Follow-Up Audit of the Hawaii State Hospital

A Report to the Governor and the Legislature of the State of Hawaii

Report No. 97-11
August 1997

THE AUDITOR
STATE OF HAWAII

The Office of the Auditor

The missions of the Office of the Auditor are assigned by the Hawaii State Constitution (Article VII, Section 10). The primary mission is to conduct post audits of the transactions, accounts, programs, and performance of public agencies. A supplemental mission is to conduct such other investigations and prepare such additional reports as may be directed by the Legislature.

Under its assigned missions, the office conducts the following types of examinations:

1. *Financial audits* attest to the fairness of the financial statements of agencies. They examine the adequacy of the financial records and accounting and internal controls, and they determine the legality and propriety of expenditures.

2. *Management audits*, which are also referred to as *performance audits*, examine the effectiveness of programs or the efficiency of agencies or both. These audits are also called *program audits*, when they focus on whether programs are attaining the objectives and results expected of them, and *operations audits*, when they examine how well agencies are organized and managed and how efficiently they acquire and utilize resources.

3. *Sunset evaluations* evaluate new professional and occupational licensing programs to determine whether the programs should be terminated, continued, or modified. These evaluations are conducted in accordance with criteria established by statute.

4. *Sunrise analyses* are similar to sunset evaluations, but they apply to proposed rather than existing regulatory programs. Before a new professional and occupational licensing program can be enacted, the statutes require that the measure be analyzed by the Office of the Auditor as to its probable effects.

5. *Health insurance analyses* examine bills that propose to mandate certain health insurance benefits. Such bills cannot be enacted unless they are referred to the Office of the Auditor for an assessment of the social and financial impact of the proposed measure.

6. *Analyses of proposed special funds* and existing *trust and revolving funds* determine if proposals to establish these funds and existing funds meet legislative criteria.

7. *Procurement compliance audits* and other *procurement-related monitoring* assist the Legislature in overseeing government procurement practices.

8. *Fiscal accountability reports* analyze expenditures by the state Department of Education in various areas.

9. *Special studies* respond to requests from both houses of the Legislature. The studies usually address specific problems for which the Legislature is seeking solutions.

Hawaii's laws provide the Auditor with broad powers to examine all books, records, files, papers, and documents and all financial affairs of every agency. The Auditor also has the authority to summon persons to produce records and to question persons under oath. However, the Office of the Auditor exercises no control function, and its authority is limited to reviewing, evaluating, and reporting on its findings and recommendations to the Legislature and the Governor.

THE AUDITOR
STATE OF HAWAII

Kekuanao'a Building
465 South King Street, Room 500
Honolulu, Hawaii 96813

OVERVIEW

THE AUDITOR
STATE OF HAWAII

Follow-Up Audit of the Hawaii State Hospital

Summary

The Hawaii State Hospital is a psychiatric facility for the care of mentally ill persons and persons who are both mentally ill and drug-addicted. The hospital is a branch under the Adult Mental Health Division of the Behavioral Health Administration in the Department of Health. The hospital has 168 beds and 626 staff positions. For FY1996-97, the Legislature appropriated to the hospital about $30.7 million for operating costs.

The Office of the Auditor conducted a follow-up audit of the Hawaii State Hospital for the period from January 1996 to March 1997. The audit examined the extent to which findings and recommendations contained in our *Management and Fiscal Audit of the Hawaii State Hospital*, Report No. 95-34, are being addressed.

In our follow-up audit, we found that management of the hospital has improved and the hospital has attained accreditation. However, significant challenges remain. The hospital has improved its management of personnel, but sick leave abuse and excessive overtime continue. Excessive absenteeism has prevented the hospital from meeting Department of Justice staffing requirements, and has resulted in high overtime costs. Also, the hospital has not ensured that all staff are evaluated in a timely manner, and that staff meet all requirements for competencies.

Progress in financial management has been mixed. While the hospital's control of purchases and payroll functions has improved, further improvements are needed. The hospital continues to have little input in negotiations concerning its contracts with the University of Hawaii. Also, new rules to control costs and improve recordkeeping in the patient work program are not always followed.

During our previous audit, the hospital raised the price of staff meals from 40 cents to $1.50. This has decreased the state subsidy on staff meals. However, the meal price is still lower than the median price at other Department of Health dining facilities, and covers less than one-fourth of the cost of the meals. We also found inadequate controls over the number of take-out meals.

We found that hospital inventory controls are stronger but are not consistently applied. The inventory system for food supplies has improved, but further improvements are needed to account for gasoline and housekeeping items. Controls were insufficient to account for gasoline from the hospital gas pump and from a commercial gas station. Gaps in recordkeeping for housekeeping and other supplies prevent accurate inventory records for these supplies.

Finally, we found that management problems posed by the forensic population—those committed by court order—remain unresolved. The hospital has made efforts to provide transitional services and return patients to the community. However, the hospital's large forensic population continues to cause problems, including security costs and limits on non-forensic admissions.

Recommendations and Response

We recommend that the Department of Health provide stronger guidance to the Hawaii State Hospital in addressing its problems with sick leave and overtime. We also recommend a wide range of improvements by the hospital or the department with regard to the hospital's personnel management, purchasing, contracting, payroll, employee meal arrangements, inventory control, and management of the forensic population.

The department says it is pleased that management of the Hawaii State Hospital has improved. The department concurs that many significant challenges remain, and says that our report seems objective and fairly presented. Its response expresses overall agreement with our recommendations and a commitment to making improvements. The department also says that the hospital finds our summary and findings agreeable. The response offers comments on some areas of our findings, including recent or planned improvements, and some other observations.

Marion M. Higa
State Auditor
State of Hawaii

Office of the Auditor
465 South King Street, Room 500
Honolulu, Hawaii 96813
(808) 587-0800
FAX (808) 587-0830

Follow-Up Audit of the Hawaii State Hospital

A Report to the Governor and the Legislature of the State of Hawaii

Submitted by

THE AUDITOR
STATE OF HAWAII

Report No. 97-11
August 1997

Foreword

This is a report of our follow-up audit of the Hawaii State Hospital for the period of January 1996 to March 1997. The follow-up audit focused on the findings and recommendations contained in our December 1995 *Management and Fiscal Audit of the Hawaii State Hospital*, Report No. 95-34. Our follow-up was conducted pursuant to Section 23-4, Hawaii Revised Statutes, which requires the Auditor to conduct postaudits of the transactions, accounts, programs, and performance of all departments, offices, and agencies of the State and its political subdivisions.

We wish to express our appreciation for the cooperation and assistance extended to us by the staff of the Hawaii State Hospital. We would also like to acknowledge the cooperation provided by other staff of the Department of Health, and other individuals who assisted us in this audit.

Marion M. Higa
State Auditor

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Chapter 1

Introduction

The purpose of this audit is to follow up on actions taken by the Department of Health with respect to the findings and recommendations in our December 1995 *Management and Fiscal Audit of the Hawaii State Hospital*, Report No. 95-34.

The prior audit was performed pursuant to Section 31 of Act 218 of the 1995 Regular Session, which directed the Office of the Auditor to conduct a fiscal, management, and staffing audit of the Hawaii State Hospital. The present follow-up audit was conducted pursuant to Section 23-4, Hawaii Revised Statutes (HRS), which requires the Auditor to conduct postaudits of the transactions, accounts, programs, and performance of all departments, offices, and agencies of the State and its political subdivisions.

Background

The Hawaii State Hospital is a psychiatric facility licensed by the Department of Health for the care of mentally ill persons and persons who are both mentally ill and drug-addicted. Chapter 334, Part III, HRS, sets out the hospital's responsibilities.

Persons may be admitted voluntarily according to the hospital's admissions standards. Persons may also be involuntarily examined and hospitalized. Emergency examinations can be initiated by police officers with the concurrence of a mental health emergency worker, by judges issuing orders for emergency examinations, or by licensed physicians or psychologists. The grounds for involuntary examination and hospitalization include imminent danger to self or others, grave disability, or obvious illness. Statutes also provide that persons who reside at a state correctional facility and are in need of hospital treatment for the primary diagnosis of mental illness will be transferred to the state hospital for care and treatment. Also, Section 704-403, HRS, provides for examinations and hospital commitments of defendants in criminal proceedings.

Mission

In addition to its statutory mandates, the Hawaii State Hospital has developed an internal mission statement. The hospital's strategic plan states that "the mission is to promote and provide quality psychiatric treatment, in the spirit of aloha (compassion), lokahi (harmony), and ohana (teamwork)."[1]

Organization

The Hawaii State Hospital is a branch under the Adult Mental Health Division of the Behavioral Health Administration in the Department of Health. The operations of the hospital are organized into three sections: clinical services; administrative and support services; and quality management services. Each of these sections is comprised of specific services referred to as units. An organizational chart is shown in Exhibit 1.1.

The hospital is headed by an administrator who is responsible for its day-to-day operations and reports to the chief of the Adult Mental Health Division.

