PERFORMANCE AUDIT

AUDIT OF
MANAGEMENT AND OVERSIGHT OF
CONTRACTORS RESPONSIBLE FOR CARE
OF PEOPLE WITH DEVELOPMENTAL DISABILITIES

From The Office Of State Auditor
Claire McCaskill

Improvements are needed in monitoring and tracking incidents of physical aggression, injury, and medication errors at contractor facilities responsible for care of people with developmental disabilities.

Report No. 2001-20
March 15, 2001
www.auditor.state.mo.us

Office Of The
State Auditor Of Missouri
Claire McCaskill

March 2001

www.auditor.state.mo.us

FACT SHEET

Missourians with developmental disabilities who rely on contractor-operated facilities are not well protected from acts of physical aggression by other clients or from medication errors.

Inadequate monitoring by the state's 11 regional centers over contractor-operated facilities, which provide day programs and residential environments to nearly 9,000 developmentally disabled, leave clients and staff at risk. A complaint made to our office alleging mismanagement at one such facility prompted this audit. The review included an analysis of incident and injury reports of eight contractors operating in five of the state's regional centers. The following highlights our findings:

Injury and incident reports not reviewed

An analysis of 4,400 incident reports over an 18-month period showed hundreds of acts of physical aggression between clients, or between clients and staff, which resulted in more than 1,000 injuries. (See page 2) But no one in the state knew the true nature of this problem until this audit because such reports were not being reviewed, computerized to track trends or even kept – one facility threw out the reports. (See page 11)

Part of the inconsistent handling of such reports is due to weak state law that does not require contractor-operated facilities to thoroughly document the incidents or submit them for review.

Review would allow a facility to track trends. Our analysis showed that often only a few clients are involved in the alleged physical aggressions. (See page 13) In one case, a client committed 65 acts of aggression against her roommate in 18 months. (See page 5) Trending would have allowed state staff to identify this situation quickly and correct it.

Contractors held to lower standard on aggressive clients

State regulations on managing behavior of an aggressive client considered dangerous to others or themselves do not apply to contractor-operated facilities. State regulations require a "dangerous" client to receive one-to-one or high priority supervision. Our analysis of incident reports at contractor-operated facilities showed numerous clients fit the "dangerous to other or themselves" definition. In one facility, 16 clients were physically aggressive with other clients or staff two or more times in a short period. But because these contractor-operated facilities are not held to this same standard, their "dangerous" clients do not receive the necessary supervision. (See page 4)

Medication errors go unreported

Contractor-operated facilities are not required to immediately report to regional centers if clients were not given their prescribed medication, an act that is required of state-run facilities. Contractor-operated facilities are only required to report an injury or incident, which could include a medication error. Our review of these incident reports showed a substantial number of medication errors, including 903 medication errors over 18 months at one facility. Such errors included failing to dispense medications or dispensing them late. Since we could only track medication errors through incident or injury reports, it is unknown how understated or widespread the error really is. (See page 6).

Inconsistent record-keeping makes monitoring difficult

Our tests showed that contractors used a variety of formats to report incidents. A standard format for all contractors is needed to facilitate managing a database of incident reports at the regional centers. This database would allow the state to trend incidents, evaluate a contractor's performance and identify clients that need to be removed from their current setting. (See page 11)

TABLE OF CONTENTS

APPENDIXES

CLAIRE C. McCASKILL
Missouri State Auditor

Honorable Bob Holden, Governor
Members of the General Assembly
Director, Department of Mental Health
Director, Division of Mental Retardation and Developmental Disabilities

The State Auditor's Office performed an audit of the Division of Mental Retardation and Developmental Disabilities and its eleven regional centers. The audit focused on the Division and its regional centers' oversight of over 3,000 contractors who operate residential and day habilitation services for about 9,000 mentally retarded and developmentally disabled Missouri residents.

The objectives of this audit were to determine (1) the effectiveness of the Division's oversight of its eleven regional centers, and (2) the effectiveness of the regional centers' oversight and inspections of contractors operating residential facilities and day habilitation programs.

Audit tests disclosed that although contractors have submitted hundreds of incident reports, which showed significant statewide problems related to (a) clients exhibiting physical aggression toward other clients, (b) clients incurring numerous injuries due to acts of physical aggression or accidents, and (c) contractors failing to administer medications as prescribed, regional centers have not trended or tracked these incidents.

We concluded that to ensure the safety and health to some of Missouri's most vulnerable residents, the Division needed to amend existing state regulations, implement a statewide quality assurance program, and require its regional centers to track and analyze contractors' incident reports.

Claire McCaskill
State Auditor

December 14, 2000 (fieldwork completion)

The following auditors participated in the preparation of this report:

Director of Audits:	William D. Miller, CIA
Assistant Director:	Kirk R. Boyer
In-Charge Auditor:	John Mollet
Audit Staff:	Debbie Yost
	Danielle Freeman

224 State Capitol • Jefferson City, MO 65101 • (573) 751-4824 • FAX (573) 751-6539
Truman State Office Building, Room 880 • Jefferson City, MO 65101 • (573) 751-4213 • FAX (573) 751-7984

RESULTS AND RECOMMENDATIONS

1. State Regulations Do Not Adequately Protect Missouri's People with Developmental Disabilities from Physical Aggression and Injuries

Division of Mental Retardation and Developmentally Disabled (the Division) contractors, who operate day programs and residential facilities for individuals developmentally disabled, have submitted hundreds of Incident and Injury Reports (incident reports) that showed significant statewide problems during the 18-month period ended June 30, 2000, including:

- 590 incidents of physical aggression by clients against other clients,
- as many as 1,000 injuries due to physical aggression or accidents, and
- over 900 medication errors by contractors failing to administer medications as prescribed.

Although Missouri Code of State Regulations (9 CSR 45-5) require contractors to document in the client's file when a client incurs an injury or unusual incident, the regulations do not (1) prescribe the information that contractors must include in their reports, (2) require that the contractors submit the reports to their respective Department of Mental Health regional centers, and (3) require clients, who reside at contractors' facilities and who have committed physical aggression toward others to be evaluated as to whether they present a danger to other clients. Audit tests showed that incident reports often were not well documented; were not sent to regional centers routinely; and when sent to regional centers, staff did not review them thoroughly enough to identify recurrent problems at facilities and with clients. Accordingly, Division regulations do not ensure that all clients are entitled to safe housing and to be free from harm as prescribed by Missouri Statutes, Section 630.115, RSMo.

