TRENDS IN LONG-TERM CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-FOURTH CONGRESS

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- Part 4. Washington, D.C., February 9, 1970 (Marietta Fire).
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- Part 6. San Francisco, Calif., February 12, 1970.
- Part 7. Salt Lake City, Utah, February 13, 1970.
- Part 8. Washington, D.C., May 7, 1970.
- Part 9. Washington, D.C., August 19, 1970 (Salmonella).
- Part 10. Washington, D.C., December 14, 1970 (Salmonella).
- Part 11. Washington, D.C., December 17, 1970.
- Part 12. Chicago, Ill., April 2, 1971.
- Part 13. Chicago, Ill., April 3, 1971.
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- Part 15. Chicago, Ill., September 14, 1971.
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- Part 17. Washington, D.C., October 14, 1971.
- Part 18. Washington, D.C., October 28, 1971.
- Part 19A. Minneapolis-St. Paul, Minn., November 29, 1971.
- Part 19B. Minneapolis-St. Paul, Minn., November 29, 1971.
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- Part 21. Washington, D.C., October 10, 1973.
- Part 22. Washington, D.C., October 11, 1973.
- Part 23. New York, N.Y., January 21, 1975.
- Part 24. New York, N.Y., February 4, 1975.
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TRENDS IN LONG-TERM CARE

TUESDAY, DECEMBER 9, 1975

U.S. SENATE,
SUBCOMMITTEE ON LONG-TERM CARE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The committee met, pursuant to notice, at 9:30 a.m. in room 235, Russell Senate Office Building, Hon. Frank E. Moss, chairman, presiding.

Present: Senators Moss, Percy, and Schweiker.

Also present: William E. Oriol, staff director; Val. J. Halamandaris, associate counsel; William A. Recktenwald and David L. Holton, investigators; John Guy Miller, minority staff director, Margaret S. Fayé, minority professional staff member; Patricia G. Oriol, chief clerk; Eugene R. Cummings, printing assistant; and Dona Daniel, assistant clerk.

OPENING STATEMENT BY SENATOR FRANK E. MOSS, CHAIRMAN

Senator MOSS. The subcommittee will please come to order. I want to welcome all of you here this morning to the Subcommittee on Long-Term Care of the Senate Committee on Aging.

Today's hearing was set aside for an examination of the activities of State- or county-owned and operated nursing homes. In this arrangement, county and State-owned facilities receive reimbursement of Federal funds for the services they provide. Frequently, this system has been criticized for its inherent conflict of interest because the entity which owns the facility also has the responsibility for the inspection of it.

We had planned to examine the services of three county facilities in three States, but the number of witnesses and the time problems proved unmanagable. Instead, we have decided to limit today's discussion to an examination of the care and services of John J. Kane Hospital, a 2,200-bed nursing home in Pittsburgh, Pa. which is in many ways typical of all the problems we have seen in the nursing home field.

Kane Hospital was brought to our attention by the Action Coalition of Elders of Pittsburgh and by the Grey Panthers of Philadelphia.

The committee was introduced to a group of former employees from Kane Hospital who had written a report. The report was critical but full of hope for the kind of care that could be offered in the wonderful physical plant constructed in Allegheny County.

We were startled by the allegations of the report. The committee staff set out to learn whether the report was accurate and if the abuses were continuing. The staff answered the questions in the affirmative. Our investigator, Mr. David Holton, a licensed nursing home administrator, made nine visits to the facility in the past several months. Mr. Recktenwald made eight unannounced visits and Mr. Halamandaris made two visits. The committee staff interviewed current employees and examined inspection files.

Investigators Visit Kane Hospital

On December 1, the team of investigators accompanied by committee consultants, Dr. Robert Butler* and registered nurse, Margaret Cushman, met with the administrator of the facility and after securing his permission, completed a detailed inspection of Kane Hospital. At that time, the administrator, Mr. Edward Deverson, was informed of this hearing and invited to testify. By subsequent telegram and letter, I informed him of this hearing and of the nature of the charges and again invited him or his representative to be present here today.

As a courtesy, we have informed the offices of Senators Scott and Schweiker, Governor Shapp, and Congressman Heinz of today's hearing. We have also informed and received cooperation from Mr. James Flaherty, chairman-elect of the Allegheny Board of County Commissioners.

The U.S. General Accounting Office is currently undertaking a financial audit of Kane Hospital. When the audit is completed early next year, we may want to arrange a subsequent hearing.

I know that today's hearing will provide us with valuable information which we can use to influence legislation with respect to the care of the aged.

We have a number of very important witnesses to hear today, and I do appreciate the presence of those who have come, as well as those who have come to listen.

Our first witness will be Mr. William C. Cobbs, Sr., president, Action Coalition of Elders, Pittsburgh, Pa.

Will you come forward and be seated at the table here in front of that microphone, Mr. Cobbs?

If you have others that you want to bring to the table with you, you may do so.

Mr. Cobbs, before you begin, will you introduce the other people who have come to the table with you?

---

*On May 1, 1976, Dr. Butler was appointed Director of the National Institute on Aging. He also recently received a Pulitzer Prize for his book "Why Survive? Being Old in America."

Mr. COBBS. On my right I have Mary Lewin, a former employee of Kane Hospital and coauthor of the Kane report, Pittsburgh, Pa.; Joseph Nagy, former employee of Kane Hospital, coauthor of the Kane report, Pittsburgh, Pa.; Emily Eckel, former employee of Kane Hospital, coauthor of the Kane report, Pittsburgh, Pa.

Senator MOSS. Thank you very much.

We are pleased to have all of you here.

STATEMENT OF WILLIAM C. COBBS, SR., PRESIDENT, ACTION COALITION OF ELDERS, PITTSBURGH, PA.

Mr. COBBS. Good morning, Senators. My name is William C. Cobbs. I am president of the Action Coalition of Elders in Pittsburgh, Pa.

With me this morning are Emily Eckel, Joseph Nagy, and Mary Lewin, coauthors of the report we are presenting, and Harold E. Silverstein, corresponding secretary of the Action Coalition of Elders. With your permission we will present testimony and answer questions about the report before you entitled, "Kane Hospital, A Place To Die."* This report details many of the abuses and problems at Kane.

The Action Coalition of Elders is an alliance of nearly 30 organizations of older people in the Pittsburgh area. Several months ago the report, "Kane Hospital, A Place To Die," was presented to us. After careful study it was clear to us that the information in the report demanded an immediate, complete, public investigation. The conditions described in the report are terrifying examples of our society's structured rejection and isolation of old people. The crimes illustrated in these pages are intensified by the fact that Kane Hospital is a public institution. Most older people and their families in our area depend on Kane as the only available long-term nursing care they can afford. Kane Hospital was constructed by and is operated with, tax dollars from residents of Allegheny County and the Commonwealth of Pennsylvania and the Federal Government. The Allegheny County Board of Commissioners is directly responsible for the functioning of Kane.

The report describes Kane Hospital as local evidence of a national crisis. Americans have been relying upon the Federal and State governments to protect us from abuses in the entire long-term care system. For the last several years, your committee has examined the failure of the regulatory agencies to control this system. This report is another indictment of those agencies.

Because it indicts a public nursing home, the report must be made a public issue. We appreciate the subcommittee's response to our request to investigate Kane Hospital. We are looking forward to the continuation of these hearings that you plan to hold in Pittsburgh in January.

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* See p. 3321.

Long and Difficult Battle Envisioned

The Action Coalition of Elders views these hearings as the beginning of a long and difficult battle to stop the tragedies described in the report. This battle will require the support and participation of many people. We are confident that the battle will be won, and that older people in Allegheny County will be protected from these abuses.

Today, the three authors of the report will summarize its contents. Following that presentation, Harold Silverstein will describe the lack of adequate community services for older people in the Pittsburgh area that force people into Kane and lock them in once they arrive.

With your permission I will supply some background information about Kane Hospital. Almost 2,200 chronically ill and elderly people live at Kane. The county claims that it is the second largest institution of its kind in the United States. The hospital is located in a suburban area southwest of the city of Pittsburgh. It opened in 1958. Will the members of the committee please turn to page 7 of the report and take note of the diagram there? Kane is made up of an eight-floor tower which houses 480 patients who are declared to need skilled nursing care. The convalescent and infirmary areas are in long low buildings that stretch out from the tower. About 570 people, most of whom are said to be debilitated or terminally ill, are in the convalescent area. The largest number of people, over 1,000 are in the infirmary area. Kane Hospital claims these residents require skilled and intermediate nursing care.

In point of fact, as is noted on page 90 of the report:

> Most of the hospital's patients are over 65 years of age and suffer from a chronic, although not necessarily disabling, disease such as hardening of the arteries, diabetes, or emphysema. Other Kane patients are permanently disabled, some are in the terminal stage of their illness. All Kane residents are "medically indigent" and cannot afford care elsewhere. The hospital's annual reports show that the average length of stay at Kane is nearly 2 years. Although the expressed purpose of Kane is to rehabilitate patients, less than 200 patients are discharged each year. In the same period, over 1,000 Kane residents die.

That is a huge number. It must be reduced.

A great number of people have contacted us to offer support for our effort, and this was while A.C.E.'s phone number was not public knowledge. They had to search out various members to enlist aid for our effort.

Two of these people who did try to reach us were former employees. Many of them had relatives in Kane, and one is the head of the department at Kane Hospital.

Many of these individuals are willing to testify about their experience of the terrible conditions at Kane Hospital.

We did expect two of them to be here from Pittsburgh. They decided to come at their own expense. They would probably like to speak to the committee, if possible.

Mr. Chairman, I would like this report entitled "Kane Hospital, A Place To Die," made a part of the record.

Senator Moss. So ordered.

[The report follows:]

KANE HOSPITAL

A PLACE TO DIE

DISTRIBUTED BY
THE ACTION COALITION OF ELDERS
PITTSBURGH, PENNSYLVANIA

(3321)

FROM THE ACTION COALITION OF ELDERS

October 14, 1975
Pittsburgh, Pennsylvania

To the residents of Allegheny County,

The Action Coalition of Elders is distributing this report on John J. Kane Hospital because it demands a serious, public investigation. The conditions described in it are terrifying. Kane Hospital is a public institution, controlled by county and state officials. The quality of its operations are an issue of public concern and responsibility. The residents of Allegheny County pay for this institution and depend on it to rehabilitate their chronically ill parents and grandparents who have no where else to go.

The Action Coalition of Elders studied this document carefully and after much discussion voted to make it a public issue. The three authors of the report are prepared to testify under oath to the truth of their observations. In addition four individuals, current and former employees of the hospital have stated that the substance of the report is accurate. The issues and questions raised demand an open and complete investigation.

As a coalition of organizations of older people from the Pittsburgh area we are well aware of the hardships forced on us by this society. The quality of care at Kane Hospital cannot be separated from the quality of care provided older people living outside institutions. Again it is the responsibility of government officials to provide community services to help older people stay in their own homes as long as possible. They have failed to supply the level of services necessary to keep people out of nursing homes, and to keep them alive when they are able to leave nursing homes. Kane Hospital is a part of society's structured neglect of older people.

This structure must be changed. The Action Coalition of Elders calls upon the people of Allegheny County to join with us in our battle for this change. A.C.E. needs the support of community and professional groups concerned about a decent life for older people. Organizations and groups of older people are important allies in this fight. The Action Coalition of Elders is also anxious to talk to employees and past employees of Kane Hospital and the families of patients or former patients. All communications about conditions in the hospital are welcome. They will be kept in strict confidence.

Only by organizing a large public effort can the older people of our community be protected from the conditions described in this report.

Sincerely,

William C. Cobbs, Sr.
President
Action Coalition of Elders

ACTION COALITION OF ELDERS
P. O. BOX 7587
PITTSBURGH, PA. 15213
PHONE: 682-4501

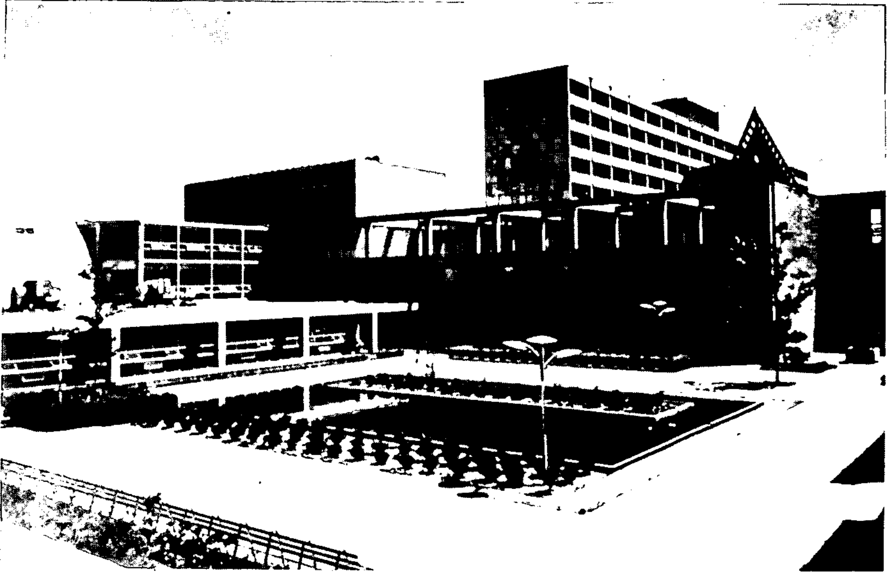
WOMEN LEFT FACING SOLARIUM WALL

PREFACE

Kane Hospital is a terrible place. We have written this report to draw attention to the inhuman conditions there. We are people who have worked at Kane Hospital over a two year period — two of us as nurses aides and the other as a social worker. Our efforts and the efforts of others to change the hospital from within have failed. With the contributions and help of people who live and work at the hospital, we have written this report. Some of these people fear they will lose their jobs or be mistreated if it is known that they talked frankly about the conditions at Kane Hospital. For this reason individuals who are quoted are protected by the use of only their position title or substitute names. We are hoping that a first hand account of conditions within Kane Hospital will create public outrage — enough outrage to force the Allegheny County Commissioners and the state and Federal governments to change their policies and improve the hospital.

But changing Kane Hospital is not enough. Growing old in the United States today is frightening. Nursing homes, like Kane Hospital, are only part of that fear. Small fixed incomes, lack of public transportation, poor housing, lack of social opportunities, and inadequate health services all add to the nightmare of becoming old. There is not much to look forward to after age 65. There are no special duties or jobs the elders of our country perform. Older people are excluded from anything important, and then told that they are burdens. This country fails to make available basic community and social supports older people need in order to live. The lack of these necessary provisions makes living in an institution or nursing home the only available living arrangement for many older people.

As we wrote this report outrage about nursing homes has surfaced in many places around the country. Likewise the terrible conditions many older people are forced to endure while living in the community are being publicized. More and more people are becoming angry — realizing that there is no dignified way for the great majority of Americans to grow old anywhere in our country.



THE EMPTY COURT YARD
KANE HOSPITAL

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INTRODUCTION TO KANE HOSPITAL

This report is about the results of putting people who are growing old in institutions. It is a description of one institution, the people who live there, and the people who operate and sustain it – John J. Kane Hospital. **Kane Hospital is a public, government-financed, extended-care facility for people who cannot afford private nursing care or care in their own homes. It is the second largest institution of its kind in the United States – housing nearly 2,200 elderly and chronically ill people.** The hospital is a modern looking facility, opened in 1958, and located in Allegheny County near Pittsburgh, Pennsylvania. It is part of the Allegheny County Institution District, and the Allegheny County Commissioners are in charge of its administration and supervision. In a 30 page pictorial brochure, published by Allegheny County entitled **Kane Hospital Cares,** the hospital is described as:

> one of the most advanced hospitals in the United States today for the care of the chronically ill and aging. . . It has achieved a national reputation in the field of rehabilitation and restorative care, and serves as a guide for similar programs in hospitals nationally. . . The goal of Kane Hospital is the restoration to health of the geriatric and chronically ill patient and his return to the community. [1]

Kane Hospital's annual reports reveal that of the 2,200 people housed in Kane Hospital, about 200 are discharged each year while nearly 1,000 Kane residents die each year. The average length of stay at Kane is nearly two years. This situation has existed unchanged for 10 years. Kane Hospital is failing to meet this goal.

The County Commissioners have alleged their personal concern for the aging citizens of Allegheny County in a letter from Commissioner Leonard Staisey included in the **Kane Cares** Brochure:

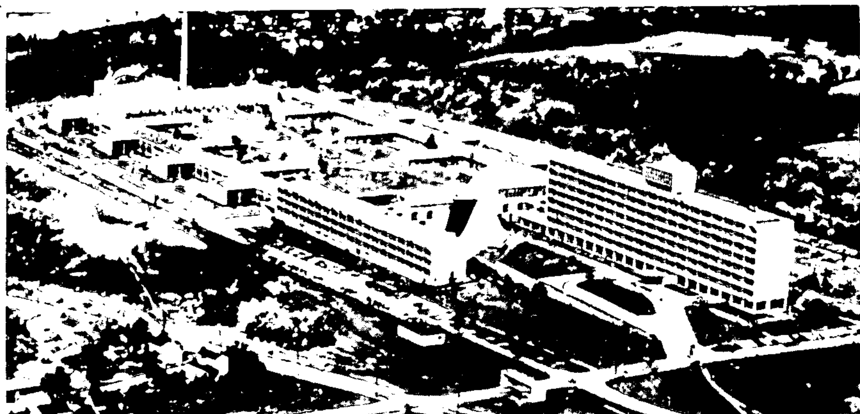
> It is my earnest wish that this brochure will introduce you to the wonderful things that are being accomplished at John J. Kane Hospital. I do not believe that county government has a more essential duty than to care at the highest level for our aged and chronically ill citizens of Allegheny County.
>
> Top rate medical services are provided, but more than that is the emphasis that is placed on the way in which they are administered. The medical executive director, the staff and volunteers have been instructed that in the carrying out of their duties, compassion for the patient must be the first order of every day. Sympathy and understanding are essential ingredients in treating and prescribing for these older women and men who may well have a feeling that society has forgotten them. At John J. Kane Hospital, one of the finest of its kind in the nation, these patients are not forgotten people.
>
> I do hope you will find time to visit this outstanding institution which really belongs to you, the taxpayer. I think you will find it worthwhile and I am certain the patients will welcome your interest.
>
> Sincerely,
> Leonard Staisey, Chairman
> Allegheny County Board of
> Commissioners [2]

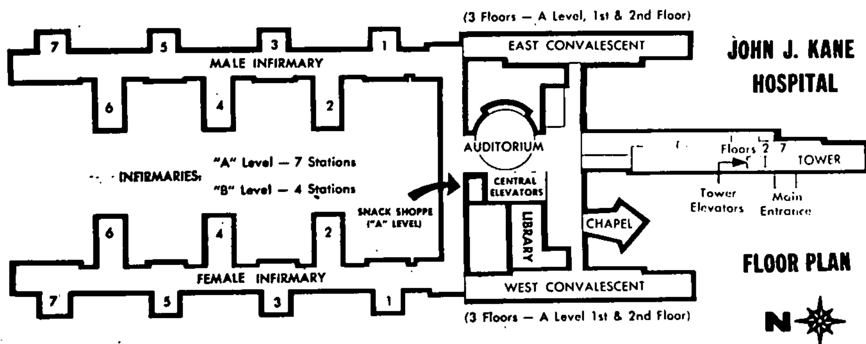
Patients Talk About Kane

The men and women who live each day confined in Kane Hospital describe their situation in a different way:

Social Worker: Mr. Myers, could you tell me a little about yourself.

KANE HOSPITAL: FLOOR PLAN AND PATIENT AREAS





TOWER — 480 PATIENTS

Houses the specialty clinics, the laboratories, the 130-bed Rehab Program, and patients requiring skilled nursing care.

CONVALESCENT — 576 PATIENTS

Houses mostly debilitated and terminally ill patients requiring skilled nursing care.

INFIRMARY — 1056 PATIENTS

Designed for independent and ambulatory patients — but is now used completely for patients requiring skilled and intermediate nursing care.

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Harry Myers: Well, where do you want to begin? What age? (he says humorously).

Worker: No particular age. How old are you?

Harry: 71.

W: Tell me a liitle about what you did for a living, what happened that you had to come here, what it was like coming into Kane. . . How did you feel about it?

H: To start off with, when I first started my workin career, I was driving a horse and wagon hauling coal and freight. . . my father and I was in the transfer business. And then later on, I started driving long distance freight. Then I stopped that and went into the race horse business and I was in that for 18-20 years, and done alright according to their standards, but got hurt a few times. Decided to get out a that and I went into trucking again. Then I went from there to road construction and operating heavy equipment. I was in that for a long time. Then at the end, I was in an automobile accident and got my hip broke, and I was sent to Allegheny General, and from there to Kane.

W: Who recommended that you come to Kane?

H: Well – I don't know definitely – I would imagine one of the doctors at Allegheny General.

W: When did you come into Kane?

H: In 1969.

W: What were your impressions of the hospital when you came? Tell me about the care you receive here.

H: **I don't get much medical attention here. I only took medication for a couple a months, when I first got here (5 years ago), and I've never received any since. . . seeing the doctor. . . Well, that's been a rare occasion. I only seen him three times while he was on duty here and there wasn't anything mentioned about the hip or anything. He just wanted to know how old I was and how I was feeling. And it was just written down, I never moved out of the wheelchair.**

W: How long has it been since you've seen a doctor?

H: I haven't seen or had any discussion with a doctor for a year and a half.

W: What happened at that examination?

H: Nothing really, because he needed a doctor about as bad as I did. He just asked me three or four questions and wrote something down on my chart and said "good-bye".

W: You talked to me the other day about the way the hospital staff treat the patients.

H: I guess a lot of poeple wouldn't call it abuse – but its quick, rough handling of patients that are not fit and not capable of moving fast, or anything like a healthy, able-bodied person. And they're not too careful about helping you into bed at night either – they don't take very much time about that. They want you in there in a hurry. . . and they lots of time don't use the best language. The other thing is the stealing. It goes on every day. If you have anything of any value or possibly with any use to someone else you better keep it right with you, or you're not goin' to have it.

W: Who do you think is doing the stealing?

H: Employees. . . usually. (He goes on to tell several incidents of theft.) . . .A birthday card with five dollars in it from my son. It had been torn open and the money taken out before I even got it. . . they tore my mail open, which is not in the book according to the law. . .

W: You said a few days ago you were unhappy here.

H: Well, it's a little like Bing Crosby's song "Don't Fence Me In" – and that's what I am. You can't go no place – no place to go. And it's a little tiresome looking at the same faces, going through the same action, the same routine 365 days a year. It gets a little tiresome after a while.

W: Mr. Myers, tell me something. When you go into the "mushroom" corridor, you see lots of people just sort of staring into space – not talking to each other. Why is that – why don't people talk more to each other?

H: Well, I suppose. . .I don't know. It don't seem like their mind's on any one topic or subject of interest – a hobby or what have you. People seem to rather sit and think about whatever they're thinking about – I don't have any idea why that is.

W: What do patients see as the reason for their being at Kane?

H: I would say quite a few of them are here because they don't have any other place to be. It's certainly not because they want to be here.

W: You said something the other day about them seeing it as the last stop.

H: Yeah, I feel that way about it myself. And I know there's lots of others who feel the same way. . . high bridge (he gestures with his hands).

W: High bridge?
(He hesitates. I ask him to tell me, to tell me in words.)

H: End it all, get it over with. Get to the happy hunting ground. And then stay there and you're out of your worry and misery.[3]

Since this interview, Mr. Myers has died. He was not eating well for several months and began losing weight. The nursing personnel took no action. His legs and feet became swollen to twice their size. The doctor responsible for Mr. Myers' care minimized his medical problems despite repeated requests from a social worker to re-evaluate his condition.

Mrs. Kate McAlberts entered Kane in 1967. She was born and raised in the South and was educated at a prestigious southern college, majoring in English literature. Mrs. McAlberts, her husband and two children eventually settled in Pittsburgh, where she worked for several years at a school for handicapped children. Mrs. McAlberts has had a stroke, which left her left side stiff, numb, and hard to move. She also has arthritis, from which three fingers on her right hand are badly crippled. Now she wears a brace on her left leg, and her left arm, which is paralyzed, is bent at the elbow and held close to her body. In the following interview, Mrs. McAlberts describes living at Kane Hospital:

Kate McAlberts: When I first came in I was terribly unhappy. I cried and didn't see how I was going to make it. I stayed in my room and wouldn't do anything. I slowly began to realize that I might be spending some time here. I saw how most of the other women sat staring at the walls and each other – and decided I had to force myself to begin moving around and taking part in as many things as I could. I try to keep my mind off things. . . how horrible it is around here. I have to keep myself up and moving. It's hard and it's painful, especially when I get these sores on my good foot, and you know I sometimes have trouble moving this good leg 'cause of arthritis, but if I were to stop trying, I'd reach a point where I wouldn't be able to do things for myself, and I don't want to be in that position. **I see other patients who are dependent on the aides and nurses for things and lots of times they don't get the help they need, like taken to the bathroom, that sort of thing. . . On my area there are patients who give aides cigarettes or storebook coupons. This is a way of making sure they'll get the things they need and be treated half-way decent. . .**

You know, Nancy used to be able to walk. She had to walk real slow and careful. There were a couple of days about a year ago when Nancy was dizzy and had an upset stomach. She wanted to go to the drinking fountain and she needed help. Nobody gave her help and she fell. She's been in a wheelchair ever since. Nancy seems so shaky and scared all the time. I think it has a lot to do with her falling the way she did.

W: What medical care do you get?

K: The toes on my good foot sometimes get these sores on them, and it makes it hard for me to walk. I've been asking to see the foot doctor for about a week now and I can't get anybody to take me up. So they give me aspirin, but that doesn't help much. When I ask, they tell me they're not sure if the doctor's in today. I've been down here about 2½-3 years, and I can remember going upstairs once to see the doctor – that's when I cut my leg and he put some ointment on it. You know that doctor is in his 80's. He can't

see what he's doing, he can't hear very well and he really doesn't seem to know what he's doing.

W: Does the doctor ever come down here to see the patients?

K: No, I've never seen him. He should, it would be a lot better. The aides don't have time to take every patient all the way upstairs. If a patient can't make the walk to the steps from here and then up that long flight of steps, it means that the nurses aides have to travel half-way around the building to get to the right floor to get to the doctor. That's a lot of hard leg work and a lot of time spent in taking just one patient up. And then sometimes I don't think the doctor is there.

W: What about the nursing supervisor – does she make daily rounds and try to see patients?

K: Well, I sometimes see her walk through but she doesn't talk to patients. [4]

Mrs. McAlberts died a few months after this interview took place. She had been complaining of having pain and stiffness in her right leg. In trying to get out of her wheelchair, she slipped and fell and broke her leg. She never recovered.

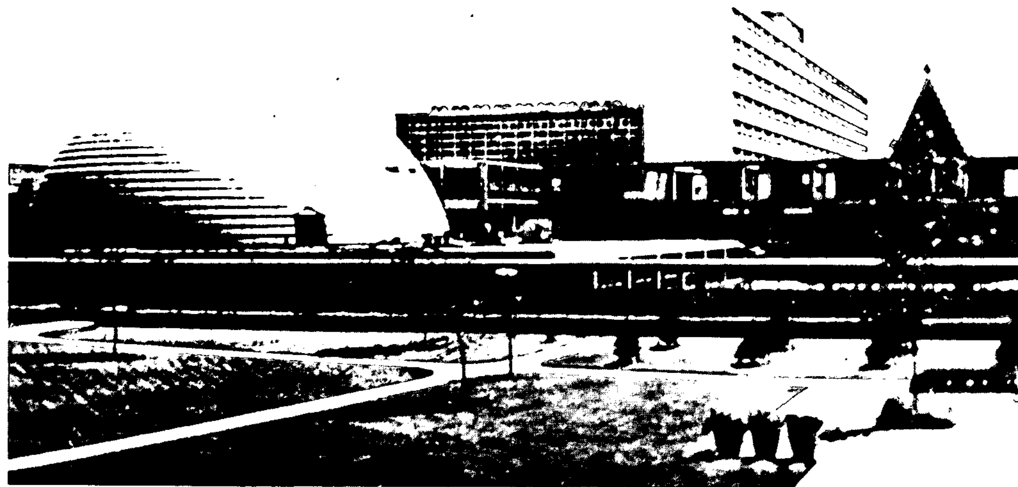
Another hospital resident wrote a letter to the **Pittsburgh Post-Gazette** about the conditions at Kane Hospital. It was published as a letter to the editor on November 16, 1971. She is still at Kane Hospital and feels little has changed since she wrote the letter.

> I am an educated woman having graduated from Pitt in 1929. I am writing this letter for public consumption. Due to a stroke, I landed at Kane and must say it is terrible. We do not get one good meal a day. If the patients received as much attention as the grounds, it would be okay, but we do not get any attention at all. As I am partially blind I cannot compose nor write a decent letter. We need you. Please publish this letter so the public knows how their tax money is being wasted. This is a horrible place to have to spend your time. Much of the food goes into the garbage. No one can eat it. Please excuse the writing as my eyes are so bad I can't see. Your help in this matter will be greatly appreciated. Something should be done but what I do not know. [5]

The publication of this letter in the **Pittsburgh Post-Gazette** was followed by these events. A high-ranking administrative official ordered a re-evaluation of her admission file to determine if she could be dismissed from the hospital. Prior to her admission in 1969 there was a question about her financial eligibility. It was thought she was in possession of property that would prevent her placement in a public facility. Negotiations, however, between her lawyer and the admissions department resulted in her admission on the condition that when the property was sold, she might have the financial resources to get care elsewhere. This matter had not been investigated for two years, despite the patient repeatedly expressing interest in leaving to various hospital employees. Then on December 9, the County Solicitor was directed to contact the family's lawyer to determine if the patient's financial resources made her ineligible for care at Kane. This proved ineffective. On December 28, she was transferred to one of the most inaccessible and depressing areas in the female infirmary wing of the hospital. Finally, on January 2 a psychiatric evaluation was ordered to determine if the patient could be committed to a state mental hospital. The psychiatrist's report reads as follows:

> This 62 year-old lady is said to have written articles to the paper criticizing food, etc. She is also said to create dissension, etc. on all levels. Mental status reveals good cooperation, coherence, and relevance. Questions were answered directly and there was no indication of blocking or of association disorder. There was superficial indication of paranoid ideation. Insight was adequate and judgment superficially appears adequate. There was some indication of concretism. She seemed oriented and there was some indication of memory disorder superficially. . . In my opinion, this patient has Organic Brain Disease involving the right cartoid and right middle cerebral artery. There was the suggestion that this might be associated with paranoid behavior at this time. Would recommend continued Dilantin, physiotherapy and present management. I do not feel that this patient is commitable at this time.[6]

The hospital administration and staff have responded in threatening, punitive ways when patients, patients' families, or staff criticize the hospital. Patients are given psychiatric evaluations and moved to



"If they took as good a care of the patients as the grounds, it would be all right."

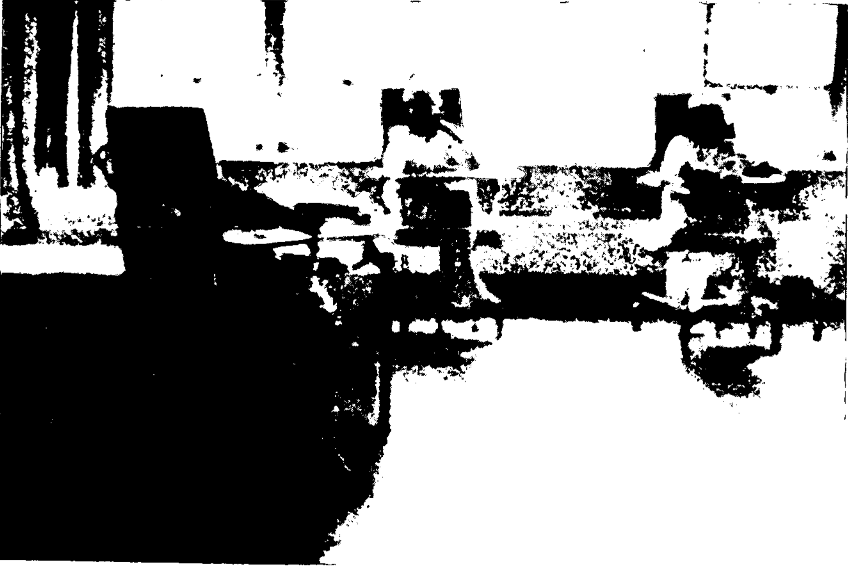
Kane Patient
Letter to the Editor
Pittsburgh Post-Gazette

less desirable areas of the hospital. Families are told, "if you don't like it here, put her somewhere else." Hospital staff are threatened with the loss of their jobs and told they have not learned to accept death and suffering.

An Aide Talks About Kane

A female nurse's aide describes the working conditions at Kane Hospital:

> I feel a responsibility to talk about what it is like to work as a nurse's aide at Kane Hospital. I think the neglect and abuse of patients are a product of the situation aides are forced to work in. I think people have to become callous and insensitive to get through week after week of work at Kane Hospital.
>
> **I found the nurse's aide training at Kane inspiring. Most of the other people in my class of trainees did too. But, when we were sent out on the floors during training, we would come back shocked and upset by what we had seen.** We discovered there weren't enough wash basins, sheets, laundry, bedpans, urinals, linen, catheter plugs, and silverware. We discovered that things were done very, very differently on the floor than in class. Diet cards were often neglected. Mouth care was unheard of, as was sterilizing bedpans; cleanliness procedures for connecting and unconnecting catheters were often disregarded. As a group, our class talked about what we could do. We decided that if we could be assigned to areas in groups of two we could be stronger and do things as they should be done. None of us wanted to be disliked by everyone that we worked with. If we could be assigned with someone else who wanted to do their job well, it would be a little easier to resist the shortcuts. We sent a request to the nursing administration and we were turned down. So we were assigned to areas alone.
>
> When I was assigned to my regular area the impact of the lack of supplies and lack of nursing staff really hit me. It was physically impossible to do the job that I wanted to do. If we washed every patient that wet themselves we would not have time to get the rest of the work done. Taking a patient to the bathroom means lifting them several times. It is much easier on your back to just move their chair and mop the puddle. The work was very tiring and every aide had a sore back. We used to talk about support hose and girdles during our breaks. The lifting we were required to do day after day, especially around bathing, took a toll on everyone. We were always careful to lift like the people from the "rehab" department taught us to, but it didn't help much. Often I would go home and be so tired and sore that I would eat supper and go right to bed. It's hard to work here. . .
>
> Aides watch people sit and stare day after day. Aides watch people lose their ability to talk and participate in the world. We have to be with people who are unhappy and have no more chances. Aides watch people die alone and have to handle the bodies. So, Debbie says to me one day, "All these patients disgust me" but the next day she says "we must really frighten these people, the way we walk up to them and strip them naked and stand them up, it must be like a bad trip." Yet she tells Mary, a patient, if she doesn't 'stop whimpering' she will make her 'eat shit'.
>
> Aides have to do the monotonous work of making beds and serving meals, cleaning up, mopping puddles, lifting, moving, and bathing people who have difficulty caring for themselves. . . I was treated like I was dumb and I felt dumb. We had to be servile to our superiors, many of whom obviously didn't take their jobs seriously. Aides have to do things that could get them fired, when a superior tells them to. We take the risk when isolation technique is not done, but the decision is not ours. Aides have nothing to say about how things are run, and yet we have all the day to day contact with the patients and do all the dirty work. . .
>
> As an aide I averaged between $60-$65 for a week in take home pay. Aides are told in many small ways that they are worthless people who are insensitive to sad and terrible things. Aides know that words of concern about patients from the administration are hollow lies. It is clear there's little concern for the patients. . .
>
> Every aide I met worked for financial reasons. Every one said they would jump for a better or even equally paying job somewhere else. **My anger is at the situation that changes people who come out of training wanting to do what is right for the patients and end up having to make themselves callous to be able to face an impossible situation day after day.**[7]



WOMEN CONFINED IN GERI-CHAIRS

The nurse's aide goes on to describe the floor on which she works:

> A lot of people on my floor are tied with restraints in geri-chairs. Geri-chairs are like the high chairs babies eat in, except they are for adults. They have foot rests and trays that clamp around a person. Once someone is clamped in, they can't move around or get out. Geri-chairs have roller wheels so the nurses aides can move people to where they want them. About one-quarter of the people at Kane Hospital are confined in geri-chairs all day long. People who have difficulty walking or are troublemakers, are kept in geri-chairs. They are lined up in hallways, against walls and around tables. Often they stay in one place all day long. Often the staff doesn't have time to make regular bathroom trips with all the people on the floor, so geri-chair patients sit in wet and dirty clothing.
>
> Frances Adams — very weak. Could walk with one assistant. Was developing bedsores. Didn't talk too much. Sometimes was put to bed in the afternoon.
>
> Geraldine Proter — Did not talk much around the staff. Didn't trust them. Couldn't walk. Would go to the bathroom if helped, but won't ask to go. She does not like to depend on anyone.
>
> Mary Miller — Can walk well. Never taken to the bathroom. If she gets out of her geri-chair, she will let other women loose. Does not like the hospital.
>
> Elsie Sawer — Called "Big Elsie". Disoriented. Can not walk. Usually incontinent. Bedsores developing. Is sometimes moved to the solarium and given a cigarette.
>
> The usual dress for women is a white hospital gown and a pair of white sweat socks. No underwear is used. The geri-chairs are in very bad condition. They are sticky with urine, food and saliva. They are seldom cleaned. Most of the foot rests are stuck. It takes

"Many patients could be discharged if suitable supportive and home care were available in Allegheny County. . ."

"Kane Hospital Cares" Brochure
Allegheny County Bureau of Public Information

> months to get anything repaired at the hospital shop, so a lot of the women sit with their feet dangling all day long. This cuts circulation to their lower legs, causes their foot arches to drop, and leads to a loss of strength in their legs. Patients confined in geri-chairs and not given any exercise, soon lose their ability and desire to walk. . .[8]

Failure In County Government

Irvin Foutz, Director of Social Services and Admissions at Kane acknowledges that Allegheny County has "institutionalized 8-10% of its aging population, while nationally 5% of the over-65 population has been confined in institutions. . .even 5% is too high a figure to have institutionalized. . . but it's easier to do than set up home maintanence programs. . . probably only 2% of the aging population needs to be in institutions."[9]

According to a study by the Health and Welfare Association of Allegheny County (HWA) released March, 1974, Allegheny County had missed out on Federal money that could have been used to help its elderly citizens outside of institutions. Edith King, director of the HWA study, said the exact amount the district has failed to apply for has not been determined:

> Of five federal educational programs for the elderly, carrying a possible $44 million, none was applied for from 1971 to 1973.
>
> Of three possible sources of funds for health facilities for the elderly, carrying a possible $2 million, none was applied for.
>
> Of nine possible federal sources of money for specialized housing, including nursing homes, none was applied for.
>
> Part of the problem is that we have no organizational framework based on the needs of the elderly which would allow us to designate amounts of money needed in various categories.[10]

The result, according to the study is the widespread neglect of the health, social service, recreational, transportation, and other needs of the County's 186,000 older residents.