The hospital's three areas of services have a total of 626 staff positions. Exhibit 1.2 summarizes the units, staff, and types of services in each section.

Patient characteristics

The hospital has a 168-bed capacity. These beds are for the forensic mentally ill (committed by the courts through the criminal justice system) and the non-forensic mentally ill. The non-forensic mentally ill include voluntary commitments, acute care, and long-term geriatric patients. Presently there are 160 patients at the hospital. Of these, 110 are forensic patients from the courts and 50 are non-forensic patients.

Budget

The Legislature appropriated $32,324,182 in general funds for the hospital's operating costs in FY1995-96. For FY1996-97, the hospital was appropriated $30,717,889 from the general fund for operating costs.

Prior problems at the hospital

In 1974, the Joint Commission on Accreditation of Healthcare Organizations revoked the hospital's accreditation. In 1986, the U.S. Health Care Financing Administration denied the hospital its certification, which effectively prevented the hospital from collecting any Medicare reimbursements. In 1986, 1988, and 1990, two patient-rights advocacy groups published editions of their survey *Care of the Seriously Mentally Ill: A Rating of the State Programs* that rated Hawaii last in all of the 50 states and the District of Columbia.

The U.S. Department of Justice reported in 1990 that hospital conditions violated the constitutional rights of patients and in 1991, imposed a wide-scale settlement agreement detailing operational requirements for the hospital. On January 10, 1995, the State of Hawaii was found to be in contempt of the 1991 settlement agreement. The State entered into another settlement agreement—a remedial plan—to address the contempt action. Failure to comply with new requirements in the remedial plan could be grounds for a federal takeover of the administering of the hospital but with the State still responsible for all costs.

Exhibit 1.1
Hawaii State Hospital Organizational Chart

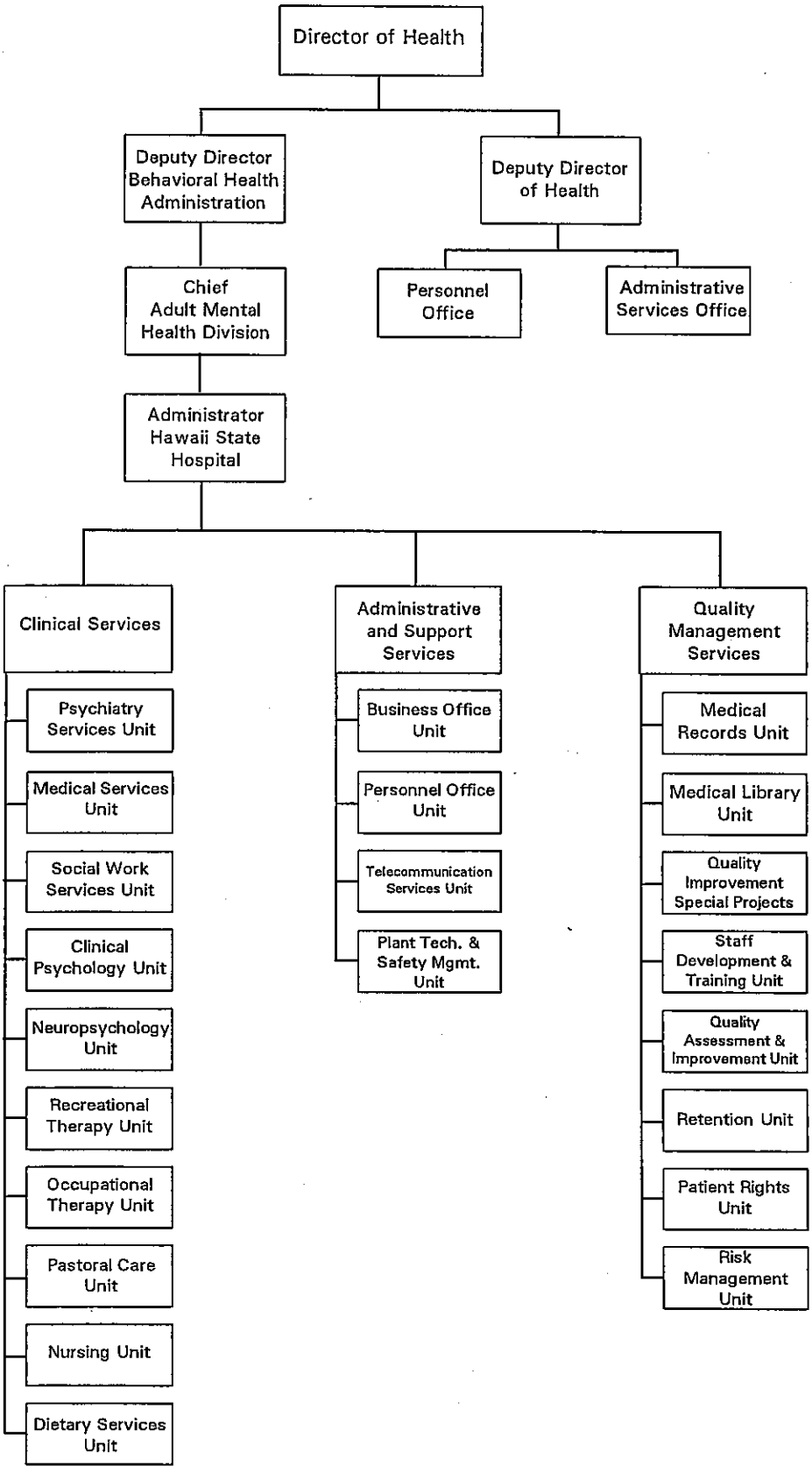

Exhibit 1.2
Hospital Services Units

Sections	Number of Units	Number of Staff	Types of Services
Clinical Services	10	478	Provides direct patient services in psychiatry, medicine, social work, clinical psychology, neuropsychology, recreational therapy, occupational therapy, pastoral care, nursing, and diet.
Administrative and Support Services	4	118	Includes business, personnel, plant technology and safety management (including housekeeping), and telecommunications units.
Quality Management Services	8	30	Maintains medical records and a medical library, provides staff development and training, and is responsible for quality assessment and improvement, staff retention services, patient rights, and risk management services.

In response to the contempt action, the director of health hired several key people in 1995, including a hospital administrator and an associate administrator for administrative and support services.

Recent developments

The new administrator has expressed a commitment to obtaining accreditation for the hospital and meeting all justice department mandates.

In December 1996, the hospital received accreditation from the Joint Commission on Accreditation of Healthcare Organizations. Effective for three years beginning October 12, 1996, this accreditation means that the quality of care provided to patients has improved and that the hospital meets certain performance standards. Accreditation also will aid the hospital in being able to collect third party reimbursements.

The next step for the hospital is to receive certification by the federal Health Care Financing Administration. Certification will enable the hospital to collect Medicare fee-for-service, Medicaid aged and disabled, and QUEST reimbursements for treatment provided to eligible patients.

With regard to the Department of Justice settlement agreement and remedial plan, a report released after a May 1996 visit by the Department of Justice observed that the State had made some progress in staffing, treatment planning and rehabilitation programs, restraint and seclusion practices, curtailing abuse and neglect, and discharge and out

placement, but that many areas of significant, systematic non-compliance remain. Consequently, a stipulation agreement to address areas of non-compliance was filed with the court. The hospital is required to improve in several areas including employment of additional staff; treatment plans and psychosocial rehabilitation; restraint in seclusion; protection from harm; and discharge planning and aftercare services.

The Department of Justice reported in December 1996 that the hospital had made strides towards complying with the court's orders, but that the State had not yet achieved compliance in several areas including meeting staffing ratios in particular units; hiring a director of psychosocial rehabilitation planning; reporting serious incidents promptly to the proper administrative authorities; and reducing a backlog of outstanding investigations of alleged abuse and neglect. The Department of Justice seeks full compliance with its requirements.

Prior audit findings and recommendations

Our prior audit found that past administrations had failed to properly manage the Hawaii State Hospital. The hospital lacked sufficient personnel policies and procedures. Chronic absenteeism contributed to excessive overtime costs. The lack of policies and procedures made it impossible to discipline employees. We recommended that the Department of Health and the hospital strengthen personnel policies and procedures to reduce absenteeism and grievances and to more effectively guide hospital employees in their work.

We also found that the hospital's financial management was weak. Hospital management did not administer—and thus was not accountable for—its purchasing and payroll functions. Also, the hospital's business and personnel staff were underutilized. We recommended that the department and the hospital evaluate current purchasing and payroll processes for inefficiencies and make improvements and that the hospital administrator directly negotiate professional services from the University of Hawaii. We also recommended that the hospital better utilize its business and personnel office staff and improve the supervisory and recordkeeping controls of the industrial therapy program.

Our prior report also found that the hospital had not exercised prudence in providing heavily subsidized employee meals. We recommended that the department and the hospital reconsider the practice of subsidizing meals for hospital employees.