Department of Mental Health contracts for services

An estimated 27,500 Missourians with developmental disabilities such as mental retardation, cerebral palsy, and autism receive services from the Division each year. The Division operates 17 facilities that provide or purchase specialized services.

- Eleven facilities are regional centers, which are the primary points for clients to obtain services from the Division. These facilities provide assessment and case management services, which include coordination of each client's individualized habilitation plan.

- Six facilities are Division-operated habilitation centers, which provide residential care and habilitation services for people with more severe disabilities.

Division officials contract with over 3,000 agencies (contractors) to provide residential facilities, and day habilitation programs for about 9,000 individuals who are developmentally disabled. The regional center staffs are responsible for

- providing assessment and case management services, which include coordination of each client's individualized habilitation plan, and

- overseeing and monitoring contractors to ensure its clients are living in safe and sanitary facilities and are free from physical and verbal abuse.

Contractors have reported hundreds of incidents of physical aggression and injuries

Incident reports are not tracked or trended

Although Division regulations do not require contractors to submit incident reports to the regional centers, eight contractors included in audit tests submitted over 4,400 reports to their respective regional centers during the period January 1, 1999 to June 30, 2000. An analysis of these reports showed serious statewide problems related to (1) clients committing acts of physical aggression against other clients and their direct care staff, and (2) injuries to clients due to physical aggression and accidents.[1] The following analysis of contractors' incident reports shows that hundreds of the Division's clients were subject to physical aggression during the period January 1, 1999 through June 30, 2000.

Number of Incident Reports by Selected Contractors

Contractor Regional Center	*No. of Clients at Risk*	*No. of Reports*	*No. of Injuries*	*Number of Acts of Aggression*	
				Clients	*Staff*
Kansas City	70	798	552	36	0
St. Louis	115	1,381	83	121	140
Joplin	38	835	189	104	88
Springfield	109	836	111	209	139
Albany	53	612	137	127	51
Totals:	**385**	**4,462**	**1,072**	**597**	**418**

Source: SAO analysis of contractors' incident reports

It should be noted that the 385 clients at risk shown in the above table only represent 4.3 percent of the Division's total 9,000 clients living in contractor-operated facilities. Therefore, many more clients could be at risk. The data gathered for the 385 clients came from incident reports (i) provided to the regional centers, (ii) reviewed at provider facilities, and (iii) both provided by and reviewed at provider facilities. We could not specify whether these other 8,615 (9,000-385) clients were actually at risk because our teams did not visit the facilities where they reside nor acquire access to their incident reports. However, as the table shows, the number of incidents are substantial where we did review incident reports and it is reasonable to assume the same conditions could exist elsewhere based on the commonality of the problems found at the sites we visited.

[1] Incident reports included the following types of physical aggression: hitting, kicking, biting, scratching, hair pulling, and throwing objects.

Many clients should be categorized as dangerous to others in order to protect other clients from physical injuries

Division regulations for managing clients' behavior do not apply to contractor-operated facilities. These regulations provide better protection for the clients and staff particularly when clients are dangerous to others. Regulation 9 CSR 45-3.050 defines "Dangerous to others"—when presented with an opportunity, a client attempts to harm others by physical or sexual aggression through spontaneous action, or the client has committed any serious incidents of physical or sexual aggression in the last 3 months. The regulation requires that clients who are categorized as dangerous to others must receive one-to-one, line-of-sight or high priority supervision. 9 CSR 45-3.050 also states a client's risk determination should be revaluated within twenty-four hours after a serious incident of aggressive behavior.

Some clients are dangerous to others

Analyses of contractors' incident reports showed that numerous Divisional clients living in contractors' facilities met the criteria to be classified as dangerous to others. For example, 16 clients residing with one St. Louis contractor were physically aggressive with other clients and/or staff two or more times, and 12 clients residing with one Joplin contractor were physically aggressive with other clients and/or staff two or more times. The following are narratives from three incident reports that involved serious incidents of aggressive behavior. They also show that a single incident report involving an aggressive act can involve multiple aggressions to more than one client and/or staff.[2]

1) Client A began hitting client B "out of the blue." Client A was calm previously. After trying to move client B away from client A's punches, client A came after me (staff). Client A hit me repeated times—I finally got away when another staff helped redirect client A. Client A suddenly attacked client C and refused redirection, so two other staff tried to restrain him. He got away from one staff while swinging at other staff (and) hit me as I was trying to help staff. This hit caused the cut on my face. The staff, who prepared this report, also reported that client A has been attacking other clients and staff recently and "swings violently with the intention of truly harming another person." Also, the staff reported the steps taken to prevent reoccurrence that day were to put the client under one-to-one direct supervision.

2) Client A had been throwing constant insults at another client causing this client to become very agitated. Client A then threw a couch cushion at another client. Then client A proceeded to pull the fire alarm. Staff stood in front of the fire alarm and began trying to redirect client A to either the couch or her room to calm down. Client A then began to scratch, hit, and kick staff while screaming profanities. She also tried to repeatedly bite staff. Client A threw a table at staff and another client. Staff then escorted client A to couch and then called the assistant manager who was scheduled to come in shortly. Client A then ran back to the fire alarm, staff got between client A and the alarm. Client A then began to hit, kick, and scratch staff. Client A grabbed staff's collar and tried to strangle staff. Staff escorted client A back to couch. At this point staff knocked on the apartment door for some assistance, the apartment staff

[2] We edited the narratives to protect the clients' and staffs' identities, and for clarity purposes where needed.

came out to help. Client A continued to scream profanities at staff. Client A then ran back to pull fire alarm. In staff's attempts to stop client A from pulling the alarm, client A again began to hit, kick, and scratch staff. Client A also attempted to bite staff multiple times. Client A grabbed one of the staff's glasses off her face. Client A then turned on the other staff grabbing at the staff's collar. At this point client A ripped staff's bra off. Staff escorted client A back to the couch. After a couple minutes of everyone sitting calmly in the living room, client A ran back over to the fire alarm. Client A began hitting, kicking, and scratching staff again. Client A then grabbed one of the staff's collar. Client A then let go of that staff and grabbed the other staff's collar. Staff then escorted client A to a chair. Client A then kicked staff between the legs and began to threaten the staff's first-born child. Client A then remained in the chair as she screamed and flailed her arms and legs. Client A then broke her own necklace. Client A almost immediately stopped screaming and began to beg staff to fix her necklace. Staff was eventually able to fix her necklace and then client A chose to go to bed.

