate of 57% and nursing has a vacancy rate of 56% in 2024. We calculated the hospital's overall vacancy rate before and after contract staff. When accounting for contract staff, OSH's overall vacancy rate falls from 39% to 18%.

- OSH also relies heavily on overtime to meet its minimum staffing requirements. This is a short-term solution because it can lead to staff burnout and dissatisfaction. It can also lead to decreased service quality if staff work extended shifts on consecutive days. We reviewed OSH and AAC's overtime data for state staff in 2023 and 2024. OSH does not monitor how much overtime any individual employee works and has difficulty tracking overtime on a person-by-person basis, especially for contract staff.

- State staff worked a total of about 34,400 overtime hours in 2023 and 27,400 overtime hours so far in 2024. Staff volunteer to work overtime. OSH officials told us they have not had mandated overtime since 2021.

- About 350 state staff worked overtime in each of the 2 years we reviewed. This is roughly 95% of the state employee workforce at OSH. The largest amount of overtime a single person worked was 840 hours in 2023 and 574 hours in 2024. On average, state staff who worked overtime worked about 80-100 hours of overtime in those years.

High reliance on contract staff and overtime result in increased state costs and risks for staff safety.

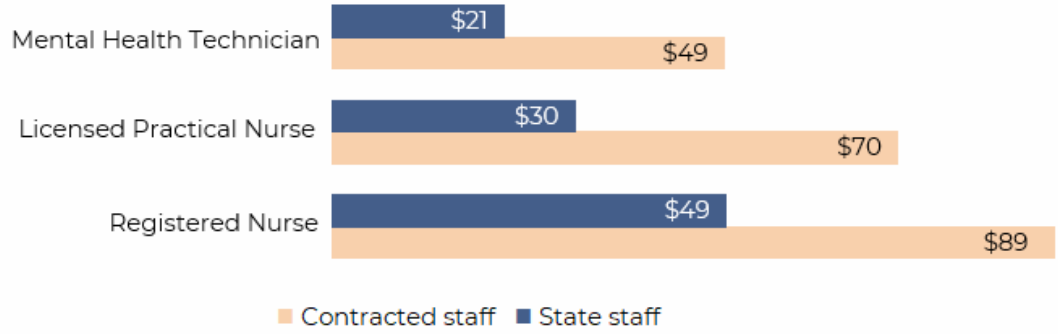
- High vacancy rates and turnover rates mean that OSH must rely on contract staff and overtime to fill positions and meet their minimum staffing requirements despite the higher costs.

    - Hiring contract staff to fill vacancies created by state staff increases OSH's costs. That's because contract staff are more expensive than state staff. **Figure 2** shows the hourly rate of state staff compared to contract staff in 2024. As the figure shows, contract staff cost almost twice as much as state staff. Nursing agencies pay contract staff salaries directly. OSH and AAC pay a set hourly rate to the nursing agencies for the staff the agencies provide. These rates pay for the hourly wage and benefits of the contracted nurse, as well as costs like staffing agency overhead costs and the agencies' liability insurance.

    - Having staff work large amounts of overtime also increases OSH's costs. Staff who work overtime cost OSH 1.5 times their normal wage (or for contract staff, 1.5 times their contracted rate). The hospital paid state and

contract staff $6.5 million for overtime in fiscal year 2024. In 2023 and 2024, OSH paid state staff who worked overtime varying amounts up to $56,000 per worker per year.

Figure 2. Average state nursing staff salaries at OSH and AAC are lower than the average cost of contracted staff.



Sources: Salary and wage data from 2024 (audited), agency contracted rates provided by OSH management (unaudited).

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- We estimate OSH spent about $4.5 million more on contract costs and $2.2 million more on overtime costs in 2024 than it would have if it had sufficient state staffing. This is a rough estimate based on the cost difference between contract and state staff and overtime and regular pay.

- High vacancy rates, turnover rates, and overtime also increase risks to staff safety and likely compound the physical security issues we identified. Staff turnover can lead to decreased institutional knowledge and experience with the patient population at OSH and AAC. It can also lead to a lack of knowledge and experience with proper policies, procedures, and de-escalation techniques necessary to work with the population at OSH and AAC. Additionally, overtime may increase risk of fatigue, burnout, and low job satisfaction.

- This is particularly true for mental health technicians, which make up about 20% of all staff at OSH and AAC. Mental health technicians work closely with patients and are supposed to fill more than half of the minimum nursing staff on each unit at a time. Yet, mental health technicians have the highest turnover and vacancy rates of any other position categories.

Working Environment and Culture

OSH management has not promoted a culture that prioritizes following guidelines or ensuring a safe workplace.

- OSH is a large campus with a large workforce. It's important for management to cultivate a culture of safety to ensure that staff feel supported and

empowered to report safety incidents and potential hazards. A culture prioritizing safety encourages staff to follow procedures.

- There are no clear standards for environment and culture in regulation, statute, federal code, or best practices to use as benchmarks. Therefore, we used our professional judgement to conduct our review. To determine whether management promotes a culture prioritizing staff safety, we reviewed the hospital's investigations of a sample of 30 complaints staff reported in 2023 and 2024.

- Throughout this audit, we also reviewed policies and procedures to determine whether adequate policies and procedures were in place that detail standard operating procedures and promote a culture of safety. We also reviewed safety-related data and reports to determine whether management was taking a proactive approach to identifying potential safety concerns and appropriately responding to known issues. Finally, we talked with staff via phone and email and conducted a survey to better understand their perceptions of the culture at the facility.

- Overall, we found that management was not adequately promoting a culture that prioritizes safety. The following sections describe additional details about these issues.

OSH management has not set clear expectations for how safety and security processes should work.

- Throughout this audit, we found many instances where policies either do not exist or are outdated. These issues suggest OSH management's policy reviews aren't timely or effective.

- We found many areas where the hospital lacks policies which detail standard practices. For instance:

    - The hospital doesn't have policies or standard practices for how security staff should document their patrols of the OSH campus and buildings.

    - The hospital doesn't have policies or standard practices for the types and amount of fire training security staff should receive.

    - The hospital doesn't have policies or standard practices for the processes staff should use to retrieve keys from departing staff.

    - The hospital doesn't have policies or standard practices for when progressive discipline of staff is warranted and what that discipline should look like (e.g., informal coaching, written reprimand, suspension, or termination).

- We also saw that policies sometimes don't reflect current practices. For example:

    - Hospital policies say staff may report security issues through a safety concerns form. However, officials told us this form is no longer used and said it's not in OSH policies, even though we observed it to be.

    - Hospital policies require staff to report the results of safety assessments to oversight committees. However, this hasn't happened in practice.

    - Hospital policies require security staff to conduct checks of personal safety alarms. However, these checks haven't happened in practice.

- Having clear expectations is critical to ensuring staff safety and security because it helps staff to know how and when to complete tasks. A lack of clear expectations leaves staff vulnerable to preventable risks.

OSH management hasn't collected and used data to proactively identify and fix safety and security problems.

- Management does not have clear expectations for monitoring areas of risk to staff safety. Management either does not have systems in place with the ability to create centralized safety data or does not appear to value what centralized data would offer. Further, there are no processes in place for management to analyze and review patterns that relate to staff safety.

- Management does not currently have processes to compile or review data relevant to staff safety. For instance:

    - Management told us they do not track the amount of overtime by staff member. High-level reports of overtime costs are readily available, but management told us that reports broken down by individuals were cumbersome to obtain. Even these cumbersome reports could only give overtime by individual for state staff. Management told us there was no way to track overtime for individual contracted staff. Further, management told us they were not interested in how much overtime a staff member worked, only in how much the hospital paid in overtime.

    - Management does not have a centralized system to track safety incidents and staff discipline. Staff report safety incidents to 2 different departments (human resources and risk management) who conduct separate investigations and recommend disciplinary action. Supervisors document staff discipline in their own, separate supervisory files but don't report this discipline to any other departments. This decentralized investigation and discipline process means that management does not have a cohesive way to track staff disciplinary action. This makes it difficult for management to take a staff member's personnel history into account for progressive discipline.

- Management does not have centralized documentation of when staff activate personal safety alarms. Management told us they do not track when or why staff activate safety alarms. This makes it difficult for management to proactively identify areas, patients, and staff at high risk.