Additionally, we found that inventory controls were lacking for gasoline, janitorial, and food services and supplies. Gasoline use was self-service on an honor system. Patient clothing and linen supplies were not monitored or verified for inventory control levels. There were no

inventory records for supplies to explain inventory shortages. Finally, the hospital needed to address problems associated with its forensic patient population.

We recommended the hospital strengthen its inventory controls by controlling access to the hospital's gasoline pump and requiring appropriate inventory recordkeeping at the housekeeping and dietary units. Finally, we recommended that the hospital continue its efforts to address problems concerning the forensic population.

Agency response

The Department of Health responded that overall, it agreed with the prior report's summary, findings, and recommendations.

Objectives of the Follow-Up Audit

Our follow-up audit had the following objectives:

1. Review the extent to which findings and recommendations contained in our prior audit are being addressed.

2. Make recommendations as appropriate.

Scope and Methodology

We reviewed federal and state statutes and rules, union agreements, and other relevant literature. We analyzed hospital and departmental memoranda, correspondence, policies, meeting minutes, documents, and forms. We also examined the Department of Justice settlement agreement, the remedial plan, compliance reports, and standards and reports of the Joint Commission on Accreditation of Healthcare Organizations.

We analyzed and observed the hospital's operations. We interviewed hospital administrators, department/unit heads, staff members, and other appropriate personnel. We also interviewed staff from the Department of the Attorney General and a union representative. We reviewed attendance records, leave records, personnel files, collective bargaining agreements, inventory records, invoices, and other documentation.

The period under review was from January 1996 to March 1997. Our work was performed from December 1996 through June 1997 in accordance with generally accepted government auditing standards.

Chapter 2

Management of the Hospital Has Improved But Significant Challenges Remain

This chapter presents the findings and recommendations of our follow-up audit of the Hawaii State Hospital.

Our 1995 audit found problems in the management of personnel, fiscal activities, controlling inventories, and providing subsidies for staff meals. The audit also found that management problems related to the forensic population needed to be addressed. In this follow-up audit, we found that the hospital has made some improvements, including attaining accreditation. However, additional improvements can be made.

The hospital's continuing personnel problems prevent a full compliance with mandates from the Department of Justice, and increase personnel costs. Other problems relating to financial management, inventory controls, meal subsidies, and the forensic population deter the hospital from operating at optimal efficiency.

Summary of Findings

1. The Hawaii State Hospital has improved its management of personnel. But problems with employee absenteeism, overtime, and evaluations continue. The hospital lacks formal policies to address these issues and to provide guidance to supervisors and staff.

2. Hospital management has begun to review and approve purchases. However, management's oversight and administration of its payroll functions remains deficient, and management does not review and approve University of Hawaii contracts.

3. The practice of subsidizing staff meals remains questionable, due to inadequate controls over the number of take-outs and the relatively low price of the meals.

4. Controls over inventories of gas, food supplies, and linen and clothing items have been strengthened. However, some of the controls are not applied consistently. Wards do not keep inventories of consumable goods, and are not accountable for these goods.

5. The hospital is beginning to address problems associated with its forensic population.

Despite Improvements in Personnel Management, Problems with Sick Leave, Excessive Overtime, and Evaluations Continue

Effective personnel management requires establishing and applying management controls. Our previous audit found that the hospital was not effectively administered. It lacked the necessary personnel policies and procedures to appropriately discipline employees. The hospital suffered from chronic employee absenteeism and excessive overtime costs.

Since that time, the hospital has tried to improve personnel management controls, including those over sick leave and leave without pay. However, sick leave abuse and excessive overtime continue.

The hospital continues to lack formal policies to address these issues. Controls for sick leave are not applied consistently, and insufficient controls over overtime exist. Also, the hospital has not ensured that all staff are evaluated in a timely manner, and that staff meet all requirements for competencies.

The hospital is operating within certain constraints imposed by the Department of Justice consent decree or established through union contracts. The Department of Justice requires the hospital to maintain a minimum level of staffing for patient care units. Union agreements limit the hospital's actions in addressing sick leave and overtime.

Despite such constraints, we found that the hospital could do more to address the problems within these constraints. Existing controls could be applied more consistently, and the hospital could learn from the efforts of other agencies.

Management has improved oversight over leave without pay and sick leave

In 1995, we found rampant employee absenteeism and employees receiving pay while on unauthorized leave without pay. Since then, the hospital has taken steps to improve its oversight over sick leave and leave without pay.

Controls over leave without pay have been strengthened

The hospital has changed its procedures to prevent staff from being paid while on leave without pay. During the previous audit, we found that employees who refused to sign leave forms requesting leave without pay continued to receive payments. The hospital has addressed this problem by changing its procedures. The hospital can now stop payroll payments without the employee's signature for employees who are on unauthorized leave without pay and has been implementing this approach.

Management reviews patterns of sick leave

Since April 1996, hospital management has been reviewing leave records to check for patterns of sick leave abuse. Such patterns include sick leave taken regularly on the same day of the week and sick leave adjacent to a holiday or day off. When such patterns are detected, management takes steps to discipline staff who engage in these practices. Apparently the success of these efforts has varied, but the efforts demonstrate an interest in stopping abuse.

Problems with absenteeism continue

Despite improvements, hospital management and supervisors acknowledge that excessive absenteeism is a continuing concern. According to one top administrator, sick leave is at the core of the hospital's personnel problems. Excessive absenteeism has prevented the hospital from meeting Department of Justice staffing requirements, and has resulted in high overtime costs.

The Department of Justice requires the hospital to maintain minimum staffing ratios for each nursing unit and shift, but the hospital has not been able to meet these criteria due to employee absenteeism. As of July 1996, the hospital was in partial compliance with the requirement to maintain a minimum level of care per patient and to meet staffing ratios for each nursing shift. The hospital was out of compliance with a requirement to meet staffing ratios without an excessive use of overtime. The Department of Justice requires full compliance with its requirements.

In order to satisfy the Department of Justice and resolve its own staffing problems, the hospital needs to do all it can to address problems of absenteeism. This includes applying existing controls, and looking into other possible actions.

Controls over absenteeism are not applied consistently

Administrators cannot effectively manage the hospital and ensure appropriate patient care if they cannot consistently control absenteeism. We found that the hospital is not consistent in applying the necessary controls.

One control is the requirement that staff submit an application for leave and a doctor's note for sick leave of five or more days. According to the personnel office, staff should submit proper documentation within five days of their return to work. Our review of a sample of leave records found that in over 30 percent of cases, staff who took sick leave for five or more days did not submit the documentation.

Another control is the review of leave records for sick leave patterns. This control is weakened because sick leave is not reported consistently. Currently, supervisors can allow staff to change leave from sick leave to other leave if an employee does not have enough sick leave available. Sick leave would then be recorded as vacation leave or compensatory leave instead of sick leave. Reviews for sick leave patterns would miss cases that are not noted as sick leave in leave records.

A third control is the development and regular review of attendance records. All units are required to submit semi-monthly attendance reports to the personnel office. The office uses these reports to process payroll forms, but does not check them for accuracy. The only controls over the accuracy of the attendance reports are at the unit level. However, these controls vary in the different units.

Patient care units do not keep records of daily attendance for nursing staff. Semi-monthly attendance forms are filled out every two weeks, based on work schedules. Absences are shown by revisions to the schedule. These procedures do not enable the hospital to check the accuracy of attendance records. For example, if a clerk neglects to note on the schedule that an employee was absent and leave forms are not submitted, the employee could be paid for that day. There are no other records to check to see if the employee was actually working.

The housekeeping unit exerts stronger control by keeping logs of daily attendance. Semi-monthly attendance reports to the personnel office are based on these records. In addition, the plant engineer checks the semi-monthly attendance reports against the daily attendance records before they are sent to the personnel office.

Other actions to address sick leave problems are possible

The hospital has not explored all possible options to address sick leave abuse. Other actions are allowed in the union contracts. The contracts with bargaining units 1 and 10—the units which include the job classifications in which the most sick leave problems were reported—allow the hospital to require employees to be examined by a physician of the department's choice, but the hospital is not doing this. It is also possible to negotiate policies with the United Public Workers—which represents unit 1 and unit 10 employees such as paramedical assistants and licensed practical nurses—that address sick leave problems.

The Department of Public Safety has faced similar issues. To address these issues, the department negotiated two memoranda of agreement with units 1 and 10. Many hospital staff belong to the same bargaining units.

One agreement requires public safety staff with patterns of sick leave abuse to undergo a medical evaluation by a physician selected by the department. The agreement also establishes a discipline schedule for each violation of the requirement. The Department of Public Safety established a pilot project with Straub Clinic and requires employees with patterns of sick leave to be examined in accordance with the agreement.

In addition, the Department of Public Safety has negotiated with units 1 and 10 to allow the department to include other forms of leave (vacation, compensatory time, and authorized leave without pay) in reviews of sick leave patterns, if the other forms of leave are used while an employee is sick. This strengthens controls over sick leave abuse, by ensuring that all episodes of sickness are considered in review of sick leave patterns.