More surveys and co-ordination of services will not reverse this situation. New and expanded programs must be developed. Social and community ties must be preserved as people grow older. The Pennsylvania State Institution District Act revised in 1965 requires that:

> County Institution Districts must provide or contract to provide services to help dependents and potential dependents to live outside County Institution District facilities.[11]

Allegheny County has failed to provide such opportunities for its older citizens.

In the 1971 Kane Hospital Cares **brochure county officials acknowledge that "many (Kane Hospital) patients could be discharged if suitable supportive and home care programs were available in Allegheny County."** [12] **These needs of older persons recognized by County government over ten years ago remain unmet. The County Commissioners have failed to appropriate the necessary funds to support older citizens in the community.** In 1973 less than $500,00 was budgeted for Adult Services (Allegheny County's community-based services to older people) while $7.5 million of county funds was budgeted for Kane Hospital. Additional federal and state monies increased the Kane Hospital budget to $15 million annually (1/10 of the entire county budget) while

1973 FUNDS
Approximations

County Department	Total	Federal and State	County	Other
Mental Health/ Mental Retardation	$23.3 million	$16.9 million	$ 1.4 million	$5.0 million (user fees)
Adult Services	$ 1.5 million	$ 1.1 million *	$ 467,000	
Child Welfare	$ 7.5 million	$ 4.0 million	$ 3.5 million	
Health	$10.8 million	$ 6.0 million	$ 4.0 million	$ 700,000 (license fees)
Kane Hospital	$15 million	$ 5.0 million *	$ 7.5 million	$2.5 million (mostly fees)
Office of Economic Opportunity	$ 1.3 million	$ 1.1 million	$ 230,000	
Manpower	$ 2.3 million	$ 2.3 million		
Totals:	$61.7 million	$36.4 million (59%)	$17.1 million (28%)	$ 8.2 million (13%)

* Note: while administered through the Pa. Dept. of Public Welfare, most of these funds originate at the federal level.

ALLEGHENY COUNTY SOURCES OF INSTITUTION DISTRICT FUNDS

ALLEGHENY COUNTY PROPOSED EXPENDITURES – 1975

Allegheny County Government 1975 and how the money is used.

County Police & Police & Fire Training
Cultural & Charities $2,704,000.00
Election & Voter Registration
Adult Welfare $1,367,580.12 0.7%
Child Welfare Services $8,780,260.84
Port Authority - Operations $5,975,000.00
Community College - Operations $11,300,000.00
Correctional Institutions - County Jail
Airports
Parks & Recreation
Maintenance - Roads & Bridges
Elective Offices
Courts & Related Offices
Health Dept. Services
Mental Health & Drug Rehabilitation
Kane Hospital less benefits
Debt Service
Administration
Miscellaneous
Employee Benefits $11,800,000.00

1975 BUDGET

COUNTY	$159,404,022.05
INSTITUTION DISTRICT	31,420,884.71
TOTAL	$190,824,906.76

Chart prepared by Nicholas Stabile, Budget Director, Bureau of Accounts and Statistics, Allegheny County, Pennsylvania

Adult Services' total annual budget was only $1.5 million. The Commissioners' budget ten times the amount of money for Kane Hospital than is budgeted for all the county's community-based services to the elderly.[13]

These figures indicate where the Allegheny County's priorities for older persons lie. The figures contradict the Commissioners' assertion that "county government does not have a more essential duty than to care at the highest level for our aged and chronically ill citizens of Allegheny County."[14] Providing many older persons in this county with no other choice but institutionalization at Kane Hospital is not providing the highest level of care for the aged and chronically ill citizens.

In Pennsylvania, county government is responsible for providing both community-based and institutional services to older persons. Medicare and Medicaid reimburse county governments in Pennsylvania for providing institutional services required by law. Both the Federal government and the Pennsylvania state government have established guidelines and regulations for these programs. Kane Hospital must comply with Pennsylvania Department of Public Welfare regulations, Federal Health, Education and Welfare (HEW) regulations, and the Life Safety Code of the National Fire Association. These government regulations define minimum acceptable levels of care, services, and personnel, provided in nursing care facilities. In some areas these regulations are weak, but for the most part the existing regulations clearly define the minimal treatment patients have a right to expect when entering a government operated, long-term care hospital or nursing home. **There are over 100 pages of government regulations which apply to Kane Hospital. Kane Hospital is in violation of over 80 sections of these regulations.**

What follows in this report is an in-depth look at Kane Hospital. The report describes how the older people confined at Kane Hospital must live in degrading, humiliating and inhuman conditions. It shows the services provided at Kane Hospital to be inadequate and in violation of Federal and state standards. The report explains Kane Hospital and the County Institution District as a source of patronage and political power for the Allegheny County Commissioners. This document is a call for all of us to demand and work toward changing these unacceptable conditions.

ADMINISTRATION OF KANE HOSPITAL: A FAILURE IN COUNTY GOVERNMENT

Kane Hospital is administered by Allegheny County. The three elected County Commissioners are responsible for its functioning, and they are required by law to maintain Kane Hospital "in compliance with the applicable laws and regulations." They have failed to do this.

Instead, the County Commissioners have minimized the hospital's budget at the expense of the health and safety of Kane residents.

Under Budgeting Kane Hospital

While publicly denying that Kane Hospital is understaffed, the County Commissioners have consistently allowed too little money to staff the hospital. Low salaries compared to other hospitals, and the large work load makes it difficult to attract and keep qualified people for the positions that are budgeted. Year after year, essential vacant positions go unfilled at Kane Hospital. The Rehabilitation Department is understaffed to the extent that it cannot provide the ongoing rehab and restorative treatments for 600 to 1,000 of the Kane residents in need of these services. Counts of employees during working hours show the lack of nursing personnel.

Clear and complete employment records that would show the Kane Hospital staffing patterns are unavailable. Such records have been denied union representatives during contract bargaining with the County Commissioners. Part-time nursing personnel, part-time high school students and untrained "limited aides" have been used to falsely inflate the full-time staffing figures at Kane Hospital.

It has been asserted by many people that Commissioners Staisey and Forrester maintain ghosts on the county payroll, further confusing the staffing situation. Minority Commissioner Hunt during this year's primary election stated he could not find "15 to 20 percent of the employees on the county payroll."[1]

Supervisory personnel have stated that employees who resign but do not submit letters of resignation are kept on the active payroll. Employees consistently absent from work (some only working 3-4 days a month) are maintained on the payroll. All of these practices cover-up the lack of hospital personnel and enable Kane to "pass" Federal and state inspection.

In addition to under budgeting for staff, **the County Commissioners have consistently under budgeted essential services, equipment and supplies to the hospital.** Thus:

1) The laundry is operated only Monday through Friday, creating a clean linen shortage every weekend.

2) There is a daily shortage of linens, towels, pillow slips and clothing in the hospital due to the short supplies actually in use.

3) There are not enough wheelchairs in the hospital.

4) Food is not appetizing and is of low quality. Menus are repetitious.

5) Recreational equipment is unavailable and activities programming is infrequent.

6) At times, personal supplies (bedpans, combs, urinals, towels, etc.) are unavailable and must be shared by patients.

7) Personal aids (false teeth, eyeglasses, hearing aids, orthodpedic shoes, braces, etc.) supposedly provided by the hospital take residents six months to a year to obtain.

8) In some areas of the hospital there are no beds with bedrails for patients who need them.

9) In some areas of the hospital bed curtains are not provided for the patients' privacy.

The County Cover-Up

Furthermore, in order to pass state and Federal inspections, county government officials and the Kane Hospital administration are covering-up the inadequate services and understaffing at Kane Hospital. During inspection periods, there are more hospital staff scheduled to be on the job. Special meals are served to cover-up the usual poor quality of hospital food. The hospital undergoes a major clean-up. Utilization review forms, patient charts and nursing care plans are hurriedly updated — often falsely.

Efforts have been made at the request of the County Commissioners, to up-grade the reputation of Kane Hospital. The county public relations staff has produced photographic booklets, provided the news media with periodic press releases and sponsored a documentary film on county services for the elderly and Kane Hospital. Much of this information is misleading. Services, activities, and a way of life that is available to only a few of the nearly 2,200 occupants at Kane get stressed. Nineteen-hundred of the residents at Kane are confined to the ward and nursing areas of the hospital. During the day, many of these people are confined to geriatric chairs. Other patients are in wheelchairs and some remain in bed. Only approximately 300 of the 2,200 residents at Kane Hospital leave their nursing areas to eat in the main dining room or participate in the movies and other recreational activities in the central part of the hospital. The photographs and reports released by the county public relations staff show only these 300 people. There are not photographs or descriptions of the conditions in which the majority of Kane residents must live.

The Hospital As Patronage

Commissioners Staisey and Foerster have been in office for eight years. In this time, they have built and control a party machine that extends throughout Western Pennsylvania. Kane Hospital is a part of this machine. While they under budget the hospital, the County Commissioners use the hospital's service contracts and the 1,800 hospital jobs as patronage. People who work toward and contribute to the re-election of the County Commissioners are appointed to administrative, supervisory and higher paying jobs at Kane Hospital. Often these people are less qualified than other applicants. At times, completely unqualified people are appointed to positions at Kane Hospital. Many of the lower paid hospital employees have received their jobs through friends already involved in the County Commissioners' machine. Employees occupying favored positions often are not required to attend work regularly or do a full day's work.

The patronage system produces clear race and sex discrimination in the county hiring practices. There is only one black person and four women in the thirty-

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ALLEGHENY COUNTY INSTITUTION DISTRICT

TO: All Employees
John J. Kane Hospital

FROM: E. R. Deverson, M.D.
Director

DATE: January 23, 1974

RE: Civil Rights Policy, John J. Kane Hospital

In compliance with Federal Civil Rights mandates of 1964, John J. Kane Hospital hereby advises you of its continued policy of nondiscrimination practices in employment and services offered to the public.

MEMO TO ALL EMPLOYEES DENYING DISCRIMINATION

1. "Senator Tom Nolan is interested in this case."

Kane Hospital Social Service Record

five department head positions at Kane Hospital. The four women are employed in what has been traditionally unacceptable work for men — housekeeping, nursing, etc. There are about fifteen full time doctors, 8 part-time doctors and 40 consultant doctors employed at Kane. We observed only two women and one black man hired as doctors over a two-year period at Kane Hospital.

Women are used as employees in over 90% of the lower paying hospital jobs (housekeeping, nurses aides and clerical). Even clearer evidence of race discrimination appears at this level:

> **— of the over 100 nurses that we observed none were black**
>
> **— of the nearly 75 women clerical staff that we observed none were black**
>
> **— of the over 250 nursing aides that we observed less than 15 were black**

Neither Kane Hospital nor Allegheny County as a whole, have a functioning Affirmative Action Program to improve this situation. This is condoned by the County Commissioners.

It is widely known that admission to Kane Hospital is another source of patronage and favor for the County Commissioners. Financial requirements for admission to Kane Hospital require that a person must not have other resources available for nursing home care. Time and guidance are given to families with political connections to transfer ownership of assets and savings to permit admission of their relatives to Kane Hospital. At other times admissions and continued stays are granted when not medically necessary as a political favor to a family. These occur while other citizens with no real alternatives to Kane Hospital are being placed on waiting lists and forced to wait for admission.

A social worker describes political interference in the discharge planning for patients:

> **Politicans have the power to get patients admitted and to keep patients in Kane Hospital.** I was involved in the case of Mrs. Barth, a 62 year old woman, who came into the hospital severely debilitated after having a stroke. A social worker talked with Mrs. Barth's daughter shortly after she came into the hospital. The daughter said that when her mother got better, she wanted to take her home. Mrs. Barth made good progress on the main rehab area and was transferred to a rehab-maintanence area. She was reviewed by a rehab physician consultant who periodically came into the hospital. At the time of the review, the following evaluation was made by the doctor: "Patient very motivated. Independent in all ADL (Activities of Daily Living). Speech is improving. Will cut brace down to R (right) short leg brace. Ambulate for one more month. Would like to review her then. May be ready to go with family by then." After this, I approached the patient's daughter, to discuss her mother's progress and the doctor's evaluation. Her daughter was not receptive to the idea of her mother leaving the hospital. She felt her mother had not made enough progress to return home. I waited a few more months and followed Mrs. Barth's progress. Again I called her daughter and set up a time for us to meet at the hospital. The following day the Director of Social Services questioned me concerning the case and told me that a call had been made to Mr. Miglioretti's office (Personnel Director) questioning my effort to discharge Mrs. Barth. On Mrs. Barth's chart appeared the following: "Senator Tom Nolan interested in this case." I

FORM 88-1

ALLEGHENY COUNTY INSTITUTION

SOCIAL SERVICE DEPARTMENT — STATISTICA

20757

Name — SEP 71 — Address Ivy W Hom

Date Admitted — FEB 02 — Admitted from Harmarville

9-2634 T

1-5073

Occupation — A. — Date last employed South

2-6546

(CUA-RF) Jane

Diagnosis CHF Atrial Fibrillation

Date Opened	Referred by	Date Closed
1. 10/6/71	Intake	
2.		
3.		1-10-72

Date — PT Consult — Reason for Referral

1. Senator Tom Nolan is interested in this case. 3 Kids 44 - 2

2. Management behavioral problem. Bedfast - had trouble

3. (15) Expressive - receptive aphasia in June 1971.

Type of Record Aug 5 1971. Aug 11 - speech test - functioning. Recommendations -

KANE HOSPITAL SOCIAL SERVICE RECORD

suspected that Mr. Nolan had interviewed for Mrs. Barth's family, since Mrs. Barth's daughter is a secretary in Senator Nolan's office. The following day I received a call from Mr. Miglioretti's secretary asking me Mrs. Barth's location in the hospital and her daughter's full name. I had a meeting later that day with Mrs. Barth's daughter who said that neither she nor her brother were in any position to take their mother home. The following day I was on my area visiting patients and the nurse said that the medical director had come down to the area earlier that day and instructed all personnel to disregard any order pertaining to discharge of Mrs. Barth. 2

Failure In Fiscal Management

While using the hospital for patronage and political favor, the County Commissioners are failing to properly oversee and direct the financial matters concerning Kane Hospital. There is

1) **Failure to provide patients and/or their families with clear and complete itemized bills of hospital expenses.** The records of patient accounts, which are provided upon request to families after a relative's death, are unclear. Many unspecified, miscellaneous and personal expenses are included. The hospital does not clarify these charges. Kane Hospital personnel have asserted that patients with money accumulated in their accounts are falsely billed for services already covered by monthly Medicare-Medicaid maintenance fees. No system of checks and balances in the billing of Kane patients exists to prevent double billing or billing for items and services never provided.

2) **Failure to permit patients, patients' families, or hospital social workers to know the balance of money with interest accumulated in individual patient accounts.** Even during discharge planning it is sometimes difficult to secure this information. Patients are required to sign over all monthly income to the hospital upon admission. Hospital maintenance expenses are deducted from each patient's income and the remainder is accumulated in the hospital account. The accumulated money belongs to the patient and is part of his or her estate upon death. There is usually over one million dollars of accumulated patients' money at any given time in Kane Hospital accounts.

3) **Failure to return money and interest which has accumulated in the patients' hospital accounts immediately to patients' families or beneficiaries upon death of the patient.** The total interest on these funds, some of which have accumulated since 1966, is over 100,000 dollars.

4) **Failure to provide all patients upon admission with the $25.00 monthly allotment for personal needs.** Some patients must wait more than six months before they are given their monthly personal funds. The Pennsylvania Department of Public Welfare requires that the hospital provide this allotment to each patient monthly. Not all patients are given adequate opportunity to spend their storebooks. At times patients' storebooks are used by the hospital staff for their own purchases.

5) **Abuse of patients' privacy by pre-screening and opening any personal mail suspected of containing cash or check gifts.** Placing all money in the "patients'" hospital account, while at the same time not permitting patients access to their accounts. This amounts to denying patients the right to their personal gifts from family and friends.

These practices are more than an oversight. All of them systematically add to the extra monies available to the County Commissioners for special investment and use. At the same time, these practices deny patients and/or families their own funds and services for which the county is paid to provide.

Also, the County Commissioners permit widespread abuse of Federally funded Medicare-Medicaid programs by falsely declaring patients to be in need of "skilled and intermediate nursing care" — both covered by Medicare-Medicaid programs. The Human Services Study Commission, appointed by the County Commissioners to evaluate human services in Allegheny County, describes the extent of these practices:

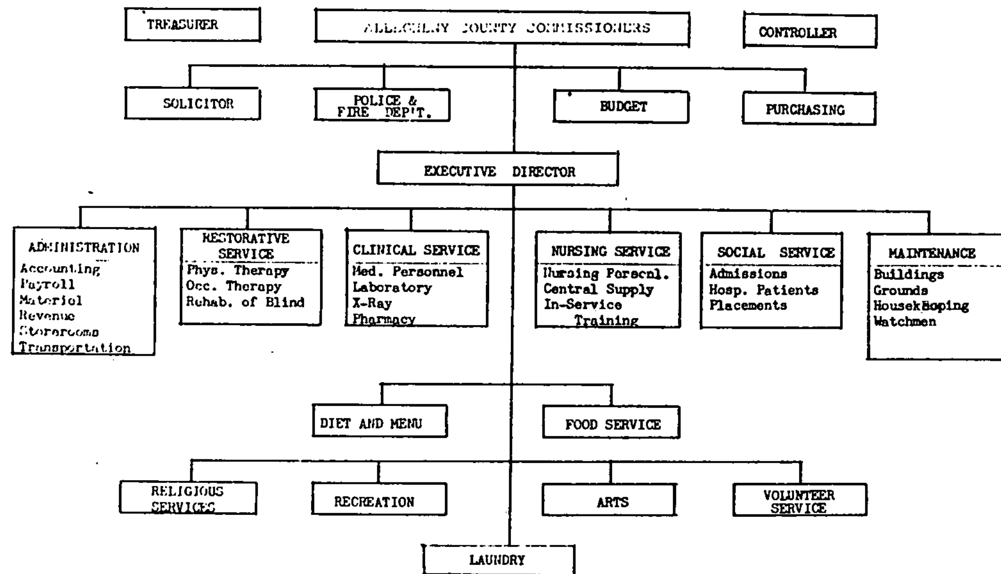
> Kane's use of such terms as "skilled care", "intermediate care", and "custodial care" differs substantially from Medicare usage of these terms. Kane claims to have no custodial beds (custodial care is not covered by Medicare), but by Medicare definitions more than half of Kane's 2,111 beds are custodial in nature.[3]

In this way the County Commissioners are obtaining Medicare-Medicaid reimbursement for providing "skilled and intermediate nursing care" to over 1,000 Kane patients who are in fact not in need of nor receiving such services.

70-080 O - 76 - 3

JOHN J. KANE HOSPITAL

ORGANIZATION CHART



KANE HOSPITAL ORGANIZATIONAL CHART

Summary

Kane Hospital is administered as a patronage system rather than a hospital. Poorly delivered and inadequate hospital care is the result. County officials have covered up the poor conditions at the hospital through misleading public relations work, and the threat of job loss to all employees who are not "loyal to the hospital". In addition, the Commissioners have failed to act decisively and fund essential community support programs for older people. The absence of in-community based services guarantees a waiting list for Kane Hospital and maintains the existing patronage system in tact.

Democratic Commissioners Staisey and Foerster are clearly responsible for initiating and carrying out these policies. Minority Commissioner Dr. William Hunt has permitted many of these practices to go unchallenged. As a medical doctor, Commissioner Hunt has doubly failed the residents of Allegheny County in his obligation to oversee Kane Hospital and ensure that the hospital meets minimum state and Federal standards.

RECOMMENDATIONS: ADMINISTRATION OF KANE HOSPITAL

1) The 3 commissioner form of county government does not offer either sufficient checks and balances or adequate division of power. Other forms of county government must to be considered. The recent proposals of the County Home Rule Study Commission were initial steps in this direction. A re-formulation of these proposals to ensure fair minority representation is necessary.

2) The County Commissioners must appropriate additional funds so that Kane Hospital can be adequately staffed and function in compliance with state and Federal regulations. This requires up-grading present salary schedules to levels competitive with other hospitals.

3) The planning, policies, and appointment of the administration of Kane Hospital should be done by a bi-partisan, non-political hospital board composed of health professionals, social service and health planners, consumers and health and welfare advocates.

4) The hiring of hospital personnel should be based upon qualification and work experience. The department heads within Kane Hospital should have a major role in the recruitment and hiring of their staff.

5) The hospital Personnel Director should not be a political appointment of the County Commissioners charged with overseeing and passing out patronage jobs. Rather she/he should be a professional personnel director skilled in recruitment and interviewing of prospective employees.

6) An Affirmative Action plan to correct present race and sex discrimination must be implemented.

7) An in-depth investigation and audit of the fiscal records and practices at Kane Hospital should be undertaken by proper government authorities. New policies instituting strict checks and balances in billing and purchasing should be instituted.

8) Patients and their designated representatives should receive quarterly itemized bills indicating all services received, which services are covered by Medicare-Medicaid or other third party payments, any additional charges, and total funds or deficit remaining in the account.

9) Prior to admission, Kane Hospital should make available to prospective patients and their families a list of services and articles provided at Kane. This list should include all nursing care, professional services and supplies, as well as, recreational and personal care services and items (hairnets, cosmetics, hairsetting, etc.). The frequency of all services should be indicated. Charges for all services not covered by Medicare or Medicaid should be clearly indicated, as well as all items that will be charged directly to the patient.

10) Patients and their designated representatives should be informed, in advance, of any changes in services available, frequency of services, or costs of services.

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KANE HOSPITAL; MENTAL HEALTH AND MENTAL RETARDATION; CHILD WELFARE; ADULT SERVICES (B)

DIRECT SERVICES

AGRICULTURAL COUNTY AGENT; AVIATION (D); COMMUNITY DEVELOPMENT (B); CIVIL DEFENSE; DEEDS AND ASSESSMENT REGISTRY (B); ELECTIONS AND VOTER REGISTRATION (D); HOUSING COORDINATOR; PUBLIC HEALTH (D); INFORMATION (B); OFFICE OF ECONOMIC OPPORTUNITY

PARKS, RECREATION AND CONSERVATION (D); PERSONNEL CLASSIFICATION (B); PLANNING (D); POLICE (B); PUBLIC DEFENDER (B); CONSERVATION COORDINATOR; WASTE SYSTEMS MANAGEMENT (D); WORKS (D); VETERANS AFFAIRS (B); WEIGHTS AND MEASURES

MODEL CITIES (B); PUBLIC EMPLOYMENT PROGRAM; COMMUNICATIONS (B); CONSUMER AFFAIRS (B); POLICE TRAINING ACADEMY; FIRE TRAINING ACADEMY

ISSUED AS A PUBLIC SERVICE BY THE BOARD OF COUNTY COMMISSIONERS — LEONARD C. STAISEY, CHAIRMAN, THOMAS J. FOERSTER, AND WILLIAM R. HUNT, M.D.

PATIENT SERVICES AND MEDICAL CARE

SHORTAGE OF NURSING PERSONNEL

Nursing Staff/Patient Ratios

Kane Hospital is understaffed. The shortage of nursing personnel is critical. The low numbers of nurses aides, licensed practical nurses and registered nurses on staff clearly violate the Pennsylvania Department of Public Welfare regulations. The regulations require the hospital to have nursing staff to patient ratios of " 1 to 8 on the day shift, 1 to 12 on the evening shift, and 1 to 20 on the night shift."[1] Over a two month period on randomly observed 48 bed floors only 4-5 nursing personnel were present on day shift where 6 nursing staff are required. This means that Kane Hospital is operating with a shortage of at least 50 nursing employees on the day shift. Nursing personnel who work on evening and night shifts indicate that there is frequently one less staff person per 48 patient unit than necessary to meet the regulations. Understaffing is an even greater problem on the evening and night shifts. This means that Kane Hospital needs at least 150 additional nursing personnel each day to meet minimum state standards. A registered nurse comments:

> Recently inspectors have forced the county to hire more dietary aides, housekeepers, and ward clerks. (This was required because nursing personnel had been performing many of these duties in addition to their nursing work – a practice specifically prohibited by government standards.) After a long fight the County Commissioners have begun to hire new people, but as they do so, fewer and fewer nurses aides are being hired. It seems to me they're just filling vacant aide positions with dietary and housekeeping personnel. This makes the lack of nursing staff worse. [2]

Pennsylvania Department of Public Welfare regulations recently increased the numbers of required nursing personnel. They now specify the minimum number of hours of nursing care that must be provided for each patient every day:

> General nursing care for each 24 hour period for each patient shall be provided as follows:
> (a) There shall be a minimum of 2 hours for each patient until 7/1/75.
> (b) There shall be a minimum of 2.25 hours for each patient from 7/1/75 until 1/1/76.
> (c) There shall be a minimum of 2.5 hours for each patient after 1/1/76.[3]

These new standards require Kane Hospital to employ 140 additional nursing personnel daily by 1976, in addition to the estimated 150 nursing personnel required to bring Kane into compliance with the old standards. Therefore, **Kane Hospital is in need of an estimated total of 290 nursing personnel per day, to meet government standards. Without these additional nursing personnel, Kane Hospital will be providing only 1.5 hours of nursing care per day per patient.**

Inadequate Basic Nursing Care

The practices used to cover-up the lack of nursing staff have been discussed earlier in this report. **The only satisfactory way to determine if Kane Hospital is adequately staffed, is to asses the extent to which the existing nursing staff can complete the necessary tasks and duties for which it is responsible. These duties are clearly defined by both state and Federal regulations as ensuring that:**

> **Each patient receives treatments, medications, and diet as prescribed, and rehabili-**

tative nursing care as needed; receives proper care to prevent decubitus ulcers and deformities, and is kept comfortable, clean, well-groomed, and protected from accident, injury, and infection; and encouraged, assisted, and trained in self-care and group activities. . . [4]

Even the most basic of these nursing measures are not consistently provided at Kane Hospital. A nurses aide comments:

> On Wednesday I was working PRN (wherever needed) and got assigned to Convalescent Area E1A. I walked onto the floor – a man was groaning and calling for help. I entered his room and recognized him from times I had worked E1A as Herbert Fitzwalt. Mr Fitzwalt is a diabetic, who was disliked by the staff on the floor because he continually asked everyone for a glass of water. The staff usually ignored his calls. He was confined in a geri-chair and had slipped down. His legs were extended; the back of his heals resting on the floor in a puddle of urine. I helped him up in the chair and he complained that his "foot really hurt today."
>
> The dressing on his right heal had begun to come off, so I examined his right foot more closely. His dressings were soaked in urine. An open decubitus ulcer was draining and bleeding slightly. I examined his lower leg and found it swollen about twice its normal size. A red line was visible on his inner thigh, and the lymph glands on his groin were swollen. After moving Mr. Fitzwalt to a dry place in the room, and placing his foot on a clean towel, I informed the nurse of his condition. She assured me she would do something for Mr. Fitzwalt.
>
> During the afternoon changes (about 5 hours later) I found Mr. Fitzwalt still with his same urine soaked dressing. I went to the medicine woman, who was a substitute on the floor for the day. She examined Mr. Fitzwalt and was angry and disgusted that his dressing had been neglected for "2 or 3 days" and that his "ulcer had become infected." Together we changed the dressing and complained to the nurse that nothing was being done about this man. The nurse arranged for Mr. Fitzwalt to be seen by a doctor. The doctor confined Mr. Fitzwalt to bed with his leg raised, and prescribed Strepomycen and Penicillen, five times a day. [5]

Mr. Fitzwalt's infection, which had progressed to a serious stage by the time he was seen by a doctor, resulted from neglect. Kane Hospital policy requires that dressings on decubitus ulcers be checked and changed at least once a day by the nurse or medicine aide. If these procedures had been followed, Mr. Fitzwalt's infection might have been prevented.

This is one example of inadequate nursing care. Situations similar to those which led to Mr. Fitzwalt's infection occur daily throughout Kane Hospital. **Often patients must wait 3 or 4 days before urine-soaked dressings are changed.** A nurses aide describes the situation on her floor:

> Dora Johnson had a constant urine drip that couldn't be catheterized. Each morning I would come in and fine her lying in a puddle of urine, her dressing soaked; often they had fallen off and she had no dressings on her bedsores. . . The nurse was the only person who could bandage Dora's sore because it was so large – as large and as deep as my fist. She usually went 2 to 3 days with unchanged dressings – wet with urine. Bedsores (decubitus ulcers) develop whan an area receives prolonged pressure causing poor blood circulation, when the area is usually moist, and when the patient gets little exercise. Bedsores can develop in one month and take 4 months to intensive care to heal. They can be prevented by changing the patient's position, exercise, massaging sore areas, and by keeping the patient dry.
>
> **Because patients are not changed and washed when they are incontinent, because many of them are confined in geri-chairs all day with no exercise, and because bed patients are not turned or positioned regularly, many patients develop bedsores.**
>
> On my area (48 patients) there were 10 or so patients with bedsores and ten others who were beginning to develop decubiti – getting red and purple pressure areas and complaining about being sore. We were supposed to report any developing bedsores to the nurse. Aides don't like reporting bedsores to the nurse because it indicates the patient hasn't been taken to the bathroom and cleaned regularly. They usually don't report developing bedsores so the sores are not treated until they are progressed and open. [6]

"From 80 to 90 percent of the care (in nursing homes) is provided by aides and orderlies. Most are grossly overworked and paid at or near the minimum wage. With such working conditions, it is understandable that their turnover rate is 75 percent a year. . ."

"Nursing Home Care: Failure In Public Policy
U.S. Senate Committee on Aging Report

There are not enough nursing staff employed at Kane to keep every patient in clean, dry clothing and bedding, assist every patient who needs help in going to the bathroom. Helping a disabled patient to the bathroom requires 2 aides, a lot of heavy lifting and moving, and quite a bit of time. There is simply not enough staff to do this for everyone. On most floors patients are permitted to defecate where ever they are at the time. Puddles on the floors are mopped but, patients with wet and dirty clothing or bedding, must wait until the regularly scheduled clothing changes at 1:00 p.m. and 6:00 p.m. to receive clean clothing. A nurses aide describes how he was taught to do afternoon changes:

> We have to change 30 or so patients out of the 48 on the area during afternoon changes. Just those who are visibly wet or covered with BM. We usually work in two teams of two if there are 4 aides; if not, all of us work together. First we push all the patients in geri-chairs or wheelchairs back into an aisle in the ward, and then screen off the door. We wet a lot of towels and leave them in the sink. We work from one end of the line to the other. There is no privacy when this is going on – everybody sees each other. Some of the aides handle patients roughly – slapping, arm twisting and jerking goes on. Every day the patients get sworn at – asked if they are "full of shit today" and called "old bastards" and the like. Some patients fight back during changes, but most are scared and offer no resistance. The patients' restraints are untied and his gown is unsnapped and removed Then the aide in front, pulls the patient by his arms to a standing position naked, and holds him there, while the other aide wipes his buttocks with a wet towel from the sink and puts a clean pad on his chair. The patient is then dropped back into his chair and a new gown is slipped over his arms and snapped behind his neck. No effort was usually made to clean and dry patients who had urinated. If there were clean socks in the laundry room, we changed the socks if they were wet with urine. If we didn't do changes in assembly line fashion how else could 2 or 3 aides clean and change 30-48 patients in an hour – that's all the time we had. [7]

Bed patients are sometimes "padded" with 3 or 4 folded sheets beneath the buttocks instead of being given the bedpan when necessary. The sheets are pulled out, one after another, each time the patient wets the bed. "Padding" is poor nursing practice and is prohibited by hospital policy because the prolonged pressure and wetness contribute to the development of bedsores. This practice continues at Kane Hospital – especially on the night shift. **Under these conditions, without adequate access to bathroom facilities and bedpans, patients confined in geri-chairs, wheelchairs or bed, quickly begin to lose control of their bowel and bladder movements. Between one-third and one-half of the patients, both male and female, are fitted with catheters – plastic bags connected to tubes inserted in the urinary tract to collect urine.** A nurse doing In-Service training for new nurses aides lectured on this problem:

> If patients were helped to the bathroom and regular bowel and bladder schedules were followed in this hospital, many of the patients wouldn't need catheters. Catheterizing patients is done because it's convenient, not because it's necessary (given the patient's condition). [8]

She went on to say that the overuse and improper use of catheters at Kane Hospital is destroying the "bladder tone" of patients who can hold their urine, making them permanently incontinent. The experience of not having a bathroom or bedpan available; lying in one's own excrement after being unable to hold it any longer; and finally being fitted with a catheter, is deeply degrading.

Kane patients are also not given the proper help or opportunity to bathe and wash at regular intervals. Residents are awakened between 6:00 - 7:00 in the morning by aides. Their gowns are changed if they are urine-soaked or dirty. Some patients are given clothing. Those patients who cannot or are not permitted to walk about are placed in geri-chairs or wheelchairs. They are then taken to a dining area to await breakfast at approximately 8:30. Morning care which consists of washing faces and buttocks if necessary, brushing teeth or dentures, combing hair, and shaving is not provided on most of the nursing areas for residents who require this help. Patients who can perform these taks for themselves are given little opportunity to do so. On some floors, morning washing is prohibited because patients would be "late for breakfast".

In some areas of Kane Hospital residents must wait 3 to 5 weeks between baths or showers. Hospital policy states that each patients should receive one bath per week, except in the case of patients who may require daily bed baths instead.

Ongoing bath schedules and bath books are required to be kept on each nursing unit. These records are filled in to indicate all patients have received weekly baths. Often two people are bathed while 6 to 8 people are checked off as having received baths. Powder and spray deodorant are used to cover-up body odor and the smell of urine on patients who are not bathed. An aide describes the baths that are given on her area:

> Bathing is very had work. A lot of lifting and bending. It's hot and smelly. Aides don't like to give baths. A lot of patients resist getting baths because they have had bad experiences. There is no privacy. Several people are bathed once, in open view of anyone who uses the bathroom. Patients are handled roughly when put in and taken out of the tub. Some are set down very hard. They get jerked around and are especially afraid of falling because the floor is always wet. There is a lot of abuse at bath time – yelling and slapping at patients. . . often aides are not careful about the temperature of the water. It is sometimes too hot or too cold. Shampoo is not always rinsed out completely. Hard to reach places are left unwashed, so there are cakes of dirt under the rolls of fat or in pubic areas. The foreskin of male patients with catheters needs to be pulled back and washed. This is rarely if ever done. Several patients in Kane have developed penis infections and had to be transferred to other hospitals for surgery. Catheter plugs are reused from patient to patient. Fat patients are given showers instead of baths. They are put on a "potty chair" and rolled into the shower and the water turned on. This saves the aides a lot of heavy lifting but buttocks and pubic areas never get washed. This is especially bad for incontinent patients with bedsores.[9]

Summary

The nursing staff is clearly unable to consistently provide adequate basic nursing care to the patients at Kane Hospital. Patients are not receiving the proper care to prevent decubitus ulcers and to be kept comfortable, clean, well-groomed and free from infection as required by government regulations. This is the result of the critical shortage of nursing personnel, and directly threatens the health and safety of Kane patients.

Recommendations: Shortage of Nursing Personnel

1) Additional nursing personnel should be hired to meet the immediate hospital needs. Nursing staff/patient ratios should be:

8 nursing personnel day shift/48 patient unit
5 nursing personnel evening shift/48 patient unit
3 nursing personnel night shift/48 patient unit

2) Existing salary levels for nursing personnel should be upgraded to enable the hospital to attract and keep qualified personnel.

3) Nurses aides should not be assigned housekeeping, dietary and other non-nursing duties.

WAITING FOR LUNCH

LACK OF RELIEF PERSONNEL

Both state and Federal regulations require that Kane Hospital have sufficient numbers of relief personnel available to cover all daily operating functions.[1] Kane does not have adequate relief coverage to meet this standard. Nursing personnel work five out of seven days each week and alternate days off. **Relief personnel are usually unavailable to cover for nursing personnel on these assigned days off. Likewise, virtually no relief provisions are made by the hospital to cover the high absentee rate among its full-time employees.**

The lack of relief RN's leaves nursing units without proper supervision when the charge nurse is sick or scheduled for days off. In this situation, on-duty charge nurses are required to cover two nursing units – their own and the nearby unit without an on-duty nurse. It is impossible for one nurse to assure that 96 patients receive proper treatments and care. Likewise, relief provisions for nurses aides are inadequate. New aides in training are used whenever necessary (PRN) throughout the hospital for relief work. **Aides from floors with full attendance are "pulled" to floors where few staff are on duty. "Pulling" personnel distributes the staff evenly throughout the hospital, forcing each nursing unit to function with one or two less employees each shift than required by the state regulations.** Pulling of necessary staff from their assigned unit regularly forces Kane employees to provide care to patients with whom they are unfamiliar – highly increasing the impersonal nature of the hospital.

Recommendations: Relief Personnel

1) Additional relief personnel, to cover the high rate of absenteeism, assigned days off and vacations, should be employed at the hospital.

2) Nursing staff/patient ratios should not be relaxed on weekends, due to the ongoing and skilled nature of the daily nursing care needed by Kane Hospital patients.

3) The practice of "pulling" staff from their assigned floors to equally distribute the on-duty personnel should be prohibited. Adequate relief personnel would make "pulling" unnecessary, and permit the maximum number of nursing staff to work on floors where they are familiar with the patients.

INADEQUATE REHABILITATION AND RESTORATIVE SERVICES

Restorative services, to assist each patient to achieve and maintain his/her highest level of self-care and independence, must be provided by Kane Hospital in order to meet both state and Federal regulations. Minimum standards for these services require that:

> Nursing personnel are trained in rehabilitative nursing, and the facility has an active program of rehabilitative nursing care which is an integral part of nursing service and is directed toward assisting each patient to achieve and maintain an optimal level of self-care and independence. Rehabilitative nursing care services are performed daily for those patients who require such service, and are recorded routinely.[1]

There are not enough nursing personnel employed at Kane Hospital to meet this requirement. An earlier section in this report described how the small nursing staff is unable to provide even the most basic nursing care (regular bathroom visits, clean dry clothing, treatment to prevent bedsores, regular baths, etc.) consistently to all patients. The section described how the nursing staff is forced to catheterize patients because they can not help them to the bathroom when necessary. If there are so few nursing personnel that patients can't be helped to the bathroom, how can the nursing staff find time to provide rehabilitative services which consist of supervising patients in exercising and practicing to walk? The minutes of a Rehabilitation Department meeting indicates the extent of this lack of staff.