3) Client A was sitting at kitchen table eating snack, smiling and laughing. His roommate (client B) was in wheelchair talking to staff. There had been no incidents of the two men not getting along all day. Client A jumped out of kitchen chair and pushed client B in his wheelchair deliberately into file cabinet forcefully then took off out of the room. Staff told client A he needed to go to his room to calm down because he hit client B. He complied, stayed in room about five minutes yelling then came out and sat at kitchen table and said he was sorry to client B. Client A then began shouting, picked up phone off of counter and hit client B in groin, popping battery out from the force of the blow. Staff then again instructed client A to go to room and calm down.

Contractors' incident reports also showed that several clients were physically aggressive with their roommates and direct care staff numerous times over an extended period of time. For example:

- In Albany, one client committed physical acts of aggression against his roommates 27 times during an 11-month period.

- In Columbia, one client committed physical acts of aggression against her roommates 65 times over an 18-month period.

- In St. Louis, two clients shared an apartment and one client committed physical acts of aggression against his roommate 30 times and his direct care staff 29 times over a 10-month period.

Recurring aggression unnoticed by State officials

- In Joplin, one client living in a group home with six other clients committed physical acts of aggression against her roommates 29 times and her direct care staff 23 times during an 18-month period.

- Another Joplin client living in a group home with seven other clients committed physical acts of aggression against his roommates 24 times (including two sexual assaults) and his direct care staff 16 times during a 5-month period—May to September 1999.

In the latter case, the client was moved at the end of the 5-month period to a state habilitation center. The contractor's staff asked Joplin regional center staff why it took so long (5-months) to move the client, when the client's behavior began getting worse in May 1999. According to the service coordinator's case notes, she replied she was not informed that things were as bad as they were. However, if the service coordinator or other Joplin regional center staff had analyzed the client's incident reports, they would have been able to recognize that the client had committed physical acts of aggression against his roommates and staff 21 times during July and August 1999.

Contractors' incident reports show many clients are dangerous to themselves

Division regulation 9 CSR 45-3.050 states that a client who demonstrates self-injurious behaviors, such as biting or hitting self, is considered dangerous to self and must receive one-to-one, line-of-sight, or high priority supervision. Contractors' incident reports showed several clients demonstrated serious self-injurious behaviors over an extended period of time. For example, a Joplin contractor's incident reports showed a client abused herself 26 times over a 6-month period. A Springfield contractor's incident reports showed a client abused himself 28 times over a 7-month period.

Contractors' incident reports show numerous medication errors

Contractors' incident reports showed that some contractors had committed a substantial number of medication errors. Medication errors include, (1) failure to give clients their prescribed medications, (2) failure to give medications when due and/or the correct dosage, and (3) failure to document that medications were given. Examples follow:

Medication errors should be reported and trended

- A St. Louis contractor, with 115 clients, provided reports showing the contractor committed 903 medication errors over an 18-month period, such as failing to dispense medications, or dispensing them late.

- Another contractor in Joplin, with 38 clients, committed 191 medication errors over the same 18-month period. Failure to administer medications as prescribed can result in clients suffering unnecessary pain or more serious ramifications.

- A Division investigator stated that when she visited a contractor to investigate allegations of numerous medication errors, she found one client in a wheelchair crying loudly, because she had not been given her pain medication. According to the investigator, the contractor's Director stated the client was not given her prescribed dosages of pain medication, because the drug made the client groggy.

The Division's regulations are not consistent for reporting medication errors. Division regulation 9 CSR 45-5.010 for Medicaid Waiver program contractors states individuals are to take medications as prescribed and are supported safely in managing their medications. This regulation does not require contractors to report to the regional centers if clients were not administered the prescribed medications. The regulation only requires contractors to document in a client's file if the client has suffered an injury or an unusual incident, which could include a medication error. Conversely, regulation 9 CSR 40-5.305 for group homes and residential centers serving persons with developmental disabilities, but not enrolled in the Medicaid Waiver program, states errors in administering or in self-administration of medications shall be reported immediately to the regional center or placement office.

The Division cannot take timely action to intervene in potentially serious cases since the contractors are not required to send incident reports to the regional centers, and regional centers do not adequately review the reports that they do receive.

Conclusion

The Division's regulations do not adequately protect its clients living in contractor-operated facilities from acts of physical aggression. As a result, clients, who should be categorized as dangerous to others, have been allowed to routinely commit acts of physical aggression against other clients and direct care staff without the knowledge of the regional center officials. And, regional centers do not have appropriate management tools such as copies of incident reports and trend analyses to identify such incidents or incidents of individuals who represent a danger to them. Also, the Division's regulations do not require that all medication errors be immediately reported to the regional centers. Accordingly, the Division does not always receive the information it needs to ensure its clients receive their medications as prescribed.

Recommendations

We recommend the Director, Division of Mental Health

1.1 Amend 9 CSR 45-5 and 9 CSR 40-5.030 to require contractors to submit Incident and Injury Reports to their respective regional centers immediately when serious injuries are involved and within 24 hours for other injuries and incidents.

1.2 Amend 9 CSR 45-3.050 to apply to clients living in contractor operated facilities.

1.3 Amend 9 CSR 45-5.010 to state errors in administering or in self-administration of medications shall be reported immediately to the regional center or placement office**.**

Department of Mental Health Comments

The Director, Division of Mental Retardation and Developmental Disabilities agreed with the recommendations and provided acceptable implementation plans. The detailed comments are included in Appendix IV, page 24. Pertinent excerpts follow:

1.1 The Division agrees that contract providers should systematically report specified incidents and injuries to regional centers. In this regard, the Division will amend all applicable state regulations, contracts and department operating regulations to include types of reportable incidents and injuries including medication errors, provider reporting and documentation requirements, and sampling methodology.

1.2 DMRDD accepts the recommendation and agrees that a process needs to be clarified which will result in risk assessments being accomplished for individuals who live in the community and who exhibit aggressive behavior which may be considered "dangerous to self and others". The Division will pursue an amendment of 9 CSR 45-3.050 or establish a separate CSR to address the recommendation.

1.3 DMRDD agrees that contract providers should report errors in medication administration to regional centers. Reporting of errors that may have an adverse effect on the client is of particular importance. These should be reported immediately to the client's primary care physician/practitioner and the regional center. In addition to reporting requirements, contract providers should establish policies and procedures, in accordance with acceptable standards of practice, to monitor errors in medication administration and proper documentation. To ensure quality improvement in medication administration, the division will include language in applicable state regulations and contracts to specify the types of reportable medication errors and provider responsibility to monitor medication administration.