The hospital should learn about efforts by the Department of Public Safety and other departments as applicable to address sick leave problems and should specifically apply the policies negotiated by the Department of Public Safety to hospital staff who belong to units 1 and 10. The hospital and the Department of Health could also look into negotiating other policies with the United Public Workers that are similar to those negotiated by the Department of Public Safety. These steps would allow the hospital to strengthen controls over sick leave abuse.

High employee absenteeism results in excessive overtime costs

Staffing requirements force the hospital to fill absences by calling in other staff to work overtime. Consequently, absenteeism is directly linked to high overtime costs. In an August 1995 memo, the hospital administrator noted that overtime costs increased even as the hospital hired more staff, and stated that overtime must become the exception and not the rule. However, we found that overtime costs have remained high, and many staff earn large amounts of overtime payments.

Overtime costs remain high

Of the 626 hospital staff, about 250 receive overtime payments during a typical pay period, according to the hospital's personnel office. Overtime costs in calendar year 1996 were $2.3 million for staff overtime, and $1.5 million for contract nursing.

Hospital staff volunteer to work overtime, and have an incentive to work large amounts of overtime. Besides receiving pay at a rate of time-and-a-half for overtime hours worked, they also receive other premium payments as required by union agreements. The unit 1 and 10 agreements require that staff earn overtime if they are required to (a) report back to work with less than 10 hours of rest, or (b) report to a new shift with less than 12 hours of rest. They earn overtime for every hour

worked until the required amount of rest is granted. Staff who work more than 6 days without 24 hours of rest receive overtime for each hour worked until they rest for 24 hours.

Our review of payroll records covering a two-month period found that some staff earned a large amount of overtime payments in addition to their regular salaries:

- The top three overtime earners accumulated 40 or more hours per week in overtime—equivalent to an additional full-time shift.
- About 4 percent of the staff working overtime earned 30 hours per week or more in overtime payments.
- About 11 percent of staff working overtime earned 20 hours per week or more in overtime payments.

Moreover, we found that high overtime earners also earn significant amounts of premium payments in addition to their regular salaries and overtime earnings. We reviewed payroll records for the top 10 overtime earners and found:

- Over a two-month period, they received a total of 110.5 premium hours for reporting back to work with less than 10 hours of rest, or reporting to a new shift with less than 12 hours of rest.
- During the same period, they received a total of 188 premium hours for working more than six consecutive days without 24 hours rest.
- One employee received pay for 36 additional premium hours in each of two pay periods for working more than six days without 24 hours rest.
- One employee received pay for 24 additional premium hours in one pay period for working more than six days without 24 hours rest.

Supervisors in patient care units are frustrated because they cannot deny overtime to staff, even if they think that the overtime is excessive. In addition, supervisors do not have information on the total amount of overtime worked by their own staff because staff can sign up for overtime in other units. Staff sign up through the nursing office, and paperwork is filled out by the unit in which the overtime is worked.

Working large amounts of overtime negatively affects patient care and reduces efficiency. Reportedly, staff who work many overtime shifts in addition to their regular shifts become exhausted. Some staff are found sleeping on duty after working several overtime shifts. Abuse or neglect of patients after staff worked several shifts without resting has also been reported.

Constraints block limits on overtime

The hospital operates within the constraints of union agreements and the Department of Justice consent agreement. The justice department requires the hospital to meet minimum staffing requirements in its patient care units. In order to fulfill this requirement, the hospital must fill vacancies if an employee is absent. To fill vacancies, supervisors: (a) call in "floaters," who are hired to fill in for other staff; (b) call in regular staff to work overtime; or (c) call in contracted nursing staff. If the hospital calls in regular staff to work overtime, it must follow rules in the union agreements which specify the overtime rate of pay and the situations that require overtime pay.

The outcome of an arbitration decision on a grievance filed by the United Public Workers union has limited the hospital's ability to control overtime. Since July 1996, the hospital has allowed staff to work more than six consecutive days in a row. This is due to a grievance that was filed by an employee in unit 10 who was denied overtime work after working for six consecutive days. An arbitrator decided that the hospital should offer overtime to its staff before calling contract staff. According to a hospital administrator, the hospital and unit 10 need to clarify this requirement. This requirement will also apply to nursing staff in bargaining unit 9 when its collective bargaining agreement is settled. Because the requirement significantly affects the hospital's ability to limit overtime, we believe the clarification of this requirement should be a priority.

According to hospital administrators, the hospital might not have staffing problems if staff were required to work eight hours before receiving overtime payments. However, state administrative rules and union agreements allow staff to receive overtime payments even if they take leave during their regular shift. In other words, an employee can call in sick during a regular shift, work the following shift and receive payment for overtime following the shift.

The federal court required the hospital to implement requirements to address the problem. The court required the hospital to hire 20 floater staff by August 1996 to fill in for staff who are absent, and to implement by September 1996 a policy limiting overtime. The hospital did not meet the deadlines, but continues to work on both requirements. These initiatives should be vigorously pursued to decrease overtime costs.

Patterns of leave and overtime suggest abuse

Some staff who work large amounts of overtime take leave during their regular shift. Supervisors report that the following are common occurrences:

- Staff work overtime, then call in sick during their regular shifts;
- Staff call in sick, then work overtime when they return; and
- Staff on sick leave call their supervisor to ask if they are next on the list for overtime.

Our review of leave and overtime patterns for staff who earned the most overtime in a two-month period found 40 instances in which these staff took leave during their regular shift either before or after working overtime. Although this is allowed by state administrative rules and union agreements, it appears that staff are utilizing leave in order to be able to work more overtime. When staff take leave during their regular shift, other staff must be called in to work overtime. This creates a cycle of leave and overtime use that increases the costs of staffing the hospital.

Personnel policies are insufficient

The Department of Health does not give the hospital guidance on difficult personnel issues related to sick leave and overtime and hospital management has not implemented policies sufficient to guide its staff. Policies would help ensure that rules are consistently applied. This is especially important in addressing the most pressing problems with sick leave and overtime.

Hospital receives little guidance from the department

The department has no department-wide, written policies on sick leave, overtime, or progressive discipline. Without departmental policies, the hospital has little guidance and support in establishing its own policies.

Formal hospital policies are needed

Like the department, the hospital has no detailed, formal written policies on sick leave, overtime, and discipline. The hospital began drafting progressive discipline policies during our previous audit, but these policies have remained in draft form. Until the policies are negotiated with the unions and formalized, they cannot be practiced without challenges from the unions. Although it may be difficult to establish formal policies, doing so would provide more consistent guidance to staff and supervisors.

Informal policies are not effectively communicated to staff

The hospital asserts that policies and procedures are guidelines to direct action and ensure uniformity of behaviors. Without formal written policies on personnel issues including discipline, it is difficult to ensure that staff understand rules and that supervisors apply them consistently. The hospital administration is using other means of communicating guidance to staff, including memoranda and verbal instructions. Supervisors report needing clear written guidelines because many issues are ambiguous. They also report receiving conflicting information on personnel policies.

Probationary review has improved

Our previous audit found that new employees serving a six-month probationary period were not effectively screened during this period. Employees who received poor ratings or took leave without pay during probation were appointed to permanent status and continued to work.

In the current audit, we found indications that the hospital is now more willing to take action on probationary staff. We reviewed the personnel records of 20 percent of the staff who completed their probationary period during 1996. We found one case in which an employee had unsatisfactory performance ratings during the probationary period and the hospital fired the employee. The person was rehired after the union filed a grievance. However, the hospital extended the person's probation to one year. The hospital thus took actions to address the employee's unsatisfactory ratings during the period.

Evaluations of staff are deficient

The purpose of the State's performance rating system is to appraise the service of employees in the civil service system and to improve employee performance. To be effective, evaluations should be timely and should review whether staff meet all requirements of the position. However, the hospital has not ensured that staff are evaluated in a timely manner and has not established and enforced requirements for competencies. The Joint Commission on Accreditation of Healthcare Organizations noted these problems as deficiencies in its report on the hospital.

Feedback is not always timely

Supervisors are responsible for evaluating staff performance through timely feedback. The State's new Performance Appraisal System (PAS) requires supervisors to meet with staff at the beginning of the rating period to discuss expectations and set goals for the period.

Our review of a sample of 26 staff evaluations found that, in 50 percent of the cases, initial discussions of expectations occurred over one month *after* the period began. Also, over a fourth of staff had evaluations that were completed and discussed over a month after the rating period ended.

The hospital also reported that many evaluations in 1996 were turned in late to the personnel office. Over 25 percent were turned in during the next quarter of the year, or later. As of December 1996, 152 evaluations were outstanding.

Competency requirements are not applied

The hospital currently requires employees in direct care units to meet competency requirements. A competency is the ability to do a task which meets a current established standard. Examples include training in cardiopulmonary resuscitation and infection control. The hospital's competency requirements state that employees who are out of compliance with requirements should be placed on workplans, work only under supervision, and should not work overtime. We found that these requirements are not being applied.