> Dr. Melotti (Director of Rehab and Part-time Consultant at Kane Hospital) and Mrs. Cassidy RN, presented St. Francis' (a private Pittsburgh hospital) nursing staff requirements for its 49 rehabilitation bed unit – for 3 shifts (weekly average number of staff per day).
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> | | |
> |---|---|
> | Head Nurse | 1.0 |
> | R.N.'s | 9.3 |
> | L.P.N.'s | 8.3 |
> | Nurses Aides | |
> | Male | 5.2 |
> | Female | 5.2 |
> | Secretaries | 3.0 |
> | Total | 32.0 |
>
> Mr. Steinmetz (Coordinator of Rehab Services) handed out copies of a survey done Sept. 9, 1971 for minimum nursing staff needs for all seven rehab wards, 7 days per week, for 3 shifts. To his knowledge no other report exists, and the nursing service has been unable to meet those needs. Since the time of the survey, nursing needs and responsibilities have increased at least one-third or more per ward.[2]

Employee counts show that Kane Hospital has 11 or fewer nursing personnel per day working with 48 patients, while St. Francis Hospital has 32 nursing personnel working with 49 patients on a rehabilitation unit. The lack of staff to do the necessary restorative and rehabilitative nursing has led to much disagreement and resentment between the Nursing and Rehab Departments within Kane Hospital. A rehab aide describes the effects of this problem:

> We work like heck on the rehab areas teaching people to walk again, dress themselves, and go to the bathroom. Then they get assigned to a nursing area and put in a wheelchair or geri-chair where they stay all day – without daily exercise – and in a month they regress to

the way they were before we worked with them — or worse. [3]

A physical therapist comments:

> Rehabilitative nursing care is not an integral part of nursing service at Kane — that's one of the problems. The Rehab Department and the Nursing Department don't work together. Nurses and nurses aides on the floors are not rehab oriented. Nurses at Kane do not receive in-service training that really teaches them about the importance of daily rehab and restorative nursing care on all the floors of the hospital. At this kind of hospital it's essential. Nurses aides, who are providing most of the direct nursing service don't receive this kind of training either. So what happens — patients don't get even minimal rehab or restorative nursing care. . . Standing up a patient who's in a wheelchair or geri-chair a couple of times a day, or walking a patient to and from a meal or the bathroom can prevent the patient from becoming stiff and hard to move. In the long run it benefits the nursing staff.[4]

Nursing personnel state that they do not have time to walk and exercise patients and do all the other necessary work. These inadequacies are apparent to the staff of the hospital. A nurse talked about several people recently transferred to her floor:

> George over there. . . There's no reason he should be a bed patient — he can't even feed himself now. After his leg was removed he should have been put back in rehab. There are stroke patients here too who should have been in rehab. With stroke people it's important — the longer you wait after the stroke, the less you can do. If the rehab begins right after the stroke, often normal functioning can be restored. The right things just aren't being done here.[5]

In addition to the lack of nursing personnel, there is a significant shortage of personnel with specialized skills in the Rehabilitation Department qualified to supervise and direct ongoing rehabilitation services.

Both Federal and state regulations require that:

> In addition to rehabilitative nursing, the skilled nursing facility provides, or arranges for, under written agreement, specialized rehabilitative services by qualified personnel (i.e. physical therapy, speech pathology and audiology , and occupational therapy) as needed by patients to improve and maintain functioning.[6]

Minutes of rehab department meetings document the lack of skilled professional rehab staff:

> Dr. Melotti also reported that St. Francis' physical therapist/patient ratio is one physical therapist per patient per hour. Therapists average 8-12 patients per day. Mr. Steinmetz stated that **the American Hospital Association reported that there should be one physical therapist and assistant for every 10-20 patients. Our (Kane Hospital's) present physical therapy staff/patient ratios are: 1 physical therapist for 80 patients and one aide or assistant per 25 patients.** [7]

A physical therapist talks about the rehab program:

> All the patients in the hospital could benefit from an on-going program of restorative care and at least one half of the patients could benefit from on-going rehab services as well. There isn't enough trained staff to do it. There are basically three out of 46 nursing areas in the hospital where there's an active rehab program operating. Even on these areas there isn't enough trained rehab staff to provide patients with the services they need.
>
> There are four other areas in the two infirmaries called rehab-maintenance. The level of functioning that a patient reaches on the rehab floor is supposed to be maintained on these areas. There is one physical therapy aide trained by the hospital, for each of these areas. Regular Occupational therapy (training in daily living skills) is minimal. One physical therapist is assigned to the 192 patients in these areas. Rehab outside of the four maintenance areas in the infirmary is minimal — about 30 patients out of 800 — provided by a physical therapy aide. No rehab services are provided to

"Kane Hospital has achieved a national reputation for excellence in the field of rehabilitation and restorative care. . ."

"Kane Hospital Cares" Brochure
Allegheny County Bureau of Public Information

patients in convalescent areas of the hospital.

The turnover of staff is a big problem in the Rehab Department. Many people won't stay because the salaries and benefits are way below what they are at other hospitals. Rehab staff caseloads are high and there's frustration because of the lack of coordination and cooperation among different departments, particularly Rehab and Nursing. Staff see their efforts going to waste when they aren't continued after the patient leaves the main rehab area. The indifference on the part of some people in administrative positions is also frustrating.

Once a patient leaves the main rehab area, their rehab needs are supposed to be evaluated by the staff on their area. The staff physician and nursing personnel on the patient's area have the responsibility for this. But it isn't done. Patients who need specialized services or basic rehab equipment (walkettes, canes, braces) go without it. I've seen some patients who just needed a new tip for a walkette, in order that it could be used, go without it because the staff on the patient's area didn't do anything about it.[8]

Speech therapy is often critical in the rehabilitation of patients, especially stroke patients. The regulations quoted above demand that the hospital employ qualified personnel to provide the necessary rehabilitative services for patients with speech, hearing and language difficulties. Kane Hospital does not have sufficient personnel to provide these services to all patients who need them. A male aide comments on the effects of the lack of rehab speech theraphy:

> I was working PRN (wherever needed) in the hospital. . . on a different floor each day. There were always some people on the floor who couldn't talk and let us know what they needed. They were forced to pound with their fists, groan, or kick to get attention. We couldn't figure out what they wanted. These people should be helped to communicate somehow.[9]

There are no special provisions made in the hospital for deaf or hard-of-hearing patients. An aide describes this situation.

> I was working PRN in a convalescent area and was told to give a woman a bed bath. The aides told me that she was a little confused. I found that she could not hear. A friend that I was living with knew sign language and had taught me a few signs and part of the alphabet. I gestured my name to her to see if she would be into working a few signs between us. She repsonded with a series of signs that I could only partly understand. Later I asked my friend what some of the gestures she kept repreating meant. She said that they meant that the woman knew sign language and that she wanted her hair washed. My friend taught me some useful signs like bedpan and how do you feel?, etc. I was never sent back to that area and I never saw her again. Something should be done to help patients like this woman at least let the staff know the things they need.[10]

Inadequate Rehab Plans

Ongoing rehabilitative planning for individual patients is also required by government regulations.

> Rehabilitative services are provided under a written plan of care, initiated by the attending physician and developed in consultation with appropriate therapist(s) and the nursing service. . . A report of the patient's progress is communicated to the attending physician within 2 weeks of the initiation of specialized rehabilitative services. The patient's progress is thereafter reviewed regularly, and the plan of rehabilitative care is re-evaluated as necessary, but at least 30 days, by the physician and the therapist(s).[11]

Rehabilitation plans are not established in conjunction with the nursing service at Kane Hospital. Review and re-evaluation of patients rehabilitative needs are not systematically done at least every 30 days on nursing care areas, as required by law. The failure of Kane Hospital to provide ongoing rehabilitative services while admitting patients who need them is a serious form of patient neglect and directly threatens the health of the hospital's patients.

If necessary rehabilitation services are not available at a facility, the state and Federal regulations both clearly state what must be done:

> If the facility does not offer such services directly, it does not admit or retain patients in need of this care unless provision is made for such services under arrangement with qualified outside resources under which the facility assumes professional and financial responsibilities for the services rendered.[12]

Kane Hospital has not made arrangements with outside providers, but continues to admit and retain patients in need of services it cannot provide.

Lack of Rehab Equipment

In addition to the lack of rehab staff and the lack of consistent rehab planning, **it is hard to obtain rehab equipment. Wheelchairs, walkettes, braces, canes, and other equipment patients need to be able to remain mobile are often unavailable to them.** A social worker describes her effort to obtain orthopedic shoes for one patient:

> A 61 year old woman living in the infirmary needed a new pair of orthopedic shoes. She had not had new shoes since coming to Kane. Her shoes were worn and tattered and stretched from constant use. She had a limp, and the loose fitting shoes made walking cumbersome for her. Previous requests for shoes by the patient had produced no results. I took her request to an infirmary nurse and asked how to get Mrs. Aldrich the shoes. The nurse suggested that a requisition slip be filled out and sent to the Rehab Department. After a few weeks, the Rehab Department contacted an infirmary nurse and told her they could only order orthopedic shoes for patients who were on the active rehab program,and that the doctor on the patient's area should order the shoes. I went to the area doctor, explained the situation, and asked if he would see the patient. He refused saying it was not his job to do anything like that. I told him that the Rehab Department had already been contacted, that they could not see the woman, and recommended that he order the shoes. The doctor still refused. It was necessary for me to arrange to buy the shoes from a store and use the patient's personal money — even though the hospital receives government Medicaid money to provide patients with such things as orthopedic shoes. While making arrangements to take Mrs. Aldrich to the shoe store, she fell in the dining room and broke her ankle.[13]

The failure of hospital staff to evaluate patients for and order necessary rehab equipment for patients on regular nursing areas continues to be a major problem.

Summary

The absence of necessary personnel and equipment and the overwhelming neglect of the rehabilitation needs of patients in many areas of the hospital flagrantly violates both state and Federal regulations. Much of the work that the Rehab Department is able to do is undone when patients are transferred to understaffed nursing areas, where they are confined in wheelchairs and geri-chairs and given no opportunity to exercise. The expense and effort devoted to patients by the Rehab Department is often wasted. Too often patients are simply permitted to become dependent when in many cases higher levels of functioning are possible. Public relations work and political pressure, initiated by county officials, continue to cover-up this situation. "Prize patients" are being displayed as typical Kane residents to the media and visitors, while the majority of Kane residents must go without continued and adequate rehabilitative and restorative services.

RECOMMENDATIONS: REHABILITATION SERVICES

1) The staff of the rehabilitation department should be doubled.

2) The existing salary levels of rehab personnel should be increased to attract and keep qualified personnel.

3) Physical Therapy and Occupational Therapy personnel should make daily rounds to nursing areas to continue rehab work with patients. They should be responsible for assuring that nursing care practices are in accordance with the rehab needs of the patients.

4) A written rehab plan should be part of the patient's chart. Rehab progress notes should be recorded in the nurses' notes by attending rehab personnel.

5) Doctors with rehabilitation experience should be available to evaluate patients, and participate in formulating a written discharge plan.

6) An oral/hearing rehab program under the direction of a speech and hearing specialist with sufficient trained staff should be established.

7) Restraining patients in geriatric chairs and wheelchairs should not be used as a substitute for restorative and rehabilitation treatment.

8) Additional training should be provided to the nursing staff in follow-up rehabilitation care.

9) The rehabilitation needs of all hospital patients should be regularly evaluated, and the required treatments and equipment (canes, walkettes, braces, etc.) should be ordered.

WOMAN IN GERI-CHAIR

INADEQUATE SUPERVISION OF EXISTING STAFF

Administrative and supervisory personnel are not providing adequate direction and supervision for the medical and nursing staff at Kane Hospital. Patient neglect, poor nursing practices and continued patient abuse are results of the lack of supervision.

Poor Nursing Care Plans

Government regulations require that:

> . . . a written care plan for each patient shall be developed and maintained by the nursing service consonant with the attending physician's plan of medical care, and is implemented upon admission. The plan shall indicate care to be given and goals to be accomplished and who is to give each element of care. The patient care plan is reviewed, evaluated, and updated as necessary by all professional personnel involved in the care of the patient. [1]

At Kane Hospital the nursing care plans are incomplete and often inaccurate. A nurse's aide comments:

> I never use the nursing care plans — neither does anyone else. The only time they make out nursing care plans is just before an inspection. In between inspections the names and bed numbers on the plans sometimes don't even match with the real person assigned to the bed. . . a while back I was working PRN (wherever necessary). It was my first time on an infirmary area. The charge nurse came around with nursing care forms and told us they had to be "filled out for the inspectors". She gave each of us some forms (me included — even though I was new to the floor) and told us to fill out "one for each patient and make it look good". She and the doctor should have been doing the nursing care forms. That's their work. How do they expect the aides to know what to do if they don't prescribe treatments and say what each patient needs. But in this hospital the nurses aides know more about the patients than the nurses and the doctors, so maybe we aides ought to be the ones writing on the nursing care plans. [2]

In recent inspections, Kane Hospital's nursing care plans have been cited as incomplete and in violation of state and Federal regulations. This has been a repeated violation. The lack of relief personnel and high staff turnover rate at Kane force nursing personnel to work on floors where they are unfamiliar with the patients. In this situation the lack of complete, and written nursing care plans is a direct threat to the health of hospital residents.

Poor Medication Practices

The medication practices at Kane Hospital are poorly organized and supervised. The prescribing of medication is usually done by the doctor at the request of the nurse. Frequently Kane Hospital doctors do not see or examine the patient to make an independent judgment in determining the necessity for medication and the dosage and type required by the patient. An aide talks about the situation:

> On all the floors I've worked, the nurse and the doctor get together about once a month. She tells him a little about the patient and what kind of medicine she thinks the person needs. Usually the doctor signed medicine orders without seeing the patients. Often the medicine for the whole floor (48 patients) would be ordered without the doctor visiting a single patient. And, on one floor I knew of, the

> nurse just wrote out the medicine orders and the doctor signed them without even reading them.[3]

On some floors, "PRN" or "Standing Orders" permit the nursing staff to give medications to disruptive, sleepless, or problem patients without calling upon the doctor in charge for his evaluation of the situation.

The distribution of prescribed medication to patients offers ample opportunity for mistakes and theft. A nurse's aide describes the medication system:

> Medication is ordered in bulk from the central pharmacy and stocked in bulk containers in medicine rooms on each of the 46 nursing units. Nurses aides, trained at the hospital to pass out medicine, give the medicine to patients. Cards with each patient's name, bed number and medication are filed on a "medicine cart". The "medicine aide" fills small paper cups next to each medicine card with each patient's medication, and then pushes the cart around passing out medication to patients.[4]

A nurse working at the hospital comments:

> The way medicine is passed out around here is chaotic. No general hospital would stand for it. I have to teach classes of medicine aides. How can I do it when we go onto a floor and the names and bed numbers on the medicine cards don't match the patients in the rooms? What about the days the regular medicine woman is off and somebody who is not familiar with the floor has to pass medication? And they call this a hospital. . .[5]

Strict Pennsylvania State regulations govern the medication practices of hospitals and nursing homes. State law permits only Licensed Practical Nurses or Registered Nurses to pass medication. However, at Kane Hospital unlisenced nursing aides have the primary responsibility in passing medications and giving injections. The medication practices at Kane Hospital clearly do not meet state standards and no effort is made by state agencies to ensure the hospital's compliance.

Poor Treatment of Infectious Diseases

It is essential and basic in any hospital that proper treatments are first prescribed and then administered as prescribed. It is the responsibility of the supervisory personnel to assure that this occurs. **The treatment of people with highly infectious diseases demonstrates more clearly the failure of medical and supervisory personnel in prescribing and demanding proper treatment for patients.** Federal regulations require that:

> Provision is made for isolating infectious patients in single rooms, ventilated to the outside (and) having separate toilet and hand washing facilities. Procedures in asetpic and isolation techniques are established in writing and followed by all personnel. Such areas (where infectious patients are housed) are identified by appropriate precautionary signs.[6]

Usually there are more than 25 patients at Kane with diseases requiring isolation. Most of these patients have a form of staph infection. **Isolation is required to prevent the transfer of the infection to other patients or hospital personnel. While working at Kane Hospital we have seen patients with staph infections in double rooms, 5 person rooms, and 22 person ward rooms. The doctors, nursing supervisors, and charge nurses fail to require the proper procedures to be carried out — ignoring both hospital policy and Federal regulations. The lax treatment of patients with staph infection occurs daily at Kane. Usually people with staph infection are permitted to remain in their regular accomodations. They are never provided with separate toilet and bathing facilities.**

Nurses aides who have not been trained in the special procedures required to work with staph infection patients are at times ordered to do so by the charge nurse. At other times, nursing personnel unfamiliar with the patients are assigned to administer nursing care to staph patients unaware of the dangers to themselves and other patients. A nurse's aide describes the treatment of patients with staph infection:

> When I was in training we spend time on different floors throughout the hospital. One day I was assigned to a convalescent area and told to get the patients in a 5 person room "out for breakfast". Mr. Geonig, one of the men in the room, was

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> covered with BM and it was necessary to clean him before he could go to the solarium to eat. Half-way through the clean-up, a regular aide told me not to touch the patient while I was cleaning him (an impossible thing to do) because he had a bad staph infection.
>
> I reported this incident to my In-Service teacher, since we had been told that only specially trained aides could work with staph patients. Other students were having similar experiences on other floors. Our teacher was outraged.
>
> The next day I was assigned to the same floor, my teacher accompanying me, and she confronted the RN in charge. The nurse responded that "the doctor didn't require these people to be put in isolation and sometimes we had staph patients in the ward (a 22 person room). There is too much work to do. Everybody has to chip in – if you don't want your students to work, don't send them here." They argued and nothing was settled.
>
> Later my instructor told me that the floor had been evacuated twice in the last month and sprayed to eliminate the staph germs but the patients there are still developing the infection. She said she now understood why.[7]

Another aide talks about the treatment of staph infection on her floor:

> Nobody likes to do the staph patients because of the risk of getting the infection. The older aides usually try to get the newer aides to do this work even though they haven't been trained to do it. The nurse often sides with them saying "There aren't enough trained people and somebody has to do it." The RN and the medicine woman were the only ones on our floor trained to work with staph infection patients so I got all of the aides together on my floor and we told the RN we weren't going to do the staph patients because it was against hospital policy and it was her and the medicine woman's work anyway. She didn't like us much after that but she knew we were right. This doesn't happen on most floors. Usually the older aides just pawn the staph patients off to someone new and the RN ignores what's going on.[8]

Other Poor Nursing Practices

The lack of adequate supervision permits poor nursing practices to continue. Untrained personnel are assigned specialized nursing duties. The dressing and packing of large decubitus ulcers, the changing of ileostomy and colostomy bags, and other aseptic and sterile procedures are assigned to aides not trained in these procedures. These are the responsibilities of the RN and the medical personnel or aides trained in special procedures classes. Assigning these tasks to an untrained aide is a violation of both state and Federal regulations, disregards hospital policy, and threatens the health of Kane Hospital patients.[9]

Often asecptic and cleanliness procedures required by hospital policy are ignored by the hospital staff. The same catheter plugs are used from person to person without sterilization, especially when patients are being bathed one after another. During catheter care, the use of alcohol sponges to clean tube ends and joints is often neglected. Catheter plugs once used are sometimes left in holes in the bedframes to be used again the next day instead of being sterilized. These shortcuts contribute to the high incidence of urinary tract infection in Kane Hospital patients. Charge nurses and nursing supervisors tolerate these practices.

Other treatments and procedures, although prescribed by the attending physician or required by hospital policy, are not being administered. Dressings for bedsores are not being changed as required. Patients sometimes wait more than a month for baths which hospital policy requires be given to each patient at least once a week. Rehabilitation exercises and restorative nursing practices are not carried out as prescribed. Morning care (brushing teeth, washing face and hands, changing soiled clothing, etc.) is not provided on most nursing areas. Patients who can care for themselves in the morning are often denied the opportunity to do so by the nursing personnel in the haste to "get everyone out to breakfast". Bedpans and urinals are not sterilized before being given to patients.

In addition, supervisory personnel are not assuring that Kane patients receive privacy during treatment – a basic right guaranteed patients by law:

> The patient shall be treated with consideration, respect, and full recognition of his/her dignity and individuality, including privacy in treatment and care for his/her personal needs.[10]

Privacy is seldom provided patients during clothing changes, bathing and other nursing care. A nurse's aide comments:

> I have seen patients stood up in the main hallway and their buttocks cleaned and their pants changed. On most nursing areas, patients who are incontinent are lined up in their wheelchairs or geri-chairs once a day, in assembly line style, and individually stood up, cleaned, and changed —each in full view of the others. On some areas, 15 to 20 patients at a time are cleaned up and changed in this way. On some areas, patients are bathed or must bath themselves in full view of anyone entering the lavatory. Although the hospital has folding privacy screens for such purposes, often the staff does not take the time to use them. When nursing care like bed baths, clothing and linen changes are done for bed-ridden patients, most of the staff does not draw the bed curtains and the care is given in full view of the hallway. Some RN's and supervisors try to get the aides to use curtains and give the patients privacy. The aides know who these people are and when they come around everybody acts right. But that's for only 5 minutes every day or so...[11]

Supervisory personnel are in a difficult position. To demand quality and consistent nursing practices from the staff would mean asking for more work than the small staff could possibly do. Nursing supervisors are responsible for nearly 500 patients. It is impossible for them to maintain the close contact with all the patients and personnel necessary to adequately oversee so large an area. **There is inadequate supervision on many nursing areas. As a result, patients are not being prescribed the proper treatments and those treatments prescribed are often not administered properly.**

Physical Abuse of Patients

The lack of supervision permits patient abuse to occur. On some floors patient abuse is a continuous and daily practice of the hospital personnel; on other floors it occurs infrequently or not at all.

Abuse of patients is a controversial subject — it is difficult to define what constitutes abusive conduct. Likewise, it is difficult to substantiate cases of patient abuse, for abuse seldom occurs in the presence of supervisory personnel, staff known to report misconduct or newly hired personnel.

In an article, "What Constitutes Abuse of Patients" (Journal of the American Hospital Association, December 1973), Wanda Nations RN and L.L.B. writes:

> Physical abuse can be classified legally as assault and battery or both. . . battery is intentional, harmful, or offensive touching of another person, and assault is an intentional placing of another person in reasonable apprehension of immediate battery. . . both are prohibited by law. Court action can result in criminal sentencing and for filing of a judgement for damages. [12]

The examples of abuse which follow are taken from the authors daily notes, written while employed at Kane Hospital. Only incidents which were witnessed first-hand have been included.

Convalescence Area

> The RN requested that I help the male aide assigned permanently to the floor give patient baths. I went with the aide to the bed of a young multiple sclerosis patient who was unable to walk and considerably overweight. The aide said in a threatening manner, "I'll take care of him myself," and roughly pulled the man out of bed and dropped him into a wheelchair. The patient groaned. The aide smiled at the patient and said, "You know I hate dagos don't you?"
>
> The patient was taken to the bathtub and sat quietly as the aide continuted to berate him. "You know I hate you. Now that you are in the tub, I ought to drown you."
>
> The aide soaked a washcloth in the water and slapped the patient on the head and the shoulders several times with the cloth. "The headlines in tomorrow morning's paper are going to read 'Aide Kills Patient In Bathtub', you dago son of a bitch. . ." and slapped the patient with the wet washcloth again. This time the patient grabbed hold of the washcloth. The aide punched his arm forcing him to let go of the cloth, and decided the bath was finished.
>
> The man, not wanting to be dropped

stiffened up as the aide lifted him out of the tub. He was punched in the stomach, pushed back into the wheelchair, hastily dried and returned to his room. The aide returned with another wheelchair patient to bathe. This was a black man, in his 70's also unable to walk. While undressing him for the bath, the aide discovered the patient had a mild case of diarrhea. The aide lifted the man into the empty tub and began to spray him in the face with cold water from the sprayer used to clean out the tub after baths. The man cried out begging him to stop. The aide told him, "You better learn never to shit yourself again, nigger," and sprayed the man with cold water again.

The aide looked over to me (I had been bathing other patients in the second bathtub) and said, "Hey, watch him jump." He adjusted the sprayer so a forceful 1/2 inch jet of cold water came out, turned it on full, and sprayed the man's genitals. The patient screamed and covered his genitals with his hands. The aide whispered, "Do you know why I hate you?. . . cause you're a nigger."

Holding the man's hands the aide sprayed him again with cold water, this time with the sprayer less than a foot away from the man's genitals. The aide then questioned the man.

"Are you a black man?"

The patient did not respond.

The aide (louder) "Are you a black man?"

Patient: (softly) "Yes."

Aide: "Are you a nigger?"

Patient: No repsonse.

Aide: (very loud) "Are you a nigger?"

Patient: "Yes"

Aide: "Is this nigger ever going to shit again?"

Patient: "No"

Most Kane employees do not abuse patients in this manner. This aide had been reported several times for his daily abusive conduct. He was permitted to go on working at the hospital for over 1½ years before he was terminated.

Female Infirmary

After lunch, we were taking a break and one of the janitors began teasing a woman named Edith. Others joined in; they picked up her skirt. They held onto her skirt and wouldn't let her walk away. She tried to hit the janitor and swore. There was a lot of laughter. One of the aides asked her where her purse was and turned to me and said she was always losing it. "We get it back from all over the infirmary." The woman became frantic and tried to walk away to find her purse. The janitor would not let go of her skirt. She became very agitated and almost fell. They let her go. Throughout the afternoon, I saw the janitor walk up to her ocassionally and she would try to hit him with her purse and tell him to go away. There was a lot of laughter among the employees.

Convalescence Area

I transferred a patient from the Tower to a convalescent area. She was obese. When we got to the convalescent ward, the aide on the floor and myself tried to transfer her to another wheelchair. She was very limp and hard to handle. We had her halfway up and the other aide shoved her back into the chair and slapped her. The aide yelled, "You want to break my arm and my back too. You people come in here and don't do nothing but sit around and eat."

Convalescence Area

A patient stands up slowly. The aides yell at her to be quicker. Several times when she was accused of not standing up fast enough they told her that if she didn't say "fungola" (which an aide said meant fuck in Italian), they would drop her. She refused the first time. They let her slide to the floor and stay there for a minute. After that she said fungola when she was told to.

Some forms of physical abuse are not so easily noticed.

Convalescence Area

There was one woman patient who Diane, an aide, didn't like. The aide would put a heavy blanket across the patient's feet and say to her, "Oh, I can just feel my feet getting squashed." The woman was not strong enough to remove the blanket

herself, so when no one was looking, I would take it. But the aide always piled another one on the woman's feet. (In addition to being uncomfortable, constant pressure from blankets causes a foot deformity [foot drop], and the loss of the use of the feet). Diane would also tell patients, "I know you shat, I knew an hour ago. We'll clean you up when we're ready." She called this her "sit in shit punishment."

Convalescence Area

On my first day on the floor Sharon and Bonnie gave me a show. Two patients, Jo Parkins and Bessie Blake, were put next to each other in geri-chairs. Sharon got a sheet and covered herself like a halloween ghost and squatted behind the chairs. She grabbed Josephine's hand and hit Bessie with it. Both of them got frightened and yelled. Sharon hit Bessie on the side of the head and hit her with Josephine's hand again. Bonnie told Josephine to stop it and Sharon kept it up. The two patients began scratching, hitting and yeling at each other. Sharon uncovered herself and asked them what the matter was. Sharon covered herself again. This time when the fight was going she took the sheet and covered both of them with it. They began yelling so loud that Sharon was afraid the nurse would hear. She took the sheet off and separated the chairs.

Verbal Abuse of Patients

Verbal abuse is more difficult to define than physical abuse. In the article referred to earlier, Wanda Nations states:

> Words alone cannot constitute a crime against a patient but can be abusive. Any of the following types of words spoken to or in the presence of a patient is verbal abuse unless such treatment is prescribed or is used therapeutically by professional personnel:
>
> Words of extortion: are used in attempts to illegally deprive a patient of his money or property. The act of extortion is a crime.
>
> Threatening words: cause a patient or member of his family to feel fearful or intimidated. For example, "Shut up," "You call me too often for unimportant things," and "Why do you think you should have more attention than anyone else?" may be construed as implying a threat of harm or reprisal. Threat of bodily harm is the extreme.
>
> Words of correction: tend to leave a patient without the freedom to act or choose because of fear of threat or force. Such a threat might be to deprive a patient of a meal, a bed or dignified and adequate treatment such as tying a confused, hyperactive geriatric pateint to a bed or chair and leaving him alone, when more humane treatment might alleviate his hyperactivity.
>
> Words of vulgarity: include curse words, profanities and obscenities. Such words may be acceptable in certain social situations in which the persons involved can choose their conversational companions. Hospital patients are conversational captives and may construe such words as offensive and threatening.
>
> Derogatory words: cause a patient to feel ridiculed and can include teasing, rude or harsh words, words of scorn or contempt, and deliberate lies. [13]

Verbal abuse of Kane Hospital patients is a daily occurence on almost all floors of the hospital. Hospital policy forbids employees to swear at patients and requires hospital personnel to report abusive employees to their supervisor. This policy is not enforced.

Convalescence Area

Audrey Pope is a pretty, young, severely crippled arthritic. During the day she is in a large wooden wheelchair with her feet up. She cannot move the chair around by herself. She wears the same nightgown day after day. It is dirty with food and has been soaked with urine many times. Audrey won't let it go down to the laundry because her last one didn't come back. Audrey does not like the hospital or how she is treated by the staff. When she thinks that no hospital employees are around, she hisses and swears about the way she is treated. When staff is around she is real nice and says things like, "Thank you for the lovely lunch, honey." And, "Hi, pretty girl." Audrey receives a lot of abuse because of her two ways of talking. Aides ask her what swear words mean — "What's a cocksucker?" "Does

"Abuses of patients in nursing homes have been well publicized and well documented. And yet they persist, perhaps because of the belief that they are exceptions to the rule. However, subcommittee transcripts are replete with examples of cruelty, negligence, lack of human dignity, and unnecessary regimentation. . ."

"Nursing Home Care: Failure In Public Policy
U.S. Senate Committee on Aging Report

your mother blow?" Her response to them is always, "I don't know honey, what's that?" Aides tease her about sex—"I had a good fuck last night, did you?" She is told that masturbation is part of her therapy and asked if "she has done it yet today?" Aides always take new employees on the floor back to Audrey's bed after the curtains are drawn and listen to her swearing about the hospital. When she says something choice they pull back the curtain and scream, "We heard you." She always responds to them, "What, honey?" They tell her she is "Disgusting and a dirty pig."

Convalescence Area

Four or five patients on each area get most of the physical and verbal harrassment. Usually they are either the patients who stand up to the staff, or patients who are the most helpless. The rest of the patients see what happens, and offer no resistance to the hospital staff. Patients who need a lot of care are humilated in front of other patients. Take Mr. Stobbs. He's a double leg amputee on a convalescent area. The aides on the floor don't like him and one male aide especially. Any time Mr. Stobbs does not make it to the bathroom in time, the aide puts him on the commode and won't take him off for an hour or longer. When other patients come in the bathroom the aide makes fun of Mr. Stobbs to them. Aide: "You know Stobbs chart says he blows. Do you want to see what he can do? (pointing to another patient). . . His daughter does a good job. I had her in the back seat of my car last night. Jeanette is her name, ain't it Stobbs? Hey, Stobbs is what the chart says, true – are you a cocksucker? Hey, Stobbs (The aide throws a wet washcloth at Mr. Stobbs hitting him in the face) Better answer, or you'll be in here all day."

Mr. Stobbs: "Yeah"

Aide: "Yeah what?"

Mr. Stobbs: "I'm a cocksucker."

I've worked on that convalescent area on four different days. Each time Mr. Stobbs was harrassed in a similar way.

On some floors in Kane Hospital payment in the form of cash, storebook coupons, or cigarettes is required of patients in return for a bath, clean underwear, a shave, or help in going to the bathroom. The practice is referred to by the hospital personnel as "tipping". This is a form of verbal abuse, and constitutes the crime of extortion punishable by law. Likewise, acceptance of money or gifts from patients is forbidden by Kane Hospital policy.

Convalescent Area

A patient said that the week before she fell in the bathroom because no one would help her and she did not want to mess herself. She had cut her back from the fall. She said that some of the aides on her floor demanded tips for trips to the bathroom. Up to three dollars from store books. She was slapped if she had no tip.

Later the same day, I went into the bathroom and found two women trying to help each other go to the bathroom. One could not walk, the other could walk only with support. Both were soiled with BM. Neither had been wiped recently. I got help from another PRN aide. We got gowns and got the woman who could walk cleaned up first. When she left we cleaned up the other woman. She offered us three dollars from her store book. She

said to come around to her bed in the afternoon and she would have it ready for us. We refused the tip. She started crying and apologized for making a mess for such nice people. She cried and cried. She said we would go to heaven if she had anything to do about it.

Male Infirmary

Shaving men today. Several offered me tips from the storebooks in return for the shave. When I refused the tip one man responded, 'You usually have to pay to get anything around here.'

Patient "tipping" to ensure decent treatment from hospital personnel occurs on one-third or more of the nursing care areas at Kane Hospital. The monthly personal funds allotment for Kane patients is $25.00. That is hardly enough for a patient who smokes regularly to buy cigarettes. On floors where tipping is common, patients simply understand that they must pay for what they get. On days when few staff are working – patients offer a "tip", wink and say "don't forget about me later". Many patients "tip" unwillingly, knowing that only if they become floor favorites will their life at Kane Hospital be bearable. If a patient is not on the "good side" of the staff, it means no bath or shave, fewer clean clothes and linen, no socks, no help going to and from the bathroom, and sitting in urine and BM longer.

It is criminal for hospital staff to take what little personal money patients have in return for basic nursing services. Likewise, the authorities who supervise, administer and inspect Kane Hospital must be held responsible. The hospital staff is too small to provide decent and complete care. The patients of Kane Hospital are forced to compete among themselves (offering what ever they have as tips) in an effort to get limited but necessary hospital services. There is not enough hospital personnel to do all that should be done – there is not enough nursing staff to help everyone when they go to the bathroom. Each day, due to understaffing, patients are forced to deficate on themselves while in bed or sitting in chairs. To a visitor or an inspector it simply appears that these people are incontinent. For these patients tipping is their last effort not to be forgotten.

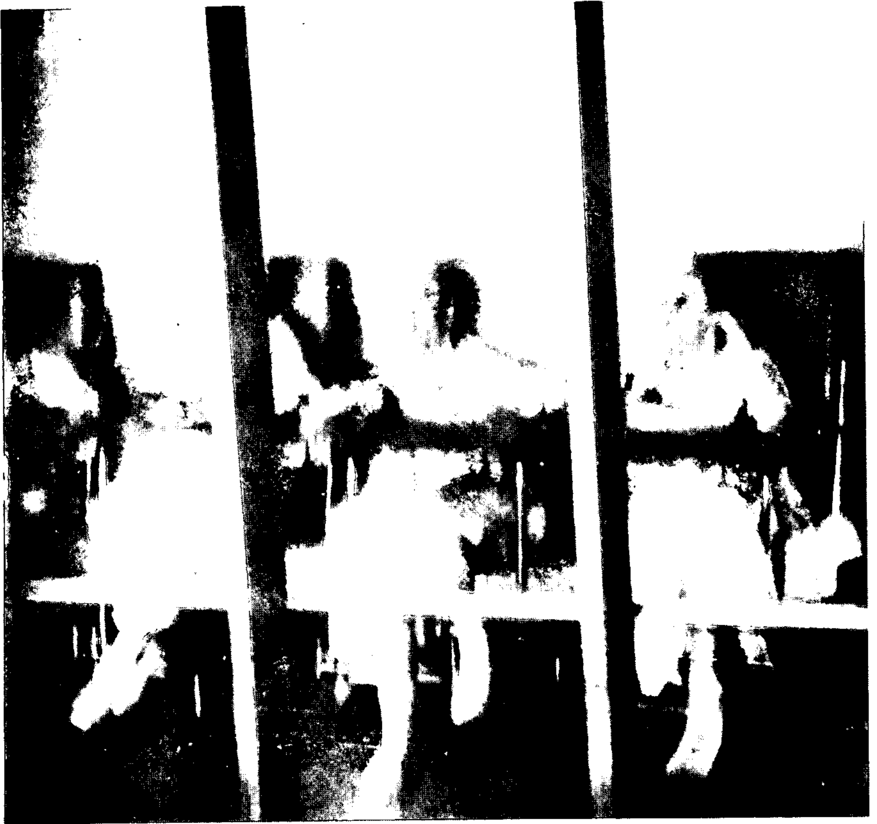
Poor Working Conditions:
A Major Factor In Patient Abuse

Staff abuse of Kane patients is a direct result of the intolerable working conditions in the hospital. The inadequate staff and supportive services required for decent care reminds the employees daily that the County Commissioners and the hospital administration have no commitment to the goals of the hospital. The lack of facilities and resources necessary to maintain even a minimal level of concern for patients forces the staff to harden themselves emotionally against the suffering around them. Because the large majority of Kane patients have chronic diseases and most of them will die before they leave the hospital, it is a highly depressing place to work. The work is repetitive, physically exhausting and dirty; often unhealthy.

Hospital employees have been traditionally underpaid. The salary ranges for many job classifications at Kane are lower than in other hospitals in the Pittsburgh area. Kane Hospital employees are subject to the unpredictable and confusing maneuvers of the political patronage system. The race and sex discrimination in hiring and promotion practices at Kane creates resentment among employees and fear in others. **These factors combine to make Kane a depressing and frustrating place to work. Employees are often distraught, bitter, angry and callous. Too frequently they release these emotions at the nearest targets – patients. Physical and verbal abuse is a product of the working conditions at Kane, which are dictated by the policies of the County Commissioners. Individual employees should be held responsible for their own treatment of patients. However, the abuse situation at Kane will not change until the working conditions at the hospital improve and the employees as well as the patients are treated as human beings.**

Institutional Abuse of Patients

Other forms of abuse are more institutional. The overuse of medication and restraints are examples. On some floors there are standing PRN (whenever necessary) doctors orders prescribing sedatives to patients at Kane. The use of PRN sedatives is often left to the discretion of the charge nurse. Whenever a patient is deemed demanding or disruptive, PRN medication is given. Often no effort is made to discover what is disturbing the patient. **Medication is frequent-**



MEN CONFINED IN GERI-CHAIRS ALONG A CORRIDOR

ly dispensed based on the needs of the hospital staff to reduce their work load and create a quiet, calm, orderly environment. The needs of the patients are often only covered up with sedative medication.

The use of restraints is another way the hospital staff restricts patient movement and activity. About ¼ of the patients at Kane Hospital are confined in geriatric chairs for the full day. As described earlier, "geri-chairs" are like a baby's high chair – with a large tray that clamps around the waist holding the patient into the chair. The chairs have small wheels so the hospital staff can push geri-chair patients from place to place; but once confined in the chair, the patients cannot move themselves about. Sometimes patients in geri-chairs are additionally restrained by a cloth restraint looped around their waist and knotted behind their chair. Patients in geri-chairs are moved to a hallway or solarium in the hospital and left sitting there all day except for meals. Sometimes if they resist or try to move to another place, their chair is tied to a railing or pole, and their arms tied with cloth restraints to the chair. Restraints are also used on patients in wheelchairs and bed. Clear Pennsylvania Department of Public Welfare regulations govern the use of restraints:

> The patient shall be free from mental and physical abuse and free from chemical and (except in emergencies) physical restraints.
>
> Restraints shall be applied only when in the opinion of the attending physician it is necessary to prevent injury to the patient or others and used only when alternative measures have failed to accomplish these purposes. If it is necessary to continue the use of restraints, the physician shall evaluate the physical and mental condition of the patient to determine what care or treatment needs to be prescribed.
>
> There shall be a signed order for any physical restraint including justification and duration of application.
>
> Restraints shall not be used or applied in such a manner as to cause injury to the patient. [14]

Kane Hospital is in violation of the above regulations regarding restraints. The physicians at Kane Hospital are not consulted when patients are restrained. Usually the nurses' aides make the decision to restrain someone without even consulting the charge nurse. Seldom are alternative measures tried before restraints are applied to patients.