2. The Division Lacks Standard Quality Assurance Programs and Reporting Systems to Ensure All Clients Are Afforded the Same Safety And Quality of Care

The Division does not have a centralized quality assurance or Incident Reporting systems statewide to ensure that all clients receive the same quality of care. Currently, there are decentralized systems across the 11 regional centers with little or no oversight by the Division. The Division has not established standard guidelines or staffing levels for the regional centers' quality assurance teams. In addition, it has not established a centralized Incident Reporting system to identify trends in client behavior or abuse patterns. Accordingly, the Division does not have any assurance that the regional centers' oversight of contractors is consistent and adequate to ensure all clients receive quality care.

The Division's quality assurance efforts are not adequate

Division management stated that they were redesigning a statewide quality assurance program and acknowledged that there is not a uniform system of quality assurance in place at all regional centers. In May 2000, the Division's Deputy Director sent a memorandum to the 11 regional centers requesting information regarding local quality assurance programs. Key questions in the letter were:

1. Do you have a Quality Assurance Team?
2. How many staff positions are dedicated to quality assurance?
3. What are the positions, for example RNs, and are the positions full or part time?
4. Who does the Quality Assurance team report to?
5. What are the functions of the Quality Assurance team?
6. Does the Quality Assurance team routinely visit contractors and if so, how often?

Quality assurance could be improved

The regional centers' responses showed substantial differences in the number and types of staff, and staff time the regional centers have dedicated to quality assurance teams. For example, the St. Louis Regional Center, which had 9,150 clients, reported its quality assurance team consisted of three full-time staff—a Quality Assurance Officer, a Quality Assurance Specialist, and a Case Management Supervisor (who also does abuse/neglect investigations full-time, thus this staff is not full time for either position). In contrast, the Poplar Bluff Regional Center, which had 1,080 clients (or 8,070 fewer clients), reported its quality assurance team consisted of 13 full-time staff—five Quality Assurance Specialists, two Registered Nurses, two Clerk Typists, one Clerk Stenographer, one Program Specialist, one Accountant, and one Abuse and Neglect Coordinator.

Because the Division has not established a statewide staffing standard for the quality assurance program, it does not know whether the St. Louis Regional Center Quality Assurance team is understaffed, or the Poplar Bluff Regional Center Quality Assurance team is overstaffed. The following table shows for each regional center, the number of quality assurance staff, total number of clients, and ratio of clients to quality assurance staff as reported to the Division.

Regional Centers' Quality Assurance Staffing Levels

Regional Center	*No. of QA Staff*	*No. of Clients*	*Client/Staff Ratio*
Poplar Bluff	13	1080	83
Sikeston	9	1106	123
Rolla	11	1632	148
Hannibal	7	1218	174
Central MO	9	2011	233
Joplin	6	1419	237
Kirksville	3	901	300
Springfield	7	2209	316
Kansas City	6	3793	632
Albany	1	1432	1432
St. Louis	3	9150	3050

Source: SAO analysis

According to the Division, the regional centers' quality assurance teams are responsible for ensuring contractors are operating in accordance with the Division's certification principles, which includes ensuring clients are free from physical aggression. Also, several regional center officials stated that the centers' quality assurance teams are responsible for reviewing contractor's incident reports to identify trends such as increased medication errors and injuries to clients. Accordingly, it is critical that each regional center has adequate quality assurance staff to ensure clients are free from physical aggression and to effectively review contractors' incident reports.

The Division has increased the number of service coordinators at several regional centers

Data we obtained from five regional centers showed substantial differences in several center's service coordinator to client ratio (caseloads) prior to state fiscal year 2001. The Division has substantially increased the authorized number of service coordinators that several regional centers can employ and thereby reduced service coordinators' caseloads. For example, the St. Louis Regional Center was authorized an additional 42 service coordinators and the Springfield Regional Center was authorized 5 additional service coordinators. Reducing coordinators' caseloads should allow them more time to review contractors' incident reports. The Division also authorized an additional registered nurse (RN) position for each regional center. These RNs could be used to determine if the contractor's training on medication administration was adequate and help to mitigate medication errors. The following table shows the caseloads for service coordinators before additional service coordinators were authorized:

Service Coordinator Caseloads for Selected Regional Centers

Regional Center	Average Caseload	Caseload Range
St. Louis	**75**	**23-139**
Springfield	**58**	**29-77**
Albany	**56**	**44-80**
Joplin	**44**	**21-67**
Central MO	**41**	**20-53**

Source: SAO Analysis

The Division does not have a standard policy or system for regional centers to retain and review contractors' incident reports

Retention policy needed for incident reports

Each of the six regional centers we visited had different procedures for reviewing and retaining contractors' incident reports. At each regional center, the affected client's service coordinator reviews the reports first. However, five of the six regional centers did not have an effective system to archive the reports for follow-up analyses after the service coordinators reviewed them. In fact, one regional center's service coordinators were throwing contractors' incident reports away after they reviewed them, and their supervisors or the regional center's quality assurance team did not review the incident reports.

Although the other five regional centers retained the reports after the service coordinators reviewed them

- three regional centers stored the reports in large boxes without any organization,
- one regional center archived the reports in individual client files, and
- one regional center had developed an automated database to archive contractors' incident reports that at the time of our visit included about 4,700 reports.

None of these methods for keeping the incident reports on file were effective enough to provide for follow-up analysis. The first two methods did not provide for easy retrieval of reports and the automated database was not maintained in a current status. We were provided over 100 incident reports that two contractors had submitted during the period January 1, 1999 through June 30, 2000, that had not been entered into the database due to lack of staff. As such, the regional centers had not been performing follow-up analyses to identify (1) clients who were dangerous to others or themselves, (2) clients incurring a large number of injuries, and (3) contractors who had committed a large number of medication errors.

The Division does not have a standardized incident report database for regional centers

Automated databases would help tracking

Seven of the Division's 11 regional centers are operating or plan to operate automated databases to archive and review contractors' incident reports. Officials from three of the six regional centers we visited said they planned to develop an automated database to archive and analyze contractor's incident reports. Audit results at the Division's five other regional centers showed that one regional center had been operating an automated database for over 3 years, and two other centers had implemented an automated database during 2000. Since automated databases are evolving at some of the regional centers, the Division needs to ensure (1) all regional centers develop and implement an incident report database, and (2) the databases will facilitate comparisons of contractors' performance among the regional centers. Comparing contractors' performance statewide would allow the Division to identify potential best practices or contractors who are not reporting all incidents, and set standards for performance measurements such as medication errors.