- In situations where data does exist, management sometimes does not have adequate processes in place to utilize it. For instance, safety coordinators perform quarterly checks to collect and report safety data such as physical issues with buildings (like doors not working properly or chipped floors or walls that could become safety issues) and whether a small number of randomly selected staff wear personal safety alarms. However, management does not appear to use the information collected to feed into any risk assessments or systemic issue analysis. Further, the results aren't communicated to oversight committees as required by policy. Similarly, management does not adequately report or respond to information included in the Environment of Care Committee reports.

- Collecting and using data is critical to ensuring staff safety and security because it allows management to be aware of and take preventative action for staff safety risks. For instance, excessive overtime could lead to fatigue and/or burnout of staff, which puts staff and patients at risk. It also may lead to further issues with vacancy and turnover. Similarly, a lack of centralized data to monitor staff safety alarm usage means management may not see patterns of individuals with high incident rates or areas of the hospital that may be particularly high risk.

OSH management hasn't adequately addressed safety and security problems when it becomes aware of them.

- We reviewed a small sample of complaints staff reported to OSH management in 2023 and 2024 to determine how management responded to and addressed safety and security issues. We selected 15 complaints that staff reported to human resources and 15 complaints that staff reported to risk management. We also ended up reviewing documentation for a few other incidents that were related to the 30 we selected. This is only a very small percentage of the total number of staff complaints reported in those years. Therefore, our results are not projectable. But we think they're still useful for identifying strengths and weaknesses in management's processes for addressing safety issues. Finally, we reviewed staff disciplinary records to determine what, if any, discipline was taken in response to incidents that investigators substantiated.

- Management didn't take disciplinary action when we expected them to in several of the incidents we reviewed. For instance:

    - A staff member was injured at work and appeared drunk. According to OSH HR notes about the incident, the individual should have gotten a

suspension. That didn't happen, though, because the HR notes also say OSH didn't follow up fast enough. This suggests that management sometimes does not respond to issues timely. This is also a problem because, as we'll later discuss, this staff member was accused of drinking on the job on 2 subsequent occasions.

- In 2 other cases, a supervisor failed to respond appropriately to reports of misconduct that included sexual harassment. In 1 case, an HR investigator found the supervisor failed to respond to or take disciplinary action about allegations of employee misconduct. The HR investigator substantiated the allegations, including that the accused staff member had engaged in sexual harassment. In a subsequent case, an investigator found the same supervisor had thrown a welcome back party for an employee who was on leave for sexual harassment and was planning a welcome back party for another employee who was also placed on leave for sexual harassment. This implies that supervisors sometimes are not adequately holding staff accountable and may be engaging in favoritism.

- In other instances, management took disciplinary action, but we don't think it was appropriate to address the issue. For instance:

  - For the previously mentioned individual who appeared drunk and was injured at work, another complaint was filed for a separate, similar incident. The staff member was drinking while on duty and then passing out. The staff member ultimately received a letter of reprimand. But the letter only addressed that the staff member was asleep while on duty, not that the staff member had been drinking at work. That individual was again accused of drinking while on duty again about a month and a half later. This suggests that management does not always hold staff accountable for the severity of their actions.

  - In 1 case, a staff member was accused of driving a patient in a vehicle while intoxicated. Other staff members also reported that the staff member had been inebriated. The staff member acknowledged having consumed alcohol over lunch. The initial proposed disciplinary action was termination. However, management suspended this staff member for 5 days because management said the staff member appeared to take responsibility for their actions. This suggests lack of accountability and potential favoritism.

  - In another case, a staff member allegedly visited another staff member at their home, asked for sexual favors, then sexually assaulted them. The assaulted staff member called police and filed a report. Management made the decision to terminate both employees' contracts, but it appears OSH did not conduct a formal investigation.

  - Finally, an individual in 1 case was not completing job duties, leaving keys unattended, and disposing of patient possessions improperly. Instances included spending time with another staff member instead of performing

job duties and leaving keys to patient units in areas where patients had access to them. This staff member received 5 verbal consultations over 15 months, but there was no evidence of discipline progressing beyond that. This may lead staff to feel like they can continue these behaviors because their actions are not progressively penalized.

- Addressing safety problems is critical to ensuring staff safety and security because it establishes a culture of compliance with guidelines. It also ensures that staff feel that management holds them accountable for their actions and that they are held to the same standards as their peers. Lack of effective disciplinary procedures means staff may view management negatively. For instance, staff may see management as engaging in favoritism or retaliation.

OSH management hasn't established a culture that prioritizes professional boundaries or encourages people to speak up about known safety risks and issues.

- Throughout our work, we observed or heard about multiple instances that suggest an unprofessional culture at the hospital. For example:

    - The investigation reports for several staff complaints that we reviewed described an environment where staff appear to regularly discuss inappropriate or unprofessional topics including sexual innuendos, physical appearance, and bullying behaviors.

    - The investigation reports also described staff spending time together or communicating outside of work, which included drinking together and facetiming or texting other staff. While staff camaraderie is important for a healthy work environment, the investigation reports made it clear these interactions were common and sometimes crossed professional boundaries at OSH. This informal culture increases the risk for staff to cross boundaries or discuss things they shouldn't while at work. It may also fuel staff perceptions of favoritism.

    - Staff communicated concerns to our team via a staff survey, phone calls, and emails about issues with culture and management such as favoritism and unprofessional work environment. For example, staff members claimed it means management is looking for a reason to get rid of someone if they are moved to the "float pool" (i.e. a group of staff that fill in where needed). Staff also reported that there is an "in-crowd" that have been at the hospital many years and are exempt from any kind of correction.

- We also observed or heard about multiple instances of staff feeling discouraged to report safety-related problems. For example:

    - The investigation reports we reviewed included multiple instances of staff admitting to knowing, hearing, or experiencing issues but not reporting

them because they were fearful of retaliation or didn't think it would make a difference. For example, during an investigation, 1 supervisor reported that management didn't want staff to take leave. When a staff member took family and medical leave, management instructed the supervisor to write the staff member up, or management threatened that the supervisor would be written up.

- Staff communicated concerns to our team via a staff survey, phone calls, and emails about issues with staff not feeling comfortable reporting issues to management because of concerns with retaliation or that it wouldn't make a difference. For example, 1 staff member told us that they were being micromanaged by management, and did not have anyone they could report to. That's because complaints get reported to management. Another staff member told us that if they question their supervisor, the supervisor will retaliate by withholding information, making the job difficult. This staff member said they have previously reported to the OSH assistant superintendent, but nothing was done.

- Establishing a good culture is critical to ensuring staff safety and security because it encourages employees to report incidents and safety concerns, follow procedures, and actively take part in maintaining a safe environment.

Other Findings

Staff had mixed opinions about their safety and security, but our survey suggests current management may be making some improvements.