Supervisors are responsible to place staff on workplans to remedy deficiencies if they do not meet competency requirements. They also should ensure that these staff do not work overtime. We found that the supervisors are not meeting these responsibilities.

We checked records of 40 staff earning the highest amounts of overtime during a two-month period. During this period, about a third of these staff were out of compliance with competency requirements in the first month, and half were out of compliance in the second month. However, their supervisors did not put them on workplans and allowed them to work considerable amounts of overtime.

Joint Commission noted deficiencies in staff evaluations

In its accreditation report, the Joint Commission on Accreditation of Healthcare Organizations found problems in the hospital's evaluations and competencies. The hospital received the lowest rating in these areas, which indicates deficiencies.

The hospital is working to update evaluations, and write competency requirements to address the commission's requirements. The hospital should continue to pay attention to staff evaluations and competencies after meeting the requirements, to ensure that the improvements are sustained.

Progress in Financial Management Is Mixed

Financial management controls are policies, practices, and procedures to ensure that funds are spent prudently for necessary goods and services, and that moneys received are properly safeguarded. Controls also help ensure that program objectives are met. With the State's tight financial situation and the hospital running a $2 million deficit for FY1996-97, it is particularly important to have these controls in place.

We found in 1995 that the hospital's financial management controls did not safeguard the State's assets. Responsibilities for the oversight and administration of purchasing and payroll were inappropriately split between the hospital and the Department of Health; consequently the hospital was unable to fully control costs.

In our follow-up audit, we found some improvements in controlling purchases and payroll functions. However, we found that the hospital still needs to improve processing of purchase orders, negotiations of contracts with the University of Hawaii, payroll duties, and the patient work program.

Management now reviews purchases

Our previous report found that the hospital's purchasing procedures were blurred because the Department of Health and the hospital shared purchasing responsibilities. The hospital's business office was responsible for reviewing purchase orders for accuracy only, not for content such as propriety, reasonableness, and least cost. The Department of Health's administrative services officer was responsible for approving a majority of the hospital's purchases.

In our follow-up, we found some improvements. In September 1996, the hospital hired a new business office manager and has increased management review of purchases. The business office now reviews purchase orders from the units for reasonableness, cost, and need. If questions arise, the business office contacts the wards about the purchase request before approving it and sending it to the hospital's associate administrator for review. After the associate administrator's approval, the purchase orders are sent to the department for processing.

Although the new procedures allow the hospital to more carefully scrutinize purchase orders, problems still exist in responsibility for purchase orders.

Hospital's authority over its purchase orders is weak

Sound financial management principles require management to be accountable for its purchases. In our previous report, we found that accountability was blurred because hospital management was precluded

from approving purchases for hospital operations. Although new procedures have been implemented by the business office, problems in the hospital's authority over its purchase orders exist.

Department continues to share responsibility for processing and approving purchase orders

We found that department administrators continue to be involved in the processing and approval of purchase orders. The hospital sends purchase orders to the department's Adult Mental Health Division for review because the hospital is anticipating a deficit for FY1996-97. Following the division's review, the department's administrative services officer conducts a review, approval, and transmittal of approved purchase orders to the Department of Accounting and General Services for review and payment.

We believe that hospital management should be authorizing all purchase orders. Hospital management is in the best position to know what is needed and what should be purchased. In addition, the process of reviewing purchase orders at the department level adds time to the process. This may be a critical problem when supplies are needed immediately.

Hospital has little input in University of Hawaii contract negotiations

The 1991 settlement agreement between the Department of Justice and the hospital requires the hospital to have an affiliation with the University of Hawaii. The hospital currently contracts with the university for psychiatry, nursing, psychology, medical, social work, and administrative services (totaling more than $3.5 million in FY1996-97). Although the hospital negotiates other contracts, it is not allowed to negotiate contracts with the university.

Our previous report found that the health department's Adult Mental Health Division negotiated the contract with the university on behalf of the hospital. In doing so, the division sought input from the affected operating units of the hospital. We recommended that professional services from the University of Hawaii be negotiated by the hospital administrator for better results.

During our follow-up audit, we found little has changed in this regard. The Adult Mental Health Division continues to negotiate the hospital's contracts with the university. The hospital provides informal input. Although the hospital superintendent has been requesting that the hospital be responsible for the contract, the division will not relinquish control of the contracts. We tried but were unable to obtain an explanation for this from the division.

We believe that the hospital administrator should have a greater role in negotiating the hospital's contracts with the university. The administrator should decide which services should be contracted, the parameters of those services, the timeframe of the contract, and the reporting obligations of the contractor.

New rules were established for the patient work program

The primary objective of the industrial therapy program is to assist patients in their recovery by preparing them for employment in the community by developing good work habits, interpersonal skills, and specific vocational skills. Patients can work in grounds maintenance, laundry, library, and hospital workstations if the attending physician approves and if a hospital employee is willing to supervise the patient. For calendar year 1996, a total of $43,700 was paid to the patients in the industrial therapy program.

In our previous audit, we found that supervisors did not properly review time sheets to track patients' work hours. As a result, some patients were paid for work that they did not perform. In addition, we found that patients were not properly supervised at their work sites. We recommended that the industrial therapy program improve its supervisory and recordkeeping controls.

Since that time some changes have been made. The industrial therapy program now falls under the hospital's Occupational Therapy Unit. Patients can work no more than 10 hours per week and 400 hours in one work area. After reaching the limit of 400 hours, patients must be moved to a new work area. Patients are allowed to work only during their supervisor's work hours. The program also adopted new payroll justification forms to track patient work activities.

New rules for patient work program are not always followed

These new rules were implemented to control costs and improve recordkeeping. However, the rules are not always followed.

Supervisors are responsible for completing payroll justification forms which should identify specific work activities in 30-minute increments. We reviewed these forms for 15 patients who worked in October and November 1996. We found at least one incomplete or incorrect payroll justification form for each patient. As a result, there is no assurance that the work performed by patients is consistent with their job descriptions.

As a spot check, we also conducted random visits to the patients' work areas to determine if patients and supervisors were performing their duties as required. On one of our visits we found that the patient left 10 minutes before the end of the shift. At another worksite the patient's supervisor left the patient with other workers for 10 minutes and dropped

off the patient's timesheet 30 minutes before the end of the shift. Our visits, while limited, suggest that supervisors do not fully ensure that patients work the entire shift and are under continuous supervision. Management controls over the industrial therapy program need to be strengthened to ensure that patients are properly supervised and are being paid for the hours they actually work.

Oversight and administration of payroll duties remains deficient

During our follow-up audit, we found that the hospital's oversight and administration of its payroll functions continue to be inadequate. The payroll process has not changed since our last audit. The department's administrative services officer still is primarily responsible for administering the hospital's payroll. As a result, inefficiencies continue.

Duplicative transcription continues

In our previous audit, we found that the hospital and the departmental Administrative Services Office were transcribing time sheet information. Twice a month, the office sends a batch of time sheets to the hospital's personnel office. Every regular employee's name, social security number, department, payroll number, and branch are preprinted on this three-part time sheet. The form does not include the employee rate of pay. The hospital payroll clerk manually records the overtime hours worked, the related pay codes, and total hours for overtime claims.

The Administrative Services Office receives these forms from the hospital and a clerk manually transcribes the same information to a duplicate employee form that includes the employee's rate of pay. The clerk manually computes the amount to be paid, and the office then reviews the form and sends it to the Department of Accounting and General Services for processing.

During our follow-up audit, we found that this redundant transcription of payroll information continues. Hospital personnel staff stated that payroll procedures are unchanged and no attempts have been made to remedy the situation. We believe that much employee effort and transcribing could be saved if the information were completed at the hospital and sent directly to the Department of Accounting and General Services for processing.

Controls Over Employee Meal Costs Have Improved, But Problems Remain

In December 1996, a memo informed hospital department heads of a projected $2 million deficit for the year and asked their assistance in restricting spending. They were told to "learn to say no to those things that are not an absolute necessity."[1] However, the hospital continues to serve subsidized meals to hospital staff that the State is not obligated to

provide to employees. The hospital has decreased the cost of these subsidies, but the subsidies are still significant and the hospital should reconsider them.

Subsidies are reduced and take-out containers are not provided

During the previous audit, the hospital raised the price of staff meals from 40 cents to $1.50. This move decreased demand dramatically, from about 64,000 to 33,000 meals per year. The hospital also stopped providing styrofoam take-out trays, which cost about $30,000 per year. These changes have decreased the subsidy for staff meals, from over $300,000 to about $170,000 per year.

Number of employee meals is not controlled

Although the hospital claims to limit the number of meals to one per employee (except for employees in patient care wards), we found no actual limits. The hospital said that only employees who work in patient care wards are allowed to purchase more than one take-out meal per person for other staff who cannot leave their posts. However, we found that food service staff do not check if staff who purchase more than one meal work in patient care units. Moreover, the cafeteria no longer requires staff who purchase take-out meals to sign a log. Thus there are no controls to ensure that the number of meals purchased by staff is limited.