Incident reports submitted by two contractors, each located in a different regional center, showed significant differences in the number of reported injuries to clients and reported medication errors as shown in the tables below. (For the Period January 1, 1999, through June 30, 2000.)

Reported Injuries

Contractor Reg. Center	No. of Clients	No. of Incident Reports	No. of Injuries	Client/Injury Ratio	Client/Report Ratio
Kansas City	70	798	552	7.9	11.4
Springfield	36	17	10	0.3	0.4

Reported Medication Errors

Contractor Reg. Center	No. of Clients	No. of Incident Reports	No. of Medication Errors	Client/Error Ratio	Client/Report Ratio
Kansas City	70	798	88	1.3	11.4
St. Louis	97	902	902	9.2	9.2

Source: SAO analyses of contractors' incident reports

As the charts show, there were significant differences in incident reporting. At Kansas City, 11 incidents per client were reported, while there was less than 1 incident per client in Springfield. Either, Springfield staffs do a much better job, or they do not report incidents in a comparable manner as Kansas City. Since there is not any analysis of the incident reports neither the Division nor the audit staff know the answer. However, these are the types of issues that a comparative analysis would disclose and should prompt questions for quality reviewers.

Regarding the table on medication errors, a comparative analysis would show that there could be problems with St. Louis since the medication errors are over 10 times the number reported at Springfield with only a small increase in the number of clients. Or, perhaps Springfield is not reporting all of their incidents. Either way, an analysis should prompt these type questions.

Incident report trends reveal that few clients have been responsible for many of the reported incidents of physical aggression

Contractors' incident reports show that if the Division and its regional centers had taken action to quickly place a few clients under one-to-one, line-of-sight supervision, a substantial number of incidents of physical aggression could have been prevented. As discussed below, only a few clients committed a large number of physical acts of aggression. In fact, at every location we visited, there were only two clients who committed large numbers of these incidents. Two out of

- 109 clients reviewed in Springfield were responsible for 70 of the 209 (33%) acts of physical aggression against other clients, and two clients were responsible for 46 of the 139 (33%) acts of physical aggression against staff,

- 53 clients reviewed in Albany were responsible for 53 of the 127 (42%) acts of physical aggression against other clients, and 15 of the 51 (29%) assaults against staff,

- 115 clients reviewed in St. Louis were responsible for 47 of the 121 (39%) acts of physical aggression against other clients, and 42 of the 140 (30%) acts of physical aggression against staff,

- 37 clients reviewed in Joplin were responsible for 50 of the 104 (48%) acts of physical aggression against other clients, and 38 of the 88 (43%) acts of physical aggression against staff.

The Division does not require contractors to use a standard form to report incidents

Contractors were using several different types of incident report forms to report basically the same information in a different format, which would make it difficult to readily enter data into an incident report database and perform detailed analyses. For example, some contractors used a checklist form to identify if the incident involved an injury, seizure, medication error, physical or sexual aggression, and an assault with object; which facilitates entering critical information into a database for follow-up analyses. Other contractors, however, used a narrative form that had to be read in detail in order to identify if the report involved incidents such as seizures, sexual aggressions, and assaults with an object. Accordingly, it would require more time to review these reports and enter the data into a database. Because each regional center is receiving thousands of incident reports annually, the Division needs to

Standard incident report forms are needed

evaluate the feasibility of contractors submitting their reports electronically and developing a standard form that can be scanned.

High turnover of contractors' direct care staff increases the need to analyze contractors' incident reports

Turnover emphasizes need for tracking

In July 2000, the Division requested residential and day habilitation contractors to report their turnover rates and annual starting salary for direct care staff employed during state fiscal year 2000. The Division requested this information to determine the need for additional funding from the legislature to help curb excessive turnover rates. As of August 25, 2000, 280 contractors responded and reported turnover rates ranging from zero percent to as high as 500 percent. Of the 280 contractors who responded, the average turnover rate was 70 percent. Sixty-eight contractors reported turnover rates of 100 percent or higher. To put these rates in perspective, a contractor who had an average number of 25 direct care staff and had a turnover rate of 70 percent, would have had about 18 staff leave during the year.

High turnover rates of direct care staff result in clients being taken care of by staff who have limited personal knowledge of the clients' physical and mental conditions and needs. For example, one of the contractors we visited reported a turnover rate of 300 percent. Data from this contractor showed as of August 10, 2000, the contractor had 78 direct care staff and 42 (54 %) of these employees had been employed 6-months or less. This contractor's incident and injury reports showed that 70 clients incurred over 550 injuries (about 8 injuries per client) during the period January 1999 through June 2000. Conversely, another contractor reported a turnover ratio of 23 percent. This contractor's incident reports showed that 34 clients incurred 29 injuries (about .9 injuries per client) during the same period. High turnover rates of direct care staff make it even more imperative for Division staff to review contractors' reports to identify contractors who have (1) staff committing a large number of medication errors, (2) clients continually committing physical acts of aggression against other clients and/or direct care staff, and (3) clients incurring a large number of injuries.

Conclusion

Division staff does not have an effective statewide quality assurance program to ensure all of its clients are living in an environment that is safe and free from harm. An effective and efficient system to record, store, and analyze information reported on contractor's incident reports is needed. Division staff does not require regional centers to analyze contractors' incident reports to identify patterns of acts of physical aggression or medication errors.

Recommendations

We recommend the Director, Division of Mental Health:

2.1 Develop an effective Quality Assurance program and ensure it is uniformly implemented by all regional centers.

.

2.2 Establish a Divisional policy that requires regional centers to systematically analyze contractors' incident reports to identify patterns of aggression, injuries, and medication errors and other incidents that can affect clients safety and well being.

2.3 In concert with contractors and regional centers, develop a standard incident report form (which could be scanned) to record and report information that needs to be included in incident reports.

2.4 Require each regional center to install an automated database to record and analyze contractors' incident reports. The Division should require centers without a database to adapt an existing database currently used by other centers until the Division can develop a standard database.