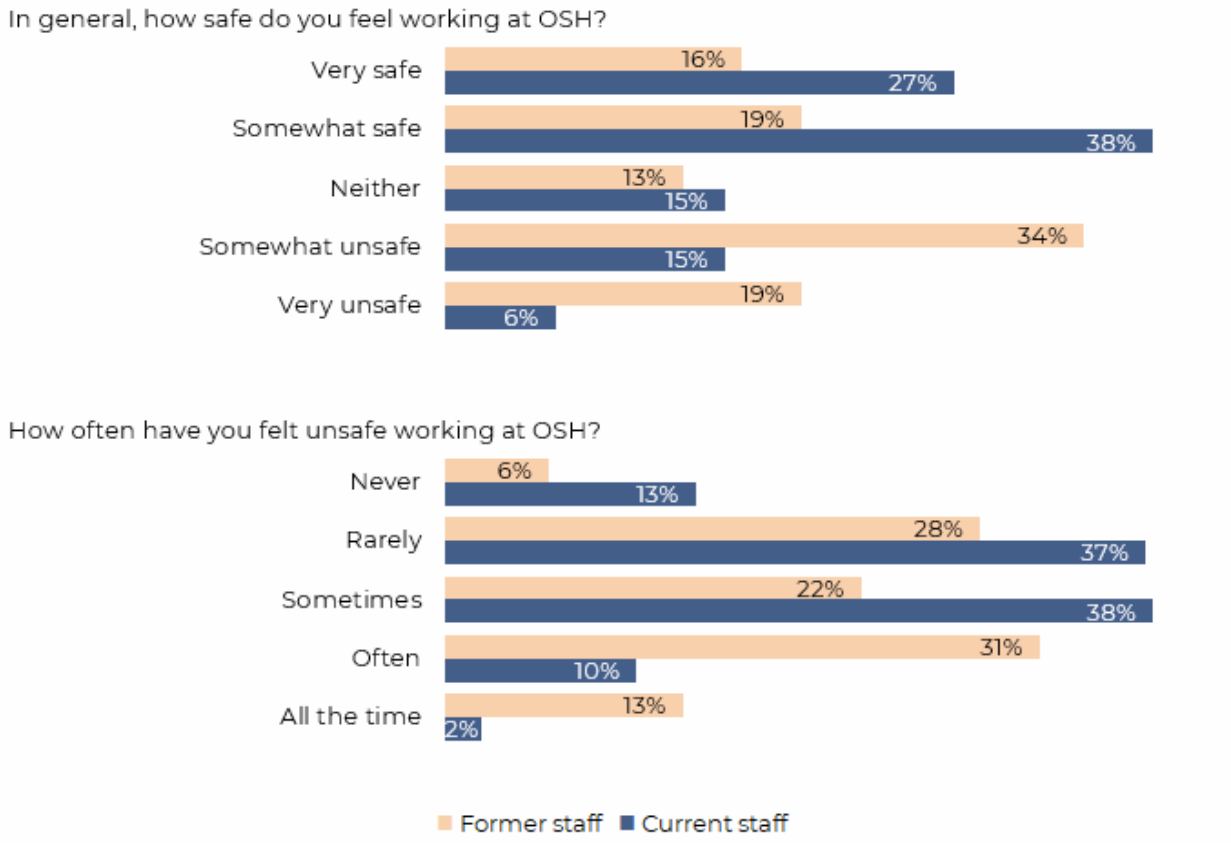
- We surveyed 1,220 staff who worked at OSH and AAC in fiscal years 2020 through 2024. The survey went to all current and former staff including state and contracted staff employed at OSH and AAC. Our survey had a response rate of 32% or 395 employees. 333 individuals, or 84% of our respondents, submitted complete responses. 62 (16%) submitted responses that were incomplete. 52% of the respondents were current state employees and 19% were previous state employees. The other respondents were current or former contracted staff. We asked for respondents to give further information if they mentioned things like feeling unsafe. However, responses were general and did not give enough information like dates, times, or names for us to follow-up on any reported incidents.

- This survey allows us to understand their perception of safety at OSH as well as staff's perception of how management handles safety issues. We were also able to compare former staff and current staff perceptions. The current OSH superintendent took over in October of 2022, so this helps us to see change over time and evaluate whether changes in administration have changed staff perceptions. Finally, the survey allowed our audit to focus our work on higher risk areas such as management culture and physical security. **Appendix A** includes the summarized results of the full survey.

- **Figure 3** shows respondents' feelings about their overall safety and what factors contributed to those feelings. As the figure shows, almost two-thirds (65%) of current staff respondents said they generally feel somewhat or very safe when working at OSH, which is significantly higher than former staff (35%).

- As the figure also shows, 12% of current staff survey respondents reported feeling unsafe often or always when working at OSH. This is significantly less than the 44% former staff survey respondents who reported feeling unsafe often or always.

Figure 3. Most staff reported feeling safe working at OSH, but also mentioned that they have felt unsafe at times.

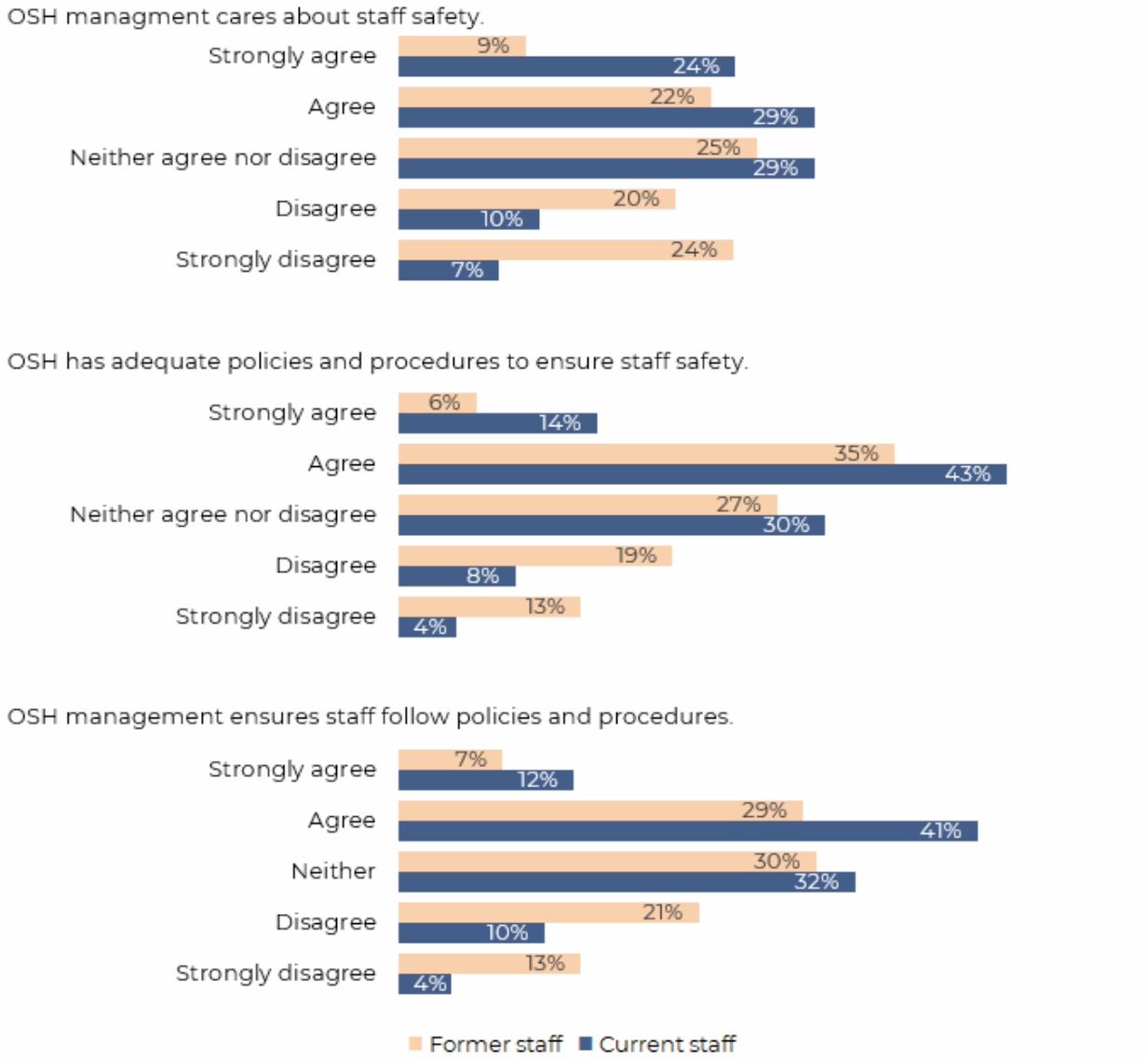


Source: LPA Survey of current and former OSH staff.

- More current staff respondents said that management cares about safety than former staff. However, less than half of current staff agreed OSH's policies and procedures are enough to ensure staff safety. **Figure 4** shows respondents' opinions about management's role in staff safety. As the figure shows, significantly more current staff than former staff agree or strongly

agree that management cares about staff safety and ensures staff follow policies and procedures.

Figure 4. Current staff agree that management is committed to staff safety and safe policies and procedures at a higher rate than former staff.



Source: LPA Survey of current and former OSH staff.

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- In other areas of management, current staff was more positive than former staff. 36% of current staff responded that morale at OSH is low. Conversely, 61% of former staff responded that morale was low. Former staff expressed that management did not make fair personnel decisions and that retaliation concerned them at higher rates than current staff. However, staff also mentioned that issues like poor management and a hostile or unprofessional workplace make it hard for OSH to attract and retain qualified staff.