In the previous audit, we noted wide variations in meal ticket counts (number of staff meals purchased), which affected food planning, preparation, labor, and costs. Meal ticket counts continued to vary widely during 1996, from 9 to 312 on weekdays, and from 8 to 142 on weekend days and holidays. Stronger controls on meal purchases could decrease the fluctuations and reduce waste.

Employees sell disposable trays

After the hospital stopped providing take-out trays, staff who purchased take-out meals were required to bring their own containers. A group of hospital staff began purchasing take-out trays on their own and selling them to other staff. This practice enables staff to easily take out meals, and further weakens controls over the number of meals purchased.

Meal prices are not comparable to prices at similar facilities

In 1995, the hospital raised the price of staff meals to $1.50, the median price at other Department of Health dining facilities. Since then, the other facilities have raised their meal prices while the meal price at the hospital stayed at $1.50. The median price for the other facilities is now $2.50.

The $1.50 that Hawaii State Hospital employees pay for meals covers less than one-fourth of the cost of the meals, which we calculated at $6.35. For this price, the staff receive a full meal, including dessert.

Inventory Controls Are Stronger But Are Not Consistently Applied

Supply inventories at the dietary, automotive, and housekeeping units are subject to waste, fraud, or abuse. The potential for loss is great, therefore control over these items is essential. In our prior audit, we found that inventory controls were inadequate. In our follow-up audit, we found that some improvements have been made, but further improvements are needed to account for gasoline and housekeeping items.

Inventory system for food supplies has improved

In our prior report, we found that the dietary unit ordered and re-ordered food supplies as needed. The unit counted inventory on hand at year end but these counts were not used as an inventory control. No inventory records were kept to compare the "in" against the "out" to determine whether the "in" inventory was short or items were missing.

In our follow-up audit, we found that improvements have been made in the dietary unit's inventory control procedures. Food supplies are accounted for on individual inventory cards. These cards show the balance, receipt, and issuance of each item. Monthly inventories also are performed for all food supplies. The dietary unit is now able to account for food items on hand, and the purchase and usage of each item. We encourage the dietary unit to continue its inventory controls over food items.

Lapses in procedures for gasoline use exist

The hospital operates 57 vehicles and has its own gasoline tank. This gas pump, which dispenses about 1,900 gallons of gas per month, is also used by Windward Health Center and Windward Community College.

In our prior audit, we found that the gas pump was run on an honor system. Drivers were allowed to pump their own gas and were expected to record the amount of gas pumped and the car license number on the daily gas log. Drivers from other agencies were expected to record the amount pumped on a separate gas receipt form and the other agencies were billed from these receipts. Our prior audit found discrepancies between the amount of gas actually dispensed and the amount of gasoline charged. The gas pump meter could not be reconciled to the totals on the daily gas logs and the other agencies' receipts.

In our follow-up audit, we found a few improvements but weaknesses in the controls over gasoline still exist. Improvements include eliminating the honor system and limiting operational hours of the gas pump. However, accountability for gasoline is still questionable and additional controls are needed.

Accountability for gasoline is still a concern

Some new controls have been established at the hospital gas pump but they are not consistently followed. The pump is now open only two hours per day, and is secured with a padlock when not in use. Only two individuals, both hospital mechanics, have the key to remove the lock and open the pump.

These controls require mechanics to pump the gas and fill in the daily gas log on which they are to note the vehicle license number, vehicle mileage, amount of gas and oil dispensed, and the vehicle driver. If the state vehicle is not from the hospital, the mechanic is responsible for completing the gas receipt.

The plant operations engineer reviews the logs and daily inventory sheets to ensure that the numbers correlate with the amount of gas pumped. The daily inventory sheet includes information on the gas pump meter readings and the amount of gas logged for each vehicle. The meter reading, and the amount of gas logged for the vehicles is to be compared to check for discrepancies in the recordkeeping of pumped gas.

We found that these procedures are not always followed. We reviewed the gas logs and daily inventory sheets for calendar year 1996. The total amount of gas on the gas log (gas pumped into each vehicle) should match the amount on the daily inventory sheet (gas pump meter reading).

In two instances, the daily inventory sheets were missing. In these instances we compared the gas logs to the gas pump's meter readings and found a discrepancy of about 40 gallons of gas in total for those two instances.

We also found other discrepancies. In 11 instances, the discrepancies were greater than 10 gallons for the day. The most common reason given was that a vehicle was refueled but not logged. In one case, there was a discrepancy of 13.8 gallons, and a note explaining the discrepancy stated that gas was stolen.

We also observed activities at the gas pump and found that standard operating procedures were not always followed. The procedures require the mechanic to fill in the gas log information. However, vehicle drivers

sometimes completed the log while the mechanic refueled the vehicle. Consequently, controls over the gasoline can be weakened and discrepancies can occur.

Controls are needed over gasoline credit card

We also found weak controls over gas purchased from a commercial gas station. When the gas pump is not operating, a commercial service station in Kaneohe can refuel the hospital's vehicles. The gas station maintains a credit card for the hospital. When a hospital vehicle comes in for fuel, the station will refuel the car and fill out a gas receipt. The vehicle's driver signs the receipt and is required to submit it to the hospital's maintenance office. The receipt should show the amount of gas pumped, the vehicle's license number, the dollar amount of the purchase, and the driver's signature. The hospital is then billed for the amount of gas that is purchased from the gas station.

We reviewed the gas receipts for the months of September 1996 to January 1997 and found that controls were insufficient to prevent abuse. The gas company bill notes only the total dollar amount owed, so the maintenance office can compare only the total owed the gas company to the total dollar amounts of the gas receipts.

Tighter controls are needed. The hospital should ensure that the gas receipt is completely filled out, investigate any unusual frequency of refueling vehicles, check the mileage the vehicle traveled between refuelings, and check the vehicle's license number to ensure that only hospital vehicles are being billed for using the commercial gas station. Instituting these controls would help the hospital ensure that fraud, waste, or abuse does not occur with the commercial gas station account.

From a review of the gas receipts, we found that 13 of the receipts did not note the vehicle's license number. As a result, there is no assurance that the vehicle was a hospital vehicle. The hospital needs to ensure that the vehicle's license plate number is noted on the gas receipt.

In two instances a vehicle was refueled two times in the same day. Because the vehicle mileage is not noted on the receipt or checked by plant operations staff, it was not possible to determine the number of miles the vehicle traveled that day or the destinations of the vehicle. A control is needed to investigate such circumstances to ensure that the hospital's vehicles are used for official hospital business.

We also compared the vehicle license numbers on the gas receipts to the list of hospital vehicles. One vehicle that refueled at the private station was not on the vehicle list. We were informed that the vehicle had been disposed of and the license plate stored under lock and key; the vehicle's

license plate number being on two gas receipts remains unexplained. In the future, to ensure against abuse, the vehicle license plate numbers noted on the gas receipts should be compared to the hospital's vehicle list.

We also found that gas from the commercial station was over twice as costly as gas at the hospital's gas pump. As of January 1997, gas at the commercial station reportedly averaged $1.65 per gallon. The cost of gas for the hospital gas pump was $ .71 per gallon. The hospital should consider limiting the use of the commercial gas station to emergency situations only.

Recordkeeping for linen and clothing supplies has gaps

The hospital's housekeeping unit maintains supplies of linens, towels, clothing, and personal items for the patients. The housekeeping unit issues these supplies to the patients' wards upon the wards' request.

Sound management practices require that inventory, purchases, and usage are recorded, and a continuous record of the inventory balance is maintained. Periodic inventory counts should be made and compared to the inventory balances in the inventory records. Differences can then be investigated and corrective action taken.

In our prior audit, we found that the housekeeping unit was not monitoring usage and not questioning unusual requests for these supplies. Also, we found the hospital lacked controls for street clothing issued to patients. Nurses at the wards simply called housekeeping and the clothing was issued. The housekeeping unit did not require the clothing to be replaced or returned, and it did not keep records of the clothing issued to the wards.

In our follow-up audit, we found that the housekeeping unit has tried to improve supply recordkeeping on hospital supplies. Our prior report recommended that the hospital strengthen its inventory controls by having appropriate recordkeeping that would include comparing inventory counts to check for abuse. In our follow-up, we found that the housekeeping unit developed new inventory sheets to account for these supplies.

Although the unit is using these inventory sheets to account for the supplies, accountability is still a problem. We conducted random inventories of items stored in housekeeping's storage area and found the inventory counts were not always accurate; issues of items were not always documented; and some items in storage were not on the inventory list. In one example, the inventory sheet listed 105 extra large tee shirts, but we counted 101 extra large tee shirts in storage, a shortage of 4 shirts. In another example, the inventory sheet listed 55 pillows on hand,

yet we counted only 52 pillows in storage. When asked about this difference, housekeeping staff stated that they recalled issuing 3 pillows but were unable to show the documentation for this. We also found 46 large muumuu's that were not listed on the inventory sheet.