2.5 Encourage contractors to electronically submit their incident reports.

Department of Mental Health Comments

The Director, Division of Mental Retardation and Developmental Disabilities agreed with the recommendations and provided acceptable implementation plans. The detailed comments are included in Appendix IV, page 24. Pertinent excerpts follow:

2.1 The Division agrees that its Quality Assurance/Enhancement program that began in 1995 and is currently being re-designed should be uniformly implemented by all regional centers. In October 2000, the Division began re-designing its current program to more effectively integrate quality assurance and enhancement functions among the regional centers, providers, and the Division. The re-design will include increased oversight of the regional center quality assurance functions to ensure that all consumers receive quality care. By December 31, 2001, the Division will implement the re-designed program, "Quality Framework: A Partnership for Consumer-focused Systems."

2.2 DMRDD accepts the recommendation and agrees that the Division implement a policy to assure that all regional centers collect and analyze incidents/injuries that affect client safety and/or well being. The Division will develop and implement a Division Operating Regulation by July 1, 2001, to include protocol for tracking, analyzing and maintaining reportable incident and injury reports.

2.3 DMRDD accepts the recommendation that contractors and regional centers should use a uniform incident/injury report form. The Division will develop a uniform report form by July 1, 2001.

2.4 DMRDD accepts the recommendation to utilize an automated database at each regional center to record and trend contractors' incident/injury reports. The Division anticipates that all regional centers will have an automated system in place within this calendar year. The Division will also work with the Department to incorporate incident/injury data fields and trend reporting in Phase I implementation of the new Department Consumer Information Management Outcomes and Reporting (CIMOR) system. Phase I

is scheduled to be implemented by October 2002 pending approval of the Department's FY 02 budget request.

2.5 DMRDD agrees that electronic submission of incident reports is beneficial to the Division. The Division will explore the feasibility of including this component in the new CIMOR system. Until that system is implemented, the Division will reinforce with providers and staff the importance of receiving the incident reports expeditiously.

APPENDIX I

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objectives of this audit were to determine (1) the effectiveness of the Division's oversight of its eleven regional centers, and (2) the effectiveness of regional center officials' oversight and inspections of contractors operating residential facilities, and day habilitation programs.

Scope and Methodology

The audit included

- a review of state laws and regulations that govern the operations of the Division and its 11 regional centers,

- a review of Division contractors who provide services to the people with developmental disabilities, and developmentally disabled,

- interviews of officials from the Division's 11 regional centers to determine their policies and procedures for obtaining, reviewing, and archiving contractors' incident reports.

We analyzed incident reports for eight contractors operating in 5 of the Division's 11 regional centers—Albany, Joplin, Kansas City, St. Louis, and Springfield. These regional centers were selected because they serve both rural and urban client populations and have both large and small client caseloads.

At each regional center, we selected contractors who provided residential services to 30 or more clients in order to obtain an adequate client representation for each regional center. The incident reports analyzed were for the period January 1, 1999, through June 30, 2000. We also obtained a copy of the incident report database from the Central Missouri Regional Center in Columbia. We did not perform detailed analyses of this database, because it did not include all incident reports contractors had submitted during the period January 1, 1999, through June 30, 2000. We did, however, include in our report some information from this database related to acts of physical aggression by individual clients.

At the Kansas City and St. Louis regional centers, incident reports provided by the selected contractors were analyzed. We gathered the incident reports these contractors prepared and submitted during the above period to their respective regional centers. At the Albany, Joplin, and Springfield regional centers, we confirmed with the contractors that these were all of the

reports sent to the regional centers. We reviewed all incident reports that the selected contractors had reportedly submitted during the above period. It should be noted that many of the reports that were provided at the latter three regional centers could not be included in our analyses, because they were illegible.

Our analyses focused on identifying instances of potential physical aggression, which included (1) clients who had committed physical acts of aggression against other clients or clients who were victims of aggressive acts, and (2) clients who had incurred injuries, such as bruises, abrasions and scratches. We also identified incidents of clients committing physical acts of aggression against direct care staff because these clients potentially represented a danger to other clients. Audit tests included an analysis of incidents of medication errors, because they can adversely impact clients' health and safety.

The audit was made in accordance with generally accepted government auditing standards and included such tests of the procedures and records as were deemed appropriate.

APPENDIX II

BACKGROUND

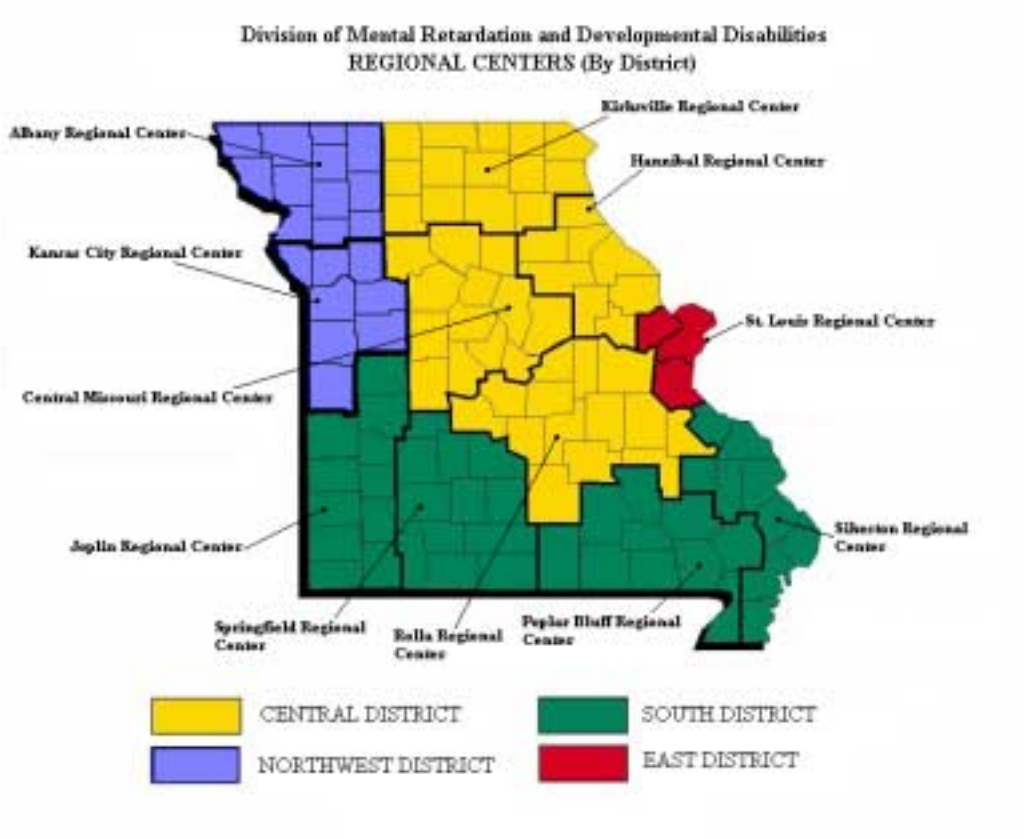
The Division of Mental Retardation and Developmental Disabilities ("the Division") of the Department of Mental Health ("the Department") was created by the omnibus reorganization act of 1974. It is responsible for insuring that mental retardation and developmental disabilities prevention, evaluation, care, habilitation and rehabilitation services are accessible, wherever possible. The Division is also responsible for supervising Divisional residential facilities, day programs and other specialized services operated by the Division, and oversight over contractor operated facilities, programs and services funded or licensed by the Division. Its goals are to improve the lives of persons with developmental disabilities through programs and services to enable those persons to live independently and productively. In 1988, the Division began participation in the Medicaid home and community-based waiver program, designed to help expand needed services throughout the state.