Conclusion

Osawatomie State Hospital is an historically tough environment. It serves a challenging population and staff have a demanding job that inevitably involves safety risks. While the management can't eliminate the staff safety risks created by the population and related challenges, we saw ample evidence that Osawatomie State Hospital officials can and should do a better job of managing the safety risks they can control. Our focus was on physical security, staffing, and workplace culture all of which management can address. We saw evidence of inadequate physical security processes in multiple areas including door checks and tracking facility keys. We also saw staffing challenges with high turnover, numerous vacancies, and costly overtime. Finally, we saw evidence of workplace culture issues like not setting clear policy expectations, not collecting and using data to monitor staff safety risks, and not taking appropriate disciplinary actions when made aware of safety incidents.

While this audit had many findings, we also saw evidence suggesting current management may be making some improvements. Survey responses from current staff were more positive than responses from former workers. The current superintendent also demonstrated an interest in improving some of these areas through actions like reporting staff who did not meet expectations, committing to a comprehensive audit of facility keys, and exploring alternative options for providing fire response resources on the campus.

Recommendations

1. To ensure staff have clear expectations regarding physical security and processes, Osawatomie State Hospital management should develop and regularly review, update, and clarify policies. This includes areas we noted in this report such as:
    - Security staff patrol processes and documentation
    - Security staff fire training
    - Key return for departing staff
    - Progressive discipline

Agency Response: Policies and procedures, forms and training on Safety and Security Officer Patrol Process will be reviewed, edited, and or created as needed to ensure consistency through the department. Forms will be used daily to document patrols and reviewed monthly by supervisors to ensure proper patrols are being conducted. Trainings and competencies will be conducted upon hiring and annual thereafter. Each Safety and Security Officers training will be documented and retained in their training file. A new policy and procedure outlining the expectations

of Safety and Security Officer training will be created to ensure this practice is ongoing

All Safety and Security will be trained on responding to fire alarms and conducting evacuations. A staff member will be identified to become certified as Fire Fighter 1 and will then be responsible for the Safety and Security Fire Training Program. Select Safety and Security Officers will be selected from each shift to become Fighter Fighters while all officers will be evacuation specialists. Trainings and competencies will be conducted upon hiring and annual thereafter. Each Safety and Security Officers training will be documented and retained in their training file. A new policy and procedure outlining the expectations of Safety and Security Officer training will be created to ensure this practice is ongoing.

All supervisors will be trained on hospital property assigned to staff members, including keys. This training will include how hospital property is assigned, how it should be handled during employment and how it should be returned at the termination of employment. This training will be given to all supervisors at the time they become a supervisor and annually thereafter.

All hospital staff will receive formal education at the time of hire on the expectations of handling keys assigned to them, the proper way to return keys at the termination of employment and the potential consequences if keys are not returned.

Human Resources has completed a comprehensive staff transition, with all new team members receiving thorough training on the effective implementation of progressive discipline. Additionally, supervisors have undergone, and will continue to receive, ongoing training to equip them with the necessary tools, skills, and expectations to effectively manage and support their teams.

2. Osawatomie State Hospital should regularly review, update, and clarify existing policies to ensure policies and practices align. This includes areas we noted in the report such as:
    - Personal security alarm checks
    - Communication of safety assessment reports
    - Safety concerns form

Agency Response: Hospital policy and procedure EC-1.1 Personal Safety Alarms has been updated to reflect:

> "1. Staff will be educated on the proper use and management of Personal Safety Alarms at the time of hire and annually thereafter.
> 2. On a monthly basis, the Safety Coordinator will perform random drills to determine the response time upon hearing an alarm. In addition, the Safety Coordinator will conduct random checks to ensure each employee on a unit has an alarm on their person.
> i. The results of these drills and checks will be reported to the Environment of Care Committee monthly
> ii. The Environment of Care Committee will be responsible for making

recommendations to the Administrative Executive Committee based on drills and results of checks."

The Safety Coordinator, who chairs the Environment of Care Committee, will create a formal written report with standing items to be reported. This report will be approved by the Administrative Executive Committee and then reported out on in Environment of Care Committee and Administrative Executive Committee on a quarterly basis. This report will also be included in the hospital quarterly Governing Body Report and shared will staff hospital wide.

Safety Concerns form FSE 1.3 will be reinstated and added back to policy EC-1.0 Safety & Security Management Plan to allow staff a standardized place to report concerns that do not rise to the level of supervisory or Risk Management.

3. As part of Osawatomie State Hospital's policy review and updating, management should develop data systems and tracking to inform the updates. This includes important areas we identified such as:
    - Use of personal security alarms
    - Overtime
    - Disciplinary action

Agency Response: Hospital policy and procedure EC-1.1 Personal Safety Alarms has been updated to reflect:

"1. Staff will be educated on the proper use and management of Personal Safety Alarms at the time of hire and annually thereafter.
2. On a monthly basis, the Safety Coordinator will perform random drills to determine the response time upon hearing an alarm. In addition, the Safety Coordinator will conduct random checks to ensure each employee on a unit has an alarm on their person.
i. The results of these drills and checks will be reported to the Environment of Care Committee monthly
ii. The Environment of Care Committee will be responsible for making recommendations to the Administrative Executive Committee based on drills and results of checks."

Overtime will be tracked and reviewed. The Chief Financial Officer will distribute an overtime report, broken down by discipline and staff member, per month and distributed to Department heads for review and verification overtime was indeed warranted.

Human Resources will be implementing a QAPI goal to track and trend disciplinary actions. By the end of each month, HR will track and report disciplinary actions by hospital, location, and position classification to AEC with 90% accuracy. Additionally, HR will provide quarterly reports to the governing body. If any disciplinary trends are identified, HR will design and implement supervisory or hospital-wide training within the following quarter to address the issues.

4. Osawatomie State Hospital should use newly created and already existing data to monitor safety issues to include:
    - Environment of Care Committee results
    - Trends in personal security alarms (i.e. by area, staff member, and patient)
    - Overtime by staff member
    - Trends in disciplinary action (i.e. by area and staff member)

Agency Response: The Safety Coordinator, who chairs the Environment of Care Committee, will create a formal written report with standing items to be reported. This report will be approved by the Administrative Executive Committee and then reported out on in Environment of Care Committee and Administrative Executive Committee on a quarterly basis. This report will also be included in the hospital quarterly Governing Body Report and shared will staff hospital wide.

Trends in personal safety alarms will be recorded by the Safety Coordinator and reported to Environment of Care Committee who will then share trends and make recommendations to the Administrative Executive Committee.

Overtime for individual staff members can be tracked and be monitored. The Chief Financial Officer will distribute an overtime report, broken down by discipline and staff member, per month and distributed to Department heads for review and verification overtime was indeed warranted.

Human Resources will be implementing a QAPI goal to track and trend disciplinary actions: By the end of each month, HR will track and report disciplinary actions by hospital, location, and position classification to AEC with 90% accuracy. Additionally, HR will provide quarterly reports to the governing body. If any disciplinary trends are identified, HR will design and implement supervisory or hospital-wide training within the following quarter to address the issues.

5. To improve morale and working conditions, Osawatomie State Hospital management should work on communication and setting clear expectations. Management should develop processes to ensure all staff are held to expectations consistently.

Agency Response: Each supervisor will provide their staff members with a specific job classification competency skill sheet, ensuring that all employees are clear about their roles and responsibilities. Supervisors will review and sign off on each staff member's competency annually, as part of the performance review process.

Agency Response

On November 22, 2024, we provided the draft audit report to Osawatomie State Hospital and the Kansas Department for Aging and Disability Services. Their joint response is below. Agency officials generally agreed with our findings and conclusions.

Osawatomie State Hospital
Ashley Byram, LMSW, Superintendent
500 State Hospital Drive
Osawatomie, KS 66064-0500

Kansas
Department for Aging
and Disability Services

Phone: (913) 755-7000
www.kdads.ks.gov/OSH

December 6, 2024

Mohri Exline
Legislative Division of Post Audit
900 SW Jackson Street, Suite
Topeka, KS 66603

Dear Ms. Exline:

Thank you for the opportunity to respond to the audit report on safety and security at Osawatomie State Hospital (OSH.) We appreciate the work of you and the audit team to understand the environment of care, statutory and regulatory requirements, and management approach at our hospital. We are committed to ensuring the safety of our staff and patients while providing high quality psychiatric care.