Some patients are confined in restraints daily for months – the attending physician is not notified, and no alternative measures are tried. Restraints are not removed for supervised free periods – often patients remain in restraints 8-10 hours in the same position. This practice contributes to the development of decubitus ulcers, the loss of circulation and the loss of ability to stand and walk.

The abuse of the right to restrain patients at Kane Hospital is extensive. Usually 500 or more patients are placed in some form of restraint each day. At times it is necessary to protect weak and frail patients from falling and hurting themselves. Now and then a patient is a danger to other patients and must be temporarily restrained. Too often though, restraints are used as a substitute for restorative nursing care in order to make the staff's work load more manageable. A rehabilitation aide comments:

> We take a patient and put him through the rehab program. He has begun to walk again and take care of himself. So we send him to a nursing area with instructions to encourage him to walk and care for himself. They put him in a wheelchair. . . tie a restraint around his waist, and never bother to let him exercise. It's easier for them – one less patient moving around. They can move him out to lunch ten times faster in a chair than he can walk with supervision. In a couple of weeks all the rehab work we've done is undone. His desire to walk is gone. He doesn't want to try any more. You wouldn't feel like doing much if you were tied in a chair all but a few hours a week, not let out and wheeled around everywhere you had to go. I've seen it happen time and time again here. [15]

A nurses aide replies:

> We don't have enough time and staff to do daily rehab exercise sessions with the patients and do everything else we have to do. Sure – patients regress when they leave the rehab program and are assigned to another floor. . . but other patients are screaming to go to the bathroom, beds have to be made, puddles mopped, lunch trays passed – everybody has to eat. We don't have time to supervise and encourage walking and do everything else. . . and if we don't tie them into chairs, they'll

> try to walk themselves and fall and break
> a hip. What are we supposed to do? [16]

The lack of nursing and rehabilitation personnel leaves the extensive daily use of restraints and medication as the only available means of managing the hospital's patients. Tying people with restraints who could regain their ability to walk and care for themselves and neglecting to give them the opportunity and help necessary to regain their normal functioning is physical abuse. Abusive restricting and restraining of patients is wide-spread throughout the hospital. These practices are condoned as necessary by the Kane Hospital administration, making them institutionally acceptable forms of abuse and neglect.

Summary

The inadequate supervision of hospital staff permits neglect of patients, poor medical practices and patient abuse to continue. The chain of command and responsibility is poorly defined. Often supervisors are unwilling to demand that employees perform their duties due to the political nature of the hospital and the lack of support from the hospital administration. Employees are frequently unable to perform their duties because of tremendous overwork and inadequate resources and supportive services. The coordination between day, evening and night shifts is poor. Some supervisors do not have the experience and training required for supervisory positions. Most supervisors obtain and hold their jobs with the help of political connections. The failure of the Kane Hospital administration to demand complete and good nursing and medical care leaves the supervisory staff powerless. At times, supervisors are forced to act to maintain their jobs at the expense of decent patient care. These factors produce poor staff morale at all levels. Supervisors and employees are victims of the patronage system and terrible working conditions. Patients are victims of the resulting pervasive staff attitude; "Nobody else cares so why should I."

RECOMMENDATIONS: SUPERVISION OF THE STAFF

1) Clear and effective channels must be established through which supervisory personnel can deal with staff members who are not performing their duties.

2)A clear and effective grievance procedure must be established to permit employee grievances to be heard and resolved fairly.

3) The chain of command and responsibility should be more clearly defined within the nursing teams. The day duty registered nurse should co-ordinate the activities of all 3 shifts, and be responsible for assigning duties and ensuring that they are accomplished. At this time no mechanism exists to effectively work out disagreements between shifts.

4) Additional registered nurses should be hired. The registered nurse/patient ratios should be:
  2 RN day shift/ 48 patient unit (tower and convalescent areas)
  1 RN day shift/ 48 patient unit (infirmary areas)
  1 RN evening shift/ 48 patient unit
  1 RN night shift/ 48 patient units

5) Ward clerks (1 to each 48 patient unit, day and evening shift) should be assigned to each nursing unit to relieve the RN's of paperwork and give them adequate time to do their patient care and supervisory duties.

6) Supervisory nurses and the Director of Nursing should be hired based on experience and ability to supervise and direct the nursing department. The Director of Nursing and the supervisory nurses should be responsible for assuring:

—nursing care plans for each patient are appropriate, accurate, up-to-date, and show evidence of sufficient input from the attending physician.

— proper nursing care practices are followed

— special procedures (isolation of infectious patients, changing of colostomy and illeostomy bags, catheterizing) are done when necessary and only by trained personnel

— sufficient numbers of trained nursing personnel are available to provide the necessary nursing care

— nursing practices are consistent with efforts to rehabilitate and discharge patients

7) Employees abusing patients should not be tolerated. Employees found physically abusing patients or soliciting tips should be terminated. Employees found verbally abusing patients should receive disciplinary suspension; and if repeated suspension is necessary, termination should follow. Employees should have the opportunity to appeal such cases through clear grievance procedures.

8) Restraining and medicating patients, instead of providing supervised rehabilitation and restorative nursing for patients should not be permitted.

INADEQUATE SUPPORTIVE SERVICES

Supportive services are essential aspects of any long term care hospital. They include laundry, inhalation therapy, housekeeping, recreation, dietary, and social services. At Kane Hospital the supportive services are poorly organized and in violation of state and Federal regulations. Without these basic services functioning properly it is impossible for a hospital to provide a healthy environment conducive to good medical and nursing care. In the following section the problems in these services at Kane will be described and specific recommendations relating to each will be offered.

I. Laundry

Clean clothing and linen are a basic need at any hospital. **There is a serious lack of clean laundry creating an imminent health hazard at Kane Hospital. This health threat is especially bad for patients who are bed-ridden or incontinent. Wet and dirty linen and clothing contribute to the development of bedsores, the spread of infection, and an oppressive odor.** Patients forced to wear or sleep in soiled clothing lose their dignity and become resentful and bitter. Federal regulations require that:

> The facility shall have available at all times a quantity of linens essential for proper care of patients. The facility should have available at least three (3) changes of linen per patient per day. Each bed shall have clean linen (at all times).[1]

Kane Hospital fails to comply with this regulation. There is not enough linen in use to meet the daily needs of the 2,200 occupants. Over 90% of the days we worked in Kane Hospital there was not enough clean laundry. **The laundry operates with one shift per day (day shift), Monday through Friday and does not operate on week-ends. By late Sunday or early Monday there is no clean linen available. People often remain in soiled bed linen and clothing for 11 to 18 hours until clean laundry arrives on the floors between 11:00 a.m. and 3:00 p.m. on Monday (the exact time depending on the area of the hospital). On week-days, most floors run out of certain linens part way through the day. There are seldom enough clean washcloths and towels for morning use.** Some mornings there were only 3 washcloths and 1 towel for 22 people in a ward.

Even when clean laundry comes there are frequently not enough socks and underwear to go around. Socks are often worn by patients for two weeks at a time before clean ones are available. On most floors underwear is not used at all. Kane Hospital patients are given institutional uniforms to wear – hospital gowns, green pants and tops, housedresses or grey pants and shirts. This clothing is often torn, without buttons or strings, and generally unattractive. It is also in short supply.

Women who are given only short hospital gowns to wear, complain that their genital area is exposed when they are seated. Men wear similar gowns or green pants and tops. Incomplete dress occurs in mixed male and female areas as well as all male or fe-

male wards. The people confined at Kane Hospital find the lack of proper clothing deeply degrading.

Patients are actively discouraged from wearing their own clothing. Often personal clothing is lost or sent to the wrong floor after being sent to the laundry. For this reason, few of the residents with personal clothing have it laundered. Some patients go for a year or longer with the same clothing — never washed. **There are no washers or dryers available for the residents of Kane. Pennsylvania State Department of Public Welfare regulations require that facilties be provided "for patients who desire to do their personal laundry."** [2] Kane Hospital is in violation of this regulation. The patients have been requesting such services for many years and the hospital administration has refused, stating washers and dryers would be too costly.

On many floors no slippers or shoes are provided and socks are the only foot covering. Pillow cases are frequently not available and bed sheets must be used to wrap pillows. Employees steal laundry from other floors to use on their own areas. Nursing personnel working different shifts hide clean laundry from each other so they will have enough for the next day. The day shift on one floor hides laundry in the night stands of isolated patients, with contagious staph infection, because as one aide said, "the night shift will never think to look there." The lack of clean laundry at Kane makes it impossible for the staff to maintain good nursing care practices.

The administration at Kane Hospital and the Allegheny County Commissioners are clearly aware of the inadequate laundry supply and laundering policies at the Hospital but fail to improve the situation. A nurse comments:

> Several years ago the County Commissioners were about to make available funds to permit the laundry to operate 2 shifts a day, 7 days a week, but the employees who worked in the laundry (some of whom were holding patronage jobs) refused to work swing shifts and weekends — so the County Commissioners didn't do anything.[3]

RECOMMENDATIONS: THE LAUNDRY

1) The feasibility of employing a professional linen service (as used in most hospitals) to provide clean linen and clothing, to the hospital on a daily basis should be investigated.

2) If in-house processing of the laundry is the best option, additional personnel should be employed to operate the laundry 7 days a week to provide clean laundry on weekends.

3) Sufficient amounts of clothing, linens, sheets, towels, washcloths, and pillow slips should be purchased for daily use.

4) Equipment should be installed in accessible places throughout the hospital for patients who wish to do their own laundry. Patients should be taught to use this equipment.

II. Inhalation Therapy

The Inhalation Therapy Department is responsible for distributing and administering oxygen and administering treatments for respiratory ailments. This department is staffed with only 3 people – 2 inhalation therapy technicians and 1 aide. These three people must provide respiratory care for nearly 2,200 patients. The Inhalation Therapy Department is located in a drab basement-like room. It is usually empty. At times patients can be seen in the IT room, administering their own treatments, with no one from the IT Department present. A member of the Inhalation Therapy Department disclosed:

> We're not doing a lot of things we should be doing, because we're not being given the proper staff or equipment. We're understaffed and no certified inhalation therapist would work here for the pay.[1]

Patients at Kane Hospital who have emphesema and other diseases never get treatments that are standard, daily practices in other hospitals. The therapist went on to say, "too many people handle the oxygen here. We're running one shift a day when we should be running three shifts. . . like other hospitals." This, he explained, leaves no one from Inhalation Therapy on duty for the evening and night shifts. Any oxygen that is needed in the hospital on those shifts must be obtained from the oxygen storage room by a nurses aide assigned to the floor where the oxygen is needed. It is then administered by the RN on that floor. The nurse is required to write out a requisition order to inform the IT department that another patient has been put on oxygen. The Inhalation Therapy Department will then attend to the patient the next day – checking the equipment and changing the oxygen tanks when necessary. He complained that nurses frequently do not submit these requisitions, and often the IT department "doesn't know who has the oxygen and who doesn't." To his knowledge, this resulted in the death of one patient who was placed on oxygen at night, and suffocated in the oxygen tent the next day because no one in the IT department knew that the time on the oxygen tank had expired. The charge nurse, when questioned by the member of the IT department, replied that the patient "would have died anyway."[2]

The critical understaffing of the Inhalation Therapy Department and the resulting disorganized and unprofessional way oxygen is distributed and administered, and the minimal respiratory care provided to the patients threatens the health and safety of Kane residents and deeply disturbed the employee quoted above.

RECOMMENDATIONS: INHALATION THERAPY

1) The staff of the Inhalation Therapy Department should be increased to include sufficient personnel skilled in handling oxygen and providing inhalation therapy treatments on duty all three shifts, seven days a week.

2) Salary scales should be upgraded to attract and keep qualified inhalation therapy personnel.

3) A certified inhalation therapist should be hired to supervise the department.

4) A systematic method for evaluating hospital patients to determine if individuals need respiratory treatments should be established by the inhalation therapy supervisor in conjunction with the medical and nursing staff.

5) Inhalation therapy treatments should be given only by registered inhalation therapists or inhalation therapy technicians. Untrained hospital aides should not be allowed to provide inhalation therapy treatments.

6) A systematic and orderly procedure for handling and administering oxygen must be developed to provide around the clock coverage.

7) The equipment necessary to provide complete inhalation therapy services should be purchased by the hospital.

III. Social Services

Federal Extended Care Facility regulations and state Department of Public Welfare regulations require Kane Hospital to "have satisfactory arrangements for identifying the medically related social and emotional needs of the patients. . . (and) social services offered by a facility must be provided under a clearly defined plan, by qualified persons, to assist each patient to adjust to the social and emotional aspects of his/her illness, treatment and stay in the facility." [1]

Kane Hospital's social service staff is made up of a director, a supervisor, a foster-home coordinator and eleven caseworkers. It is impossible for the eleven caseworkers to provide the necessary services to the 2,200 hospital patients. On approximately eleven areas or one-third of the hospital there are no regularly assigned social workers. These areas include Convalescent areas (where the conditions are some of the most depressing in the hospital) and approximately 5 areas in the Tower, for patients requiring intensive nursing. Where social workers are assigned, their caseloads are high. For example, three workers are available to 450 patients in the Female Infirmary and 2 workers for the same number of patients in the Male Infirmary. Even in the Admissions and Rehab areas, where social workers are responsible for an area of 48 patients, it is impossible for workers to provide adequate social services.

Ignoring The Long Term Patient

In addition to a lack of sufficient caseworkers to meet the social needs of Kane Hospital patients, the role of social workers is defined in narrow terms by the hospital administration and Director of the Social Service Department. **Social workers' primary function is considered to be planning for patient discharge. As a result the social service staff is able to direct little of its energies to meeting the social and emotional needs of the majority of Kane patients who have no immediate potential for discharge. These patients, many of whom live at Kane for 2 to 6 years face the complex problems of growing old and institutional living. They confront the loss of their friends and family, boredom, feelings of worthlessness, physical disability, and impending death. Little, ongoing support is provided for these patients who remain at Kane.**

To visitors the sights at Kane Hospital are shocking and sad. There are corridors as long as football fields with men and women lined up in chairs sitting idly, staring ahead or down, not talking. Some sit silently in green hospital clothing strapped into geri-chairs or wheelchairs lining the walls. The people at Kane live in these conditions for months, sometimes for years. The majority until they die. Many are isolated and alone. A common reaction of Kane residents to the conditions at the hospital is to withdraw into themselves. With nothing to do, and nothing to look forward to, some residents retreat into the past and become pre-occupied with the times in their life when they were happier and more productive. Others stop talking to those around them, become bitter and resentful about the way they have to live.

An aide describes some of the people on her floor:

> Emma Geiser — is a walking patient. She dresses herself and goes to the bathroom herself. She wears street clothes her family brings in. She is always frightened and whimpers a lot. She whimpers when anyone goes up to talk to her. She stays in her room as much as possible and comes out to eat at the last minute. She sits at the table and stares straight ahead often quivering. If I would approach her and offer to set her hair or clean her ears, she would refuse. When it came time for her weekly bath, one of us would have to get her and she would whisper all along the hall, "I don't want to — all these people will see me." She would quiver during the whole bath and as soon as she got enough clothes on to go back to her room, she would and finish dressing.
>
> Louella Henry — Another aide and myself were told to give her a tub bath. She didn't want to go. We had to take her—we were told to. She is really old — in her 90's. When we got into the tub she started yelling — "go ahead and kill me. . . please get it over with — stop this torture." We got her finished quickly and back in bed. She looked me in the eye and said, "I curse you, I curse you — that you will live to feel ninety years old in your bones and will know what you've done to me."
>
> Mary Washington — A large woman, paralyzed on one side. She is heavy and hard to move. Most of the staff think she can't hear well. They yell at her. She is often skipped on afternoon changes and isn't taken to the bathroom very often, so she

"Through individualized counseling techniques and the utilization of group discussions for mutual support and encouragement, patients reach a level of self-esteem with dignity and self-respect."

"Kane Hospital Cares" Brochure
Allegheny County Bureau of Public Information

is wet. I once found her false teeth in her mouth upside down. It looked like they had been in that way for a month or longer. She pretends she can't talk. After I spent a month on the floor she would talk to me. She usually sat next to a blind woman at meals and would tell her where things were on the tray.

Aide: Mary, this is my last day here. I won't be back anymore. I want to tell you that I'm glad to have known you. You are a very strong woman.
Mary: Thank you.
Aide: I know that the staff is mean to you. I wish there was some way you could speak up about it.
Mary: It would get worse. Do you have another job?
Aide: Yes, closer to where I live.
Mary: Good-luck.

Anne Lubechek, Dorothy Russell, Gladys Esserman, Myrtle McGivern, Nellie Gorey, Ella Madden and Gladys Garner were our walking patients. They dress themselves – go to the bathroom themselves. They spend the morning sitting in their rooms. A couple spend the afternoon in the solarium. Once a week they get a bath. [2]

When a person living at Kane Hospital withdraws to escape the depressing surroundings they are frequently stereotyped by all levels of hospital staff as being senile. Assumptions are made that patients are old and therefore confused. This attitude is widespread at Kane Hospital and is apparent in the way patients are treated. Staff respond to patients as either children who are talked down to, ordered around, or scolded; or like persons without feelings who are teased, laughed at and insulted. **Usually staff assume that patients are senile due to deterioration of the arteries in their brains.** Senility is viewed simply as a physical disease, characterized by mild confusion and depression which often progresses over time to disorientation, loss of memory, and incoherent speech.

The adequacy of this conception of senility has long been challenged by doctors and other persons investigating the aging process. As early as 1948, M. Gitelson writing in Geriatrics **magazine, stressed that his findings indicated that "there is no one-to-one relationship between cerebral arteriosclerosis (disintegration of arteries in the brain) and the degree of mental failure."** [3] **Other studies of aging primarily done in Great Britain and Eastern Europe, indicate that older persons who remain an active part of their community and family can withstand considerable cerebral artery damage and continue to function. Other older persons confronted with the loss of their community ties, family, friends, home, and meaningful work and purpose, exhibited the symptoms of senility with only mild arterial deterioration. Much of the recent study of aging indicates that often the signs of senility are stress-related and indicate withdrawal from new and unbearable situations rather than a physical disability.** This despair-induced senility is a threat to all older persons confined in nursing homes and institutions.

The Social Service Department and the hospital as a whole do little to combat this disabling dispair and hopelessness. Within the hospital only small efforts are made to involve residents in meaningful social groups and activities. Most Kane residents become isolated and withdrawn. As a result they remain unacceptable candidates for discharge.

Obstacles Preventing Patient Discharge

Even though the hospital administration restricts social workers' efforts almost entirely to discharge

WOMAN IN GERI-CHAIR

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planning, fewer than 200 patients are returned to community living each year. There are numerous obstacles which frustrate social workers' efforts to discharge patients who could live outside of an institution. Barriers to social workers' facilitating patients return to the community include insufficient medical, rehabilitative and nursing services provided to patients. Successful physical rehabilitation of patients has to be achieved before planing for a return to the community can be implemented. Although solutions to this problem are continually presented by the Social Service Department Director, it has remained unchanged for 15 years.

A second barrier to working with patients towards discharge are the politics influencing the admission and discharge of patients. A social worker comments:

> Often when families were contacted in regard to their parent or relative leaving the hospital, they responded by saying they were assured by an Admissions Department investigator that Kane would be a permanent living arrangement for their relative. Many times, the family would tell the social worker that it was through the help of a certain politician that their parent was admitted to Kane and they would use the politician to keep their parent in Kane.[4]

The minutes of social service staff meetings further reflect discussion of this situation:

> In discussing problems surrounding Kane's rate of patient discharge, staff members cited the problems of encountering hostility and angry verbal barrages from families who were assured prior to admission that Kane would be a long-term living arrangement for their family members. . . the reality of the political admission. . . and families who threaten the social worker with this wedge rendering them ineffective in making discharge arrangements.[5]

The documentation of a state senators' interference in rehabilitation and discharge of patients was presented earlier in this report.

A third barrier to patients leaving the hospital is the serious shortage of housing and living situations for older persons in Allegheny County. Only persons considered "indigent" (poor) can be admitted to Kane. To qualify, a person must have:

(a) Less than $500 in cash or assets
(b) No more than $800 in escrow or cash value of insurance for burial.
(c) Equity in a domicile (home) of less than $7,500 if single or $12,500 for a married couple.[6]

Before a person enters Kane, arrangements must therefore be made to transfer or dispose of a person's property, savings and other assets, to conform with admission requirements. The admissions investigators and/or the families of patients make these arrangements. The Department of Public Welfare requires the hospital to make every effort possible to maintain a person's home or apartment for a period of time after admission to encourage the patient's return to the community following their rehabilitation. However most persons who enter Kane lose their homes or apartments either prior to admission or soon after admission because hospital personnel responsible for maintaining patients' property do not make a conscientious effort to do so and/or because the hospital fails to rehabilitate patients quickly enough. Consequently, patients who can leave the hospital are faced with the problem of finding suitable housing in the community. Most patients at Kane have relatively low, fixed incomes. They require housing that takes into consideration their physical disabilities, and many also require some level of assistance with such things as shopping, cleaning, cooking, transportation and health care. Low-income, public housing for older persons in Pittsburgh and Allegheny County is scarce and much of it is inadequate. Speaking about the housing situation for older persons, David O'Laughlin, City of Pittsburgh Housing Co-ordinator, said, (Pittsburgh Post-Gazette, Feb. 14, 1975), "27,000 of the 67,000 elderly families are living in conditions that are inadequate and 2,500 elderly families are on the City Housing Authority waiting list."[7]

Although some patients leave the hospital and live with a family member, this arrangement is not feasible for most patients and their families. Often, before a person entered Kane, their families were forced to care for them because sufficient supportive social services were not available. The effort required of a family close to a sick or disabled older person often taxes them beyond endurable limits. Frequently families are unwilling to have older relatives return home knowing this situation will likely reoccur. In addition many patients prefer to live independently of their families, as they did before entering Kane.

"There is no firm national policy with respect to alternatives to institutionalization. This glaring lack of policy is all the more evident when the American health delivery services are compared with European systems where home health is a full partner in a genuine contiuum of care. Older Americans, more than any other group, have been adversely affected by this failure."

"Nursing Home Care: Failure In Public Policy"
U.S. Senate Committee on Aging Report

Even when a patient and family agree to living together, the family often doesn't have the resources to provide adequately for a relative in their own home.

The Foster Home Program, operated by the Kane Social Service Department, was set-up to provide Kane patients with an alternative to remaining in the hospital. A foster home is defined as a "family-type abode. . . wherein a patient at Kane Hospital might be placed for room, board, personal needs, and other requirements." The homes are limited to the "care of two patients not members of their family." [8] There are currently between 80-90 patients in foster homes; however the homes in most cases do not offer a permanent or even long-term living situation, and patients return to the hospital. Regular contact with the patient or supervision of the home by social workers seldom occurs. There is no department policy which requires it and the time limitations of the small social service staff are great. A social worker talks about the problems with foster home placement:

> To begin with, for many patients, going into a foster home is a last resort. Most patients' first choice is to live in an independent situation. Patients have reservations about moving into a living situation with people they don't know; or moving into a home where they fear they won't fit in and maybe not like the family. Many patients were suspicious of homemakers' motives — and questioned turning over their personal income to someone without knowing what kind of treatment to expect.
>
> Often foster homes are unable to meet the special needs patients have, such as few or no steps in the house, a bathroom near their bedroom, a special diet or help in the bathroom. Many of these needs either couldn't be met by the available homes or homemakers were unwilling to deal with them. There are additional problems inherent in moving an older person used to living in a certain way for a long time into a new and strange situation. It requires a lot of give and take. Often the arrangement just didn't last. Finally there was the question of the adequacy of some of the homes, and the motives of the foster homemakers. [9]

Thus, **the foster home program offers an alternative to only a small number of Kane patients.** Of the patients who do try to live in a foster home, many do not find it a feasible, long-term alternative to hospitalization.

A fourth obstacle to the effective discharge of hospital patients is the lack of community support services. To live adequately in the community, older persons often times require other kinds of assistance. Help with maintaining a household, shopping and preparing food, supervision of medications and diet, home-health care and day centers to meet recreational and social needs are just some of these services. The need for community based services for older people in Allegheny County was recognized long ago. In 1966, the Kane Hospital annual report discussed the failure of the hospital to discharge patients because of a "lack of facilities and services within the communities to permit acceptance of discharges from the hospital." [10] In the same annual report, the need for community services in Allegheny County receives greater emphasis:

> For years, we have been taught that adequate medical care could only be provided in a hospital. Likewise, with Kane Hospital, we accepted the assumption that the proper disposition for dependent oldsters was in County Homes or Nursing Homes. Today, we are sympathetic to the rights of the aging to remain in the community and maintain their human dignity by supplying needed supportive ser-

> vices. . . No longer will correct ministrations of Kane Hospital be sufficient in keeping with modern concepts of care, home services must be offered to help patients remain out of Kane Hospital or to effect their return from Kane Hospital to normal community living. . . [11]

The serious lack of community based services for older persons throughout Allegheny County, and the failure of County government to fund such services were described in the Introduction of this report. Important services that made assistance with cleaning, shopping, cooking, etc. available to older persons were eliminated in county public housing in 1972. At the same time, these services were severely cut-back in the City of Pittsburgh public housing.

The following observations were made about county Adult Services by the Allegheny County Human Services Commission (a commission established by the County Commissioners to evaluate county social service and health agencies) in November, 1974:

> (1) Adult Services acts more as a "holding company" and "fiscal agent" for Federal and State programs than as a comprehensive system of services to the elderly.
>
> (2) Design of services within Adult Services is based more on available funds than an assessment of community needs. [12]

In 1974 the County Commissioners set up an Area Agency on Aging in compliance with Federal funding guidelines. But no significant effort to expand and improve the community-based services for the elderly has been endorsed by the Commissioners. **The Allegheny County Commissioners' negligence in instituting and funding community-support programs for older persons continues to force unnecessarily large numbers of Allegheny County's older citizens to be institutionalized, and severely hinders discharge of Kane patients. This leads directly to poor staff morale, and the prevailing staff attitude that "there's nowhere for them to go, so why try. . .they're at the end of the line." The policies of the Allegheny County Commissioners concerning both community based services for older persons and the operation of Kane Hospital, renders the Kane Social Services Department ineffective.**

RECOMMENDATIONS: SOCIAL SERVICES

1) There should be an increase in the social service staff so that all patient areas in the hospital have a regularly assigned social worker. Caseloads should not exceed 48 patients per worker.

2) Admission to Kane Hospital should not be influenced by the political patronage system in the county. Persons should be admitted only when it is medically necessary.

3) Admissions personnel should not be permitted to allow political favor and patronage to influence the admission of patients.

4) Serious efforts should be made by the Admissions Department to systematically evaluate each person applying for admission to determine if institutionalization is necessary or if an alternative living arrangement in the community exists. In order to do this, admission personnel should be knowledgeable about community resources for older people.

5) Admissions personnel should work under the assumption that when patients improve they will leave the hospital. They should not indicate to the person being admitted and/or to their family that Kane is a permanent arrangement.

6) Undue pressure should not be put on families to take their relatives into their own homes after the patient has been admitted to Kane, but if a Kane resident wants to leave and an alternative living situation exists, there should be no interference by family and/or politicians to discourage or stop the relative from leaving.

7) The Allegheny County Commissioners must develop and fund the long needed system of community based services to older persons to enable them to live outside of county institutions and nursing homes.

8) The social service staff should address the needs of Kane residents who have no potential to leave the hospital. The number of patient groups that are already operating on 1-2 areas in the hospital should be increased. Resources of other hospital departments such as Rehab, Recreation, and Volunteers as well as staff on patient areas should be used to develop activities for long-term residents.

9) To ensure that foster homes are adequate living situations for Kane patients, the homes should be more carefully screened and the social service supervision of the homes should be improved. Foster home makers should receive financial reimbursement that reflects increases in the cost of living.

IV. Housekeeping

There are not enough housekeepers and janitors to maintain all nursing areas of the hospital. The floors, walls, tables, chairs and equipment at Kane are dirty. Federal and state regulations require that sufficient housekeeping staff be employed to maintain the hospital in a "safe, clean and orderly" [1] manner. In addition, the regulations demand that "nursing personnel are not assigned housekeeping duties" [2] as a precaution against the unnecessary transfer of disease.

Some housekeeping duties are routinely assigned to the nursing staff (mopping puddles and bathroom floors, cleaning tables and chairs, cleaning geri-chairs) in violation of state regulations.

The housekeeping practices at Kane Hospital are poor. On some nursing areas, urine puddles are spread out with a dry mop rather than cleaned up. In these puddle-stained areas there are dark circles of dirt stuck on floors, and the soles of your shoes stick to the floors. Bathroom floors are often wet and slippery. Patients complain about being afraid of falling in the bathroom and avoid using them. The bathroom and bathroom equipment is especially dirty. Stall curtains, toilet seats, tissue dispensers, floors, etc. are spotted and stained with fecal material, urine and blood. Where there are curtains around the beds they are similarly stained. The solarium dining areas on the nursing units are dirty and often smell of urine. The food preparation and storage areas accompanying some of the dining areas in the infirmary wings of the hospital have been cited by health inspectors for violations of cleanliness regulations. This atmosphere is not conducive to eating.

Kane Hospital has no fans and is not air-conditioned. The air smells of urine, and in the summer heat the odor is very bad. It is necessary to keep the doors to the outside open on nursing areas in the summer to maintain some flow of fresh air throughout the building. This permits field mice to enter the hospital causing a year round rodent problem. In the summer months the dirty conditions permitted by poor housekeeping practices attracts flies. Flies are intolerable annoyances to patients who are restrained, bedfast or paralyzed. The irritation of a fly is unbearable when a person cannot move to brush it away.

The insufficient numbers of housekeeping staff, and the poor housekeeping practices create a disgusting environment, and threaten the health and safety of the people who must live and work at Kane Hospital.

Recommendations: Housekeeping

1) Housekeeping personnel should be hired to provide one housekeeper each shift/48 patient nursing unit, in addition to housekeeping personnel to maintain all other areas of the hospital.

2) Supervisory personnel should clearly define the chain of responsibility, improve the cleanliness practices at the hospital, and demand housekeeping employees properly maintain the areas to which they are assigned.

V. Recreation Department

Patients at Kane Hospital sit idle, staring blankly at the opposite wall. Now and then someone breaks the silence with a word or two. There is nothing to do – day after day, month after month. **For the majority of Kane residents boredom is a major problem. Government regulations demand that:**

> **Provision is made for an ongoing program of meaningful activities appropriate to the needs and interests of patients, designed to promote opportunities for engaging in normal pursuits, including religious activities of their choice, if any. Each patient's activities program is approved by the patient's attending physician as not in conflict with the treatment plan. The activities are designed to promote the physical, social, and mental well-being of the patients. The facility makes available adequate space and a variety of supplies and equipment to satisfy the individual interests of patients.** [1]

Kane Hospital is in violation of this regulation. Only about 200 Kane residents are regularly involved in the Recreation Department's programs. The activities are not suitable for the remaining 2,000 residents. The director of the Recreation Department, Wes Parker, is aware of this situation and comments on it in an orientation session for nurses aides:

> We have 200 steadies that participate in our recreation programs – it's the other people (2,000) that's the problem. . .After patients eat supper on their areas, they are given sedatives and put to bed when they could be going to a movie, church or something. . ."[2]

Parker went on to blame the nursing staff for not encouraging patients to attend recreation programs.

Most of the Recreation Department's activities are large spectator affairs (movies, montly birthday parties, etc.) occuring in the central corridor and cafeteria on the A level of the hospital. The majority of Kane residents are unable to move themselves from their areas to this central area. These activities are unsuitable for most of the hospital residents. A nurses aide describes attempts she made to involve women on her floor in these activities:

> I took Mrs. Hershel down to a birthday party in the main dining room. I was told to leave her there. After the party I went down to help her and the other women back to the floor. The party disoriented and frightened her. When I told Mrs. Hershel that I knew the way back to the area, she grabbed onto my arm and would not let go. When we got back she did not recognize her bed and would not let go of me. She cried and cried. I took several women to this party and most of them were very frightened that they would be lost. Most of my patients had never left their area before. Two were so upset that they abandoned their wheelchairs and tried to walk back. Once a month all the patients who had a birthday in that month and are able, go to the main dining room for a party. They get a piece of cake or a cookie and listen to a polka band. Patients from each area are grouped together, but the staff that the patients are familiar with are not with them. The patients who go to the parties are sometimes upset for days afterwards.[3]

The Recreation Department provides virtually no activities on the nursing areas where most of the hospital's patients are forced to stay. In a typical three month period, one such activity was scheduled – an easter egg coloring contest in which patients colored an egg shaped circle on a sheet of paper with crayons. It took less than half an hour.

The recreation activities at Kane Hospital are paid for out of the profits from the hospital snack bar. Department of Public Welfare regulations require that all Kane residents be issued a $25.00/month allotment for personal needs. The hospital provides residents with a $25.00 storebook each month, which must be spent in the snack bar. Snack bar prices are high – equal to or higher than prices at a local snack bar or store outside of the hospital. Since profits are being made off the storebook sales, Kane residents end up paying for the recreactional activities provided at the hospital out of their own monthly personal allottment

The large parties and affairs (summer folk festival, Christmas party, etc.) photographed and described in county publications are infrequent and repetitive

from year to year. At times, 4-5 months pass between these activities. Movies are attended by only 20-50 residents because the auditorium seating and sloping floors are not suitable for residents in wheelchairs and geri-chairs. Also there is not sufficient staff to help residents get from their floor to the movies. Kane Hospital also has equipment for shuffleboard, billiards and other games but it is rarely available for the residents to use.

Recommendations: Recreation Department

1) The full-time staff of the Recreation Department should be increased to ten people trained in recreational programs.

2) The Recreation Department, Occupational Theraphy Department, and the volunteers should provide activities on the nursing areas of the hospital where most patients are confined.

3) Mobile activities carts, traveling snack, tobacco and magazine vendor carts, and a mobile stage and performance cart should be built and circulated throughout the hospital making daily visits to all floors.

4) The Recreation Department should provide an ongoing program of events and activities outside the hospital to keep patients able to travel in contact with the community.

5) The hospital should not arrange a profit on snack bar items (tobacco, health aids, snacks, etc.) which patients purchase with their $25.00 monthly storebook. These items should be available to hospital residents for cost.

6) The Recreation Department, in conjunction with the Social Service Department should approach schools and invite them to establish ongoing training programs in recreational and creative therapies (art, music, drama, poetry, etc.) involving students in supervised hospital residencies.

"Recreation is not an extra-curricular activity, but a necessity for improvement of the health of the patient. Inactivity results in muscle weakness, stiffness, fatigue, heart inefficiency and mental deterioration. In the chronically ill and aging these patterns are hard to reverse. . ."

"Kane Hospital Cares" Brochure
Allegheny County Bureau of Public Information

MEN SITTING IDLE

"John J. Kane Hospital maintains an extensive recreational program in an attempt to minimize the institutional problems of idleness, loneliness, and worry. . ."

"Kane Hospital Cares" Brochure
Allegheny County Bureau of Public Information

VI. Dietary Services

Some of the most frequent complaints of the people who live at Kane Hospital concern the meals. Major deficiencies exist in the dietary services and practices at Kane. Low quality, unappetizing food has serious physical and physchological consequences for an older person confined in an institution. The symptoms of a deficient diet were described by the Commissioner for Aging before a Senate hearing in 1969: "loss of appetite, fatigue, anxiety, irritability, loss of recent memory, insomnia and mild delusion states. Lack of vitamin B produces severe depression and confusion."[1] Kane is failing in several food-related areas to meet the minimal standards established by the Federal and state governments.

One large kitchen and bakery area is located in the basement of Kane Hospital. All the food is prepared in the kitchen and distributed to nursing areas throughout the hospital in large metal carts called steamers. Following the meals, the trays are collected and the dishes scraped. The steamers and dishes are returned to the large kitchen area for cleaning.

Mealtime Environment

There is one large centrally located room which is used as a cafeteria. It serves about 400 patients. The remaining 1800 people are served their meals in solarium rooms located on each of the 48 nursing areas. In the Tower and Convalescent sections of the hospital, each nursing unit (48 patients) has a solarium. In the Infirmaries, residents from two nursing units (96 patients) share one solarium. In most areas of the hospital solariums are the only space available to patients other than their rooms. Geri-chair patients are moved into the solariums for breakfast and spend all of their day there. **The smell and atmosphere in solarium areas are not conducive to eating.** An aide describes the solarium atmosphere on her area:

> Most of the women sat in the solarium all morning and were there when lunch was served. Patients continued to sit in the solariums untildinnerwas served with a break when afternoon changes were made. Every day, many of the geri-chair patients would wet themselves during the morning. The floor under their chairs was mopped, but their clothing was not changed nor were they cleaned up. They sat in gowns and pajamas that were dirty and didn't always cover their bodies. Patients that were bowel incontinent were sometimes cleaned up but I saw patients eating lunch while sitting in their feces. If a patient became incontinent after we started serving, we waited until after the meal was over to clean it up. . . so we had meals with puddles on the floor. . . the odor in the solarium was bad, the place was never clean and the things that patients had to look at while they ate weren't pleasant. [2]

Another problem is overcrowding in infirmary solariums at mealtimes. On some areas 96 patients must use lunch room space designed to accomodate less than 50 people. In addition, infirmary solariums were built for patients who could walk and use regular chairs. Now many patients in wheelchairs and some in geri-chairs must use them. An aide comments:

> Patients are packed around the tables so tightly that they can't get out unless they're given help. Even then, it's difficult. When someone had to go to the bathroom often five to eight other people in wheelchairs had to be moved into the aisle before the person could get out. Usually nobody wanted to create such a stir so they just went in their seat. [3]

Shortage of Staff

Federal and state standards require "a sufficient number of dietary personnel to meet the dietary needs of patients."[4] Kane Hospital, under pressure from government inspection teams, recently employed more dietary aides. Until this time nursing personnel were assigned the dietary duties of setting up trays, dishing out food from the steamers, serving trays, collecting trays, discarding garbage, and preparing dishes, silverware and trays to go back to the kitchen. These practices significantly cut into time nursing personnel could use for patient care and violatedgovernment regulations. Current Kane Hospital employees report that the recent hiring of additional dietary staff was accompanied by a reduction in the number of nurses aides. This shift has led to no net

gain in the amount of nursing time available to Kane patients.