An estimated 27,500 Missourians with developmental disabilities such as mental retardation, cerebral palsy, and autism receive services from the Division each year. About 9,000 of these clients live in contractor operated residential facilities. The Division operates 17 facilities that provide or purchase specialized services. Eleven of these facilities are regional centers, which are the primary points for clients to obtain services from the Division and they provide assessment and case management services, which include coordination of each client's individualized habilitation plan. The other six facilities are Division operated habilitation centers, which provide residential care and habilitation services for people with more severe disabilities.

Regional Centers

The following map shows the Division's 4 Districts and the 11 regional centers:

APPENDIX II



The following table shows the number of counties and clients served by each regional center:

Regional Centers	No. of Counties	No. of Clients
Albany	12	1432
Central Missouri (Columbia)	13	2011
Hannibal	8	1218
Joplin	11	1419
Kansas City	8	3793
Kirksville	14	901
Poplar Bluff	10	1080
Rolla	14	1632
Sikeston	9	1106
Springfield	12	2209
St. Louis	3	9150
Total	**114**	**25,951**[3]

[3] The Division's six habilitation centers serve 1,509 clients resulting in a total of about 27,500 clients.

APPENDIX II

The Division's Budget

In fiscal year 2001, the Division received $258.2 million in total funds. This is an increase of 9 percent from fiscal year 2000. The following are some of the areas receiving additional funding for fiscal year 2001:

- $2.7 million for 64 additional case managers to maintain adequate client-to-case manager (service coordinator) staffing ratios;
- $2.7 million for provider rate increases targeted to improving direct care staff salaries; and
- $605,228 for 13 nurses to improve and monitor the health care of regional center clients.

APPENDIX III

STATUTES AND CODE OF STATE REGULATIONS

Section 630.115.1 of RSMo prescribes that each client shall be entitled to certain rights without limitation that include: (1) humane care and treatment; (2) to the extent that the facilities, equipment and personnel are available, to medical care and treatment in accordance with the highest standards accepted in medical practice; (3) safe and sanitary housing; (4) to be treated with dignity as a human being; and (5) to be free from verbal and physical abuse. Section 630.655 of RSMo, directs that the Department of Mental Health promulgate rules which set forth reasonable standards for residential facilities, day programs or specialized services such that each program's level of service, treatment, habilitation or rehabilitation may be certified and funded accordingly by the department for its placement program clients or as necessary for the facilities or programs, to meet conditions of third-party reimbursement.

Section 633.010 of RSMo states the Division of Mental Retardation and Developmental Disabilities shall have the responsibility of insuring that mental retardation and developmental disabilities prevention, evaluation, care, habilitation and rehabilitation services are accessible, wherever possible. The Division shall have and exercise supervision of division residential facilities, day programs and other specialized services operated by the department, and oversight over facilities, programs and services funded or licensed by the department. The powers, functions and duties of the Division shall include the following: (1) assurance of program quality in compliance with such appropriate standards as may be established by the department, and (2) participation in developing standards for residential facilities, day programs and specialized services operated, funded or licensed by the department for persons affected by mental retardation or developmental disabilities.

9 CSR 45-5 defines the terms and principles for Medicaid contractors, who provide residential and day habilitation services to persons with developmental disabilities. The regulation requires that individuals incurring injuries or experiencing unusual incidents have the injuries or incidents documented in their files. The regulation does not require contractors to report injuries or unusual incidents to their respective regional centers. The regulation also states that individuals take medications as prescribed and are supported in safely managing their medications. The regulation does not require medication errors to be reported to the Division's regional centers.

9 CSR 40-5 defines the rules for non-Medicaid contractors, who provide residential and day habilitation services to persons with developmental disabilities. The regulation does not require that individuals incurring injuries or experiencing unusual incidents have the injuries or incidents documented in their files, and accordingly reported to the individuals' respective regional center. The regulation, however, does require that all errors in administering or in self-administration of medications shall be reported immediately to the physician and regional center.

APPENDIX III

9 CSR 45-3.050 defines the terms and establishes procedures for admission and treatment of clients with aggressive behaviors in facilities operated by the Division of Mental Retardation and Developmental Disabilities. According to Division officials, this regulation does not apply to clients living in contractor-operated facilities. The regulation defines "Dangerous to others" as presented with an opportunity, a client attempts to harm others by physical or sexual aggression through spontaneous action, or the client has committed any serious incidents of physical or sexual aggression in the last three months. The regulation requires that clients who are categorized as dangerous to others must receive one-to-one, line-of-sight or high priority supervision. 9 CSR 45-3.050 also states a client's risk determination should be revaluated within twenty-four hours after a serious incident of aggressive behavior.

BOB HOLDEN
GOVERNOR

ROY C. WILSON, M.D.
DIRECTOR

APPENDIX IV

DORN SCHUFFMAN, DIRECTOR
DIVISION OF COMPREHENSIVE PSYCHIATRIC SERVICES
(573) 751-5212
(573) 751-8017 TTY
(573) 751-7815 FAX

ANNE S. DEATON, DIRECTOR
DIVISION OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES
(573) 751-4054
(573) 751-8217 TTY
(573) 751-9207 FAX

MICHAEL COUTY, DIRECTOR
DIVISION OF ALCOHOL AND DRUG ABUSE
(573) 751-4942
(573) 751-7093 TTY
(573) 751-7814 FAX

STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH

1706 EAST ELM STREET
P.O. BOX 687
JEFFERSON CITY, MISSOURI 65102
(573) 751-4122
(573) 526-1201 TTY
www.state.mo.us/dmh

February 15, 2001

Claire C. McCaskill
State Auditor
224 State Capitol
Jefferson City, MO 65101

Dear Ms. McCaskill:

This letter and the attached documents represent the formal response from the Division of Mental Retardation and Developmental Disabilities to the recent state audit performed at six of the Division's eleven regional centers by your staff. This response addresses each of the recommendations separately along with a corrective plan for each recommendation.