Our agency response to the audit recommendations is included in a table at the end of this response. In general, we agree with the audit recommendations and have proposed actions which are consistent with the recommended policy and procedural changes. Our management team, with the support of the Kansas Department for Aging and Disability Services, has focused on improving the staff culture at OSH and Adair Acute Care. This includes the work environment for our staff through clear communication of expectations, holding staff accountable, and updating policies and procedures to reflect best practices. In our internal measurement of staff perception of safety, we have seen improvements in how staff feel about the environment, safety practices, management and organizational support have improved over the last 2 years. The Governor and Legislature's support for pay increases, bonuses for retention and hiring, pay incentives for 24/7 days a week facility, and improvements to the facilities also contributes to employees feeling valued and supported in delivering care to our patients.

Working with the auditors clarified areas where OSH can continue to improve. In our response below to specific findings and recommendation, I highlighted actions we have taken as a leadership team to improve safety and security for staff and patients. The audit covered many areas of our operations including some that are in cooperation with KDADS Central office and State Hospital Commission. The response captures the input of the OSH leadership team and KDADS.

In the following sections, we included quotes from the audit report showing the finding and the audit report. The OSH response to the statement in the audit report is italicized.

Background

In the Background Section, the auditors made statements that require some additional context.

"State law and CMS regulations require that OSH and AAC provide services to patients in the "least restrictive manner".

- "During a tour, we observed OSH and AAC patient rooms are not locked. Patients can generally enter and exit their rooms and the rooms of other patients. Patients may also have permissions based on level

of risk. For instance, some patients may leave their building for activities or outside walks typically with a staff escort."

By Policy, there is a patient status known as having a "green band" that could allow patients to leave their building with a limited escort. This is not a current practice and no current patients have achieved a green band status based on their behaviors and clinical progress. OSH has updated the procedure for escorting patients and all staff have been educated about the updates over the last year. In 2 years, we have not allowed patients to leave the unit without staff escorting them.

- "We also observed there is no physical barrier or fencing encompassing the campus. There are no security checks at the campus entrance or on campus roadways. There are cameras throughout the facility, but these cameras are not monitored in real-time. Rather cameras are use retroactively to review specific incidents when necessary. Further, security staff do not use or carry lethal or non-lethal weapons or other defensive items such as batons, tasers, or pepper spray."

It is accurate that the entire perimeter of campus is not fenced. None of the other state hospitals have a completed perimeter fence. Every unit on OSH and Adair Acute Care (AAC) has an enclosed, locked courtyard. Over the last 2 years, all the courtyards have been updated with newer fencing and a perimeter guard fence installed along the building.

Physical Security

"Security staff patrols of the OSH campus are incomplete and inadequate."

Our current Chief of Security took over this position just over a year ago. During this time, the Chief of Security has been focused on ensuring unit staff and patient safety. Vacant buildings have not been a priority however, we will be taking corrective action to ensure these are completed. Policies and procedures, forms and training on Safety and Security Officer Patrol Process will be reviewed, edited, and or created as needed to ensure consistency through the department. Forms will be used daily to document patrols and reviewed monthly by supervisors to ensure proper patrols are being conducted.

Safety and Security have moved from a patrol and respond approach to a zone approach for daily monitoring. This has included having daily(every shift) walk throughs of patient buildings by a designated Safety and Security Officer to have more routine presence on the units. A different patrol officer checks perimeter security of occupied buildings and campus facilities. This effort to have more security presence on the units has helped staff feel safer on the units and improved the response time when there are incidents that require Safety and Security support.

A new policy and procedure outlining the expectations of Safety and Security Officer training will be created to ensure this practice is ongoing. OSH and AAC use a quality improvement process as part of its federal certification process known as Quality Assurance and Performance Improvement (QAPI.) A QAPI project will be implemented and monitored by Chief of Security to ensure all Safety and Security Officers know the safety are aware of the expectations.

"Security staff do not have enough fire-trained staff to respond to campus fires because they haven't conducted fire training since March 2024."

All Safety and Security Officers will be trained on responding to fire alarms and building evacuations. A staff member will be identified to become certified as Fire Fighter 1 and will then be responsible for the Safety and Security Fire Training Program. Safety and Security Officers will be selected from each shift to become Fighter Fighters while all officers will be evacuation specialists. OSH has met with the City of

Osawatomie in November and discussed the current standards for Fire Safety. At this time the hospital is evaluating entering an agreement with Osawatomie Fire Protective Services or maintaining our own.

"OSH doesn't ensure staff carry required personal safety alarms and doesn't check if staff respond to alarms timely."

OSH and AAC recognize the importance of personal safety alarms as part of the safety protocol. However, personal safety alarms are not the sole line of defense in managing safety risks or responding to emergencies. The following measures demonstrate a layered approach to safety and the ongoing efforts to improve staff response and patient safety:

- ***Multiple Emergency Notification Systems:***
- *Emergency codes can be activated through various means:*
- ***Overhead Codes**: Staff are trained to call for a code verbally, which is announced over speakers and the radio.*
- ***Zone-Specific Panic Buttons**: Strategically placed panic buttons across units trigger immediate responses.*
- ***Dialing 222**: Any hospital phone can activate a "Code 2" response. This is trained on a monthly basis and annually*
- ***Staff Education on Active Safety Practices:***
    - *Staff are educated on maintaining situational awareness, which includes:*
        - *Limiting the number of Mental Health Technicians (MHTs) in the nursing station to one, ensuring others are actively engaging with patients on the unit.*
        - *Regular reminders that effective safety practices involve MHTs monitoring their assigned units and being present in patient areas to mitigate risks proactively.*
        - *Defined Roles and Responsibilities for Safety Monitoring and Active Awareness*
        - *Staff are encouraged and educated to prioritize patient interaction, actively observe the unit, and respond swiftly to emerging risks.*
- ***AAC Zones:** AAC has implemented an initiative to assigning specific zones to MHTs which reinforces coverage across all areas of the unit.*
- ***Evaluation of Advanced Personal Safety Alarms:***
    - *In last 2 years, a workgroup has explored advanced GPS and electronically integrated personal safety alarm systems. These systems, designed to enhance real-time tracking and response capabilities, are currently being tested for effectiveness and feasibility.*
    - *It is important to note that the implementation of such systems requires significant financial resources, and the hospital is actively evaluating options to align with available funding.*

Our practice has changed as the new Safety Coordinator will be completing safety alarm checks. The new policy states:

"1. Staff will be educated on the proper use and management of Personal Safety Alarms at the time of hire and annually thereafter.

2. On a monthly basis, the Safety Coordinator will perform random drills to determine the response time upon hearing an alarm. In addition, the Safety Coordinator will conduct random checks to ensure each employee on a unit has an alarm on their person.

i. The results of these drills and checks will be reported to the Environment of Care Committee monthly

ii. The Environment of Care Committee will be responsible for making recommendations to the Administrative Executive Committee based on drills and results of checks."

"Facilities' staff key tracking does not include a complete and accurate accounting of all keys, many of which are missing."

In 2022, OSH identified that the individual responsible for assigning keys was not adhering to the established Key Policy, particularly signing keys in and out. As a result, OSH implemented a key audit for both staff and buildings. That audit identified keys that have been unaccounted for several years. Given the size of the campus and the complexity of rekeying, a work group has been formed to determine the best course of action moving forward. Secure key boxes, like those used at Larned State Hospital, are being considered. However, due to the financial implications and the scope of the project, this solution presents significant challenges.

All supervisors will be trained on hospital property assigned to staff members, including keys. This training will include how hospital property is assigned, how it should be handled during employment and how it should be returned at the termination of employment. This training will be given to all supervisors at the time they become a supervisor and annually thereafter.

All hospital staff will receive formal education at the time of hire on the expectations of handling keys assigned to them, the proper way to return keys at the termination of employment and the potential consequences if keys are not returned.

"OSH has a process to monitor for safety risks and noncompliance with policies, but management hasn't followed the process."

OSH purchased a new policy and procedure platform which not only pulled new policies but also archived policies. To support the use of the system, OSH will form a Policy and Procedure Review Committee. This committee will work directly with the Policy Coordinator and policy owners. The primary functions of this committee will be to ensure a timely review of all policies and procedures, that all policies and procedures match current practices, and all policies and procedures are approved by the appropriate persons and committees. The system pushes out policy updates as well as a providing a central source for all staff to access policies and procedures.