Poor Food Quality and Handling

The food served to Kane Hospital patients is repititious, tasteless and of low quality. Patients continually complain that they do not get enough of the right kinds of food. The meals are starchy and inexpensive. The same breakfast – mush, two slices of white bread (untoasted), butter and jelly, milk, coffee, and a small glass of juice – is served four or five days a week. A typical lunch is mushroom soup, a cheese sandwich, milk, coffee and a bowl of canned plums. A typical supper is macaroni with stewed tomatoes on top, two slices of white bread, butter and jelly, milk, coffee and ice cream. Fresh fruits and vegetables are rarely served. Poultry, meat and fish are seldom served and when served usually appear in the form of a casserole. Often salt, pepper, sugar, ketchup and mustard are not available to the patients. Large amounts of food go uneaten. **The food is served hurriedly, carelessly, and in a manner that is unsanitary and unappetizing. Often food is lukewarm or cold.**

The hospital has plate covers to keep food warm but they are used only when inspectors are present in the hospital. Federal regulations state that "foods are to be prepared by methods that conserve nutritive value, flavor and appearance and are attractively served at the proper temperature and in a form to meet individual needs."[5] The regulations further require that not more than 14 hours pass between a substantial evening meal and breakfast. At Kane Hospital there is often a 15-16 hour time period between evening and morning meals.[6] An aide comments about the meals that are served on her area:

> The dishes, glasses and silverware were often dirty. Big particles of food were stuck to them. Most aides washed anything they used themselves to avoid getting sick they said. I saw one nurse who ate cake with her fingers. . . she wouldn't use the silverware. We were always short of silverware. . . everyday we'd have about ten trays short of one or two pieces of silverware. How do you eat with just a knife? I saw patients eat cereal with their hands. Silverware and plates were put on the trays so there was no front or back to them. The plates didn't have dividers and because the consistency of the meals was often mushy, the food would run together. Half the time napkins weren't used. Bread was put right on the trays. . . milk and coffee would be spilled on the trays soaking the bread and making the trays generally messy. Covers for the trays to keep the food warm were never used even though we had a big stack of them in the kitchen. The trays for patients that needed help in eating were dished out at the same time as the others. . . they just sat until all the trays were served (usually 10-20 minutes) so that people who needed help in eating ate cold food. [7]

Federal regulations state that nursing personnel have the responsibility of assisting patients who need help in eating. This is to be done "promptly upon receipt of meals."[8] An aide comments:

> On areas where there are a number of handicapped patients, the nursing staff is not large enough to give the kind of help in eating that the patients require. While the patients who could feed themselves were eating, we would feed the people who needed help. Most aides did feeding quickly and sloppily. Aides decide for the patient when the meal is over. Some aides take patients' trays before they are finished eating. Sometimes there was physical struggle between an aide and a patient, each trying to get the tray. Usually there's a compromise and the aides leave the patient a piece of bread and take the rest of the tray. One patient on my area would throw her food on the aide rather than give up her tray. Aides try to get the meals over with in a half an hour so they can get on to the other work. [9]

A practice common in some areas of the hospital involves aides taking the best food from the steamers and eating it themselves. Kane Hospital policy forbids hospital staff from taking food intended for the patients, nonetheless, this practice continues. An aide comments:

> It's a very common practice for aides to fix themselves toast with butter and jelly for breakfast. There were toasters on most areas, but patients never got toast because it took too much time. When

setting up the trays, aides saved half the jelly and butter for themselves. Bread is from the loaves stashed around the kitchen, which is taken from the steamer. Milk from the milk machine, and boxes of cereal that was saved from the steamer. Cans of juice were stored in the kitchen and oftentimes aides drank it, which meant there wasn't enough for patients (for meals, with medications, and at night). Often aides have a share of the best food like pudding, applesauce, canned fruit and ice cream. It's taken from the steamer before the patients get anything.[10]

Patients With Special Dietary Needs

The Federal and state regulations require that "therapeutic diets are prescribed by the attending physician".[11] At Kane Hospital, the charge nurse usually determines the special diet needs of the patients on her floor without the consultation of the doctor. The regulations further state that "nursing personnel are to assure that each patient receives treatments, medications and diets as prescribed."[12] Frequently, therapeutic diets are served to the wrong patients. A nurses aide describes this situation:

> The state requires diet cards identifying the patient and the kind of diet - (regular, mechanical soft, diabetic, low salt and high calorie) to be included on every food tray. This was done on our floor only when inspectors were in the hospital. Without the cards, it makes it difficult to know who is to get what diet. PRN aides and aides pulled from another floor who weren't familiar with the patients have no way of knowing who should get special diets. The regular aides must tell them as best they can remember. This usually means trays are mixed up and given to the wrong people. I've worked all over the hospital and the same thing happens on most floors. Mix-ups and errors in passing out the trays occur at every meal. Diet cards aren't used – except during inspections – then all the floors use them.[13]

The recent addition of more dietary aides, some of whom regularly use diet name cards on each tray, has reduced tray mix-ups – although on some floors diet cards are still not used.

Often the special food needs of patients are met by serving patients only part of the regular diet. For example, if ice cream was sent up as a desert, diabetic patients would not be given ice-cream and no substitute, sugar-free desert would be given to them. A social worker comments:

> A woman who had a bad gall-bladder could not eat greasy or fatty foods. She informed the nursing staff of her problem. She usually had to choose something from the regular diet to eat. There were a number of times she left her meals hungry and was forced to go to the snack bar and buy a sandwich. Each time this happened, she told an infirmary nurse that the kitchen was not sending up food that she could eat. The nursing staff called the kitchen and reported the problem. But the kitchen continually failed to provide her with adequate meals.[14]

Federal regulations require that "a patient be offered substitutes when food is refused."[15] No effort is made to provide patients with substitute foods at Kane Hospital. A second Federal regulation requires that patients be offered between-meal or bed-time snacks of nourishing quality. At most some patients receive a small glass of juice at night, however this is not a regular practice in all areas of the hospital. It is of critical importance that patients who are not eating be encouraged to do so by providing patients with assistance and offering substitute foods.

Federal regulations require that "food and fluid intake of patients be observed and deviations from normal be reported to the charge nurse. Persistent, unresolved problems are to be reported to the physician."[16] On many nursing areas, failure to eat is a daily occurrence and no notice of it is taken. Only after long periods of refusal to eat, is attention given to the patient. A social worker describes one such incident:

> One day I was on the 7th floor where very sick patients are sent. I saw Mrs. Riley lying on a stretcher in the hallway. I stopped to talk with her and asked her why she had been transfered to the 7th floor. She was weak and seemed very confused. I asked the nurse on the floor why Mrs. Riley had been transfered there from the infirmary. She said that Mrs. Riley hadn't been eating. I wondered why that resulted in her being sent up to the very

sick floor. The nurse said she hadn't been eating for the last two weeks. The nurse didn't understand why they waited so long before doing anything about it. Mrs. Riley didn't live long following this incident.[17]

Summary

The food at Kane Hospital and the conditions in which it is served, are offensive. Poor quality food served sloppily and cold, in crowded, dirty rooms smelling of urine clearly threatens the physical and emotional health of the patients. The hospital administration and county officials are aware of this situation and continually budget too little money for food and nursing personnel.

Recommendations: Dietary Services

1) Additional money should be budgeted by the County Commissioners to provide Kane patients with nutritious meals. The quality of food should be improved and the kinds of food served should be varied.

2) Special attention should be given to the planning of therapeutic diets to ensure that patients with special diet needs receive complete meals.

3) Diet cards should be used at all meals, to ensure patients who are prescribed therapeutic diets are receiving them as ordered.

4) Substitute foods, as required by regulations, should be provided patients who find the meal as planned unacceptable.

5) Two dietary aides should be provided each 48 patient nursing unit per meal. Nursing aides should not be assigned dietary duties.

6) Sufficient time should be allowed patients to eat their meals, without being rushed or hurried.

7) More care should be taken in preparing trays, serving food and feeding patients who need help eating.

8) Tray covers should be used to keep food warm while serving.

9) The hospital policy not permitting employees to take patients' food before, during, or after serving should be enforced.

INADEQUATE PHYSICAL PLANT AND ACCOMODATIONS

Kane Hospital was completed in 1958. It is a modern looking building constructed of glass and steel. **Although from the outside the hospital's landscaping and architecture look dramatic, the patient accomodations and fire/safety provisions are inadequate.**

The infirmary areas of Kane were designed for ambulatory patients who could care for themselves. Over one-half of the hospital's patients, 1,000 people, live in infirmary areas.

Many of these patients are receiving skilled nursing care and are in wheelchairs or geri-chairs. Others are not mobile at all. The physical accomodations are inadequate for these people. Beds with bedrails are not available for all the patients who need them. **Bathroom and toilet facilities do not meet state and Federal standards.** There are not enough bathtubs, showers and toilets to meet the Pennsylvania Department of Public Welfare regulations. Infirmary areas have one bathtub and one shower for every 49 patients. A minimum of one tub and two showers is required. This means that an additional 26 showers are needed in the infirmary areas to enable the hospital to meet the standards. [1] Likewise, over 150 additional toilets are needed in infirmary areas to meet government standards. [2]

Safety provisions (grab bars, handrails, etc.) have not been properly installed in these areas. The entry way and space within the bathrooms is cramped and wheelchair patients have difficulty turning and moving to use the facilities. Likewise, other adjustments (mirrors, positioning of equipment, etc.) for handicapped patients required by government standards have not been made. Privacy in the infirmary bathrooms and other bathrooms throughout the hospital is minimal. State and Federal requirements for bathroom privacy are not met. Most toilet stalls have no doors or curtains, and users are in open view. Baths and showers are frequently given to patients in open view of other patients using the bathroom. Cubicle curtains required by Pennsylvania State regulations to ensure privacy around beds, are absent in some areas of the hospital. [3]

Sleeping accomodations for Kane residents are equally poor. Forty-six large, 22-bed ward rooms house almost half of the patients at Kane. Both state and Federal regulations require that no more than four persons be housed in one room. [4]

The State Department of Labor and Industry has required Kane Hospital to partition and subdivide these ward areas which are cited in violation of Federal Life Safety Code Standards. The hospital administration and the County Commissioners have refused to comply with these standards saying the partitions would limit the mobility of the patients and restrict the staff efforts to provide nursing care.

The Department of Labor and Industry has also required Kane Hospital to remove window glass which could shatter during a fire and substitute safety glass in many patient areas throughout the hospital. Likewise, four long hallways which connect the infirmary areas, housing over one-half of the hospital's patients are cited as being smoke hazards if a fire would occur (most deaths in nursing home fires result from suffocation due to smoke inhalation). The hospital has been asked to erect partitions and doors at intervals along the hallways to provide smoke and fire barriers in the event of an emergency. The County Commissioners have resisted making these changes for several years, but due to threats to cut off Federal funds, have consented to erect the smoke barriers and shatter-proof glass. [5]

The ventilation in all areas of Kane Hospital is poor. Both state and Federal regulations require adequate ventilation. [6] Although Kane Hospital is a modern-looking building, no air-conditioning or fan system exists at the hospital. The lack of ventilation requires that doors be left open during hot weather, creating the rodent and pest problem described earlier in this report.

WOMAN TIED IN BED WITH A SHEET – WET, DIRTY AND NO BEDRAILS.

Both state and Federal regulations require that a nurses call and signal system (both emergency and routine) be provided for "each bed. . . each patient toilet, bath and shower area" [7]. State regulations further require all calls "activate a visable signal in the corridor at the patient's door." [8]

An emergency call system connects the bedrooms at Kane Hospital with the nursing stations, although no visible signal outside the patient's room is part of the system. Usually the system is not operating and the call buttons are placed out of reach of patients. **There is no emergency call system between the toilet, bath, and shower areas and the nurses stations as required by the government standards.** A nurse comments:

> The inspectors once made the hospital put hand bells in the shower and bathroom areas, but the patients took the bells and were walking around with them. So the nurses usually keep the hand bells and put them out during inspections. Some areas have taken the clappers out of the bells and leave them hanging. It's a farce. . . [9]

Summary

Kane Hospital was not designed to accomodate the large numbers of disabled and partially disabled people now living and requiring extended care at the hospital. The hospital is in violation of major aspects of the Federal Life Safety Standards. In addition, the physical accomodation and living environment is inadequate and does not meet state and Federal requirements. Major changes in the physical plant and accomodations are necessary to bring the hospital in compliance with the existing regulations and provide a safe and decent home for extended care patients.

Recommendations: Physical Plant

1) The 46 existing 22-person ward rooms should be sub-divided into six semi-private (2 person) rooms or the equivalent. All other rooms housing more than four persons should be converted to four person rooms as required by government standards.

2) As the above recommendation is implemented, the patient population of Kane Hospital would be reduced by 25%. This would enable the hospital to comply with government standards without altering the existing bathing and toilet facilities.

3) Grab bars should be appropriately installed in all bathrooms.

4) Ventilation in the hospital should be improved by the installation of a system of mechanical ventilation engineered to provide adequate air flow.

5) Emergency Call Systems should be installed connecting the nurses' stations with the bathroom and shower areas. This system should include visible signals located in the hall.

6) Hospital policy should require the Emergency Call System to be operating and in use at all times.

INADEQUATE MEDICAL SERVICES

Shortage of Doctors

Kane Hospital's medical staff is comprised of approximately 15 full-time physicians and 8 part-time physicians. These physicians have the major responsibility for providing medical treatment and supervision for the nearly 2,200 patients at the hospital.

For many physicians, Kane Hospital is a last resort in their career. The nature of the hospital, the nature of patients' medical problems (chronic – largely geriatric), and the poor reputation of Kane Hospital discourage doctors from practicing there. Doctors who work at Kane do so often because they cannot practice elsewhere. Three or more of the doctors are not licensed to practice medicine. Several physicians are very old and some have physical handicaps that prevent them from working in a general hospital or private practice situation. As with other positions at Kane Hospital, physicians are often hired on the basis of their political affiliations and political contacts. Their jobs are protected by the patronage system regardless of their performance. Six full-time doctors are given rent-free homes by the county in addition to their salaries.

Physician caseloads at the hospital are large. In the Tower areas, doctors can have caseloads of 50-100 patients; a 100 patient caseload being the more common. In the Male Infirmary, three doctors are responsible for providing medical services to approximately 450 patients, while in the Female Infirmary, two physicians are responsible for approximately 450 patients. The part-time physicians cover primarily Convalescent and Rehab-maintenance areas in the Infirmary sections of the hospital. Their caseloads average 100 patients. **The present physician caseloads make it difficult for doctors to provide patients with individualized medical attention.**

Failure Of Doctors To Perform Assigned Duties

Government regulations require that each patient at Kane Hospital have a medical doctor "who prescribes a planned regimen of total patient care. The patient's total program of care is reviewed during a visit by the attending physician at least once every 30 days for the first 90 days (and thereafter at least once every 60 days). There must be a written and signed progress note in the clinical record documenting the physician's visits." [1] Kane Hospital's by-laws further define the responsibilities of doctors employed at the hospital:

> Patients shall be seen daily. A physician visit has been defined as the personal appearance of the physician at the patient's bed, preferably with the attending nurse at which time and place necessary orders will be written. [2]

It is the exception for the medical staff at the hospital to conscientiously visit patients and evaluate their medical condition. On many areas of the hospital, doctors are never seen in the patient areas, visiting, talking to or examining patients. In the infirmaries, for example, when physicians are present, they stay in small offices at the entrance to the infirmaries, far removed from patient areas. If patients need medical attention, staff on the patients' areas (usually aides), decide when a patient should be seen by the doctor and the patient is taken to the dispensary, located next to the doctor's offices. No attempt is made by the doctors to make rounds and regularly evaluate patients. It is not uncommon for patients to have no contact with a physician for a year or longer while residing in the infirmaries.

On other areas of the hospital, doctors make brief visits to patient areas. Usually the visits involve the doctor sitting at the nurses' desk, and reviewing patients' medical status based on information provided by the nurse or nurses aides. The doctor completes this review without seeing the patients. Because of this arrangement, **nurses and nurses aides are eva-**

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uating the patients medical needs, deciding what warrents medical attention, and at times determining what procedures and medications should be ordered. The physicians then write this information into the charts usually without making any independent assessment of the patient's condition. On some areas doctors' notes and medication orders to be included in the charts are pre-written by the nurse. The doctor simply copies the information into the charts. A nurse on a convalescent area comments:

> I know more about the patients on the floor than the doctor. He doesn't know any of these people. If I didn't do it, nothing would be written on the charts. I've complained three times to the Medical Director about him not visiting the patients or doing his work. The last time Burns (Clinical Director) said nothing could be done, because the doctor had ties with the Commissioners. [3]

An aide discusses the situation on her Convalescent Floor:

> I worked on this same area for about 5 months, 5 days a week, Monday through Friday, 7:30-3:30. The doctor was scheduled to come in three mornings a week, for three hours. All I can say about the doctor is that he just wasn't around very much. When he was, he usually stayed at the nurses' desk. I worked on the area two weeks straight before I saw him. It seemed like he came in about once a week for maybe an hour. I guess the nurse did most of the things he should have been doing. He wasn't in any way a part of what happened on my area. [4]

A social worker comments:

> The general inaccessibility of doctors is a problem that most social workers ran into on their areas. Social workers and other hospital staff often discussed the problem of families who wanted to talk to the doctor, visiting or calling the hospital for long periods of time trying to find out something about their mother or father. It is even difficult for a social worker to talk to the doctor about a patient or get a doctor to look at a patient. Often patients get sicker and sicker without the doctor even seeing them, sometimes until it gets too late for anything to be done.
>
> Nursing personnel have trouble finding some doctors and getting them to a floor for an emergency. . . sometimes they wait up to three hours for a doctor to look at the patient and transfer them to the seriously ill floor. No one was really sure where the doctors were when they weren't on the floors. Some social workers and hospital personnel commented that doctors frequently gathered to play cards, spent time in the doctors' lounge, their offices, or sleeping rooms that doctors had on one floor of the hospital. One unlicensed physician who was responsible for doing histories and examinations on newly admitted patients had a sculpture studio and living quarters in the hospital. He spent most of his time there. And then there was always the possibility of doctors not coming into the hospital at all when they were scheduled.[5]

In some cases, doctors who are present on patient areas will not cooperate in seeing patients. A social worker comments on two incidents she witnessed involving the doctor on her area:

> A nurse knocked on the doctor's door. . . said that she wanted to ask him something. He opened the door and she apologized for disturbing him. His response was, "Well, what do you want, you've been bothering me all day." She said that it concerned him writing a medication order for a seriously ill patient. He suggested that it wait until Monday. The nurse was new and didn't know quite how to respond. She questioned the other nurse on duty about it. The nurse said that it couldn't wait. She returned to his office, knocked on the door, and said that it couldn't wait. She told him what medication to order. A medicine woman who had brought the chart to the front desk told him that the patient was very sick. He told her to bring the patient to his office. She said that the patient could not be moved. The doctor said no more. He wrote the order, returned to his office and locked the door.
>
> Another time at 10 a.m. there were three patients lined up waiting to be seen in the dispensary. I knew one of the patients, Mrs. Ella Ludwig. Mrs. Ludwig had

"Physicians have, to a large degree, shunned the responsibility for personal attention to nursing home patients. . ."

"Nursing Home Care: Failure In Public Policy
U.S. Senate Committee on Aging Report

the toes on her right foot removed because they had become gangrenous. She had come to Kane following the amputation. I stopped and talked with her for 20 minutes. She told me about the problems she'd been having getting a doctor to look at her foot.

I left Mrs. Ludwig and went to talk to the nurse about her. The nurse told me that when Mrs. Ludwig first came down, about a month ago, she was up on her feet and able to get around with a cane. "But the dressings on her foot weren't being changed often enough and the foot became re-infected. A daily change of dressing was necessary, but it wasn't being done on her area and she wasn't being brought up to have it done. So we decided to have her moved up to this level, so she could wheel herself up to the dispensary to have the dressing changed."

At 11:15 Mrs. Ludwig was still waiting. The doctor came out of his office and as he passed, Mrs. Ludwig called out to him. He paid no attention to her. On his way back to his office, she called out to him again, and asked if he would see her. Seeing the bandaged foot, he told her he couldn't help her – that she would have to see the foot doctor.

The nurse approached Mrs. Ludwig and told her the foot doctor wouldn't be in for the rest of the day – they would try to have somebody go back on her area in the afternoon and change the dressing. The nurse told her that she should have been at the dispensary at 9:30 if she wanted to be seen by the foot doctor (podiatry clinic is scheduled for five mornings a week, 9-12 noon, in the infirmaies). The doctor was not present and Mrs. Ludwig became angry. "No one tells me when I should be here. I had to wheel myself up. Never before in my life have I had so much trouble seeing a doctor as I do here. I'm fed up and tired of pushing myself onto the doctor." [6]

In addition to the serious problem of doctors being inaccessible, there is also a problem with the quality of medical care that patients receive from physicians. One physician had recently retired from a local university where he taught in a public health department. A social worker talks about her experience with the doctor:

> The doctor had been asked to work with infirmary social workers to evaluate patients ability to leave the hospital and live in some capacity in the community. The doctor was asked to do this after infirmary workers complained to the Director of Social Services and the Medical Director that the other doctors were unwilling to see patients. The doctor's procedure for evaluating patients was to simply review the patient's chart with the social worker. He did not visit the patient. I was surprised the first time this happened. He was looking over the patient's medication sheet and reading off the medications. I asked what one of the medications was for. He didn't know. I asked him about some of the others. He didn't know. This happened a few times and another social worker experienced the same thing. Besides this, the doctor approved every patient for discharge without seeing or talking to them – to evaluate how well a patient could walk, climb stairs, take care of herself, etc. [7]

There are physicians at the hospital whose physical disabilities seriously interfere with their providing competent medical services to the patients. There are also physicians whose language difference interferes with their ability to communicate verbally and in

writing with patients and staff. A physician, described earlier in this section, was 84 years old. His eyesight and hearing were so bad that it was difficult for him to read charts and converse with patients and staff. This, coupled with his general unwillingness to see patients, meant that medical services provided to patients assigned to his area were grossly inadequate. Staff and patients were aware of his limitations. A patient describes an examination that this doctor gave her after she fell and hurt her leg:

> I was taken to the dispensary. The doctor came in and looked at me; moved up close to my face, motioned the nurse over and asked her what was on my nose. The nurse told him there was a small sore. He had her put methialate on it. I told him about my leg. He told me it would be fine, and left the room. I had the sore on my nose because my glasses fit too tight. It didn't have anything to do with my leg hurting. [8]

Doctors' failure to carry out their professional responsibilities has serious consequences for the patients. The limited medical care that patients do receive is frequently incomplete and of poor quality. Patients with emergency medical problems do not receive any medical attention at all. Less acute medical problems go untreated or are mistreated, resulting in physical deterioration of patients that becomes irreversible. The lack of physician responsibility and supervision in the area of prescribing medication permits patients to be over-medicated or to be given medication for extended periods of time unnecessarily.

Neglect of patients' medical needs by staff physicians is wide-spread. The County Commissioners and the hospital administration are aware of the situation and yet, serious efforts to improve the quality of medical care, are not undertaken. Doctors, clearly incapable of and unwilling to give medical attention to patients are permitted to work year after year at Kane.

Specialty Clinics

Kane Hospital operates 13 specialty clinics to provide diagnostic and some direct care to patients. However the clinics are equipped to do only a limited number of diagnostic tests and procedures. No surgical procedures are done at Kane. Patients must be transferred to general, acute-care hospitals for such medical care. **The 13 specialty clinics are set up to provide services in the following areas: dental, eye, ear, nose and throat, dermatology, neurology, orthopedics, podiatry, surgical and physical therapy. The clinics are staffed by part-time physician consultants affiliated with hospitals throughout the county.** The hours that the clinics are open vary from clinic to clinic. According to a hospital clinic schedule, the dental clinic is to operate 5 days a week, the eye clinic 4 days a week, the podiatry clinic 5 days a week in the mornings. The other clinics operate 1 to 2 half days a week, once every two weeks or once a month.

Many patients at the hospital do not benefit from the services of the specialty clinics. **The full-time medical staff assigned to individual patient areas is charged with monitoring patients' medical condition, and determining when a patient should be evaluated in a clinic. Since many doctors fail to do this, patients who require specialty care in the clinics often do not receive it.** A social worker comments:

> A woman in the infirmary had a hearing aide when she came into the hospital. Over a six month period, her hearing got worse and worse. It got to the point where it was difficult for her to talk to anybody. The staff on her area was aware of the problem. Nothing was done for her. The situation existed for at least a year and a half. She eventually left the hospital to go to a church home. There were a number of patients that I encountered whose poor hearing made it difficult, if not impossible, for them to communicate with other people. No efforts were made to get these people to a clinic to see if they could be helped. [9]

Even when the staff is aware of a problem, the patient is not always referred to a clinic. Sometimes it is not until a patient's condition has progressed to a critical stage, that they are refered.

When a clinic physician diagnoses a condition and prescribes treatments, the responsibility for monitoring the patient and administering the treatment returns to the doctor and nursing staff on the patient's area. **Because of the lack of medical supervision on patient areas, the ability of staff to adequately follow-up on the clinic physician's recommendations to**

"John J. Kane Hospital is nationally recognized as one of the most advanced hospitals in the United States today for the care of the chronically ill and aging. . ."

"Kane Hospital Cares" Brochure
Allegheny County Bureau of Public Information

ensure the patients' improvement, is limited.

Long waits are another problem encountered by patients who are referred to clinics. At some clinics patients must wait months to be seen. Also transportation to and from the clinics is a problem. The escort staff at the hospital is not large enough to cover the needs of all the nursing areas in the hospital. The nurses aides on the patient's area become responsible for moving patients the long distances to specialty clinics.

Summary

Kane Hospital's literature discusses the comprehensive medical services offered to patients, yet in actuality the patients are receiving only limited services. The specialty clinics cannot operate effectively unless the full-time medical staff ensures that patients are given regular and competent medical attention. The hospital administration must supervise the medical staffs' performance and take action against physicians who do not perform their duties. The hospital administration must also monitor the operations of the specialty clinics to ensure that all patients receive the treatment they need without long delays.

Recommendations: Inadequate Medical Services

1) Physicians should be recruited, hired and reappointed to the staff on the basis of their ability and willingness to deliver competent medical services to patients, and not on the basis of their involvement in the County Commissioners' patronage system.

2) All doctors employed at Kane Hospital should be licensed; be able to speak, read and write English; and have no disabilities that would interfere with the responsible practice of medicine.

3) The number of full-time doctors employed at the hospital should be increased from 15 to 30. Special attention should be given to recruiting and hiring doctors who have medical expertise in the field of geriatrics, rehabilitation, and chronic diseases. Doctors' salary levels must be increased.

4) The hospital should explore the possibility of developing a program in conjunction with medical schools to involve interns and residents at Kane Hospital.

5) The Medical Director of the hospital should more closely supervise doctors to ensure that patients receive needed and competent medical care. When the director finds that a doctor is not performing his professional responsibilities as defined by ECF regulations and hospital by-laws, the director should have the authority to take immediate steps to correct the situation.

6) The part-time staff and the hours available in the specialty clinics should be increased to meet the needs of hospital patients.

WOMEN WAITING

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FAILURE OF ULTILIZATION REVIEW PROCEDURES

The Purpose of Utilization Review

Federal Medicare-Medicaid regulations require that long term care facilities maintain a Utilization Review Program. The purpose of the program is to ensure 1) "high quality patient care" and 2) "effective and appropriate use of an extended care facility's services by patients and staff".[1]

The Utilization Review regulations were designed to reduce Medicare-Medicaid costs and increase hospital efficiency. To meet these regulations, a written utilization review plan is submitted for Federal approval. Kane Hospital's medical staff by-laws describe their utilization review plan. **The fifteen full-time physicians at Kane have the major responsibility for carrying out the Utilization Review Program for 2,200 patients.** The goals of Kane's Utilization Review Plan are 1) "to verify each patient's need for admission, 2) provide prompt, efficient, high quality patient care, 3) provide prompt discharge when patients have reached maximum benefits of the hospital and 4) to study patterns of care at the hospital through the establishment of an educational program."[2]

Federal regulations establish two ways that utilization review objectives must be met: " 1) the review on a sample basis of admissions, lengths of stay and professional services furnished and 2) the review of each case of extended duration (30 days or more)".[3] This means that a percentage of all patients who enter the hospital and all "long-term" patients must be reviewed. The Utilization Review Program at Kane Hospital is not functioning to achieve the objectives defined in the Federal regulations or in its own medical staff by-laws.

Doctor's Failure To Review Patients

The medical staff of the hospital is responsible for regularly reviewing every patient who has resided at Kane a month or longer. This review should occur monthly or once every three months, depending on how long the patient has been hospitalized. These reviews are to be conducted by a physician, other than the doctor directly responsible for a patient's care. In this way, monthly evaluations by a second physician are to serve as a check to ensure that a patient is receiving all appropriate and necessary hospital services, and to verify the level of care a patient requires. Patients can receive three levels of care: skilled, intermediate and custodial. The amount of Medicare-Medicaid reimbursement Kane Hospital receives depends on the level of care patients require. Earlier in this report Kane Hospital's practice of falsely declaring patients to be in need of skilled nursing care in order to increase this reimbursement was documented. **Doctors assigned utilization review responsibilities are not making an independent assessment of each patient's needs and are falsely redeclaring patients to be in need of skilled and intermediate care.** A social worker comments:

> I noticed that on all of the patients' charts I looked at, there was a utilization review form in the front. It was to be filled out each month by a physician. But the form was drawn up in such a way that it didn't require the signature of the physician, only a code number. I was angry and upset that patients who needed medical attention were not being seen by the doctor. Doctors were seldom seen on the floors. I wondered how the utilization forms were being filled out. I learned from an infirmary nurse that the nurses simply write in the doctors' code numbers on the forms and there is no functioning review procedure.[4]

The Utilization Review Committee is also responsible for ensuring that every patient at Kane Hospital receives a complete annual examination. They are failing to do this. "Each patient still remaining in the

hospital on the anniversary date of his admission is examined by the staff physician, and appropriate laboratory studies and annual chest X-rays are completed. This data is available to the Utilization Committee and administration for study and any action necessary." [5] Patients are not receiving, even once a year, thorough physical exams. Although most patients' charts indicate that lab work and chest X-rays are done yearly, these procedures are meaningless if physicians fail to evaluate them. A social worker describes the situation:

> All patients, particularly those in infirmaries and convalescent areas, complained about not having contact with a doctor. Of those that did, it meant that they were usually brought up to the nurse's desk or a dispensary and talked to about what was wrong with them. I never saw a patient given what would be considered a physical examination. [6]

Politics In Admission And Discharge

A third important function of the Utilization Review Committee is to ensure that the hospital's services are being appropriately used. The Utilization Review Committee has the responsibility of ensuring that only patients who require institutional care are admitted. The U.R. Committee is failing to do this. Political patronage plays a large part in the admission and discharge of patients to Kane Hospital. The positions in the Admissions Department are political positions. The Director of Social Services at the hospital made the following statement in a closed staff meeting concerning the admissions personnel:

> The four investigators who arrange admissions came into their positions because they were elected Constables and continue to be Constables. The County Commissioners have traditionally gotten political mileage out of this set-up, in that through their intervention, they have succeded in effecting admission for constituents' relatives. [7]

A social worker comments on politics in the Admissions Department:

> It doesn't take long to find out that politics is used to get things done – to get favors or special treatment. When I first came to the hospital, social workers talked about the political interference they encountered in their cases, and the fact that there was nothing that could be done – it was just part of working at Kane. In my contacts with patients and families, references were made over and over again to the political contacts that were used to get themselves or their relatives into Kane. I can remember the daughter of a patient who was concerned about her mother not receiving enough medical attention. She told me that she was afraid of saying anything because it was through a Commissioner that her mother got into Kane. . . that if she caused any trouble they might force her mother to leave. [8]

In January 1973, The Director of Social Services' responsibilities were increased to include directing the Admissions Department. The role of politics in admissions has not been significantly changed. The four investigators still remain in their positions.

The Utilization Review Committee should not permit the admission and discharge of patients to be controlled or influenced by politics. Admission and discharge decisions should be based solely on medical need. Discriminatory admission practices allowing persons with political connections to by-pass the Admissions Department waiting list should not be permitted. This practice denies persons without political influence and in extreme need of care, admission to Kane Hospital. **By condoning these practices doctors on the Utilization Committee are failing to exercise their responsibility to ensure appropriate use of the hospital's services. The Commissioners and other County and state politicians who use their power to arrange for older residents to be admitted and confined at Kane Hospital are blocking the "effective and appropriate use of an extended care facility".** [9]

Failure To Assure Discharge Planning

Kane's Utilization Review Program requires physicians to "ensure that rehabilitation and treatment resources are adequately applied to ensure a smooth flow of patients through the three areas of the hospital (Admissions, Rehabilitation and Infirmary), with the ultimate goal of discharge." Discharge statistics show the serious failure of the Utilization Committee to ensure this process – less than 200 pa-

tients leave the hospital while 1,000 patients die there each year. The lack of living accomodations in the community to which Kane residents can return is an acknowledged problem. However, the failure of the hospital to provide adequate medical care, to rehabilitate patients, and plan for patients' return to the community is so serious that increased discharge of patients could not occur even if more community resources existed. A social worker comments on the lack of discharge planning:

> The problem of doctors not visiting patients and evaluating their conditions was discussed often by social workers. . . It was a situation that existed in varying degrees of severity all over the hospital. . . On my area the doctor didn't visit the patients. Another social worker and myself made requests for him to look at patients not only so discharge plans could be made, but also to enable patients to get medical attention. He refused our requests. The Director of the Social Service Department was aware and acknowledged the problem. He presented the problem several times to the Medical Director of the hospital. Some social workers approached the Medical Director to report specific cases of doctors refusing to evaluate patients' medical condition. No real changes were made to improve the situation.[10]

Kane Hospital receives about 7 million dollars in Medicare-Medicaid reimbursements for its patients. Kane receives this money as long as patients are institutionalized. The more disabled a patient is, the higher the reimbursement. There is no incentive for the hospital to work on improving patients' physical conditions or to try to make it possible for patients to leave the hospital.

Summary

The objectives of utilization review, as defined by Federal regulations, are not being accomplished at Kane Hospital. Kane Hospital's Utilization Review Plan exists in writing only. Over-institutionalization of older persons in Allegheny County, negligent patient care and inefficient use of Kane's facilities are the result. The falsifying of Utilization Review reports by the medical staff and other hospital personnel covers-up the problems. In addition, the Federal and state governments are not properly regulating the hospital to ensure that utilization review operates effectively.

Recommendations: Utilization Review

1) At least 25% of the Utilization Review functions should be performed by doctors unaffiliated with Kane Hospital or Allegheny County agencies. These doctors should be paid for their services. Doctors trained in geriatrics or rehabilitation should be recruited for this work.

2) The Utilization Review Committee should function to (a) evaluate and ensure high quality patient care, (b) discourage medically unwarranted political admissions and extended hospital stays and (c) ensure monthly doctor visits and evaluations of every patient.

3) The appropriate government agency should make an annual evaluation of Kane Hospital's Utilization Review Plan. The evaluation should involve assessing the quality of care, determining the extent of under or over utilization by the hospital, identifying fraud, and educating the administration and staff in the appropriate use of publicly funded health care programs. When the inspecting agency finds that the Utilization Review Plan is not functioning properly, it should require that the Plan be properly implemented. If the hospital fails to comply, action should be taken to remove the hospital's certification.

FAILURE OF GRIEVANCE AND COMPLAINT PROCEDURES

The administration of Kane Hospital does not respond constructively to grievances and complaints. Patients, families of patients, and hospital employees are disturbed and concerned about the conditions at Kane Hospital. There is a consistent pattern of suggestions, complaints and criticisims that are strongly discouraged by the hospital administration. The indifference, defensiveness, and caution with which other staff at Kane Hospital react to complaints is the result of the way the administrative and executive heads of the hospital deal with complaints about hospital conditions. In different ways, patients, patients' families, and staff are threatened with reprisals when they question conditions at the hospital.

The staff at Kane Hospital who report instances of poor care are viewed unfavorably by the administration, and discouraged from voicing their concerns. Due to the political nature of Kane Hospital, many employees receive their jobs with the aid of friends involved in the political party machinery in Allegheny County. Criticism of the hospital is viewed as a threat to the County Commissioners and their policies. Many employees feel they risk alienating their friends and losing their jobs by bringing criticism to the hospital administration. One result of this is supervisory personnel are often powerless because they are given no support from the hospital administration. A social worker comments:

> A nurse was asked to go to the Director of Nursing's office to discuss a series of incidents that had taken place between a patient and the aides and housekeeper on her area. The Director of Nursing decided to meet her after the patient had made two visits to his office and had met with other hospital administrative personnel. I spoke to the nurse following her conversation with the Director of Nursing. What was decided was the patient was possibly disturbed. It was agreed that a physchiatrist would evaluate her to see if she should be commited to a mental hospital.
>
> The nurse at different times, had talked to me about the staff on her area, saying that some of the staff were difficult to work with – talked and acted insensitively to the patients – particularly the staff persons who had been involved in this incident. I asked her why she had not talked to the nursing director about the way some of the staff treated the patients.
>
> She told me that when she came to Kane she was shocked by the poor nursing care, "At other jobs I had worked at, there was a lot of discipline and we weren't permitted to get away with the things that they do here. So when I came to Kane I was concerned and pushed the staff to give the kind of nursing care that I considered good. But I found out that my efforts weren't appreciated. I was considered too demanding and hard to work with. They told me that they were having trouble assigning people to work on my area. I was told to ease up. I've learned now to keep my mouth shut about what goes on here. If I said anything about the way patients are treated, they wouldn't do anything. And those people on my area (staff) would find out and it would make things more difficult for me. Things are bad enough as it is. I don't want any more problems. I don't have too much longer and I need to stay here till I can get my pension."[1]

In some cases staff who attempt to resolve complaints are heavily criticized and threatened with dismissal by the hospital administration; while the people who the complaint concerns are defended. There

is oftentimes no effort made to investigate the complaint to determine if it is legitimate. A social worker comments:

> A social worker was sitting in her office in the infirmary and overheard an argument in the hallway. She went out to see what was going on. There were two women and the infirmary nursing supervisor talking. They were discussing their mother, who a few days before had died. The social worker approached the women. They talked about an aide on her area who they thought did not like their mother – and thought she had possibly done something to cause her death. They reported that things had been stolen from their mother – they thought that the aide was responsible.
>
> The social worker stated that other patients had similar complaints about the same aide and that the matter ought to be looked into. The nursing supervisor said that she knew nothing about the aide that would support their accusations. The women asked to be taken to the Nursing Director's office. The nursing supervisor tried to discourage them. The social worker agreed to direct them to the Nursing Director's office. A heated exchange between the daughters and the Nursing Director and Co-director followed. The daughters left the office and the social worker was told to stay.
>
> The director and his assistant took the social worker into their office and questioned her about what she did. She tried to explain the situation with the aide, and that other patients were having difficulty with the aide. They told her that she had been wrong in saying anything – that her loyalty to the institution was in question and told her that she faced losing her job for what she had done.[2]

This kind of action against staff members who are concerned about hospital conditions and the way patients are treated, is intimidating and effectively silences personnel who have no alternative to working at Kane Hospital. A social worker describes a similar situation concerning voter registration at the hospital:

> A team of people from the Election Bureau came to Kane Hospital to register patients to vote. It was a few months before the County Commissioners were running for re-election (1972). A few social workers were asked to direct the Election Bureau people to different parts of the hospital. I accompanied an older man to the male infirmary. I stayed with him while he talked to patients to see if they needed help in voting. After he talked to a few patients, I began to realize that he was signing up all the patients as needing help in voting. He presented it to the patients as if he was doing them a favor.
>
> He approached a man who was much younger than most of the patients – who walked all over the hospital delivering newspapers, and had no physical handicaps. The man from the Election Bureau wanted him to have assistance when he voted. I interrupted and said I didn't understand why the man couldn't vote by himself. He asked me if I was questioning his honesty, and told me that we would have to go upstairs and talk to the woman in charge. As we were leaving, an aide who overheard our conversation came up to me and told me that I had every right to say what I did. She said, "I've been working a long time at the hospital and I've seen some very funny things. These people (from the Election Bureau) come in and just take it for granted that because some of the patients are old and are in wheelchairs, that they're not capable of thinking. They take advantage of them."
>
> We went upstairs and the man told the woman in charge that I was questioning his honesty. I tried to explain what happened and asked what criteria they used in determining who needed help in voting. She became angry and told me that I was dismissed.
>
> I discussed the incident with another social worker, and we called the Election Bureau office and spoke to the director. He said that if a person was capable of marking an X on the ballot, they did not require assistance – that they did not even have to be able to write. I returned to talk to the woman in charge. By this time a number of people had been told what happened and were hostile to me. The woman in charge said that I was just trying to make things difficult for them. They were considering not even signing up patients to vote, and that would mean

that I was responsible for "disenfranchising the patients at Kane Hospital." I tried to explain that I thought the patients had the right to vote like everyone else — that it didn't seem fair to have another person vote for the patients when they were able to do it themselves. I wasn't accusing the Election Bureau people of being dishonest — I was questioning only one man's method of registering patients.