The Division will exercise due diligence in implementing the corrective plans. Implementation timeframes may vary due to the fact that some corrective plans entail extensive due process procedures that require specific timelines. For example, amending a CSR to include corrective action could take at least six months.

The Division will pursue the changes as quickly as possible and will, on a quarterly basis, keep your office informed on progress until the implementation plans are completed.
My understanding is that this response will be included as an appendix to the final report, which will be made public by your office.

We very much appreciate the cooperation received from William Miller, Kirk Boyer and John Mollett as we have moved through this process. Please contact me at 573-751-8676 if any additional information would be helpful.

Sincerely yours,

Anne S. Deaton

Anne S. Deaton, Ed.D., Division Director
Mental Retardation and Developmental Disabilities

ASD:rls
c: Roy Wilson, M.D.

DEPARTMENT OF MENTAL HEALTH
DIVISION OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES'
FORMAL RESPONSE TO THE STATE AUDIT REPORT
February 15, 2001

SECTION I:

Response to Recommendations Contained in Section I "State Regulations Do Not Adequately Protect Missouri's People with Developmental Disabilities from Physical Aggresssion and Injuries"

Correction plans for the first three recommendations contained in the state audit are addressed in this section. The division will initiate the corrective plans by March 1, 2001 with an anticipated completion date of December 31, 2001.

RECOMMENDATION 1.1: Amend 9 CSR 45-5-5.010 and 9 CSR 40-5.030 to require contractors to submit Incident and Injury reports to their respective regional centers immediately when serious injuries are involved and within 24 hours for other injuries and incidents.

RESPONSE: The Division agrees that contract providers should systematically report specified incidents and injuries to regional centers. In this regard, the Division will amend all applicable state regulations, contracts and department operating regulations to include types of reportable incidents and injuries including medication errors, provider reporting and documentation requirements, and sampling methodology.

RECOMMENDATION 1.2: Amend 9 CSR 45-3.050 to apply to clients living in contractor operated facilities.

RESPONSE: DMRDD accepts the recommendation and agrees that a process needs to be clarified which will result in risk assessments being accomplished for individuals who live in the community and who exhibit aggressive behavior which may be considered "dangerous to self and others." The Division will pursue an amendment of 9 CSR 45-3.050 or establish a separate CSR to address the recommendation.

RECOMMENDATION 1.3: Amend 9 CSR 45-5.010 to state errors in administering or in self-administration of medications shall be reported immediately to the regional center or placement office.

RESPONSE: DMRDD agrees that contract providers should report errors in medication administration to regional centers. Reporting of errors that may have an adverse effect on the client is of particular importance. These should be reported immediately to the client's primary care physician/practitioner and the regional center. In addition to reporting requirements, contract providers should establish policies and procedures, in

accordance with acceptable standards of practice, to monitor errors in medication administration and proper documentation.

To ensure quality improvement in medication administration, the division will include language in applicable state regulations and contracts to specify the types of reportable medication errors and provider responsibility to monitor medication administration.

(NOTE: the audit reference to "placement office" on p. 7 is unclear: DMRDD conducts all business and service coordination activity from regional centers.)

SECTION II:

Response to Recommendations contained in Section II "The Division Lacks Standard Quality Assurance Programs and Reporting Systems to Ensure All Clients Are Afforded the Same Safety and Quality of Care".

This section contains corrective plans concerning quality assurance and the development of an automated database for documenting and analyzing data about incident and injury reports and a standardized format for collecting data.

RECOMMENDATION 2.1: Develop an effective Quality Assurance program and ensure it is uniformly implemented by all regional centers.

RESPONSE: The Division agrees that its Quality Assurance/Enhancement program that began in 1995 and is currently being re-designed should be uniformly implemented by all regional centers. In October 2000, the Division began re-designing its current program to more effectively integrate quality assurance and enhancement functions among the regional centers, providers, and the Division. The re-design will include increased oversight of the regional center quality assurance functions to ensure that all consumers receive quality care. By December 31, 2001 the Division will implement the re-designed program, "Quality Framework: A Partnership for Consumer-focused Systems."

RECOMMENDATION 2.2: Establish a Divisional policy that requires regional centers to systematically analyze contractors' incident reports to identify patterns of attacks, injuries, and medication errors and other incidents that can affect client's safety and well being.

RESPONSE: DMRDD accepts the recommendation and agrees that the Division implement a policy to assure that all regional centers collect and analyze incidents/injuries that affect client safety and/or well being. The Division will develop and implement a Division Operating Regulation by July 1, 2001 to include protocol for tracking, analyzing and maintaining reportable incident and injuries reports.

RECOMMENDATION 2.3: In concert with contractors and regional centers, develop a standard incident report form (which could be scanned) to record and report information that needs to be included in incident reports.

RESPONSE: DMRDD accepts the recommendation that contractors and regional centers should use a uniform incident/injury report form. The Division will develop a uniform report form by July 1, 2001. Please note that prior experience with scanning handwritten incident/injury reports has proven to be ineffective as handwriting is illegible in the scanning process.

RECOMMENDATION 2.4: Require each regional center to install an automated database to record and analyze contractors' incident reports. The Division should require centers without a database to adapt an existing database currently used by other centers until the Division can develop a standard database.

RESPONSE: DMRDD accepts the recommendation to utilize an automated database at each regional center to record and trend contractors' incident/injury reports. The Division anticipates that all regional centers will have an automated system in place within this calendar year. The Division will also work with the Department to incorporate incident/injury data fields and trend reporting in Phase I implementation of the new Department Consumer Information Management Outcomes and Reporting (CIMOR) system. Phase I is scheduled to be implemented by October 2002 pending approval of the Department's FY 02 budget request.

RECOMMENDATION 2.5: Encourage contractors to electronically submit their incident reports.

RESPONSE: DMRDD agrees that electronical submission of incident reports is beneficial to the Division. The Division will explore the feasibility of including this component in the new CIMOR system. Until that system is implemented, the Division will reinforce with providers and staff the importance of receiving the incident reports expeditiously.