There has been a turnover in the Safety Coordinator position, who is the chair of the Environment of Care Committee. All these policies expired during the previous employee's time at the hospital. Current safety coordinator with Director of Operations is working to ensure that current policy and procedures are being updated with current practices.

The Safety Coordinator, who chairs the Environment of Care Committee, will create a formal written report with standing items to be reported. This report will be approved by the Administrative Executive Committee and then reported out on in Environment of Care Committee and Administrative Executive Committee on a quarterly basis. This report will also be included in the hospital quarterly Governing Body Report and shared will staff hospital wide.

Safety Concerns form FSE 1.3 was discontinued due to not being used by staff. OSH will reinstate it in updates to policy EC-1.0 Safety & Security Management Plan to allow staff a standardized way to report concerns which do not rise to the level of a supervisory concern or an event that should be reported to Risk Management.

Personnel

"OSH and AAC had enough nursing staff on patient units to meet their minimum staffing requirements during the 4 weeks we reviewed."

OSH is fortunate that, during times of staffing shortages, our team members have willingly taken on additional shifts. The fact that we are only one half-shift short, rather than experiencing more significant gaps, represents a considerable improvement compared to previous years.

While registered nurses tend to be more expensive; State Registered nurses (RN), Licensed Practical Nurse (LPN), and Licensed Mental Health Technicians (LMHTs) were approved to pick up an MHT shift opposed to an agency overtime MHT shifts. Using contract staff MHTs cost OSH between $42 and $50 per hour, not on overtime, while an RN at the time were paid $28 to $39 per hour. Allowing the licensed staff to pick up MHT shifts was an initiative to save money.

Based on our experience, universally defined staff-to-patient ratios do not exist. However, through consultations with other facilities and ongoing evaluation of our staffing models, we have developed ratios tailored to meet the unique needs of each program's patient population. These adjustments are designed to prioritize both patient and staff safety. As a result, we believe our current ratios allow staff to effectively engage with and support patients while managing their daily responsibilities.

"A sample of OSH and AAC staff generally received training on the select topics we reviewed in 2022-2024."

Over the past year, OSH has conducted a comprehensive evaluation of department-wide training requirements to ensure alignment with job classifications. This approach minimizes unnecessary training sessions and optimizes staff participation. In response to staff feedback, we have introduced quarterly specialized training sessions for our nursing focused on targeted topics. Similarly, this initiative has been extended to the Safety and Security Department to enhance role-specific competencies.

We have engaged with other facilities in our region to explore their training methodologies, ensuring a continuous evaluation and enhancement of our staff training programs. This collaborative approach allows us to stay informed of best practices and align our training efforts with industry standards.

"However, the facility depends on large numbers of contract nursing staff and overtime to meet minimum staffing requirements due to high turnover and vacancy rates."

Since 2020, we have implemented several initiatives, including base pay increases and targeted bonus, additional shift opportunities, and strengthening nursing leadership, all of which have contributed to a positive shift in our organizational culture. As of November 2024, these efforts have resulted in a reduced vacancy rate (currently at 32.5%), and a continued increase in applications for state Mental Health Technician positions.

The high turnover rates for contract staff at OSH and AAC during the reviewed period align with common practices within the travel nursing and contract staffing industry. The following factors contribute to this trend:

- *Industry Norms for Travel Staff:*
    - *Contract staff often work on short-term agreements and receive stipends for housing, mileage, and other expenses. These arrangements are structured to provide flexibility and mobility, leading to higher turnover as staff seek new opportunities or rotate to other facilities.*
    - *Some staffing agencies limit the length of contracts, requiring workers to leave after a set number of months to comply with agency policies or IRS regulations regarding travel stipends*
- *Performance-Based Contract Renewals:*
    - *At OSH and AAC, contract renewals are not automatic but are carefully evaluated based on staff attendance, performance, and adherence to hospital policies.*

    - *Nurse supervisors from each hospital are involved in the renewal process, ensuring that only those who meet high performance and reliability standards are retained. This review process, while beneficial for maintaining quality, can also contribute to turnover when underperforming contracts are not renewed.*
- *Flexibility of Traveler Roles:*
    - *Many contract staff prefer the flexibility of travel roles and may choose to end contracts early or move to new assignments that better align with their personal or professional goals.*

These factors highlight that high turnover rates among contract staff are an expected characteristic of the industry and do not necessarily reflect deficiencies in hospital practices.

"Working Environment and Culture"

"OSH management has not set clear expectations for how safety and security processes should work."

OSH operates in a complex and dynamic environment due to the unique needs of its patient population, regulatory requirements, statutes, and the need to uphold patient rights. This complexity makes it challenging to establish rigid, one-size-fits-all safety and security guidelines.

The following factors contribute to this approach:

- ***Balancing Patient Rights and Safety Protocols:***
    - *Psychiatric care involves navigating sensitive situations where overly prescriptive guidelines can inadvertently infringe on patient rights.*
    - *Any intervention that could potentially violate patient rights must undergo a thorough review and approval process, which is communicated with hospital administration. This ensures a balance between safety and the dignity of care.*
- ***Commitment to Least Restrictive Interventions:***
    - *OSH prioritizes a **least restrictive approach** to care, aiming to reduce trauma and support the overall well-being of patients. This aligns with the hospital's mission to provide compassionate, patient-centered care.*
    - *While this approach places patients' needs and rights as a priority, it can sometimes create a perception among staff that their own safety is not being equally prioritized. However, it is essential to recognize that patients are the primary consumers of care, and the hospital's processes reflect this commitment to their best interests.*
- ***Flexibility in Response to Evolving Situations:***
    - *Unlike other areas of healthcare with more "cut and dry" procedures, psychiatric care often involves rapidly changing situations that require adaptive decision-making.*
    - *OSH staff are provided flexibility in their approach, enabling them to address unique and unpredictable circumstances while maintaining patient safety and adhering to regulatory requirements.*
- ***Mitigating Deficiencies Through Adaptive Guidelines:***
    - *Setting overly rigid, concrete instructions can unintentionally create gaps or deficiencies in care when situations arise that fall outside the predefined scope. Flexibility allows staff to exercise professional judgment and adapt to the specific needs of each situation.*

By allowing flexibility within safety and security processes, the hospital ensures that care is responsive, compliant with regulations, and respectful of individual patient rights.

"OSH management hasn't collected and used data to proactively identify and fix safety and security problems."

OSH and AAC both have active Quality Assurance and Performance Improvement (QAPI) programs, with 51 programs for OSH and 26 for AAC. These programs are reviewed monthly during AEC meetings, where

discussions also focus on new interventions to ensure that goals and standards are consistently met each month.

Overtime for individual staff members can be tracked and, while it is not typically reviewed on a weekly basis, it can certainly be monitored. Recently, the Chief Financial Officer distributed an overtime report, broken down by discipline and staff member, covering the prior 10 weeks. Moving forward, this report will be regularly reviewed to ensure that OSH and AAC staff maintain a healthy work-life balance.

OSH management hasn't adequately addressed safety and security problems when it becomes aware of them.

In this section, LPA identities some selected employee incidents as examples of cases where OSH management did not take a disciplinary action after a substantiated employee issue. OSH Leadership has reviewed each of these cases. The audit report is correct about the final outcome of each example. However, there are additional factors including compliance with the KOSE Memorandum of Agreement, follow up due to Family and Medical Leave Act, required timelines for investigation that were not met, and compliance with agency policy on progressive discipline that are not mentioned that resulted in the final employee action. Terminating an employee is the last step and in those cases many other attempts to address the employee behavior while addressing the underlying concern were made.