She said that because the patients were old and handicapped, they needed to be assisted. I conveyed the information the Director of the Election Bureau had given us. The aide who earlier had supported me, went to the woman in charge to verify my story and defend me. Later I met with the Director of Social Service. He told me that he didn't believe that anything like that had ever happened in the history of patients voting at the hospital. I told him that I saw it with my own eyes and there was an aide who also witnessed it. He told me that I could carry it further if I wanted to, but that I was "risking my job" if I did. I did nothing more.[3]

An aide discusses the lack of any effective channels for resolving grievances within the hospital:

Aides do not have any workable procedure for grievances or complaints. It doesn't do any good to complain to a nurse or supervisor. On my permanent floor we had several patients with staph infection. One of the patients had bad bedsores on her buttocks. The nurse on the floor told me and other aides to do the dressings by putting wadded up 4x4 gauze in the sores. When the nurse did it for the doctor's visit, she padded the bedsores with thin strips of medicated gauze. Anyway, we didn't like doing the dressings because we weren't supposed to and were afraid of getting the staph infection.

One day Debbie and I were doing the patients in the sick room when the supervisor and nurse came in. The patient with the staph sores was laying on her stomach waiting for the bedsores to be dressed. Debbie and I had decided to try and get someone who was trained to do them. The nurse asked Debbie who was near the bed, why she wasn't doing them. Debbie said she only had one stripe and wasn't trained to do them. The supervisor said, "Are you going to let her lay there like that with no dessings? You know how to do them." She and the nurse left. Debbie and I were stuck. We couldn't complain to the nurse or the supervisor. We would have to go higher and we were afraid to and didn't.

Another time I reported some aides to the charge nurse for not giving a patient lunch becuase she had "green diarreha" and they didn't want to clean it up anymore. The next time I was on that area the aides made a dramatic thing out of asking each other if "everyone had a tray?" The nurse had told them who had complained. Nurses aides are discouraged from complaining about other aides, or abuses or poor medical care. When an aide was known to have turned someone in they would be pointed out to everyone else in the lunchroom to make sure everyone knew to be careful around them.[4]

If threats of dismissal fail to silence staff members who are demanding changes in hospital conditions, outspoken employees are dismissed. Dr. Paul Soster, a dentist at Kane for five years discovered that the Director of the Dental Clinic at Kane Hospital, Dr. Edward Sebastian, was failing to come to work when scheduled. The Dental Clinic records were being falsified to conceal his absence. Soster further alleged that Sebastian was stealing dental equipment and supplies from Kane Hospital to use in his own private practice. Dr. Soster's statements were supported by other hospital personnel. Soster attempted to have the situation investigated first by the hospital administration and then by the County Commissioners. When they refused to investigate the situation, Dr. Soster went to outside agencies and the Pittsburgh Press. The following article appeared in the Pittsburgh Press on July 30, 1973.

Dr. Soster was fired effective August 1, 1973. No reason for his dismissal was given. Dr. Sebastian (a personal friend and contributor to the Staisey-Forrester campaign) [5] remains the head of the dental clinic.

Families encounter many of the same obstacles and frustrations that hospital personnel find when they try to improve conditions at the hospital. As with staff criticism, family members are discouraged and embarrassed. Responsibility for a particular in-

'Coverup' Tied To Kane Firing

A dentist who accused Kane Hospital of having "its own Watergate coverup" has been fired from his $7,368 part-time job at the hospital.

The dismissal came in a letter from county personnel secretary George D. Braun to Dr. Paul Soster of Monroeville.

Braun gave Soster no reason for the dismissal Friday, however, hospital director Dr. Edward R. Deverson said he had requested Soster's firing after he had made charges against Dr. Edward H. Sebastian, head of the hospital clinic.

Charged 2nd Source

Soster charged that Sebastian, who has a private practice in McKees Rocks and Scott Twp., was paid on numerous days when he did not work in the hospital clinic.

Sebastian, who works three half days a week at the hospital at a salary of $13,440 a year, denied Soster's charges in the presence of Deverson and a reporter from The Press.

Soster has asked State Welfare Secretary Helene Wohlgemuth and U.S. Atty. Richard Thornburgh to investigate his charges.

He also has repeated his charges in letters to the three county commissioners, the NAACP and Clerk of Courts Robert N. Peirce.

The dismissal of Soster, who has been employed at the hospital since September, 1968, was recommended to Deverson by Dr. Hugh J. Burns, clinical director.

Found No Support

Burns said he had invesigated the charges of Soster, woh worked two half-days a week at the hospital, and found them unsubstantiated.

Burns added:

"I was shown a letter written by Dr. Soster claiming Kane Hospital had its own Watergate coverup and he had notified a state official that the Kane Hospital dental was not being required work."

Burns said Soster's conduct "is not the approved action of a professional man but the action of a bitter man trying to involve the administration of this hospital in a personal quarrel."

Deverson said that there were discrepancies in the charges made by Soster against Sebastian and that the "lashing out" against the other dentist could be related to his failure to receive a pay raise.

The director cited a May 31 letter from Soster to the hospital administration in which he praised the clinic's operation by Sebastian and himself.

'No Merit Raise'

In the same letter, Soster said he had not received a merit raise although he was in his fifth year at the hospital.

Deverson also pointed to a statement made by Mrs. Nancy Wylie of Bridgeville, who had worked in the clinic and who made the allegation she had marked Sebastian present when he was not at the hospital.

Mrs. Wylie, who has resigned from the hospital effective Aug. 1, made charges concerning Sebastian's attendance at the hospital during a 13-month period when she wasn't an employe at the clinic, Deverson said.

During an interview in the clinic at which Deverson was present, Mrs. Wylie said Sebastian was marked present when he was absent from May 7, 1968 to Nov. 12, 1969.

She said during this period he should have been in the clinic 224 times but that he was absent 124 times.

At the time, she quoted Sebastian as saying:

"These (log) books are all fairy tales. Just call me in. They won't know. They led me to believe this was a political job and that if they wanted me out, I'd be out."

She said that Sebastian on occasion talked about having lunch with a county commissioner, adding:

'Assumed Staisey'

"I assumed he meant (Leonard C.) Staisey. He made dental work for Staisey."

Mrs. Wylie was employed intermittently at the hospital as an aide from July 3, 1961. Her latest employment dated from June 16, 1969.

After his dismissal, Soster sent letters again to Thornburgh, Mrs. Wohlgemuth and Peirce, commenting:

"It seems incongruous and ironic that I should be the one dismissed for Dr. Sebastian's absenteeism. This is not to say that I do not understand the political reprisal system."

Deverson said that Soster had been sending out "intemperate letters like handbills," adding:

"We feel his allegations don't hold water. We could not document any of his charges. He also took out hospital records and made marks on them which could have been alterations.

"This was grounds enough for his dismissal."

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cident is transferred to other people and the family is given the run-around. A social worker comments:

> Mrs. Nesbaum brought her mother in nightgowns, robes, underwear, and other clothing when her mother first went into the hospital. She said that many of the things were missing after a few days. She continued to bring things in, and they continued to be missing. Mrs. Nesbaum said she spent a "fortune" the six weeks her mother was in the hospital trying to keep her in decent clothes. (Her mother died at Kane.) "Every time I found something of my mother's missing I would go to the nurse and report it. But she'd just tell me that she didn't know anything about the clothes — that the night staff was probably responsible. Mrs. Nesbaum said she got tired of complaining, "because nobody seemed interested in doing anything about the stealing." In addition to her clothes, her mother lost an expensive set of dentures. Mrs. Nesbaum questioned the staff about it and was told that they probably got caught in the linens and sent to the laundry, where they couldn't be found.[6]

When families take complaints to a supervisory level, supervisors often minimize or dismiss them, saying the patient is "confused" or "too demanding". Families are also told if they are unhappy with the care that a relative is receiving, they should make arrangements to take their relative home.

Patients at Kane Hospital are the victims of inadequate care and mistreatment; often they are powerless and cannot do anything about it. Most patients must accept the mistreatment they get. Some are not able to explain how they are being treated; some are afraid of the consequences of talking about it. Many patients have no one who regularly visits them to check on the care they receive. Patients who demand the care they need are resented. **Patients who request better care are sometimes subjected to harrassment and abuse.** An aide comments:

> Dorthy had Parkinson's Disease and diabetes. She said she couldn't move any part of her body except her mouth and eyelids. She was the most demanding patient on the floor. She would always ask for things she needed. She was screamed at, slapped, and told to "shut-up" many times by the staff. I was told "she made herself like this, she could walk if she wanted to — she could when she came onto the floor." "Don't feed her, she can do it herself." So tray after tray sat in front of her and was taken away untouched. She begged us not to bring the trays in. Eventually we got orders to feed her, so we did. Some of the aides fed her quickly with giant spoonfuls. When she began choking, they would take the tray away, and tell her she was done. When her decubiti got really bad, she was put on a circolectric bed. She was afraid of the bed — afraid of her catheter being pulled out, of slipping, of getting her feet hurt and of getting hit on the head when we put her onto the litter. Some of the aides would play with the buttons on the bed when she was being turned. Make it rock. Put her head lower, keep her upright for a while so, "she wouldn't forget how to stand up." She was afraid of baths. She was stiff and uncomfortable in the tub. She yelled about it. Some of the aides teased her and poured water in her face. When she was put back in bed after the bath, she was thrown in roughly. She died on my day off. When I came in the aides talked about how the floor would be much easier, because a walking patient had been sent in her place.[7]

Out-spoken patients, not intimidated by the threat of mistreatment, sometimes face transfer to another area in the hospital. In some cases they are labeled "disturbed" and undergo an evaluation by a psychiatrist. A social worker comments:

> Mrs. Carrie Knight was a patient on the blind floor. A young woman who visited Mrs. Knight came to me and asked if it was possible that Mrs. Knight had been seen by a psychiatrist. I told her that it was. I had other conversations with Mrs. Knight's friend about some problems Mrs. Knight had been having on her area. The friend characterized her as a strong-minded woman, very clear mentally and outspoken about the way she and other patients on her area were being treated. Mrs. Knight told her that a man had come to talk with her. She suspected that he was a psychiatrist. She had asked the nurse if he was a psychiatrist and the

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nurse told her he was just a doctor. I told her friend that I would discuss it with Mrs. Knight and the nurse. The nurse told me that Mrs. Knight demanded too much attention – that she had the impression she was somehow special and should be catered to. She said that Mrs. Knight resisted leaving her room and going to the solarium for her meals. A phsyciatric consult had been ordered by the doctor on her area. The evaluation reads as follows:

"Reason for requesting consult: Patient refused to leave bed. This 83 year old female has many physical complaints including headaches and dizziness. She is said to be extremely negativistic and relatively un-cooperative. She has cataract surgery but remains "legally blind". Mental status revealed an elderly woman in no acute distress. . . She was oriented in all spheres. . . Relatively little memory impairment. . . There was minimal paranoid ideation and depression. Would suggest she be pushed to comply with ward regulations. If this is unsuccessful would feel this patient is commitable."

The nurse told me that they could not deal with her any more, and that she was being transfered from the blind floor to an infirmary area. I then spoke to Mrs. Knight. She said that it was true that she resisted going to some of her meals. She said that she was afraid to walk when she was dizzy – she was afraid she'd fall and break her hip and die. She told me a story of a woman on her area who fell and broke her hip when she was walking to the dining room. "Nobody cared she died. It was just another one gone and another bed freed. I'm afraid of walking when I don't feel good. I've asked for help but I don't get it."[8]

Some patients try to get relief from a bad situation on their area by reporting mistreatment to a nurse or nursing supervisor outside their area. At times nurses handle patient complaints by approaching the staff person who the complaint is against. This can leave the patient in a vulnerable position. When the nurse leaves, the patient is frequently faced with reprisals from the staff members. In the two infirmaries, there are 1-3 nurses each shift for 288 patients. The nurses are at a desk that is separate from the nursing areas. A social worker tells of one patient's treatment:

A patient, Mrs. Laughlin, on a back area of the infirmary, told me about an incident of mistreatment that she saw in the bathroom on her area. The geri-chair patients were being "pottied" after lunch. The aides brought in a patient in a geri-chair. They pushed her over to the toilet stall, pulled out the tray on the chair, stood her up and told her to get on the toilet. Mrs. Laughlin said the woman wasn't very strong, and tried to tell the aides the woman needed help. The patient slumped to the floor on her knees. An aide slapped her and insulted her. The woman yelled. The aide told her to "shut-up". After this happened, Mrs. Laughlin told an RN who came back to her area what she had seen. The aide still works on her area. She said that as a result of what she told the nurse, the aides won't let her into the bathroom after lunch and she must wait one to two hours before they will let her into the bathroom. She's afraid of other things the aides might do to her.[9]

Summary

The lack of a grievance system for employees results in a low level of morale among hospital staff. Healthy employee morale is vital to the provision of quality care in a hospital. Without effective, organized channels for grievances, employees' ideas and complaints, cannot receive fair and complete attention. The patients at Kane suffer directly from the low employee morale. The quality of the care they receive depends on the state of mind of the people delivering the care. The rehabilitative care Kane claims to provide requires time, understanding, patience and encouragement from staff.

These qualities are impossible under the current working conditions at Kane. It is almost impossible for employees to express simple kindness to patients. Therefore, patients have a double problem. They are the recipients of the effects of low employee morale and at the same time are also denied an effective, protected grievance system of their own. Patients and their families have no channels through which to make complaints and suggestions. They are trapped by the same administrative and government policies that control the employees of Kane.

Recommendations: Grievances and Complaints

1) There must be a formal mechanism for the expression of and resolution of patient, family, and employee grievances within the hospital. A clear grievance procedure should be established.

2) Persons initiating the grievance procedure should be protected. This can only be accomplished by removing the hospital from the patronage system and control of the County Commissioners.

3) The grievance committee should be regularly elected by patients, employees and families. One-third of the members of the committee should be unaffiliated with the hospital.

4) Three full-time advocates should be paid by the hospital to bring patient and family grievances before the grievance committee. The advocates must not be employees of the hospital. The hospital may contract for the services of advocates with a local welfare rights or patients' rights organization.

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INSPECTION AND REGULATION OF KANE HOSPITAL: A FAILURE IN STATE AND FEDERAL GOVERNMENT

Kane Hospital is required to comply with United States Department of Health, Education and Welfare regulations, Pennsylvania Welfare standards and national and local Fire Safety Codes. **Federal and state agencies are responsible for insuring that the hospital is in compliance with these regulations. They fail to fulfill this responsibility. Complete inspections do not occur. Kane is not cited for all violations of the regulations and forced to follow the law.**

In addition, many areas of the existing government regulations are weak, ambiguous and difficult to enforce. The Report of the U.S. Senate Subcommittee on Long Term Care, entitled, **"Nursing Homes in the United States: Failure in Public Policy"**, describes the "enforcement farce":

> Despite the sizable commitment of Federal funds, H.E.W. has been reluctant to issue forthright standards to provide patients with minimum protection. . . Most leading authorities concluded at the subcommittee hearings that the new standards are so vague as to defy enforcement.
>
> There is no direct Federal enforcement of these and previous Federal standards. Enforcement is left almost entirely to the states. . . the enforcement system has been characterized as scandalous, ineffective and in some cases non-existent.[1]

The Federal government (H.E.W.) does not inspect Kane Hospital. The Pennsylvania Department of Health has been delegated the authority to enforce both the Federal Medicare-Medicaid Regulations and the Pennsylvania Department of Public Welfare Regulations. The Pennsylvania Department of Labor and Industry is given the responsibility of enforcing the Fire Safety and Panic Regulations and the County Department of Environmental Resources must enforce sanitary standards.

At this time, **Kane Hospital is in violation of over 80 parts of the state and Federal regulations. Some of these violations are imminent threats to the health and safety of hospital patients and employees (poor handling of infectious disease, shortage of linen, lack of essential personnel, poor handling of oxygen). The inspection agencies have failed to act decisively even in these situations.** They are inept and disorganized in fulfilling these duties.

The inspection agencies give Kane Hospital advanced notice (usually two weeks or longer) before any inspection. This allows sufficient time for the hospital to clean up and prepare for the inspectors. In many instances, inspecting agencies are not required to give advanced notice to facilities being inspected. Unannounced inspections can be used to ensure that inspectors see the regular day-to-day functioning of the facility. Complete and unannounced inspections of Kane Hospital would make it more difficult for the County Commissioners and the hospital administration to cover up the hospital's inadequacies. The regulatory agencies are beholden to the political system of which they are a part. They must respond to the pressure from the County Commissioners and the county political machinery. The regulatory agencies in unison with the County Commissioners maintain the status quo at Kane Hospital, while minimizing public disclosures of the inadequate care and inhuman conditions there.

Recommendations: Inspection and Regulation

This report is concerned primarily with the function of county government and documentation of conditions in one county home. Complete and comprehensive recommendations for change in state and Federal regulatory agencies are not within its scope. We offer these recommendations as essential, initial steps in changing the functioning of these agencies.

1) More specific and clear Federal Medicare-Medicaid regulations should be adopted by H.E.W.

2) A citation/fine system should be coupled with the state and Federal regulations.

3) A single agency responsible for regulating nursing homes in Pennsylvania should be established and adequately funded and staffed.

4) Unannounced inspections should be standard procedure in determining quality of services in a nursing home.

5) A paid, independent consumer advocate should be a member of each inspection team.

6) Any individual or organization representative who has filed a written complaint concerning a nursing home should be permitted to accompany the inspection team during the inspection.

7) Reprisals against any individual who files a complaint should be prohibited.

8) The complete inspection reports should be available to the public.

CONCLUSIONS AND REOMMENDATIONS

Description Of Kane Hospital

Kane Hospital is a government operated 2,111 bed rehabilitation and long-term care hospital located near Pittsburgh, Pennsylvania. It is the second largest institution of its kind in the United States. The hospital is part of the Allegheny County Institution District and the County's three elected Commissioners are responsible for its operation. Kane Hospital's annual budget is over 19 million dollars. The County is reimbursed for one-third of Kane's budget through the Federal Medicare-Medicaid program.

Most of the hospital's patients are over 65 years of age and suffer from a chronic, although not necessarily disabling, disease such as hardening of the arteries, diabetes, or emphesema. Other Kane patients are permanently disabled, some are in the terminal stage of their illness. All Kane residents are "medically indigent" and cannot afford care elsewhere. The hospital's annual reports show that the average length of stay at Kane is nearly two years. Although the expressed purpose of Kane is to rehabilitate patients, less than 200 patients are discharged each year. In the same period, over 1,000 Kane residents die.

Summary Of Findings

1) Kane Hospital is poorly administered, under-funded and used for political favor and patronage by the Allegheny County Commissioners.

– Kane Hospital is under-budgeted – essential staff, supplies and equipment are not provided at the hospital.

– County officials cover-up the lack of staff and the inadequate nursing and medical care at Kane Hospital in order to pass government inspections.

– Hospital employment, service contracts, and admissions are used for political purposes by the County Commissioners.

– Underqualified and at times unqualified persons are given patronage jobs.

– Persons occupying favored positions at Kane Hospital often are not required to attend work regularly or do a full day's work.

– Poor quality patient care results from these practices.

– The patronage practices produce clear race and sex discrimination in the hiring of hospital personnel.

– Findings of the Allegheny County Human Services Commission show the County is falsely declaring over 1,000 Kane patients in need of "skilled" or "intermediate" nursing care in order to gain Medicare-Medicaid reimbursements while providing only custodial care to these patients.

– Insufficient checks and balances exist in the system used to manage patients' funds and hospital billing. Patients and/or their representatives are not provided with bills itemizing hospital charges at regular intervals.

– The hospital administration is failing to properly oversee and return patients' income, accumulated in Kane Hospital accounts, to the patient or patient's beneficiary upon death or discharge.

2) The patient care at Kane Hospital is inadequate and in violation of minimum government standards.

– Hospital physicians are not prescribing "a planned regimen of patient care based upon an evaluation of each patient's immediate and long term needs".

– Patients are not kept "comfortable, clean and well-groomed".

– Patients are not "receiving treatments and diet as prescribed".

– Patients do not receive "proper care to prevent decubitus ulcers and deformities".

– Patients are not adequately "protected from accident, injury, and infection".

– Patients are not "assisted in maintaining an optimal level of self-care and independence".

– Patients are not receiving necessary rehabilitation services.

3) There is a critical shortage of personnel at Kane Hospital.

– There are not enough nursing staff on duty to provide for the basic nursing needs of patients as defined by state and Federal regulations.

– There is a significant shortage of personnel in the Rehabilitation and Nursing Departments qualified to supervise, direct, and provide on-going rehabilitation and restorative nursing services.

– There are only 15 full-time and 8 part-time doctors (excluding consultant physicians) employed at Kane Hospital. More doctors are needed to provide adequate medical supervision.

– The Recreation, Inhalation Therapy, Laundry, Housekeeping, and Social Service Departments are understaffed.

– There is not adequate coverage by relief personnel as required in government regulations. The high staff absentee rate makes relief personnel critical for the functioning of the hospital.

– There is a high employee turnover rate at Kane Hospital due to the poor working conditions and the low salary levels.

– The County Commissioners have consistently tried to excuse the shortage of staff at Kane Hospital by saying that people are unwilling to work in a chronic disease hospital. At the same time, they have done nothing to improve salary levels and working conditions at Kane.

4) Administrative and supervisory personnel are not providing adequate direction and supervision — Patient neglect, poor patient care practices, and patient abuse result.

– Nursing care plans are incomplete, often inaccurate, and do not comply with government standards.

– Provisions for isolating patients with infectious diseases are not consistently prescribed and rigidly followed thus, threatening the health of all patients, staff and visitors.

– Nursing personnel are assigned specialized nursing tasks for which they have not been trained, including the packing of decubitus ulcers, treatment of staph infection, changing of illeostomy and colostomy bags.

– Specific treatments and procedures, although prescribed by the doctor and/or required by hospital policy are not consistently provided, including dressing changes, baths, mouth care, decubitus ulcer care and restorative nursing practices.

– Patients are not given privacy during treatment and care of personal needs.

– Physical and verbal abuse of patients continues at the hospital. On some floors patients must "tip" (with packs of cigarettes, storebook coupons, or money) in order to get care they need.

5) The medical staff is not fulfilling its duties and responsibilties, as defined by hospital policies and government regulation.

– Physicians are not prescribing a planned regimen of patient care for each patient, appropriate to their needs, and reviewed and revised as needed.

– Physicians do not make regular visits to patients in their care as required in Kane policies and government regulations.

– Records of patient care programs and doctors' visits are falsified by Kane Hospital in order to pass government inspections.

– Patients are not being referred to the hospital's specialty clinics when necessary due to the infrequent evaluation of the patients' health by the attending physician.

– Services at the specialty clinics are slow. Demand for clinic services far exceeds their limited resources and capabilities.

– Attending physicians and nursing staff do not always consistently follow-up on the recommendations of the specialty clinics' medical consultants.

– Physicians fail to perform Utilization Review evaluations. They are simply initialing UR forms without visiting patients.

6) The supportive services — Laundry, Inhalation Therapy, Recreation, Housekeeping, Dietary, etc. — necessary for any hospital to provide good care are understaffed, poorly organized, and in violation of state and Federal regulations.

– There is an inadequate supply of clean linen and clothing at Kane Hospital. The laundry operates only day shift five days per week, making the lack of linen critical over weekends.

– Housekeeping practices are poor, leading to a prominent smell of urine in the hospital, a year round rodent problem, and dirty floors, walls and equipment.

– The handling of oxygen at Kane Hospital is disorganized and dangerous.

– Essential Inhalation Therapy Department treatments are not provided to patients due to the lack of IT staff.

– The Recreation Department is understaffed and does not provide regular "activities suited to the needs and interests of Kane patients" as required by government regulations. Boredom and inactivity are major problems at the hospital.

– The diet at Kane is substandard. Food is repititious, tasteless, and of poor quality. Meals are often served sloppily and in unappetizing surroundings. Food is frequently cold by the time it is received by the patients.

– The Social Service Department within Kane is primarily oriented toward discharging patients. The Department therefore neglects the medically related social needs of the long-term Kane patients.

– The Social Service Department is ineffective in arranging discharge for Kane patients because:

1. Failure of Allegheny County to provide necessary community support services to enable older persons to live in the community.
2. The shortage of suitable housing for older persons living on fixed incomes.
3. Lack of adequate nursing and rehabilitation services at Kane.
4. Political interference in discharge planning.

7) The hospital was not designed and built to house large numbers of disabled and handicapped residents. The physical plant is inadequate and in violation of state and Federal standards.

– Almost one-half (1,058) of Kane's patients are housed in 22-person ward rooms. These rooms are in violation of the Fire Safety Standards, Pennsylvania Department of Public Welfare regulations and Federal Medicare-Medicaid regulations.

– Bathroom accomodations are inadequate and in violation of state standards.

– Safety provisions and provisions for handicapped persons are inadequate.

– The ventilation is inadequate in all patient areas of the hospital.

– The nurses emergency call and signal system is inadequate and in violation of government standards.

8) There are no effective channels for processing grievances and complaints fairly and responsibly at Kane Hospital.

– Suggestions, criticisms, and complaints from patients, patients' families, or hospital personnel are responded to in defensive and threatening ways by the hospital administration.

9) The state and Federal Regulatory Agencies in charge of inspecting Kane Hospital are failing to enforce the applicable government regulations.

– Kane Hospital is in violation of over 80 parts of the state and Federal regulations.

– In situations where imminent threats to patients' health and safety exist (lack of staff, poor isolation practices, poor medication practices, lack of clean linen, inadequate rehabilitation and restorative nursing programs, inadequate physical plant), government agencies have failed to act decisively to ensure adequate patient care.

Concluding Recommendations

In light of recent disclosures of deficiencies in both public and private nursing homes around the country, the Federal government under the Nixon and Ford administrations has proposed firmer inspection and licensing practices and the cutting off of funds to facilities not in complaince with government standards. This action has produced only limited improvement in the quality of nursing homes and long term care facilities. More importantly, **the Nixon-Ford policies have also caused grave concern about 1) the effect upon people denied services and treatment in de-funded facilities and 2) whether such cut-backs promote the development of satisfactory alternative services, or whether they are primarily budget cutting efforts meant to deal with the current decline of the economy at the expense of our older citizens. While it has become common to criticize the costly and unnecessary institutionalizing of large numbers of elderly and chronically sick persons, little is being done to provide satisfactory alternative services. Government at all levels is assuming little or no responsibility in these matters. Funding cut-backs alone will not overcome the problem; they may even compound it by forcing patients into a more costly institution — the general hospital.**

Resources and services which will enable older people to live at home must be established. This ideal is often stated but seldom applied. As previously mentioned, the Allegheny County Commissioners appropriated 7.5 million dollars of county funds in 1973 to Kane Hospital, while only $500,000 of county funds were used for community support services for older persons. The same budget priorities exist in the Federal government. Robert Morris, Director of the Levinson Gerontological Policy Institute, Brandeis University, comments:

> The parody is that our programs are designed to pay too little to keep such (aging) persons at home. (Average social security benefits for a retired couple now amount to only $310 a month, while we will readily pay an average of $600 a month to keep one person in an institution or nursing home.[1])
>
> While we pay generously for active treatment, and modestly for basic shelter, we pay nothing to reinforce the natural life system arrangements to which the disabled can turn in their own communities. The entire burden is placed upon family and neighbors who usually help for a time, until they are virtually bankrupted in money and energy; then the unfortunate individual is removed to a nursing home, instead of reinforcing and conserving these natural family and friendship supports, they are permitted to exhaust themselves until only much more costly alternatives remain available.[2]

The alleviation of the negative aspects of growing old call for a mix of medical and social provisions. The current government policies rely heavily on medical and institutional provisions while virtually ignoring long-term social, home, and personal care needs. This gap in the American system contrasts sharply with the pattern prevailing in many European countries, where a wide-spread network of home help services, public transportation, and other community provisions exist.

The lack of attention paid to the initial social needs of the aging person in America, leads to a costly overuse and abuse of institutions. But more important, the neglect of these social provisions denies people growing old their basic right to life, liberty and the pursuit of happiness.

"Institutionalization could have been postponed or prevented for thousands of current nursing home residents if viable home health care and supportive services existed. Although such alternative forms of care may be more desirable from the standpoint of elderly patients — as well as substantially less expensive — the Department of H.E.W. has given only token support for such programs. . ."

"Nursing Home Care: Failure In Public Policy"
U.S. Senate Committee on Aging Report

Recommendation I

Government policy should ensure the existence of essential community provisions to enable older persons to live outside of institutions. These should include funding for at least these minimum services to be available uniformly throughout rural as well as urban areas:

1. Home health, household tasks and shopping aides
2. Community-based day programs providing health and recreational services (day hospitals)
3. Public housing designed to accomodate the special needs of older persons and handicapped individuals
4. Supervised and licensed boarding homes
5. Meals-on-Wheels services
6. Adequate public transportation

The Federal, state and county governments should make available additional funds for these and other necessary social programs.

A Federally funded system for providing comprehensive, preventative and community-based health services to older persons in the United States must be developed. These services should be fully covered by a national health insurance plan adopted by Congress.

Recommendation II

Facilities designed to care for people requiring long-term medical and nursing services should not be used to house older persons not requiring constant medical and nursing attention.

Recommendation III

Long-term facilities built in the future should not exceed 200 beds. They should not be operated for profit. The facilities should be located in communities they serve to prevent the loss of social and community ties for persons confined in the facilities. Larger institutional settings such as Kane Hospital are impersonal and depressing for patients and staff, difficult to administer, and generally inappropriate for providing long-term care.

Recommendation IV

The patient population at Kane Hospital should be reduced by at least 25 percent. In conjunction, building renovation to sub-divide the 46 existing 22-person wards should begin in order to bring Kane Hospital into compliance with existing Life Safety Code requirements. The number of patients housed in these areas should be reduced to 14 persons housed in semi-private rooms. It is essential that the necessary community support services simultaneously become available as described in Recommendation I.

Recommendation V

The Pennsylvania State Government should be challenged and forced to change the discriminatory funding of nursing home care. The Pennsylvania Department of Public Welfare reimburses private nursing homes at a fixed rate of

– $20 per day – skilled care
– $18.50 per day – intermediate care

regardless of the actual costs of care. Fifty percent of these reimbursements are Federal monies, 50% are state. But for public nursing homes such as Kane, the Pennsylvania Department of Public Welfare uses Federal money to reimburse only 55.4% of the daily cost of care. The cost of care is about $15 per day at Kane. No state funds are used to reimburse public nursing homes.

The remaining 44.6% of the cost of care must be provided by County Government through taxation and/or fees for nursing home services. Given the indigency requirements of many public nursing homes, the state funding practices are clearly discriminatory.

Recommendation VI

Additional direct service staff should be hired at Kane Hospital to meet immediate hospital needs. Existing salary levels should be upgraded to be competitive with other hospitals and attract qualified personnel. Additional staff should be hired in these areas:

– Nursing personnel to provide on all patient care areas:
8 nursing personnel day shift/48 patient unit
5 nursing personnel evening shift/48 patient unit
3 nursing personnel night shift/48 patient unit

– Registered nurses to provide on all patient care areas:
1 registered nurse day shift/48 patient unit (Infirmary areas)
2 registered nurse day shift/48 patient unit (Convalescent and Tower areas)
1 registered nurse evening shift/48 patient unit
1 registered nurse night shift/48 patient unit

– The staff of the Rehabilitation Department should be doubled.

– The number of full-time doctors should be doubled.

– The staff of the Social Service Department should be doubled.

– The staff of the Recreation Department should be doubled.

– The Inhalation Therapy Department should be provided with personnel to provide three shifts daily – 7 day per week coverage.

– The Laundry should be provided with personnel to permit seven day per week functioning.

– Two Dietary Aides per meal should be provided each 48 patient nursing unit.

– Additional housekeeping staff to provide one housekeeper per shift for each 48 patient unit.

Recommendation VII

A detailed audit of Kane Hospital accounts and an investigation of hospital finances should be undertaken by appropriate authorities to determine if improper or illegal manipulation of funds is occuring. Attention should be given to these areas:

– Billing of Medicare-Medicaid for skilled nursing services which are not being provided

– Double billing of patients' personal accounts for services covered by Medicare-Medicaid

– Billing of patient accounts for services not provided

– Falsely declaring patients to be in need of skilled nursing care

– Failure to provide patients or patients' families with complete and explicit hospital billings

– Failure to give patients information and access to their own funds held in hospital accounts

– Failure to notify and arrange return of individual patients' funds remaining in hospital accounts to patients or patients' families following discharge or death

– Failure to provide patients with $25.00 monthly allotment immediately upon admission

– Use of service and equipment contracts for patronage and kickbacks.

– Use of patients' funds (up to $300.00 per patient) alloted for funeral expenses for political patronage and kickbacks.

– Maintaining past employees and other ghosts on the Kane Hospital payroll.

Recommendation IX

A citizens' action group should be formed to demand of all persons or groups responsible for Kane Hospital and county human services programs:

1) Improved hospital conditions to comply with all existing state and Federal regulations.
2) The initiation of the necessary community services to enable older people to remain in their communities.

This group should contact older persons' organizations, previous and present Kane Hospital employees, families of previous Kane Hospital patients, Welfare Rights and Patient Advocacy groups, nursing, social work, and other professional organizations for support.

Recommendation VIII

Structural changes must be made in the administration of the Allegheny County Institution District to insure necessary services and programs are provided, and to stop the manipulation of personnel, programs and services by the County Commissioners for their own political patronage and purposes. The county commissioner form of county government does not provide either adequate division of power or sufficient checks and balances.

NOTES

Introduction

1 Allegheny County, **Kane Hospital Cares**, Produced by D.M. Bower and Mary Wolfson Associates in cooperation with Allegheny County Bureau of Public Information, (Pictorial Brochure), Pittsburgh, 1971, p.5.

2 **Kane Hospital Cares**, p. 26.

3 Interview with Kane patient – Mr. Harry Myers, Kane Hospital, Pittsburgh, Pa., (real name withheld).

4 Interview with Kane patient – Mrs. Kate McAlberts, Kane Hospital, Pittsburgh, Pa., (real name withheld).

5 Letter to the Editor, "Protests Conditions at Kane Hospital," **Pittsburgh Post-Gazette**, Nov. 16, 1971, p. 10.

6 Phychiatric Evaluation, Patient's Medical Chart, Kane Hospital, Pittsburgh, Pa., Jan. 2, 1972, (real name withheld).

7 Author's personal experience.

8 Author's personal experience.

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10 "County Losing Out on Federal Funds for Aged Citizens," **Pittsburgh Post-Gazette**, March 14, 1974, p. 13.

11 Amendment to the County Institution District Law of 1935, Act nos. 266-267, Sec. 401(i), (1965).

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13 Human Service Commission, **Toward A Living Renaissance**, Pittsburgh, Pa., November, 1974. (Report of the Allegheny County Humah Service Commission), p. 19.

14 **Kane Hospital Cares**, p. 26.

Administration of Kane Hospital

1 "McManus Puts Fireworks In GOP Commission Race," **Pittsburgh Press**, May 11, 1975, p. 15.

2 Author's personal experience.

3 Human Services Commission, **Draft of the Kane Hospital Report**, Feb. 7, 1974, p. 3.

Lack of Nursing Personnel

1 Pennsylvania, Department of Public Welfare, **Long Term Care Facility Standards and Regulations**, (Harrisburg, Pa., Office of Medical Programs, 1975), Sec. 1306.5, p. 66. (Hereafter referred to as Pa. – D.P.W., Sec. 1306.5, p. 66.).

2 Interview with registered nurse, Kane Hospital, Pittsburgh, Pa., (name withheld).

3 Pa. – D.P.W., Sec. 1307.9, p. 67.

4 United States, Federal Register, Vol. 39, No. 12, January 17, 1974. United States Department of Health, Education, and Welfare – Skilled Nursing Facilities Standards for Participation in Medicare and Medicaid Programs. Sec. 405.1122(a), p. 2244. (Hereafter referred to as U.S. – H.E.W., Sec. 405.1122(a), p. 2244.).