Another problem occurs when laundry personnel go through the wards' soiled laundry and find torn shirts or pants that cannot be repaired. Laundry personnel get replacements from housekeeping's storage area. However, the issuance of these items is not noted on any inventory sheets. As a result, items will be missing when an inventory is done of the storage area.

We also found that when recycling worn towels into washcloths, the housekeeping unit is not accounting for the recycled washcloths. The number of towels recycled is subtracted from the inventory sheets. However, the number of washcloths produced from the old towels is not added to any of the inventory sheets to maintain an accurate count of supplies. Although recycling is an excellent practice, the hospital should maintain accurate inventory records of the recycled items.

Although the housekeeping unit is attempting to account for supplies, an accurate count cannot be achieved unless these problems are corrected. In addition, accountability of supplies must be maintained at the wards.

Wards do not keep records on inventories of supplies

The hospital wards receive supplies such as linens, towels, and clothing from the housekeeping unit. Wards also receive other supplies directly from vendors. Inventory controls should be implemented at the wards to ensure that supplies are not being wasted or abused.

Housekeeping supplies, such as linens and towels, are issued to the wards daily and are noted on an inventory sheet. Prior to issuing supplies, housekeeping staff go to each ward to determine the amount of clean supplies on hand. However, due to privacy issues, housekeeping staff are not allowed to check the patient locker or storage areas for supplies. Some patients may have extra linens or towels that will not be counted. As a result, there is no assurance that all supplies are being accounted for by housekeeping personnel.

Also, the wards do not keep inventories of housekeeping items and other supplies they receive and do not keep track of the number of items issued to each patient. Once the items are issued to the wards, accountability for them is lost. To maintain accountability, the hospital needs to implement inventory controls to track items from the housekeeping unit or vendor to the wards and to the patients.

Management Problems Posed by the Forensic Population Remain Unresolved

In our previous audit, we found that the increase in the forensic population forced the hospital to turn away non-forensic patients, and increased security costs. This population increased slowly during the late 1970s with the revision of the Hawaii Mental Health Law in 1976. The law made civil commitments more difficult, and court commitments increasingly have been used to remove disruptive individuals from the streets. The hospital still has a large forensic population, at about 69 percent of the hospital's total census.

The large number of forensic patients continues to cause problems for the hospital. Being forced to admit this population means that not all non-forensic mentally ill patients who need services can be admitted. The hospital limits admissions of the non-forensic mentally ill to maintain the Department of Justice census. Also, because forensic patients and non-forensic patients are placed together, the hospital has placed security guards in patient wards. This appears to have increased the hospital's security costs. In addition, there is little formal coordination between the Department of Health or the hospital with other state agencies or individuals involved in the decision-making process for critical aspects of care for forensic patients. Although some steps have been taken by the hospital, problems posed by the forensic population remain.

Deputy attorney general has been assigned to the hospital

To aid the hospital with its legal issues, including those related to forensic patients, the Department of the Attorney General assigned a deputy attorney general to the department's Adult Mental Health Division. Some of the attorney's responsibilities include: providing legal support related to the Department of Justice consent decree; obtaining permanent and emergency guardianship for the hospital's patients; assisting in obtaining involuntary treatment orders for criminal defendants; preparing and presenting cases for civil commitment and recommitment; and providing legal advice in disposition planning for patients. The deputy attorney general is also aiding the hospital in personnel issues. We encourage the hospital to continue working with the deputy attorney general to resolve its legal matters.

Transitional services have begun for forensic patients

In our prior report, we noted that the hospital was planning to provide transitional services for certain forensic patients who had been stabilized and could be returned to the community. The plan was for an independent contractor to provide these services in four cottages on hospital grounds. Patients would be closely supervised and receive therapy during their transitional stay in the cottages. This program was projected to open up about 20 beds for non-forensic patients.

In our follow-up audit, we found that these cottages have opened and transitional services are being provided. The capacity of the cottages is 14 individuals. As of February 1997, there were 7 individuals in the cottages. Another 16 individuals were on accepted status and awaiting discharge from the hospital. Before 14 of these individuals can be released into the cottages, the courts must provide a conditional release for them. According to one observer, the courts have been very slow in giving these releases. As a result, the cottages are not full and patients are put on a waiting list. Because forensic patients cannot be released from the hospital, beds do not open up for the admission of non-forensic patients. Despite these obstacles that are outside of the hospital's control, the hospital has made efforts to provide transitional services and return patients to the community.

Additional security is costly

In our previous audit, we found that hospital security costs increased because forensic and non-forensic patients were not segregated. This situation has not changed. Contracted security guards, responsible for maintaining security inside the buildings with regard to both forensic and non-forensic patients, cost the hospital about $540,000 per year.

Little progress has been made in coordinating with other agencies

The Joint Commission on Accreditation of Healthcare Organizations states that mental health institutions with forensic services must develop a mechanism to facilitate inter-agency communication with any agencies or individuals involved in the decision-making process for critical aspects of care. In our prior audit, we found that little formal coordination existed between the Department of Health or the hospital with other state agencies or individuals.

In our follow-up audit, we found that some progress has been made by the deputy attorney general in working with the Department of Public Safety. Formal coordination with other agencies is not so evident. Although progress in this area has been slow, we continue to encourage the hospital to coordinate with other agencies.

Recommendations

1. The Department of Health should provide stronger guidance to the Hawaii State Hospital in addressing its problems with sick leave and overtime.

2. The hospital should:

   a. require the proper completion of sick leave forms;

   b. require units to keep daily attendance records; and

   c. look into actions taken by other agencies to address problems with sick leave abuse and excessive overtime.

3. The hospital should consider centralizing scheduling of overtime.

4. The hospital should ensure that supervisors evaluate staff in a timely manner, and that all staff in direct care units who fail to meet competency requirements are placed on workplans, are directly supervised, and are prevented from working overtime.

5. The hospital should implement formal policies and procedures on personnel issues including sick leave, overtime, and discipline.

6. The hospital should continue its analysis of whether to centralize purchasing and receiving of all supplies.

7. The department should look into ways to shorten the review process for purchase orders, including bypassing the Department of Health's Administrative Services Office and sending purchase orders directly to the Department of Accounting and General Services.

8. The department should allow the hospital to have authority over University of Hawaii contract negotiations.

9. The hospital should change its payroll process to ensure that management reviews and approves payroll processes, and to assume more of the responsibility for these functions.

10. The hospital should ensure that supervisors in the patient work program properly complete payroll justification forms, and that patients are properly supervised in their work.

11. The hospital should raise the price of employee meals to at least equal the median price at other Department of Health facilities, and consider eventually moving to full recovery of costs. The hospital should restrict the number of take-out meals per person.

12. The hospital should ensure that:

    a. mechanics fill out gasoline logs properly, and supervisors investigate discrepancies between logged and pumped amounts;

    b. the credit account for gas purchases is used for emergency situations only; and

    c. wards keep inventories of housekeeping and consumable items, and are accountable for the items.

13. The hospital should continue efforts to work with other agencies to coordinate forensic admissions and releases.

Notes

Chapter 1

1. Hawaii, Department of Health, Hawaii State Hospital, *Strategic Plan 1995-96.*

Chapter 2

1. Memorandum to Hawaii State Hospital department heads from Bill Elliott, Associate Administrator, Subject: Fiscal Restrictions, December 26, 1996.

Response of the Affected Agency

Comments on Agency Response

We transmitted a draft of this report to the Department of Health on July 3, 1997. A copy of the transmittal letter to the department is included as Attachment 1. The department's response is included as Attachment 2.

The department says it is pleased that management of the Hawaii State Hospital has improved. The department concurs that many significant challenges remain, and says that our report seems objective and fairly presented. Its letter expresses overall agreement with our recommendations and a commitment to making improvements.

The department also says that the Hawaii State Hospital (1) finds our summary and findings agreeable but (2) has comments on some areas of our findings. The comments describe recent or planned efforts to reduce and restrict overtime; improve the staff evaluation process; develop competencies; control the cost of providing employee meals; and strengthen inventory control. The comments also include observations on other subjects discussed in our report, including review of payroll functions; responsibility for processing and approving purchases; and coordination with other agencies concerning the forensic population.

In response to one of the comments, we revised paragraph 2 of the Summary of Findings on page 7 of our report to more accurately describe the hospital's role in payroll administration. We also made editorial changes to address the department's concerns about our report's suggestion that security costs could be reduced by segregating forensic and non-forensic patients, an option that it believes would prevent the hospital from providing the most appropriate care to all patients according to their clinical needs. However, we wish to point out that our previous audit found other states segregating the two groups.