At Osawatomie State Hospital, the approach to disciplinary action is guided by policies, union agreements, and the principles of employee development and mental health support. The following factors explain the hospital's practices:

- ***Progressive Discipline:***
  - *OSH follows a **progressive discipline model**, in alignment with the Kansas Organization of State Employees (KOSE) union guidelines. This approach provides staff with opportunities to correct their actions or performance through constructive feedback and incremental consequences, fostering professional growth and development.*
- ***Employee Assistance Program (EAP):***
  - *Recognizing the mental health challenges inherent in working at a psychiatric facility, OSH prioritizes support over immediate punitive measures. The **EAP** is available to help staff address personal or professional issues that may impact their performance, ensuring a supportive and rehabilitative approach to addressing errors.*
- ***Focus on Growth and Development:***
  - *Allowing staff the chance to learn from mistakes and correct their actions aligns with the hospital's mission as a mental health facility. This philosophy not only supports staff development but also promotes a culture of understanding and resilience.*
- ***Severity-Based Evaluations:***
  - *All incidents are evaluated based on their severity and circumstances. Significant events are reviewed by **KDADS legal counsel, the Superintendent, and HR**, ensuring a fair and comprehensive assessment of each situation with a meeting which is held twice a week to review issues. This multidisciplinary approach ensures that appropriate action is taken while considering the unique context of each incident while aligning with the other state hospitals.*
- ***Commitment to a Balanced Approach:***
  - *While immediate action may be warranted in severe cases, most incidents are managed with a focus on corrective action rather than punitive measures. This balance allows OSH to maintain accountability while fostering a supportive and professional work environment.*

In the last two years, supervisors have been sent to Supervisor Training in Topeka and OSH has had courses on progressive discipline procedure to reinforce the established employee supervision policies.

OSH management hasn't established a culture that prioritizes professional boundaries or encourages people to speak up about known safety risks and issues.

At OSH and AAC, management prioritizes professional boundaries and encourages staff to speak up about safety risks or concerns. The following practices highlight the hospital's commitment to these values:

- ***Leader Rounding and Staff Engagement:***
  - *OSH and AAC supervisors conduct **monthly 1:1 leader rounding** with staff, a frequency that exceeds the practices of other state facilities.*
  - *These sessions provide an open forum for staff to voice concerns, discuss challenges, and share feedback directly with leadership, ensuring that issues are heard and addressed promptly.*
- ***Encouragement of Chain of Command:***
  - *Leadership emphasizes the importance of the **chain of command** in addressing unresolved issues.*
  - *Staff are encouraged to escalate concerns to higher levels of management if their immediate supervisor does not resolve the matter, creating a clear and supportive pathway for communication.*
- ***Human Resources Processes for FMLA:***
  - *OSH ensures that staff on **FMLA** leave are supported appropriately. There have been no nursing consultations or instructions for staff to consult nursing leadership after claiming FMLA.*
  - *All FMLA-related processes and communications are managed through **HR** to maintain confidentiality and compliance with labor regulations.*

The audit recommendation cover many of the same area as findings include above. The proposed agency action is included in the table following the restatement of the audit recommendation.

Recommendations

- To ensure staff have clear expectations regarding physical security and processes, Osawatomie State Hospital management should develop and regularly review, update, and clarify policies. This includes areas we noted in this report such as:
  - Security staff patrol processes and documentation
  - Security staff fire training
  - Key return for departing staff
  - Progressive discipline

Recommendation	*Corrective Action*
Security staff patrol processes and documentation	*Policies and procedures, forms and training on Safety and Security Officer Patrol Process will be reviewed, edited, and or created as needed to ensure consistency through the department. Forms will be used daily to document patrols and reviewed monthly by supervisors to ensure proper patrols are being conducted. Trainings and competencies will be conducted upon hiring and annual thereafter. Each Safety and Security Officers training will be documented and retained in their training file. A new policy and procedure outlining the expectations of Safety and Security Officer training will be created to ensure this practice is ongoing*

Security staff fire training	*All Safety and Security will be trained on responding to fire alarms and conducting evacuations. A staff member will be identified to become certified as Fire Fighter 1 and will then be responsible for the Safety and Security Fire Training Program. Select Safety and Security Officers will be selected from each shift to become Fighter Fighters while all officers will be evacuation specialists. Trainings and competencies will be conducted upon hiring and annual thereafter. Each Safety and Security Officers training will be documented and retained in their training file. A new policy and procedure outlining the expectations of Safety and Security Officer training will be created to ensure this practice is ongoing.*
Key return for departing staff	*All supervisors will be trained on hospital property assigned to staff members, including keys. This training will include how hospital property is assigned, how it should be handled during employment and how it should be returned at the termination of employment. This training will be given to all supervisors at the time they become a supervisor and annually thereafter.* *All hospital staff will receive formal education at the time of hire on the expectations of handling keys assigned to them, the proper way to return keys at the termination of employment and the potential consequences if keys are not returned.*
Progressive discipline	*Human Resources has completed a comprehensive staff transition, with all new team members receiving thorough training on the effective implementation of progressive discipline. Additionally, supervisors have undergone, and will continue to receive, ongoing training to equip them with the necessary tools, skills, and expectations to effectively manage and support their teams.*

- Osawatomie State Hospital should regularly review, update, and clarify existing policies to ensure policies and practices align. This includes areas we noted in the report such as:
    - Personal security alarm checks
    - Communication of safety assessment reports
    - Safety concerns form

Recommendation	*Corrective Action*
Personal security alarm checks	*Hospital policy and procedure EC-1.1 Personal Safety Alarms has been updated to reflect* *"1. Staff will be educated on the proper use and management of Personal Safety Alarms at the time of hire and annually thereafter.* *2. On a monthly basis, the Safety Coordinator will perform random drills to determine the response time upon hearing an alarm. In addition, the Safety Coordinator will conduct random checks to ensure each employee on a unit has an alarm on their person.* *i. The results of these drills and checks will be reported to the Environment of Care Committee monthly* *ii. The Environment of Care Committee will be responsible for making recommendations to the Administrative Executive Committee based on drills and results of checks."*

Communication of safety assessment reports	*The Safety Coordinator, who chairs the Environment of Care Committee, will create a formal written report with standing items to be reported. This report will be approved by the Administrative Executive Committee and then reported out on in Environment of Care Committee and Administrative Executive Committee on a quarterly basis. This report will also be included in the hospital quarterly Governing Body Report and shared will staff hospital wide.*
Safety concerns form	*Safety Concerns form FSE 1.3 will be reinstated and added back to policy EC-1.0 Safety & Security Management Plan to allow staff a standardized place to report concerns that do not rise to the level of supervisory or Risk Management.*

- As part of Osawatomie State Hospital's policy review and updating, management should develop data systems and tracking to inform the updates. This includes important areas we identified such as:
    - Use of personal security alarms
    - Overtime
    - Disciplinary action

Recommendation	*Corrective Action*
Use of personal alarm	*Hospital policy and procedure EC-1.1 Personal Safety Alarms has been updated to reflect* *"1. Staff will be educated on the proper use and management of Personal Safety Alarms at the time of hire and annually thereafter.* *2. On a monthly basis, the Safety Coordinator will perform random drills to determine the response time upon hearing an alarm. In addition, the Safety Coordinator will conduct random checks to ensure each employee on a unit has an alarm on their person.* *i. The results of these drills and checks will be reported to the Environment of Care Committee monthly* *ii. The Environment of Care Committee will be responsible for making* *recommendations to the Administrative Executive Committee based on drills and results of checks."*
Overtime	*Overtime will be tracked and reviewed. The Chief Financial Officer will distribute an overtime report, broken down by discipline and staff member, per month and distributed to Department heads for review and verification overtime was indeed warranted.*
Disciplinary action	*Human Resources will be implementing a QAPI goal to track and trend disciplinary actions. By the end of each month, HR will track and report disciplinary actions by hospital, location, and position classification to AEC with 90% accuracy. Additionally, HR will provide quarterly reports to the governing body. If any disciplinary trends are identified, HR will design and implement supervisory or hospital-wide training within the following quarter to address the issues.*

- Osawatomie State Hospital should use newly created and already existing data to monitor safety issues to include:
    - Environment of Care Committee results

- Trends in personal security alarms (i.e. by area, staff member, and patient)
- Overtime by staff member
- Trends in disciplinary action (i.e. by area and staff member)

Findings	Corrective Action
Environment of Care Committee results	*The Safety Coordinator, who chairs the Environment of Care Committee, will create a formal written report with standing items to be reported. This report will be approved by the Administrative Executive Committee and then reported out on in Environment of Care Committee and Administrative Executive Committee on a quarterly basis. This report will also be included in the hospital quarterly Governing Body Report and shared will staff hospital wide.*
Trends in personal security alarms	*Trends in personal safety alarms will be recorded by the Safety Coordinator and reported to Environment of Care Committee who will then share trends and make recommendations to the Administrative Executive Committee*
Overtime by staff member	*Overtime for individual staff members can be tracked and be monitored. The Chief Financial Officer will distribute an overtime report, broken down by discipline and staff member, per month and distributed to Department heads for review and verification overtime was indeed warranted.*
Trends in disciplinary action	*Human Resources will be implementing a QAPI goal to track and trend disciplinary actions: By the end of each month, HR will track and report disciplinary actions by hospital, location, and position classification to AEC with 90% accuracy. Additionally, HR will provide quarterly reports to the governing body. If any disciplinary trends are identified, HR will design and implement supervisory or hospital-wide training within the following quarter to address the issues.*

- To improve morale and working conditions, Osawatomie State Hospital management should work on communication and setting clear expectations. Management should develop processes to ensure all staff are held to expectations consistently.