5 Author's personal experience.

6 Author's personal experience.

7 Author's personal experience.

8 Lecture to nurses aide training class, In-service registered nurse, Kane Hospital, Pittsburgh, Pa., (name withheld).

9 Author's personal experience.

Lack of Relief Personnel

1 U.S. – H.E.W., Sec. 405.1124, p. 2244.
Pa. – D.P.W., Sec. 1307.4, p. 66.

Lack of Rehabilitation and Restorative Services

1 U.S. – H.E.W., Sec. 405.1124, p. 2244.
Pa. – D.P.W., Sec. 1308.1, p. 67.

2 Rehabilitation Department heads and supervisors monthly meeting, Kane Hospital, Pittsburgh, Pa., Oct. 1972, p. 1.

3 Interview with Rehabilitation Department aide, Kane Hospital, Pittsburgh, Pa. (name withheld).

4 Interview with physical therapist of the Rehabilitation Department, Kane Hospital, Pittsburgh, Pa., (name withheld).

5 Interview with registered nurse, Kane Hospital, Pittsburgh, Pa., (name withheld).

6 U.S. – H.E.W., Sec. 405.1126, p. 2245.
Pa. – D.P.W., Sec. 1314.1, p. 69.

7 Rehabilitation Department monthly meeting, p. 1.

8 Interview with physical therapist of the Rehabilitation Department, Kane Hospital, Pittsburgh, Pa., (name withheld).

9 Author's personal experience.

10 Author's personal experience.

11 U.S. – H.E.W., Sec. 405.1126(b), p. 2245.
Pa. – D.P.W., Sec. 1315, p. 69.

12 U.S. – H.E.W., Sec. 405.1126, p. 2245.
Pa. – D.P.W., Sec. 1314.4, p. 69.

13 Interview with social worker, Kane Hospital, Pittsburgh, Pa., (name withheld).

Inadequate Supervision of the Existing Staff

1 U.S. – H.E.W., Sec. 405.1124(d), p. 2244.
Pa. – D.P.W., Sec. 1304.1, p. 64.

2 Author's personal experience.

3 Author's personal experience.

4 Author's personal experience.

5 Interview with registered nurse, Kane Hospital, Pittsburgh, Pa., (name withheld).

6 U.S. – H.E.W., Sec. 405.1134(f), p. 2248.

7 Author's personal experience.

8 Author's personal experience.

9 U.S. – H.E.W., Sec. 405.1124(c), p. 2244.
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11 Author's personal experience.

12 Nations, Wanda, "What Constitutes Abuse of Patients," **Journal of the American Hospital Association**, Dec. 1, 1973, p. 51.

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14 Pa. – D.P.W., Sec. 1309, p. 67.

15 Interview with Rehabilitation Department aide, Kane Hospital, Pittsburgh, Pa., (name withheld).

16 Interview with nurses aide, Kane Hospital, Pittsburgh, Pa., (name withheld).

INADEQUATE SUPPORTIVE SERVICES

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1 U.S. – H.E.W., Sec. 405.1135(d), p. 2248.

2 Pa. – D.P.W., Sec. 621.5, p. 36.

3 Interview with registered nurse, Kane Hospital, Pittsburgh, Pa., (name withheld).

Inhalation Therapy

1 Lecture to male members of the nurses aide training class, member of Inhalation Theraphy Department, Kane Hospital, Pittsburgh, Pa., (name withheld).

2 Lecture to male members of the nurses aide training class, member of Inhalation Therapy Department.

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1 U.S. – H.E.W., Sec. 405.1130, p. 2246.
Pa. – D.P.W., Sec. 1323, p. 72.

2 Author's personal experience.

3 Gitelson, M., "The Emotional Problems of Elderly People," **Geriatrics**, 3, 1948, p. 135 in Thomas N. Rudd, "Preventing Senile Dementia: The Need For A New Approach," **Journal of the American Geriatrics Society**, 7, 1959, p. 323.

4 Author's personal experience.

5 Staff meeting minutes, Social Service Department, Kane Hospital, Pittsburgh, Pa., April 27, 1972, p. 1.

6 Human Services Commission, **Draft of the Kane Hospital Report**, Feb. 7, 1974, p. 7.

7 Moyle, Mike, "1,000 U.S. Housing Units Planned For City's Aged," **Pittsburgh Post-Gazette**, Feb. 14, 1975, p. 13.

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9 Author's personal experience.

10 Annual Report, Kane Hospital Allegheny County Institution District, 1966, p. 1.

11 Annual Report, pp. 6-10.

12 **Toward A Living Renaissance**, p. 25.

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1 U.S. – H.E.W., Sec. 405.1135(c), p. 2248.
Pa. – D.P.W., Sec. 1003.1, p. 52.

2 U.S. – H.E.W., Sec. 405.1135(c), p. 2248.

Recreation Department

1 U.S. – H.E.W., Sec. 405.1131(b), p. 2246.
Pa. – D.P.W., Sec. 1326, p. 73.

2 Lecture to nurses aide training, Wes Parker (Director of Recreation Department), Kane Hospital, Pittsburgh, Pa.

3 Author's personal experience.

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1 Townsend, Claire, **Old Age: The Last Segregation**, (Ralph Nader's Study Group Report on Nursing Homes), (New York: Grossman, 1971) p. 79.

2 Author's personal experience.

3 Author's personal experience.

4 U.S. – H.E.W., Sec. 405.1125(a), p. 2245.
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5 U.S. – H.E.W., Sec. 405.1125(e), p. 2245.
Pa. – D.P.W., Sec. 1217.1, p. 62.

6 U.S. – H.E.W., Sec. 405.1125(d), p. 2245.
Pa. – D.P.W., Sec. 1216.1, p. 61.

7 Author's personal experience.

8 U.S. – H.E.W., Sec. 405.1124(f), p. 2244.
Pa. – D.P.W., Sec. 1310.1, p. 67.

9 Author's personal experience.

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11 U.S. – H.E.W., Sec. 405.1125(c), p. 2245.
Pa. – D.P.W., Sec. 1215.1, p. 61.

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17 Author's personal experience.

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1 Pa. – D.P.W., Sec. 631, p. 38.

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3 U.S. – H.E.W., Sec. 405.1134(e), p. 2248.
Pa. – D.P.W., Sec. 614.2, p. 32.

4 Pa. – D.P.W., Sec. 614.10, p. 33.

5 "Safety Rap Unjust, Kane Hospital Says," **Pittsburgh Press**, July 29, 1973, p. 2.

6 U.S. – H.E.W., Sec. 405.1134(j), p. 2248.
Pa. – D.P.W., Sec. 705, p. 43.

7 U.S. – H.E.W., Sec. 405.1134(d), p. 2247.
Pa. – D.P.W., Sec. 707.11 - 707.13, p. 46.

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9 Author's personal experience.

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1 U.S. – H.E.W., Sec. 405.1123(b), p. 2244.

2 Rules and Regulations Governing Medical Staff Members of the John J. Kane Hospital, Kane Hospital, Pittsburgh, Pa., Jan. 1972, p. 1.

3 Interview with registered nurse, Kane Hospital, Pittsburgh, Pa., (name withheld).

4 Author's personal experience.

5 Author's personal experience.

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7 Author's personal experience.

8 Interview with Kane patient, Kane Hospital, Pittsburgh, Pa., (name withheld).

9 Author's personal experience.

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2 Medical Staff By-laws and Rules and Regulations, Kane Hospital, Pittsburgh, Pa., Jan. 1972, p. 1 (Forward).

3 U.S. – H.E.W., Sec. 405.1137(d), p. 2249.

4 Author's personal experience.

5 Medical Staff By-laws And Rules And Regulations, p. 4.

6 Author's personal experience.

7 Irvin Foutz (Director of Social Service and Admissions Departments), Social Service staff meeting, April, 1973, (not recorded in staff meeting minutes).

8 Author's personal experience.

9 U.S. – H.E.W., Sec. 405.1137, p. 2248.

10 Author's personal experience.

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1 Interview with registered nurse, Kane Hospital, Pittsburgh, Pa., (name withheld).

2 Interview with social worker, Kane Hospital, Pittsburgh, Pa., (name withheld).

3 Author's personal experience.

4 Author's personal experience.

5 " 'Coverup' Tied to Kane Firing," **Pittsburgh Press**, July 30, 1973, p. 2.

6 Interview with daughter of Kane patient, Pittsburgh, Pa., (name withheld).

7 Author's personal experience.

8 Psychiatric Evaluation, Patient's Medical Chart, Kane Hospital, Pittsburgh, Pa., Sept. 6, 1973, (real name withheld).

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1 U.S., **Congressional Record**, 93rd Cong., 2nd sess., 1974, Vol. 120, No. 163, 19882.

Conclusion and Recommendations

1 U.S., **Congressional Record**, 93rd Cong., 2nd sess., 1974, Vol. 120, No. 163, 19882.

2 Levinson Gerontological Policy Institute, **Alternatives To Nursing Home Care: A Proposal**, (prepared for use by the Special Committee on Aging, United States Senate), October 1971, p. 5.

Mr. Cobbs. Mr. Chairman, I will now ask Mary Lewin to continue our presentation.

STATEMENT OF MARY LEWIN, ASSISTANT DIRECTOR, PATIENTS' RIGHTS PROGRAM, PITTSBURGH FREE CLINIC, PITTSBURGH, PA.

Ms. Lewin. Good morning. I want to express my appreciation to the committee for allowing me to testify this morning. My name is Mary Lewin. For 2 years, from October 1971 through October 1973, I was employed as a caseworker in the social service department at Kane Hospital. I am now assistant director of the patients' rights program of the Pittsburgh Free Clinic. During my employment at Kane Hospital, my caseload was between 100 and 150 patients. I worked on six different units of the female infirmary. The infirmaries were designed for patients who were independent, however, they now house patients, some of whom are in geri-chairs and wheelchairs and require medications and skilled nursing care. In my testimony, I will describe the inadequate medical services at Kane Hospital, the failure of the hospital to respond constructively to grievances and complaints, and the difficulties I encountered in my casework.

Patients were not receiving the medical care they needed. There were approximately 15 full-time and 8 part-time doctors who had the majority responsibility for providing the day-to-day medical supervision and treatment for the nearly 2,200 patients at the hospital. For many physicians, Kane Hospital was a last resort. The geriatric nature of the hospital and the low-salary levels discouraged doctors from practicing there. It was generally known at the hospital that four of the doctors were unlicensed. They were given the title of physicians assistants, even though they performed the duties of licensed doctors.

It was also generally known that some physicians had obtained their jobs through the patronage system and they were protected by the system even though they did not completely and responsibly perform their duties.

Overburdening Caseload Hinders Individual Care

Doctors' caseloads were high. In the male infirmary, three doctors were responsible for 450 patients. Two of them were unlicensed—the other was part time. In the female infirmary, two doctors were responsible for approximately 450 patients. The physician caseloads made it difficult if not impossible for doctors to provide conscientious, individualized medical evaluation, and attention to patients. Nurses and nurses aides were evaluating the patients' medical needs, deciding what warranted medical attention, and at times, determining what procedures and medications should be ordered. On some areas, doctors' notes and medication orders to be included in the charts were prewritten by the nurse without the doctor seeing the patients. The doctor simply copied the information into the charts. A nurse on a convalescent area is quoted in the report, as saying:

> I know more about the patients on the floor than the doctor. He doesn't know any of these people. If I didn't do it, nothing would be written on the charts.

I've complained several times in the past 2 years to the clinical director about him not visiting the patients or doing his work. The last time, the clinical director said nothing could be done because the doctor had ties with the commissioners.

The inaccessibility of the doctors was a problem that nursing personnel, social workers, patients, and patients' families all complained about.

I stopped to talk with a patient I knew. She was a woman in her fifties who was crippled with arthritis. She had been at a general hospital to undergo a hysterectomy, and had recently returned to Kane. She was very distraught. She told me that she was in severe pain because of the arthritis, and she had not been getting enough pain medication, especially at night. She had been bleeding and was having discomfort as a result of the operation. She told me she thought she was going to die—she was crying and upset.

Worried Patients Seek Assurance

I went to the nurse and asked if someone who knew her medical condition could talk to her, as she needed reassurance. The nurse said that she didn't have time—that it was the doctor's responsibility to do it, but she didn't know when he would be on the floor again. She said that she had 48 patients that wanted to talk to him and needed reassurance—but they didn't get it. She told me that I would have to talk to him myself.

I later found the doctor in the doctor's lounge. I explained the situation to him. He didn't seem to know the patient. He was angry and told me that he was busy and would do it when he had time.

I saw the patient 2 days later. She said that the doctor had stopped in to see her. He was there for only a few minutes. He told her that I had no business going to him—that I thought I knew more than he did, and she shouldn't get me involved again. He didn't answer her questions and she was still upset.

I also witnessed patients' conditions worsen dramatically and doctors would not visit them to evaluate the change, even when requested by the nursing personnel and social workers.

One day I walked through Mrs. Clara Laley's area, and noticed that she was restrained in a geri-chair. She was yelling incoherent phrases over and over again and pounding her fists on the geri-chair tray in front of her. She seemed to be having tremors and had a fixed, faraway look on her face. Mrs. Laley had been alert and able to walk previous to this. I told the social worker on the area about the sudden change in her condition. He reported it to the nurse. The nurse said that Thorazine had been ordered and they were waiting to see what effect it would have on her.

Doctor "Too Old and Confused"

A few days passed, and Mrs. Laley was worse. She was agitated and was disrupting the staff and patients on her area. I talked to the nurses aides about her. They thought she was regressing because of old age. I said that I thought that she was sick. I asked if the doctor had looked at her. They said that he was unwilling to do

anything. One aide voiced a commonly held opinion of the doctor—"That he was too old and too confused to even realize what had happened to her."

Following this, the social worker went to the doctor assigned to Mrs. Laley's area and asked him to look at her, for a possible transfer. The doctor said that he didn't have time. The social worker then went to the other doctor assigned to the infirmary. The doctor wouldn't look at a patient on the first doctor's area. The social worker then went to the physician assistant assigned to the infirmary on an emergency basis. He said that he wouldn't go against the decision made by the doctor assigned to her area. The social worker went to the clinical director to report the incident. Mrs. Laley was transferred to the seriously ill floor later that day. The reason listed for transfer was possible stroke.

After infirmary social workers complained to the director of social services and the clinical director that the full-time doctors were unwilling to evaluate patients for discharge, a part-time doctor was assigned to do discharge reviews. His procedure was to talk with the social worker and look at the patient's chart without seeing or talking with the patient to evaluate how well they could walk, climb stairs, or take care of themselves.

Kane Hospital employs physician consultants from other Pittsburgh hospitals to provide specialized medical services to patients on a part-time basis. Services in areas such as dental, ear, nose and throat, podiatry, orthopedics, and rehabilitation are provided in this way. Specialty clinic services were limited and provided care to a small percentage of Kane patients. Although some of the clinics provided good services, there were long waiting periods before patients could be seen in some clinics. This was especially true of the dental clinic. The services of the specialty clinics were not properly utilized because the hospital's full-time doctors were failing to evaluate patients and refer them to the clinics. When patients were seen in the clinics, the responsibility for continued care again returned to the floor doctor. The recommendations made by the clinic physicians were frequently not followed.

"Many Patients * * * Not Receiving * * * Services"

Kane Hospital's literature discusses the comprehensive medical services offered to patients, yet, in actuality, many patients are not receiving these services. The medical staff at Kane is failing to evaluate patients and prescribe the medical and nursing care they need.

There is no grievance procedure at the hospital for constructive response to suggestions, and grievances of employees, patients, or patients' families. Complaints are strongly discouraged by the executive administrative heads of the hospital and the supervisory staff. Patients who complained about hospital conditions were characterized by the hospital administration as "confused," "senile," and "disturbed." Families who complained were looked upon as "feeling guilty about placing their relative in Kane." Some families were told that if they were unhappy with the care at Kane, they should take their relative home. Employees concerned about hospital conditions

were told they "had not learned to accept and live with old age and death." In many cases, staff who attempted to resolve complaints were criticized, embarrassed, and intimidated with the threat of job dismissal.

In our report we document the firing of Dr. Paul Soster, after he repeatedly complained to the hospital administration that the head of the dental clinic was attending work irregularly and failing to examine and treat patients. Dr. Soster's allegations were supported by the secretary in the dental clinic. It was commonly known that the head of the dental clinic was a political appointee, and his position was protected by the county patronage system. This kind of action against staff members who are concerned about hospital conditions and the way patients are treated, is intimidating. It effectively silences personnel who have no alternative to working at Kane Hospital.

COMPLAINTS GO UNANSWERED

Families encounter many of the same obstacles and frustrations that hospital personnel do when they complain about conditions at the hospital. I talked to the daughter of a patient who related the following incident to me.

She said she spent a "fortune" the 6 weeks her mother was in Kane trying to keep her in decent clothes. (Her mother died at Kane.) "Everytime I found something of my mother's missing I would go to the nurse and report it. But she'd just tell me that she didn't know anything about the clothes—that the night staff was probably responsible. Mrs. Nesbaum said that she got tired of complaining, "because nobody seemed interested in doing anything about the stealing." In addition to her clothes, her mother lost an expensive set of dentures. Mrs. Nesbaum questioned the staff about it and was told that they probably got caught in the linens and were sent to the laundry, where they couldn't be found.

Patients at Kane Hospital were the victims of inadequate care and mistreatment; often they were powerless to do anything about it. Some are not able to explain how they are being mistreated; some are afraid of the consequences of talking about it. Many patients had no one who regularly visited them to check on the care they received. Patients who demanded the care they needed were resented by the staff. They were sometimes subjected to harrassment and abuse. Outspoken patients were forced to accept transfers from one area of the hospital to another. In some cases, patients who consistently complained were labeled disturbed, and given psychiatric evaluations. I will read from a psychiatric evaluation done on a woman who's letter to the editor complaining about hospital conditions was published in a Pittsburgh newspaper. We quoted this evaluation in the report.

This 62-year-old lady is said to have written articles to the paper criticizing food, et cetera. She is also said to create dissension, et cetera, on all levels. Mental status reveals good cooperation, coherence, and relevance. Questions were answered directly and there was no indication of blocking or of association disorder . . . insight was adequate and judgment appears superficially adequate . . . in my opinion, this patient has organic brain disease involving the right cartoid and right middle cerebral artery. There was the suggestion that this might be associated with paranoid behavior at this time.

Clearly the hospital administration's response to criticism was defensive and punishing.

I want to talk now about the social service department and the difficulties I encountered in my casework. There were 14 employees, including the director, in the department when I worked at Kane. Eleven of them were caseworkers. It was impossible for us to provide the necessary services to the nearly 2,200 patients. One-third of the hospital had no regularly assigned social workers.

Hospital Lacks Caseworkers

Now there are only seven caseworkers at Kane. The hospital administration considered social workers' primary responsibility to be the discharge of patients. As a result, the social service staff was able to direct little of its energies to meeting the social and emotional needs of the majority of Kane patients. These patients, many of whom live at Kane for 2 to 6 years, face the complex problems of growing old and institutional living. They confront the loss of friends and family, feelings of worthlessness, physical disability, and impending death. When patients withdraw to escape the depressing surroundings of the hospital, they are frequently stereotyped by all levels of staff as being senile. Often staff responded to patients as either children who are talked down to, ordered around, and scolded, or like persons without feelings who are teased, laughed at, and insulted.

Usually staff assumed that patients were senile due to deterioration of the arteries in the brain. Much of the recent studies of aging done primarily in Great Britain and Eastern Europe, indicate that older persons who remain an active part of their community and family can withstand considerable cerebral artery damage and continue to function. Other older persons confronted with the loss of their community ties, home, and meaningful work and purpose, exhibited the symptoms of senility even though they had only mild arterial damage. Much of the recent study of aging indicates that often the signs of senility are stress-related and indicate withdrawal from new and unbearable situations rather than a physical disability. This despair-induced senility is a threat to all older persons confined in nursing homes and institutions.

The social service department, the recreation department, and the hospital as a whole do little to combat this disabling despair and hopelessness, resulting in patients becoming isolated and withdrawn. Patients become institutionalized and lose their desire to leave the hospital.

Strict Control Over Patient's Account Maintained

As a caseworker, I continually encountered problems related to patient finances. At Kane Hospital patients did not have access to information about their financial resources. Most patients did not have access to money in their hospital account. Patients receive $25 monthly for personal use. This money was issued in the form of a store book with coupons. It was difficult for patients to get through the month with so little money. The prices in the hospital's snack

shop where patients could purchase food, cigarettes, and some toiletries were as high as prices on the outside—in some instances higher. Patients sometimes requested additional money to purchase things they needed when their store book ran out. Some patients also requested small withdrawals from their accounts to purchase personal items that could not be purchased in the hospital.

The revenue department had strict control over all information pertaining to patient accounts. With the exception of pension checks, all income of patients was turned over to the hospital at the time of admission. Patients knew nothing about the maintenance fee at the hospital, what their income was, how much was used for maintenance, and how much surplus income they had accumulated in their account. When patients did request any of this information, or when requested a withdrawal from their account, they were refused. At times patients would request social workers' help in these matters. I was only able to arrange for patients to be told the status of their finances or arrange for a small withdrawal after persistent arguing with the revenue department. Some social workers had difficulty planning for patients' discharge because complete information about the financial resources of patients could not be obtained. These problems were presented to the revenue department and to the director of social service. They remained essentially unresolved.

Other problems that I encountered as a caseworker related to discharge. The failure of the hospital to provide medical, nursing, and rehabilitation services that patients need in order to recuperate and be discharged will be discussed. I want to talk about two additional obstacles to discharge.

Political Favors Charged

At times, admissions and continued stays were granted as political favors to a family. This occurred when other citizens with no real alternative to Kane Hospital, were being placed on waiting lists. In our report, we document Pennsylvania State Senator Tom Nolan's influence to discontinue discharge planning in which I was involved.

A serious obstacle to patients returning to the community to live, is the critical shortage of appropriate housing and community support programs. Most patients at Kane have relatively low-fixed incomes. They require housing that takes into consideration their physical disabilities. Low-income public housing for older persons in Pittsburgh and Allegheny County is scarce and much of it is inadequate. Most patients cannot live in the community without supportive services. Homemakers and home-health care are just two of the services needed. The need for these services in Allegheny County was recognized long ago. As early as 1966, the Kane Hospital annual report discussed the failure of the hospital to discharge patients because of a "lack of facilities and services within the communities to permit acceptance of discharges from the hospital."

Kane's discharge rate has not increased since that time. There must be a significant expansion and improvement of services to older persons in Allegheny County in order to prevent unnecessary confinement of older people in institutions, and to permit patients at Kane

who don't require institutional care to leave. Othewise the prevailing attitude at Kane that "there is nowhere for them to go so why try," will continue.

Senator Moss. Thank you, Ms. Lewin, for your fine statement.

Would you like Emily Eckel to be next?

Mr. Cobbs. Yes.

STATEMENT OF EMILY ECKEL, FORMER EMPLOYEE OF KANE HOSPITAL, PITTSBURGH, PA.

Ms. Eckel. Thank you, Mr. Chairman.

Mr. Chairman, my name is Emily Eckel. I want to thank you for the opportunity to testify here today. I am a graduate of Carnegie Mellon University. I was employed at Kane Hospital as a nurse's aide for a 5-month period beginning January 1, 1973. Throughout my employment, I kept notes and a jounral about my daily experiences and observations.

All patients' names used in our report and testimony here today are fictitious although they represent actual patients and events. Initially I worked wherever I was needed throughout the hospital. After 6 weeks, I was assigned to the day shift to a convalescent area with 48 women patients.

In my testimony I will talk first about the shortage of staff, equipment, and supplies at Kane Hospital. I will then describe the effect these shortages have on the quality of care at Kane. As I do this, I will describe some of the Kane residents I knew and worked with.

There is a critical shortage of personnel at Kane Hospital. Pennsylvania State regulations require that "there shall be a minimum of 2.25 hours of nursing care per day for each patient" at Kane. In January of 1976, Kane will be required to provide 2.5 hours of daily care to each patient.

This is based on counts of employees actually on duty at the hospital. We estimate Kane Hospital needs an additional 290 nursing personnel each day to meet these standards.

At this time, Kane is providing on the average only 1.5 hours of care to each patient daily. These figures mean that we could not take good care of our patients. We had too much work.

State and Federal regulations require that each patient receive treatments, medications, and diet as prescribed, rehabilitative nursing care as needed, proper care to prevent decubitus ulcers and deformities, and is kept comfortable, clean, well-groomed.

On some days, as few as 2 aides were required to care for 48 patients. We were supposed to get the patients up, cleaned, dressed lifted into chairs, and out to the solarium for meals.

We served meals with assistance from the nurse and medicine aide. We changed all the beds, gave bed baths and tub baths, changed dressings, helped patients to the bathroom and cleaned all the patients who were soiled.

On days when there were only two or three aides, it was impossible to accomplish all of this. We did not have sufficient time to treat the patients as individuals, talk with them, give backrubs, provide drinking water, or give mouth care. The lack of staff made it impossible to give proper nursing care.

Supplies and Equipment in Short Supply

In addition to the lack of staff, a major problem was the shortage of supplies and equipment. On different occasions, we were short vitamin A and D ointment, micitracin, peroxide, alcohol sponges, Phisohex, gauze packing, 4- by 4-inch gauze squares, enema cans, urinals, bedpans, dressings sets, surgical dressings, catheter plugs, catheter leg bags, and urine graduates.

There was also a serious shortage of linens. Clothing and toiletries were hard to get.

Some of the results of these shortages are the development and aggravation of bedsores due to improper dressings, catheter plugs reused from patient without sterilization contributing to the high incidence of urinary tract infection, patients sharing bedpans, and patients becoming impacted from not getting needed enemas. Clearly, patients are not receiving proper care because of these shortages.

I am angry. People come out of nurse's aide training at Kane Hospital wanting to do what is right for the patients. They end up becoming callous to be able to face an impossible situation week after week.

I want to describe some of the day-to-day nurse's aide to patient contact so you can get a feel for the quality of care and life at Kane Hospital. To do this, I will talk about bathing and afternoon changes.

Afternoon changes is a set of procedures done after lunch in which we changed and washed soiled patients. Incontinent patients sat from early morning until this time in urine and feces. When we did the changes in the ward we lined up all 24 patients by their beds.

We would wet one end of many towels and leave them hanging out of the sink. No private screens were ever used except to cover the ward doors.

In assembly-line fashion, in full view of eight or nine other patients, we would move from patient to patient, change the gown, lift the patient to a standing position, wash the buttocks with the wet end of a towel, dry them with the other end, smear ointment on the buttocks, set them back down in their chairs, and move on to the next patient.

During changes, aides have to do a lot of heavy lifting, are under time pressure, and often get angry with the patients.

Maureen, an aide with whom I worked, did afternoon changes by going up to each patient and saying "Are you full of shit?" If the patient said "no" she gave them a clean gown and conpad. If the patient said "yes" she gave them a fresh gown but did not clean them. If the patient said "no" when they were soiled, she slapped and yelled at them.

Aides are not properly supervised during the changes and a lot of very ugly verbal and physical abuse goes on. The men and women in Kane Hospital are not even receiving adequate custodial care. These patients become victims stripped of human dignity.

Weekly Bath Creates Hysteria

Hospital policy requires that each patient be bathed at least once a week. On many nursing areas, this is not being done. On some areas, patients go without a bath for 6 weeks. There is extensive use

of powder and deodorant to cover up lack of baths, especially when a patient has a visitor.

Most patients are reluctant to be bathed. Clara Daily, a walking patient on my area, would hide in her room when it was her turn to get a bath. We had to physically escort her to the bathroom every time.

She would quiver and shake the whole way and whisper over and over, "I don't want to go, don't make me." She was frightened of what was going to happen to her in the bath. Most patients have had bad experiences.

The floors in the bathrooms are wet and the patients are afraid of falling. There is no privacy screening. Usually, when baths are given, there are two patients in the bathroom getting dried and dressed, two in the tubs, two getting undressed, while an additional four patients lined up outside the bathroom in the hall.

Bathing is hard and frustrating work. There is a lot of heavy lifting. The room is hot, humid, and smelly. The patients are unhappy. There is a great deal of time pressure and baths are given carelessly.

Sometimes aides are not careful about the temperature of the water or about rinsing shampoo and soap off. Tubs are rinsed between baths but not scrubbed as they should be.

Heavy patients are sometimes put on a potty chair and pushed to the shower stall and washed with the sprayer. Hard to clean places on patients are left unwashed, so there are cakes of dirt under rolls of flesh and in the pubic area.

Additionally, we were always short of linens. We had to wash patients with socks, we would tear up towels for washcloths, dry patients with sheets, and even use sheets for conpads.

The most serious and regular trouble was the inadequate supply of gowns. We used hospital robes for gowns by turning them backwards.

Occasionally, we would have to wrap a patient in a sheet and put a sweater on backwards because there was nothing else we could do. Patients who owned a robe wore them for weeks with dried urine and feces.

They were afraid of not getting them back if they were sent down to the laundry.

It is trying to work under these conditions; it is inhuman to subject individuals to such treatment.

Frustration and Pressure "Taken Out on Patients"

During bathing, frustration and pressure felt by the staff is taken out on the patients in carelessness and abuse. Later in our testimony, we will cite examples of this.

One important aspect of geriatric nursing is the prevention of decubitus ulcers or bed sores. Bedsores are open holes of various sizes which penetrate skin and muscles. They usually develop on the buttocks and heels and elbows of patients.

These develop because patients are not washed when they are wet and soiled, because they sit all day without exercise and because bed patients aren't turned and positioned regularly. Bedsores, often referred to as pressure sores, can be prevented with proper care.

A lot of patients develop bedsores at Kane Hospital. On my regular area, there were about 10 patients with bedsores of various sizes, some as big as my fist, with bones exposed. There were about 10 other women who were showing signs of developing bedsores.

Decubiti usually don't get reported to the nurse until they are somewhat progressed and open. This makes them much harder to cure.

Anna Chase, a bed patient on my area, had a constant urine drip that could not be catherized. She had large bedsores on both buttocks. Each morning I would come in and see that her dressings were off and she was lying in a pool of urine. She could not move well but was alert and aware. She woke up every day in a puddle of urine, she knew it, and could do nothing about it.

Katherine Shell, a wheelchair patient who went to bed in the afternoon, had two deep bedsores at the top of her thighs. She was heavy and stiff and had trouble getting on and off the bedpan and often wet her dressings. Her sores were advanced and very deep. They were supposed to be packed and dressed by the nurse.

One day I put an extra piece of tape on the wet dressing and watched. The tape went for 2 days unchanged and wet with urine.

Nurses aides are faced with the choice of doing dressings they are not trained to do, or seeing them not get done. I saw aides improperly dress bedsores by filling them full of ointment and covering them with gauze. No packing was used at all. Other dressings were also neglected.

Basic nursing care at Kane Hospital is inadequate. Patients are neglected, often for days at a time.

I want to tell you a little more about the scope of neglect at Kane Hospital. As I mentioned earlier, we did not have the time to do regular morning mouth care. Cleaning of teeth and dentures, use of mouthwash, care of the gums and lips is ignored at Kane Hospital.

Haiti Beere, a patient confined to a geri-chair in the ward on my area had strangely swollen lips. After I had been working in the area for a month, I finally had a moment one day and looked in her mouth. Her lower false teeth were in upside down. The teeth were cutting into her lower gums. They were caked full of old and hard food and smelled very bad. Her gums were raw. It appeared to me that her teeth had been in this position for several weeks.

Entire Day Spent in Wheelchair

Another common way for patients to be neglected is to put them in geri-chairs and wheelchairs. It is easier for the nursing staff to allow patients to sit in these chairs than it is to exercise them and help them walked to bathrooms and meals.

Patients sit all day with their legs hanging unsupported. This causes deformities in feet and legs, and a loss of their ability to walk.

Anny Langley was a typical geri-chair patient on my area. You can see a picture of her on page 13 of the Kane report. She is the woman in the middle.

She was put in her geri-chair before 7 a.m. by the night shift. She sat in the solarium in the morning where she was served breakfast and lunch.

Anny was not exercised at all in the mornings. If she was incontinent in the morning, we could not clean her because we did not have enough time. All we could do was mop the puddle under her chair.

Anny was a little disoriented but walked well with one assistant. In the afternoon we found time to change her. She was dressed in a hospital gown and a pair of socks. Anny was left to sit in her geri-chair the rest of the afternoon.

The two other women in the picture are Frances Paulisak and Geraldine Fishel. Frances and Geraldine had the same daily schedule as Anny. Neither of them can walk any more.

Rehabilitation services in Kane Hospital are inadequate. On my area, 1 patient out of 48 was taken once a week for rehabilitation therapy. The rehabilitation department is critically understaffed and can provide services to only a few of the many Kane patients that need them.

Pages 32 to 37 of the report discuss in depth the lack of rehabilitation services.

ADVANCE NOTICE OF INSPECTIONS

Finally, we were always informed in advance when a government inspection was to occur. For about a week in advance, meals improved, supplies were replenished, the patient call bells put back in the bathrooms. We were told to clean up.

While substituting on an infirmary area in preparation for an inspection, I was told by a nurse to write patient care plans for patients even though I did not know them. We knew what day the inspectors were coming, and the hospital was ready.

I quit my job as a nurses' aide after about 5 months. I resigned because I could not stand the horror any more. I could not look my ladies in the eye. They suffer at the hospital week after week. They took the violence and the neglect and they all knew it was the end of the line. They knew that Kane Hospital means a lonely and ugly death.

I saw these people die. As an employee, I could not make the place better. That is why I am here today.

Senator MOSS. Thank you, Ms. Eckel. That is a very telling testimony.

Mr. Joseph Nagy.

STATEMENT OF JOSEPH NAGY, THERAPIST, PITTSBURGH, PA.

Mr. NAGY. Good morning Senators. My name is Joseph Nagy. I want to thank you for the opportunity to talk with you today about the conditions at John Kane Hospital. I worked at the hospital as a nurses' aide in January and February of 1973. Since then I have worked with Emily, Mary, and other Kane employees to document the conditions within the hospital and write the report you have before you. Currently I am employed at a Pittsburgh community-based mental health center as a group therapist, working primarily to help people stay out of institutions like Kane Hospital.

Each day while employed at Kane Hospital, I experienced the conditions which Emily described to you.

My testimony will deal primarily with three areas: (1) The inadequate supervision of the nursing staff; (2) the verbal and physical abuse of patients; and (3) the inadequate supportive services provided at the hospital by departments such as recreation, dietary, and inhalation therapy.

Administrative and supervisory personnel are not providing adequate direction and supervision for the medical and nursing staff at Kane Hospital. Patient neglect, poor nursing practices, and continued patient abuse are results of this lack of supervision. No charge nurses are assigned the duties of coordinating the patient care provided on each 48 patient nursing unit over the full day. Consequently, patient care provided on the day shift is sometimes inconsistent with treatments provided on the evening or night shifts. No channels exist for the nursing staff to resolve these disagreements.

Further complicating this problem is the lack of written patient care plans required by both Federal and Pennsylvania State regulations. At Kane Hospital the patient care plans are incomplete and inaccurate. Usually no physician's plan or medical care exists. Patient care plans were usually updated only before Government inspections.

These circumstances leave the nursing staff with no direction or leadership.

"A Lack of Direction and Supervision"

The medication practices at Kane Hospital also reveal a lack of direction and supervision. Frequently, Kane Hospital doctors do not visit or examine patients in order to make an independent judgment about the necessity for medication, the type, and dosage required by the patient. Usually doctors make irregular visits to each nursing unit. Often they simply sign the medication orders requested by the floor nurse without visiting the patients.

The storage and distribution of medications offer ample opportunity for mistakes and theft. Medication is ordered in bulk from the central hospital pharmacy and usually stocked in bulk containers in medicine rooms on each of the 46 nursing units. Nurses' aides, trained at the hospital are responsible for passing out medicine and giving injections. These medication practices clearly violate both State and Federal regulations.

The lax treatment of patients with contagious and infectious diseases further demonstrates the lack of medical and nursing supervision. Usually there are more than 25 patients at Kane identified as having diseases requiring isolation. Most of these patients have some form of staph infection. Isolation is required to prevent the transfer of infection to other patients and hospital personnel.

While working at Kane Hospital, I saw isolation patients in double rooms, in 5-person rooms and 24-person ward rooms. Patients with infectious diseases are, to my knowledge, never isolated in single rooms with separate toilet and bathing facilities as required by Government regulations.

Infectious Diseases Always a Threat

Nurses' aides who have not been trained in isolation procedures are at times ordered by the floor nurse to administer treatment to patients with staph infections. At other times nursing personnel unfamiliar with the patient are assigned to administer nursing care to patients with infectious diseases, unaware of the dangers to themselves and other patients. I will give an example of this from my personal experience.

When I was in training we spent time working on different floors throughout the hospital. One day, I was assigned to a convalescent area, and was told by the floor nurse to get the patients in a five-person room "out for breakfast." Mr. Geonig, one of the men in the room, was covered with feces. It was necessary to clean him before he could go to the solarium to eat. Half way through the cleanup an aide assigned to the floor told me the patient had a bad staph infection, and not to touch the patient while I was cleaning him—an impossible thing to do. No warning sign identified Mr. Geonig as an isolation patient. I reported this incident to my in-service teacher, since we had been told in class that only specially trained aides could work with infectious patients. Other students were having similar experiences on other floors. Our teacher was outraged.

The next day I was assigned to the same floor, and my teacher accompanied me. She confronted the nurse in charge. The nurse responded, "The doctor didn't require these people to be in isolation and sometimes we have staph patients in the ward. There is too much work to do here. Everybody has to chip in and if you don't want your students to work, don't send them here." They argued and nothing was settled.

The lax treatment of infectious diseases is an emminent threat to the health of Kane residents and employees.

The lack of supervision permits a host of other poor nursing practices to continue. I will list only a few of these:

(1) Personnel are assigned specialized patient care duties for which they have not been trained; (2) aseptic and cleanliness procedures are often ignored by the hospital staff; (3) patients are not given weekly baths; (4) restorative nursing practices necessary to prevent bedsores are not conscientiously administered; (5) dressings are not changed daily; (6) the walking and exercising of patients is seldom done as prescribed; and (7) patients are seldom provided with privacy during treatment.

Clearly there is a lack of leadership and proper supervision at Kane Hospital.

Physical and Verbal Abuse

I will now talk about the physical and verbal abuse of patients that I witnessed while working at Kane Hospital. Abuse seldom occurs in the presence of supervisory personnel, personnel not regularly assigned to the floor, or staff known to report misconduct. When patient abuse is reported, the hospital administration usually will not take disciplinary action unless two or more employees jointly witnessed the abuse. Patients reporting abuse are uniformly dismissed as being "senile" and "confused" by the hospital administration. Employees found abusing patients are usually given a warning by the administration and permitted to continue working in the same capacity. The incidents of abuse we will describe for you today are taken from our daily notes recorded while we worked at Kane Hospital.

Taunts for a Helpless Patient

While bathing patients on a convalescent area I had the opportunity to observe another aide giving baths. He brought into the bathroom a wheelchair patient. This was a black man, in his seven-

ties, unable to walk. While undressing him for the bath, the aide discovered the patient had a mild case of diarrhea. The aide lifted the man into the tub and began to spray him in the face with cold water from the sprayer used to clean out the tub after baths. The man cried out begging him to stop. The aide said, "You better learn never to shit yourself again, nigger," and sprayed the man with cold water again.

The aide looked over to me. I was involved in bathing other patients in the second tub. He said, "Hey, watch him jump." He adjusted the sprayer so a forceful one-half inch jet of cold water came out, turned it on full, and sprayed the man's genitals. The patient screamed and covered his genitals with his hands. The aide whispered, "do you know why I hate you? . . . Cause you're a nigger."

Holding the man's hands the aide sprayed him again with cold water, this time with the sprayer less than a foot away from the man's genitals. The aide then questioned the man:

"Are you a black man?" he said.
The patient did not respond.
The aide (louder) "Are you a black man?"
The patient whispered, "Yes."
Aide, "Are you a nigger?"
The patient did not respond.
Aide (very loud), "Are you a nigger?"
Patient, "Yes."
Aide, "Is this nigger ever going to shit again?"
Patient, "No."