The department's response also offers an explanation as to why our report found that proper documentation for overtime payments does not always exist. When an employee chooses to take all or part of his or her overtime as compensatory time off, apparently the overtime report is separated for posting and filing. Therefore one or more of the employee's overtime reports may be separated from his or her records for a pay period. We agree that this could reasonably explain why we did not see the documentation, so we deleted our finding of a lack of proper documentation and a related recommendation. However, we cannot rule out the possibility of unjustified overtime payments, because the department based its explanation on its review of different pay periods

from the pay periods we examined in our audit. We also wish to note that separating overtime reports can make it more difficult to examine whether all overtime compensation was earned.

We made additional editorial changes for the sake of clarity and completeness, including revisions in our discussion of accountability for purchases and additions to our discussion of input into the University of Hawaii contract negotiations.

Attachments and an addendum that accompanied the department's letter of response are on file at our office.

STATE OF HAWAII
OFFICE OF THE AUDITOR
465 S. King Street, Room 500
Honolulu, Hawaii 96813-2917

MARION M. HIGA
State Auditor

(808) 587-0800
FAX: (808) 587-0830

July 3, 1997

COPY

The Honorable Lawrence Miike
Director of Health
Department of Health
Kinau Hale
1250 Punchbowl Street
Honolulu, Hawaii 96813

Dear Dr. Miike:

Enclosed for your information are three copies, numbered 6 to 8 of our draft report, *Follow-Up Audit of the Hawaii State Hospital.* We ask that you telephone us by Tuesday, July 8, 1997, on whether or not you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit them no later than Monday, July 14, 1997.

The Governor, and presiding officers of the two houses of the Legislature have also been provided copies of this draft report.

Since this report is not in final form and changes may be made to it, access to the report should be restricted to those assisting you in preparing your response. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

Marion M. Higa
State Auditor

Enclosures

ATTACHMENT 2

BENJAMIN J. CAYETANO
GOVERNOR OF HAWAII

LAWRENCE MIIKE
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P.O. BOX 3378
HONOLULU, HAWAII 96801

In reply, please refer to:
File: 42601

July 14, 1997

Ms. Marion M. Higa
State Auditor
Office of the Auditor
465 S. King Street, Room 500
Honolulu, Hawaii 96813-2917

Dear Ms. Higa:

SUBJECT: Draft Report: Follow-Up Audit of the Hawaii State Hospital

Thank you for the opportunity to provide a response to the above draft report. Overall, we are pleased that management of the Hawaii State Hospital has improved and agree that many significant challenges remain. The report seems objective and fairly presented. The Hawaii State Hospital finds the summary and findings most agreeable but feels compelled to offer comments on some areas of the findings.

Specific comments on the Summary of Findings follow:

1. A total of thirty (30) direct care nursing floater positions have been added over the past year. Twenty (20) full time floater positions (15 Registered Nurses and 5 Licensed Practical Nurses) were approved in the 1997 session of the Legislature. Twenty (20) half-time floater positions (14 Para Medical Assistants and 6 Registered Nurses) have also added. These positions will be used to reduce overtime and bring the Hospital into compliance with the DOJ Settlement Agreement.

   A policy and procedure that restricts the number of consecutive overtime shifts and restricts the number of shifts per work week was implemented on June 20, 1997. Attachment (A) refers.

A six (6) month status report was forwarded to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in June, 1997. On June 20, 1997, the Joint Commission acknowledged the Hospital was effective in addressing the three (3) Type I recommendations placed upon the accreditation of the Hospital. Attachment (B) refers.

All outstanding Job Performance Report (JPR's) and Performance Appraisal's (PA's) were brought up to date and individual competencies have been developed for all employees. Attachment (C) is representative of the type of competencies developed for each employee.

2. The statement "management does not review and approve payroll functions" does not accurately reflect the efforts in the personnel office. The hospital personnel office does an extensive review of payroll functions prior to submission to the Department of Health. The hospital agrees that review by management at all levels needs improvement, but does not agree that no review or approval of payroll functions take place at the hospital.

   The Department of Health, the Adult Mental Health Division, and the Hawaii State Hospital are committed to teamwork and collaboration in all areas. This includes the negotiations of the University of Hawaii contracts.

3. Meal pricing at the Hawaii State Hospital Dining Facility will be increased to stated median price per meal. The practice of take-out meals will be strictly controlled or discontinued.

4. Controls over the inventories cited will continue to be strengthened. A requirement for the wards to keep inventories will be implemented to ensure strict accountability.

5. Hawaii State Hospital views all admitted to the hospital as patients, without regard to their status (i.e., legal, voluntary, etc.). It must be remembered that "forensic" is not a medical diagnosis but a legal status.

Other comments on specific areas of the report follows:

Page 14, Chapter 2, section "Overtime is paid without proper documentation", second paragraph, comments follow:

The hospital does not know the specific two (2) month period reviewed. A review of records for February and March, 1997 indicated a similar percentage of records that lacked forms to match overtime hours on payroll sheets. This can be explained as a result of the employee electing Compensatory Time Off (CTO).

When CTO is elected, that portion of the overtime is posted to the CTO earned section of the payroll record. The overtime report reflecting that choice is then separated for posting to the individual's leave record. After posting, it is filed in the individual's separate CTO earning folder. An employee may opt to take CTO for an entire day's overtime earnings (i.e., 8 hours worked x time and half = 12 hours earned and elected as CTO), or they might opt for only for a portion (i.e., 8 x 1.5 = 12 hours, selecting 8 hours cash and 4 hours CTO).

In both of the above instances, the overtime report would be separated for posting and filing. Consequently, one or more overtime reports may be separated from the individual's records for each pay period. It is our belief that the above accounted for the "lack of proper documentation". No one in the hospital's personnel office could remember providing this documentation to the auditors.

Page 18, Chapter 2, section, "Department continues to share responsibility for processing and approving purchases," second paragraph, comments follow:

The review at the departmental level is necessary to ensure that proper policies and procedures are followed, such as obtaining Governor's approval for consultant services, the Chief Procurement Officer's approval for sole source services, and otherwise determining if purchases are in compliance with the procurement code. This review does not duplicate the Hospital's review in determining what should be purchased.

Page 27, Chapter 2, section, "Management Problems Posed by the Forensic Population Remain Unresolved", second paragraph, comments follow:

While the hospital agrees they still have a large forensic population, we disagree that we are simply forced to admit these patients. Hawaii has laws that permit the court system to commit patients for evaluation and treatment to the custody of the Director of Health for placement in an

appropriate institution. As additional continuum of care services are implemented, which were funded by the 1997 Legislature, we anticipate diversions to these less restrictive services. This will enhance cost effective use of resources, both at the hospital and community levels. There may be a lack of clear clinical indications for admission for some patients, but all of them meet legal criteria. Since Hawaii has a unique situation wherein there is only one state psychiatric facility, patients are sent to Hawaii State Hospital for evaluation and treatment. [See Addendum]

Page 28, Chapter 2, section, "Additional Security is costly", first paragraph, comments follow:

The hospital placed security guards in patient wards not because we have "placed together forensic and non-forensic patients". The use of security guards was initiated out of a need to provide additional safeguards to ensure the safety of out patients and staff from violent or out of control patients. The security guards are assigned to units where patients require more intensive monitoring or supervision. These wards have both forensic and non-forensic patients. We have eliminated the distinction between court ordered and non-court ordered patients, and assign our patients to patient care units or prescribe treatment interventions according to their clinical or behavioral status, and not their legal status. The hospital believes the assumption that forensic patients are violent, out of control, and require more supervision than non-forensic patients is not true. There are voluntary patients who are far more in need of monitoring and supervision than court-ordered patients. On the other hand, the hospital has a patient care unit which has 35 beds on an open ward wherein all but 5 patients have legal encumbrances. The forensic patients assigned to this open unit have improved to a level where they require less supervision and thus can be managed on an open unit without the use of a security guard. "Segregating" forensic and non-forensic patients will not reduce the cost of providing security guards but unfortunately will lead to the inability of the hospital to use its limited resources to provide the most appropriate care to all our patients according to their clinical needs.

Funds were approved during the past Legislative session that will allow the hospital to purchase a "duress system". The duress system is expected to replace the need for the security guards when installed.

Page 28, Chapter 2, section, "Little progress has been made in coordinating with other agencies", first paragraph, comments follow:

> We would like to reassure the State Auditor that we have an ongoing process by which we have established communication and coordination with other agencies outside of the Department of Health aimed at expediting the reintegration of our patients back to the community. These activities range from meetings with the new City and County Prosecutor, administrative judges on Oahu and the neighbor islands, Care Home Operators, etc. Hawaii State Hospital will continue to work with other agencies and interface with systems sharing the care of our patients.

Overall, we agree with the recommendations made by the State Auditor and are committed in continuing our efforts across the full spectrum of the report. These recommendations are viewed as a means to improving the quality of services to our patients and providing an environment where our staff can thrive.

Sincerely,

Lawrence Takamura

for Lawrence Miike
Director of Health

Attachments