Finding	*Corrective Action*
Improve communication and set clear expectations.	*Each supervisor will provide their staff members with a specific job classification competency skill sheet, ensuring that all employees are clear about their roles and responsibilities. Supervisors will review and sign off on each staff member's competency annually, as part of the performance review process.*

Thank you for the opportunity to respond. I would be happy to address any questions from the Legislative Post Audit Committee.

Sincerely,

Ashley Byram, LMSW
Superintendent

Appendix A – Survey Responses

This appendix shows the results of our survey of current and former OSH and AAC staff. We surveyed 1,220 staff who worked at the hospital in fiscal years 2020 through 2024. The survey went to both state and contract staff. The response rate was 32% or 395 total employees. These results should not be projected to all OSH and AAC employees since not all of them responded to the survey. Further, the survey included open-ended questions. Few respondents answered these questions, and those that did provided little detail.

Appendix A.

In general, how safe do you feel when working at OSH?	
I feel very unsafe.	10%
I feel somewhat unsafe.	21%
I feel neither safe nor unsafe.	14%
I feel somewhat safe.	31%
I feel very safe.	23%
How often have you felt unsafe when working at OSH?	
All the time	5%
Often	17%
Sometimes	32%
Rarely	34%
Never	11%
Have patients made you feel unsafe at OSH?	
Yes	66%
No	34%
In what ways have patients made you feel unsafe? Please check all that apply. (a)	
Verbal harassment	68%
Discriminatory harassment	34%
Sexual harassment	39%
Physical harassment or assault	68%
Threats of retaliation	46%
Other	17%
Have your co-workers made you feel unsafe at OSH?	
Yes	29%
No	71%
In what ways have your co-workers made you feel unsafe? Please check all that apply. (a)	
Verbal harassment	36%
Discriminatory harassment	23%
Sexual harassment	21%
Physical harassment or assault	9%
Threats of retaliation	31%
Other	58%
Has management made you feel unsafe at OSH?	
Yes	29%
No	71%
In what ways has management made you feel unsafe? Please check all that apply. (a)	
Verbal harassment	29%
Discriminatory harassment	29%
Sexual harassment	3%
Physical harassment or assault	2%
Threats of retaliation	33%
Other	68%
Has the physical environment made you feel unsafe at OSH?	
Yes	31%
No	69%

Appendix A. (cont.)

In what ways has the environment made you feel unsafe? Please check all that apply. (a)

The areas I work in don't have enough physical security to protect me from patients.	67%
The areas I work in are in disrepair and are a threat to my health or safety.	31%
There are things in the environment patients or coworkers could use to hurt me.	30%
The environment isolates me and makes me feel like I'd be alone if a patient or coworker tried to harass or hurt me.	32%
Other	33%

When you feel unsafe, how often do you report that to your supervisors or to management?

Always	24%
Often	18%
Sometimes	21%
Rarely	12%
Never	10%
I have never felt unsafe	16%

If you ever reported feeling unsafe to your supervisor or management, how did they respond? Please check all that apply. (a)

They took my concerns seriously.	27%
They offered me useful advice or helped address the situation.	32%
They didn't take my concerns seriously.	19%
They told me it's part of the job.	21%
I have never reported feeling unsafe.	15%
I have never felt unsafe.	17%
Other	14%

OSH management cares about staff safety.

Strongly disagree	13%
Disagree	13%
Neither agree nor disagree	28%
Agree	27%
Strongly agree	19%

Have you been involved in an incident at OSH in which you felt your safety was threatened?

Yes	42%
No	45%
I prefer not to say	13%

There are enough staff on duty when you work to ensure staff safety.

Strongly disagree	16%
Disagree	19%
Neither agree nor disagree	31%
Agree	27%
Strongly agree	7%

OSH has adequate policies and procedures to ensure staff safety.

Strongly disagree	7%
Disagree	14%
Neither agree nor disagree	32%
Agree	37%
Strongly agree	11%

Appendix A. (cont.)

How often do staff follow policies and procedures?

Never	1%
Rarely	5%
Sometimes	17%
Most of the time	54%
Always	21%
There are no policies and procedures to follow	1%

OSH management ensures staff follow policies and procedures.

Strongly disagree	7%
Disagree	12%
Neither agree nor disagree	29%
Agree	41%
Strongly agree	11%

Which of the following do OSH management do to ensure staff follow policies and procedures?

Management provides training on policies and procedures.	66%
Management monitors staff to check whether they're following policies and procedures.	48%
Management penalizes staff when they don't follow policies and procedures.	29%
Management reviews incidents to determine whether staff followed policies and procedures.	62%
Management doesn't do anything.	14%
Other	17%

Which of the following topics related to ensuring staff safety have you received training on? Please check all that apply. (a)

Employee behavior expectations (e.g., dress code, behaviors toward coworkers, behaviors toward patients or visitors, etc.)	85%
Workplace harassment	82%
Physical security (e.g., ensuring hospital facilities are safe, controlling access to sensitive areas, etc.)	80%
Incident reporting	83%
Patient oversight (e.g., when to check on patients, how many staff should oversee a patient at a time, how to de-escalate situations, etc.)	74%
I haven't received any relevant training.	2%
Other	8%

Do you feel you receive appropriately frequent and adequate training on topics related to ensuring staff safety?

No, trainings don't adequately address staff safety.	12%
No trainings, aren't frequent enough.	11%
No, trainings are neither frequent enough nor do they adequately address staff safety.	16%
Yes, trainings are both frequent enough and adequately address staff safety.	61%

How would you rate employee morale at OSH?

Very high	2%
High	17%
Neither high nor low	38%
Low	28%
Very low	15%

Appendix A. (cont.)

I am concerned about being retaliated against by management.

Strongly disagree	17%
Disagree	20%
Neither agree nor disagree	26%
Agree	20%
Strongly agree	17%

Management's personnel decisions (e.g., hiring, promoting, or terminating staff, which staff are assigned certain tasks, etc.) are fair.

Strongly disagree	20%
Disagree	20%
Neither agree nor disagree	33%
Agree	22%
Strongly agree	6%

What kinds of personnel decisions have been unfair? Please select all that apply. (a)

Hiring	45%
Terminations	60%
Promotions	61%
Task assignments	47%
Shift lengths (e.g., how long one person has to work relative to another person in the same position)	20%
Other	28%

On a typical day, do you think your workload is appropriate?

No, I'm asked to do too much.	22%
No, I'm asked to do too little.	1%
Yes, my workload is appropriate.	76%

Do you feel you are paid appropriately for the work you do?

No, I'm not paid enough.	53%
No, I'm paid too much.	0%
Yes, my pay is appropriate.	47%

Which of the following best describes your experience with overtime work?

I'm not required to work overtime and I don't want to.	21%
I don't want to work overtime but I'm required to.	11%
I want to work overtime and do.	33%
I want to work overtime but I'm not allowed to.	8%
Other	26%

Do you think OSH has trouble attracting qualified staff?

Yes	74%
No	8%
No opinion	18%

Do you think OSH has trouble retaining qualified staff?

Yes	72%
No	9%
No opinion	19%

Appendix A. (cont.)

Staff turnover makes OSH unsafe.

Strongly disagree	4%
Disagree	6%
Neither	32%
Agree	33%
Strongly agree	26%

Are there any employees you think shouldn't be working at OSH?

Yes	62%
No	38%

(a) Staff could choose more than one response, so percentages do not add up to 100%.

Source: LPA Survey of current and former OSH staff.