Most Kane Hospital employees do not abuse patients in this manner. This aide had worked at the hospital for over a year, lived in the hospital's rent free dormitory, and had been reported a number of times for abusing patients. Each time he was only issued a warning by the hospital administration and permitted to continue working. Other instances of physical abuse are documented in our report. Similar verbal abuse is a daily occurrence on almost all floors of the hospital. Patients are yelled at and scolded like children. Usually patients who are demanding or who need extensive care are the most frequently abused.

Mr. Stobbs was a double leg amputee in a wheelchair. The aides on the floor resented having to care for him. When Mr. Stobbs would wet himself one of the aides would put him on the toilet and leave him balanced there for an hour or longer. When other patients came into the bathroom the aide made fun of Mr. Stobbs. He said:

You know Stobbs' chart says he ———.* Do you want to see what he can do? [pointing to another patient] . . . his daughter does a good job. I had her in the back seat of my car last night. Jeanette is her name, ain't it Stobbs? Hey, Stobbs, is what the chart says true—are you a ———?* Hey, Stobbs, [the aide threw a wet washcloth at Mr. Stobbs hitting him in the face] better answer, or you'll be in here all day.

He said, "Stobbs, are you a ———?"* I worked in Mr. Stobbs' area on several occasions. Each time Mr. Stobbs was harassed in a similar way.

Emily and Mary have also witnessed the abuse of patients at Kane Hospital.

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*Dashes replace words deleted from the transcript by the Government Printing Office due to their offensive nature.

Patients Bow to Extortion

On some floors in Kane Hospital, payment in the form of cash, storebook coupons, or cigarettes is required of patients in return for a bath, clean underwear, a shave, or help going to the bathroom. This practice is referred to by hospital personnel as "tipping." "Tipping" is a form of abuse and can be classified legally as extortion. On floors where tipping is common, patients simply understand that they must pay for what they get.

Staff abuse of Kane patients is a direct result of the intolerable working conditions in the hospital. The inadequate staff and supportive services required for decent care reminds the employees daily that the county commissioners and the hospital administration have no commitment to the health of the patients at Kane Hospital.

The lack of facilities and resources necessary to maintain even a minimal level of concern for patients, forces the staff to harden themselves emotionally against the suffering around them. Kane Hospital employees are subject to the unpredictable nature of the political patronage system. Discrimination in hiring and promotion practices at Kane create resentment and fear among employees. The salary ranges for many job classifications are lower than in other hospitals in the Pittsburgh area. These factors combine to make Kane a depressing and frustrating place to work. Employees are often distraught, bitter, and angry. Too often they release these emotions at the nearest targets—patients. Physical and verbal abuse is a product of the working conditions at Kane. These conditions are dictated by the policies of the county commissioners. Individual employees should be held responsible for their own treatment of patients. However, the abuse situation at Kane Hospital will not change until the working conditions at the hospital improve and the employees as well as the patients are treated with respect as human beings.

Supportive Services Inadequate

For the last part of my testimony, I will talk about the supportive services within Kane Hospital. These basic services, such as laundry, dietary, recreation, housekeeping and inhalation therapy, are vital to the functioning of the hospital. They are all inadequate and in many instances in violation of State and Federal regulations. I will briefly outline some of the problems in these services:

One: There is an inadequate supply of clean linen and clothing at Kane Hospital. The hospital laundry operates only day shift 5 days a week, making the lack of linen critical over weekends. One morning there were only three washcloths and one towel for 24 people in a ward room.

Two: Kane residents are forced to wear institutional clothing because the hospital lacks proper provisions to clean and return personal laundry.

Three: No provisions exist for residents wishing to do their own laundry.

Four: The housekeeping practices at Kane are poor. There is a prominent smell of urine, a year-round rodent problem, and the floors, walls, equipment, and furnishings are dirty.

Five: The inhalation therapy department is understaffed, and operates only on day shift. This leads to disorganized and dangerous oxygen handling practices. Essential inhalation therapy treatments are not provided patients due to lack of personnel and equipment.

Six: Both the regular and therapeutic diets at Kane are inadequate. Food is repetitious, tasteless, and of questionable nutritional quality. The food is frequently cold by the time patients receive it.

Seven: The recreation department is understaffed and provides activities suited for only a limited number of Kane residents. Two thousand of the 2,200 Kane residents are usually unable to leave their nursing areas. The recreation department provides almost no activities for the majority of Kane residents confined to their areas.

80 Violations Discovered

Kane Hospital is a terrible place. Its services are inadequate and in violation of over 80 parts of the minimum standards outlined in the State and Federal regulations. The government agencies charged with enforcing these standards are failing to do so. Today, we have turned to you in our effort to bring public attention to the tragedy of Kane Hospital. Our efforts and the efforts of others to change the hospital from within have failed. As we wrote this report, outrage about nursing homes has surfaced in many places around the country. Likewise, the terrible conditions many older people are forced to endure while living in the community are being publicized. More and more people are becoming angry—realizing that there is no dignified way for the great majority of Americans to grow old anywhere in our country. Thank you.

Mr. Silverstein will continue with our presentation.

Senator Moss. Thank you very much, Mr. Nagy. We appreciate that.

Mr. Silverstein, will you please proceed, sir.

STATEMENT OF HAROLD H. SILVERSTEIN, CORRESPONDING SECRETARY, ACTION COALITION OF ELDERS, PITTSBURGH, PA.

Mr. Silverstein. My name is Harold H. Silverstein. I am corresponding secretary of the Action Coalition of Elders.

Two thousand humans lay, sit, or walk in the storehouse of death. Many thousands more wait alone outside. Who can say which is worse? I cannot. But I do know that conditions inside Kane are chained to conditions outside.

We pride ourselves for being a God-fearing nation. Is this a false pride? Let us look at Kane Hospital and God's commandments. Commandment No. 5: "Honor thy father and mother so that thy days may be prolonged upon the Earth, which the Lord thy God giveth thee." In simple words, we are told to respect and be gracious to the elders so that we too will be honored and respected in our old age. Is Kane Hospital God's reward?

Oh no!

We are warned of this because of the next commandment, "Thou shalt not murder." We cannot understand Kane Hospital by only

looking at the horror within its walls. The hospital and its patients' lives are controlled by forces in the community around it. Patients are sealed within Kane Hospital because there is very little to help them survive in the surrounding community. Although funds have increased, services to enable older people to remain in their homes, are desperately needed in Allegheny County.

Hitler's concentration camps had a sign that gave hope, "Arbeit macht frei." Work brings freedom. Even that false promise is denied the Kane population. It is written in invisible letters and spoken in soundless words, "Abandon all hope ye who enter here. This is the last stop. We are waiting for you to die." Hitler was less cruel. He gave hope, albeit false, with death—Kane gives despair and creates a desire to die. Five times as many bodies leave the morgue as the discharge office.

More Support Needed for Inhome Care

It is clear that individuals who are growing older require increasing amounts of support in order to continue living independently in their homes with their families, friends, and neighbors. Members of the subcommittee, you are well aware of the personal and economic advantages of providing these supports in the community.

Over and over again for the past decade, the hearings of the Committee on Aging, have focused on this point. These hearings are important, but today in Pittsburgh, we need more. The major homemaker-home health aide program in Allegheny County ran out of money this month. They are cutting back homemaking services 75 percent and home health services 50 percent. There are 17,000 to 20,000 old people in the county who need these services. There is little hope that the situation will improve next year. A similar program in Pittsburgh public housing is being cut.

Of the major cities in the United States, Pittsburgh, has the third largest percentage of older people. Eight to 10 percent of our old people are already in institutions. The figure is 5 percent for the rest of the country. These cuts mean that many more old people in Pittsburgh will have nothing to look forward to but Kane Hospital.

We know of an old woman with no legs. She lives alone. She will now get a homemaker once a month. She may well end up at Kane.

Last February we met one of the many old men who live in parking garages in downtown Pittsburgh. He was 85 years old and living on $100-a-month from social security. By the time a bordering home was located for him, he was sick and in jail. He spent the night there and upon his release, disappeared. Perhaps he died before he got to Kane.

A comprehensive countywide system of services for old people will prevent these tragedies. Kane is indeed a death house, but is dying in a parking garage any better? These are the alternatives that older people in Pittsburgh face.

Senator Moss. Well, thank you Mr. Silverstein.

The testimony that we have heard this morning would shake the most hardened person and leave him all but sick to his stomach.

I assure you that I have not sat through more chilling testimony in all of the years that I have been chairing this subcommittee, and

we have heard some very bad situations, but nothing that seems to be quite equal to what we have heard this morning, and obviously, we are hopeful that we can be of some assistance.

It is just a horror story to think that people are neglected, not only to the problems of physical neglect, but I think even more devastating is stripping them of all moral dignity.

I do not think any greater abuse can be inflicted on a human being than the kind of verbal abuse and human degradation you described.

Mr. Nagy, you saw such horrible things, such as the bathing of the black man. Did you do anything about that? Did you report it? What did you do?

No Response to Reports of Abuse

Mr. Nagy. That incident occurred on my last day at Kane Hospital. Throughout the time I worked at the hospital, and throughout my association with Mary Lewin and Emily Eckel, we reported incidents of abuse and neglect to our supervisors. We saw there was no constructive response from the hospital administration.

When an aide reported another employee at Kane Hospital, he was pointed out in the cafeteria, and he was ostracized.

When you went to work on the floors, some aides would not work with you. A lot of the work we had to do took two people. We had to lift somebody in a geri-chair into a tub, or lift him out of bed, and other aides were needed. When they found out that we would turn them in, they would not want to help us, so it made our work much harder.

After we reported some incidents of mistreatment, we decided it wasn't worth it because nothing was done and because it made our work on the floors difficult.

I left Kane that day, and I did not return as an employee again. I spent the next 2 months writing the document that you have before you today. That is what I did about that incident.

Senator Moss. You were sort of classified as a stool pigeon, if you remonstrated in any way?

Mr. Nagy. That is right.

Senator Moss. How did you get in touch with the Action Coalition of Elders, did you know about them before you left the hospital?

Mr. Nagy. No, sir, we had written most of the report, and we felt that it would be essential that a community group of older people would become active in the Pittsburgh area to continue to put pressure on the county and the people in charge of the hospital to make the necessary changes there. When we were near to the end of writing our report, we started to look around for such a group, and we were lucky that one existed in Pittsburgh.

The Action Coalition of Elders began initially as an effort to get moneys from the city budget allocated so that transportation services for older people could be provided.

They were successful at that, and they went on to do a number of other things, so we were very lucky to have the opportunity to work with the Coalition.

Senator Moss. Did you and Emily and Mary start on your own, the three of you, to put this thing together?

Mr. NAGY. Yes, sir.

Senator MOSS. How direct was the role of the county government in the management and operation of Kane Hospital?

Mr. NAGY. The county commissioners are directly responsible for the operation of Kane.

Senator MOSS. The full commission, or is one commissioner assigned to that as his duty, do you know how it worked?

Mr. NAGY. There are three commissioners in the county. Usually, one is appointed as the chairman.

In the time that we worked at Kane, the chairman of the county commissioners was a very strong and forceful man. He made most of the decisions. It is my opinion that he and his other party affiliate made the decision about allocation of funds and resources to Kane.

PATRONAGE PROTECTION?

Senator MOSS. Well, there was a reference made to patronage protection, I think, was the term, where people are appointed to the hospital staff by the Commission, do you know anything about that?

Mr. NAGY. Yes, I can answer that question. The executive director of the hospital is a doctor. He is a figurehead, and a powerless man at the hospital.

The person who pretty much runs the hospital is the personnel director. He is in charge of the hiring and firing, and cares for the patronage concerns of the county commissioners.

That was commonly known at the hospital. The hiring of the employees was done by him, and there was very little input from the department heads, like the social service department head. For example, usually the personnel director hires who he wants.

His connection with the commissioners was very close. They worked hand in hand. He carried out their policies at the hospital, and he continues to do so today.

Emily would like to say something.

Senator MOSS. Emily, would you make a contribution to that?

Ms. ECKEL. The patronage system is very demoralizing to the staff. It means the promotions are not made on the basis of experience and qualifications. There is no career ladder.

It also means that complaints do not go anywhere, because people are protected by the patronage system.

As an aide, I talked frequently with other aides about the possibility of dealing with the supervisors. We would not take complaints to them. We could not talk to them about the lack of supplies, because they would not do anything. They were not there to do their job.

Ms. LEWIN. I would like to confirm that, from my experience at Kane. You see the effects of the patronage system over and over again.

In my testimony, I talked about a dentist and a doctor who were not performing their responsibilities, who were reported, and no action was taken against them. I saw that happening again and again with other staff at the hospital as well.

Senator MOSS. Thank you. Ms. Eckel, I believe you indicated that the hospital was notified in advance of inspection. Will you tell us

how that is managed, in a written form, for example, or how does the word get there?

Ms. ECKEL. In my experience, I was told by my immediate supervisors that it would be a nursing woman, or a nurse in my area. I do not know how the administration found that out, but we were clearly told, we were told the specific things to do.

Senator MOSS. And there was considerable change made around there, then, preparing for the inspections?

Ms. ECKEL. Yes, there was a major cleanup; there was attention given to updating charts, patient care plans, all done falsely. Bath books were updated and the utilization reviews were updated. The menus improved for about a week. Patients were cleaned, given haircuts, and shaved.

Senator MOSS. Could you do that with your limited personnel, or did they have more personnel in to freshen things up like that?

Ms. ECKEL. It was a pressure situation. On the days of the inspection, the doctors spent time on the floor, and there was more staff on duty.

Things that were unusual happened, like tray covers to keep food warm were used, only on the days the inspectors came. The rest of the days, they sat in the kitchen.

We were told to go down and take catheter plugs out of the holes and beds and to dispose of them, things like that.

Senator MOSS. Ms. Lewin, what rehabilitative services are offered at the hospital?

REHAB PROGRAM "CRITICALLY UNDERSTAFFED"

Ms. LEWIN. They are limited, very limited.

The rehabilitation department is critically understaffed. There are only three main areas in the hospital, out of 46 patient care areas, that have an active rehab program.

Outside of those areas, there are what is called four rehab maintenance areas which are located in the male and female infirmaries of the hospital. That is where rehab is supposed to be continued, but it is continued on a very limited basis. They basically have one physical therapy aide for those areas.

Outside of those areas in the infirmaries, there were only about 30 patients out of 800 that were getting any kind of rehab at all.

There was no rehab on convalescent areas, and the convalescent areas house about 560 patients.

Senator MOSS. Well, Federal regulations require a utilization review program. Do you know if Kane Hospital has any such program and, if so, does it function?

Ms. LEWIN. As far as I could tell, from my 2 years of working there, it is not functioning at all.

In the infirmaries, patients were to be reviewed by the doctors, but this never occurred.

There are utilization review forms on the front of the patients' charts. Doctors had code numbers which were simply written in each month by the nursing staff. You did not see doctors in the areas evaluating the patients and completing the utilization review forms.

Another problem was that doctors in the infirmary, and this was true of other areas as well, did not evaluate patients for discharge.

This was something that was not done. This was something that the social service staff complained about over and over. It was just not being done.

Senator Moss. Thank you.

Yearly Physical Sought

Ms. Lewin. The other thing that I want to say is that part of the utilization review is to provide a comprehensive, yearly physical examination for each patient. That did not occur at the hospital.

Patients would go for a very long time without even seeing a doctor in the infirmaries.

Senator Moss. Well, before I turn to my colleague from Pennsylvania, I want to say I really admire you three who were employed at Kane and who resolved to do something about this situation, and set out to prepare a report so that the information would be given. I am indeed grateful that there was an organization like the Action Coalition of Elders who came to your aid, to help you publish this work.

Mr. Silverstein's testimony was eloquent indeed. I think I shall remember the things that you have said there, sir, all my days. You described a situation that is intolerable, that never should have existed, but certainly, every effort must now be made to see that it is remedied and that things do change.

One of our consultants, a registered nurse, Margaret J. Cushman, who made an investigation of the hospital, has filed a memorandum which I will, without objection, insert into the record at this point.

[The memorandum follows:]

Memorandum

December 3, 1975.

To: Val J. Halamandaris, Senate Special Committee on Aging.
From: Margaret J. Cushman, R.N.
Re: Observations of Kane Hospital, Pittsburgh, Pa.; Dec. 1, 1975.

Accompanied by two other investigators, I entered Kane Hospital by way of the far entrance of the female infirmary. At the entry site the floor of the premises were dirty and littered. Beyond that point the premises were generally observed to be clean or in the process of being scrubbed. The smell of urine permeated many of the wards, especially over the unoccupied beds of patients—even many that were freshly made. However, all of the beds which were examined by this investigator possessed the required plastic mattress cover.

In both the male and female infirmary, many wards had four, six, and even eight beds. Only one ward in the female infirmary had dividing curtains between beds; several in the male ward did not.

In areas one through seven of the female infirmary on the ground floor, I observed large numbers of women up and dressed or partially dressed in street clothing. About 25 to 30 women were gathered in the central area of each ward. Occasionally, they were seated about large tables but most frequently they were lined up against walls in wheelchairs. Several patients were restrained by use of a bedsheet tied loosely about the middle and secured by knots in the back of the chair. The wheelchairs were usually arranged in a way that made communication between patients difficult. On the ground floor and first floor, no patients were seen in bed (all were up) and only one patient was seen in a geri-chair.

No Activity Observed

None of the women patients in the female infirmary were observed talking to one another during our tour of the area. Several women had unkept hair.

Four did not have slippers on their feet. None of the patients in these areas were engaged in any activity—they were sitting in their chairs, silently looking about. However, the vast majority appeared alert. They smiled and nodded; speaking to me as I walked through and spoke to them.

On the second floor, I stopped to speak with a woman for some length. I commented on how nicely her hair was combed and that she had lipstick on. She told me that she combed her own hair several times a day, and then motioned for me to bend closer. When I did so she informed me that she had asked for a bath for a week, and had not received one. She commented that she thought that was disgraceful. I asked several other women how they felt and how they were cared for. The uniform, monotone answer was "Oh, fine, everything's fine."

On the male infirmary, again, the vast majority of patients were in the common sitting area of the wards. In two of the wards, a handful of men were talking together or playing cards. The remainder appeared generally unresponsive to their surroundings: not responding to verbal or nonverbal stimuli from this investigator. On two instances, staff personnel (one nurse, and one aide) were observed speaking to patients as though they were children.

The male infirmary, like the female infirmary, smelled of urine. A leg brace with shoe was found on one empty bed, partially covered. A speech board was propped up on the windowsill of one empty ward. In one open area about 25 men were found sitting silently, most in wheelchairs and about 6 in geri-chairs. The geri-chairs were arranged behind each other in a row, front to back along the wall. Four staff members on this ward were across the hall in the nurses station, leaving the room of patients unattended. One gentleman was found slipping under his restraints in a chair, sliding to the floor. He was returned to a sitting position by two of the investigating team. Throughout the male infirmary, large numbers of patients were unshaved, with hair uncombed.

Two men were observed to have foley catheters in place; no women were seen with the same. Two men were found in bed during the tour of the male infirmary, both dressed. Of the approximately 400 patients observed by this investigator during the tours of the two infirmaries, none were observed to be receiving oxygen, intravenous, dressing changes, or other skilled nursing procedures at the time of the visit. During the tour, one male staff member in a short white lab coat was seen rolling a small oxygen cylinder through a ward and out of the door.

NURSES ADMINISTER MEDICATIONS

On two different wards, I observed nurses administering medications to patients. The manner of administration was in keeping with sound nursing principles—the patients armbands were checked against the medication cards, and the nurse stayed until the patients took the medications. On one ward, the method of medication pouring was observed: The procedure was done in a clean medication room; the medication bottles were properly and clearly labeled; the medications poured were consistent with the card; and the medication cardex and doctor's orders checked against the medication cards. Medications were recorded and current on the medication cardexes.

Nursing care plans were reviewed on one ward. The care plans were uniformly complete. A large number of plans were revised on October 24, 1975. The patient problems identified on the plans, and the nursing actions suggested were generally nonspecific and nonindividualized. An example of one need identified was "patient withdrawn." The corresponding suggestion was "place next to conversive patient." In general, the majority of patients appeared to be in minimal physical distress and receiving minimal social stimulation. Many were withdrawn and unresponsive to social stimuli.

During a tour of "A" level, about 30 patients were found gathered in a central area working on individual craft projects, under the direction of an occupational therapist and two volunteers. These patients were engrossed in their projects which ranged from embroidery to rug making, painting, and casting figurines for a nativity scene. All of the patients in this area were well groomed and conversing with one another. The atmosphere of this area and group of patients presented a sharp contrast to that found in the tour of the infirmaries.

Mr. Wes Parker, head of recreational therapy, joined us at this point of the tour. He informed me that they had started a remotivation and reality orientation program for the patients in the hospital. He estimated that about

600 patients were in need of the program. Only 30 had started receiving the program. Mr. Parker stated that they were using orientation boards but could not show us one as they have yet to be constructed. According to the employee newspaper of July, 1975, the above programs were underway at that time.

Mr. Parker provided a tour of the patient auditorium where weekly films are shown for patients. The auditorium was a spacious, ostentatious structure with ample rows of seating—and exceedingly little room for wheelchairs. Mr. Parker also pointed out the special ambulatory cafeteria for patients able to travel to level "A" by themselves. No special diets are available in the cafeteria.

In summary, the vast majority of patients at Kane Hospital appeared to be receiving custodial rather than skilled nursing care. At all times during our visit, staff members whom I contacted were pleasant, courteous, and helpful. Unfortunately, I seldom observed the same amenities extended to patients of the Kane Hospital.

Senator Moss. I think that memorandum corroborates a lot of what you have told us about the treatment of the people there.

I want to recognize my colleague, Senator Schweiker, the Senator from the great State of Pennsylvania whom I know is concerned as deeply as I am. Do you have any questions of the witnesses, or comments you would like to make?

STATEMENT BY SENATOR RICHARD S. SCHWEIKER

Senator Schweiker. Thank you, Mr. Chairman.

First, I would like to thank the chairman for letting me sit in on this hearing. I am not a member of this committee.

I appreciate two things: First, I was permitted to participate, but more than that, the committee is focusing on this problem, digging into it deeply and thoroughly. I commend the committee and the chairman for facing up to this very tragic issue.

I have to confirm what was said by the chairman, that in my 15 years in the Congress, I have never heard such shocking or depressing testimony. I think it certainly is a very clear signal to all of us, who in any way ultimately might have any say in correcting the problems you are presenting to us today. I do commend you for your willingness to undertake what is, I am sure, a very unpleasant job, but one that you feel is very necessary.

Second, I would like to ask a couple of questions relating to some of the details.

Racial Discrimination and Inhumane Treatment

Mr. Nagy, you described some very bad situations, obviously some of which involved racial discrimination and others which were just inhumane treatment.

I was wondering, what do you attribute it to? Is it the attitude at the top by the people who administer the hospital that permits this kind of situation to exist; or is it just shortage of personnel; what is it that triggers this kind of climate that is unbelievable in this day and age?

Mr. Nagy. I think it is very hard to attribute it to one cause. I think the administration, in the way they respond to the complaints about abuse, is surely one of the causes.

I think the lack of staffing is another cause. Also, the very difficult working conditions is a contributing factor. These make the nursing people on staff resentful about having to work in circumstances where they cannot do all of the work that is necessary to provide good care.

One of the things that startled me most, when I began to work on the floors of the hospital, was that it was impossible for us to take every patient who needed to go to the bathroom to the bathroom in time.

We would be assigned to floors in groups of twos, when we were in training, and so I had an opportunity, with one of my costudents, to try to get the patients that needed to go to the bathroom there in time. What happened? A line developed outside of the bathroom. The patients inside were sitting on the toilets, and so forth, doing their best to get finished. And the people in the line were going to the bathroom in the line itself. They couldn't wait and there weren't enough facilities to accommodate them.

It is just this kind of situation that makes it very hard for anybody who wants to give good care to stay and work in.

I think decent, sensitive people leave, and they leave quickly. I could not stand to work there. It is very hard.

It is just a frightening thing. I think this has a lot to do with the abuse that is happening there. I think the good people are filtered out.

Senator SCHWEIKER. They certainly must be in some way. I have been in institutions where there are obviously shortages and where the conditions you described are prevalent—everybody cannot get equal or proper treatment, because there are not enough aides to go around—but I have never seen a situation of humiliation and degradation that you have described.

That disturbs me even more, and that is the element that is so difficult to comprehend.

The other element is, unfortunately, somewhat of a tragic byproduct of our unwillingness to face up to some of the problems that senior citizens have. But that personal degradation, humiliation, degradation of the human person is permitted is, to me, quite incomprehensible.

Mr. NAGY. Emily would like to say something to you.

IMPOSSIBLE NATURE OF THE JOB

Ms. ECKEL. I would like to confirm the things that Joseph said about the impossible nature of the job. When I was assigned to my area, the impact hit me when we did not have enough gowns. We had to decide which of the wet and soiled patients to clean and which ones would get a clean gown.

We had to decide who was going to use the bedpans, when we did not have enough bedpans. It became impossible to treat these people as people.

As an aide, you have to become callous to constantly make those decisions about who is going to get what.

We did not even have enough silverware. I had to give patients trays with cereal and milk with no spoons. I saw patients eat by putting their face to the bowl. I saw others pick food up with their hands and eat it.

Senator SCHWEIKER. The other question I have relates to the kind of services, the kind of people that are employed and how they are selected.

Now, in your Kane Hospital report—the figures that you cite on page 20—clear evidence of race discrimination appears at this level. Of the over 100 nurses that you observed, none were black. Of the nearly 75 women clerical staff, none were black. Of the over 250 nursing aides you observed, less than 15 were black.

I wonder, whichever one of you worked with these figures, can you tell me what percentage of the patient load is black and how that relates here?

Ms. LEWIN. I am not sure of the figure. I would make a rough guess that 5 percent of the patients at Kane are black.

Senator SCHWEIKER. Then I gather, these figures are, in your estimation, pretty indicative of exactly what the makeup of these service groups are. Is that correct?

Mr. NAGY. Yes, sir. Only a small percentage of people belonging to racial minorities are admitted to Kane.

One of the explanations given at the hospital for the reason that there are so few black patients is that "black people generally care for their relatives in their homes."

Senator SCHWEIKER. I can understand why black people do not want to go to Kane.

Mr. NAGY. So do I.

TALES OF TREATMENT REACH BLACK COMMUNITY

Senator SCHWEIKER. I think many of the stories that were presented here today got to the black neighborhood of Pittsburgh, and I can see why none would want to show up at Kane. That does not surprise me. But I think these figures are revealing, and I understand that there is some kind of GAO investigation on the way.

Mr. HALAMANDARIS. That is correct.

Mr. NAGY. I would like to comment on the discrimination issue again.

According to the studies of the statistics at Kane Hospital, I attempted to compile a percentage of the black people that died in a year, and the percentage of white people that died in a year.

As I recall those statistics, there was a fairly large difference. The black people died much more frequently at Kane.

I am not sure what to attribute that to, maybe they are only accepting black people who are really in bad shape physically. It may also be the care of black people at Kane is not as good as the care white people receive.

Ms. ECKEL. In my area, all of the black patients were kept in the ward. There was an area where the case was slightly less better than the others. There were 24 people in the ward room.

Senator SCHWEIKER. Thank you, Mr. Chairman.

Senator MOSS. Thank you.

You talk about the lineup at the bathrooms, it makes me wonder if this fine looking facility, of which there is a picture in the report, was built with too few facilities. Was there a scarcity of the bathroom facilities?

Mr. NAGY. The majority of Kane Hospital infirmary areas were designed to house ambulatory, self-care patients.

Those areas of the hospital now have many people who are in wheelchairs and geri-chairs and cannot care for themselves.

The bathrooms of those areas are not designed to properly, comfortably facilitate wheelchair patients. The number of toilets, showers, and bathtubs do not meet State and Federal regulations.

Senator MOSS. Well, let me once again thank you all for coming here to testify before us and to bring your report to us.

We, of course, are confronted with a difficult problem. Under the law, the inspections, the police power, lies with the States, even though the large amount of the money that is used comes from the Federal Government.

As a result of this, we have been trying, through the Federal statutes to require certain standards and require that the States enforce them. I have some corrective legislation pending.

LOVING CARE DIFFICULT TO LEGISLATE

I hope these bills will pass. They are amendments to the social security law, in order to bring about better care in these cases. But it is difficult to legislate tender loving care. One of the problems that we are seeing here is that the same entity that owns the hospital —the county—also has the inspection authority, therefore, in effect, is inspecting itself. Obviously there ought to be a divorce of those two functions so that you can have real arms length inspections.

I want to assure you that from the Federal level, we are going to continue to press these reforms. We must see to it that our elderly people are treated as humanely as possible and that they have the physical, psychological, and the social care and the dignity to which all people are entitled.

Thank you very much. We have to move on, because of our limited time.

Mr. COBBS. Thank you, Mr. Chairman.

Senator MOSS. I'll call our next panel, but we will have to have a brief recess. The buzzer told us that we have to go to vote.

When we return, our witnesses will be Eileen Frenchik, registered nurse, currently employed by Kane Hospital, Father Hugh McCormley, chaplain at Kane Hospital; and Joan Kiefer, registered nurse, inservice training instructor at Kane Hospital.

If you will all please be ready to testify when we return, we will save time.

We stand in recess.

[Whereupon, the subcommittee was in short recess.]

AFTER RECESS

Senator MOSS. Our next witness is Ms. Joan A. Kiefer, registered nurse, Pittsburgh, Pa.

STATEMENT OF JOAN A. KIEFER, REGISTERED NURSE, PITTSBURGH, PA.

Ms. KIEFER. Good morning, I am here at your request to testify in reference to the conditions at John Kane Hospital. My name is Joan A. Kiefer. I am a registered nurse currently licensed in the State of Pennsylvania. I graduated from St. Joseph's Hospital School of Nursing in 1957. I am a member of the following organizations: Pennsylvania Nurses' Association where I serve on District 6, the Commission on Nursing, representing geriatric nursing, the Inservice Education Interest Group, and the League of Intravenous Therapy Education. I am presently employed as a registered nurse at John Kane Hospital. I have a total of 10½ years of experience there through two different employments.

I worked as a staff nurse on a unit from 1962 to 1966. In 1969 I was reemployed and worked as a staff nurse on a unit until 1972, at which time I became an instructor in the in-services education department. I continue to be employed in this capacity. My duties include: Classroom instruction and on the unit supervision of community groups working within the hospital and developing in-service education programs and supplementing nursing care policies.

I am here on behalf of the residents who live there. From the time they are admitted to Kane Hospital, in my opinion, they become nonpersons. I have had an opportunity to examine the Kane report submitted earlier and feel that it substantially reflects current conditions at the hospital.

"THEY CANNOT DO A GOOD JOB"

I feel there are many qualified and good personnel at Kane hospital, but in my opinion, due to the structure of the hospital, they cannot do a good job. The type of patient we have needs more care, we do not have enough qualified help on all levels, or proper equipment to carry through their care. I can only cite eyewitness examples that I alone have experienced. There are 1,800 employees who have experienced more. The following are my most recent experiences:

I came upon a resident tied in a wheelchair with three restraints around his body and sheets tied around the wheels of the chair. A nurses' aide was standing guard at the door of his room. When I asked why he was tied, since it was obviously making him agitated, the answer was, "to keep him out of bed." I reported this to the supervising nurse and was told he goes back to bed in the afternoon and the 11 p.m. to 7 a.m. shift complains he doesn't sleep at night.

I observed a nurses' aide talking abusively to a resident and I reported it to the registered nurse on the unit. The aide was questioned by the registered nurse and she stated the patient was hard of hearing so you had to yell at him. Very shortly, I observed the same nurses' aide yelling at five different patients in the same abusive tone. This same aide had an incident report filed by students from a class for being physically abusive to residents. The nurses' aide was suspended for 5 days and is now on the 11 a.m. to 7 a.m. shift.

There are standing doctors' orders for medication on some nursing units with the registered nurse making the decisions to give the patient the medication and the doctor the next day will cosign this order.

An employee was recently rehired who had a poor past record of patient abuse. While on probation an incident report on this employee was filed stating she had washed a patient's mouth out with soap for swearing. She received a 3-day suspension and is still employed.

Residents have stated to me that they have to go to bed at 6 or 7 p.m. whether they want to or not. They have no choice in what television program they watch; the employees watch what they want to see.

Residents have told me they are refused pain medication because it is not time whereas in reality they are long overdue medication for pain.

Residents have told me that they have had to lie in their own excrement because they are told it is not time to change the bed.

Another resident told me of an incident where he had profuse perspiration and was simply told by the physician to go and dry out in the air. This patient is a quadriplegia—paralyzed from the neck down—and is very concerned anytime there is a change in his condition.

I have observed employees who have only limited training doing advanced nursing procedures. For example, these untrained aides were changing dressings on decubitus ulcers, with no formal classroom instruction on sterile technique was ever given to them. When some were questioned they replied that the registered nurse on the unit had taught them how to do this.

Training Instructions Disregarded

The registered nurse is bogged down with administrative duties which include: Patient-care plans, monthly summaries, re-ordering all medications monthly for the physician, and filling out utilization forms that the physician just signs his name to. This keeps her from patient care.

We teach in the classroom ideal situations, that is, care of the patient, equipment, and materials. We also teach this on the "one-to-one basis" or in other words one patient to one nurse on their first level of training. Two weeks later when they are assigned to five to eight patients to give them complete care, they are told to forget the way they were taught in the classroom and are told this is the way we do it here.

My main concern is the complete lack of respect with which the patient is treated. He or she loses his or her dignity. To all concerned they are merely the object of work. They literally become part of the bed that has to be made. They have no decisionmaking in their plan of care. The routine of the unit must not be disturbed. A "good patient" is one who never asks for anything, who becomes a "nothing" and fades into the wall. A "bad patient" is one who asks for care, decisionmaking, and attention. The patient is only trying to strive for individuality and dignity. In many ways they are carrying out "please look at me, I count, I was somebody once, I am a person."

Thank you.

Senator Moss. Our next witness is Ms. Eileen Frenchik, registered nurse, Pittsburgh, Pa.

STATEMENT OF EILEEN FRENCHIK, REGISTERED NURSE, PITTSBURGH, PA.

Ms. FRENCHIK. Mr. Chairman and members of the committee, my name is Eileen Frenchik. I am here at your request to testify in reference to conditions at John J. Kane Hospital, Pittsburgh, Pa. The following statement contains my opinions, personal observations, and information related to me by other nursing personnel. I am a registered nurse currently licensed in the State of Pennsylvania. I graduated from Western Pennsylvania Hospital School of Nursing in 1963. I am currently a member of the Pennsylvania Nurses Association, one of the negotiators for the Professional Nurses Association of Kane Hospital, and member of the Inservice Education Interest Group. I was employed at John J. Kane Hospital April 4, 1966, as a staff nurse and worked as a staff nurse in the female infirmary until September 1972. At that time, I remained a staff nurse but was assigned to the inservice education department. Duties of a staff nurse in the inservice education department include classroom instruction and on-the-floor supervision of newly employed and permanent nursing personnel, interviewing new employees, assisting in developing inservice education programs and tour guides.

I have had an opportunity to examine the report submitted earlier today to the committee. As a current employee, one with over 9 years experience at Kane, I must state that I feel it is an accurate reflection of the day-to-day conditions currently at the hospital.

Within the nursing department, there is an insufficient number of registered nurses and nursing personnel and that insufficiency is definitely reflected in the quality of care. Let me give you a few examples of what I mean.

I frequently receive complaints from registered nurses on the floors that they have been assigned too many patient areas to cover with only a handful of nurses' aides. On one such occasion, a registered nurse stated to me that on the 3 p.m. to 11 p.m. shift in the Tower area, patient census approximately 300, she was the only registered nurse on duty. She, like many others, expressed deep frustration at the inability she felt to properly perform her professional nursing responsibilities.

STAFF SHORTAGES DEVASTATING

From personal experience, I can tell you that these staff shortages over a prolonged period are devastating. In self defense, I—like many other coworkers—frequently adopt a way of doing my job referred to as the "Kane Way." The Kane way includes attempting to work without sufficient supplies, equipment, and personnel, and not making waves about it because it has never done any good in the past.

Most Monday mornings at 7 a.m. when the daylight shift begins, there is an inadequate supply of linen on most of the nursing units available to begin giving complete a.m. care to patients. I have observed patients being washed with socks because there were no washcloths available. These laundry shortages are only a single

example of shortages. The same thing can be said of most other supplies. But continuing with the laundry problem, let me give you an example of the kind of response we get whenever these shortages are called to the attention of the administration. I approached one member of the administration to complain about the laundry shortage a short time ago. I was told if I was so worried about it I could take it home, clean it, and bring it back the following day. Although the remark may have been made in jest, I think it conveyed a lack of concern.

If you will permit me just a few more brief comments.

The geri-chair is an adult high chair on small caster wheels. In such a chair the patient is confined and unable to move freely. Patients in these chairs are less likely to fall out than in an unrestricted wheelchair. They are also less trouble. They are widely used in the institution. The problem with the use of geri-chairs at Kane is that because of staff shortages, patients placed in these chairs are frequently left in the chairs for extended periods of time unattended.

Over all, the major problem I see at Kane Hospital is the lack of sufficient professional supervisors given the authority to discipline and hold accountable all aides and support services within the hospital.

I firmly believe that every nursing area needs a professional registered nurse responsible for the quality and continuity of nursing care 24 hours a day, 7 days a week.

Thank you.

Senator Moss. Our next witness is Father Hugh J. McCormley, a Catholic priest from the diocese of Pittsburgh, Pa.

STATEMENT OF FATHER HUGH J. McCORMLEY, CATHOLIC PRIEST, DIOCESE OF PITTSBURGH, PA.

Father McCormley. I am Father Hugh J. McCormley, a Catholic priest from the diocese of Pittsburgh, Pa. Currently, I am the resident Catholic chaplain at the John J. Kane Hospital. I have been chaplain to the patients for almost 8 years.

My ministry during these years has been considered effective and was recognized as such by the Joint Commission on Accreditation of Hospitals, especially for the development of a unique volunteer program. This program involved a select group of people who assisted the dying in the last phase of their life.

The American Medical Society of Allegheny County honored me with a special citizens award because of my work involving the training of seminarians in ministering to the patients of our hospital. They would come to Kane and shave patients, give help in feeding patients, get them a drink of water or fruit juice, and assist at the various religious activities offered for the patients' spiritual benefit. It was the director of the hospital who nominated me for this award.

At this time I would like to share with you my deep feelings and concern for the patients of Kane. They mean very much to me and their comfort and happiness are constantly on my mind. I feel for them as I feel for my own dear parents who need me. The patients have given my life deep and rich meaning. When I look at them, I

realize how deeply I love working with and for them. In looking over the years as their chaplain, I realize to what fullness of life they have brought me. I have extended myself to them in many ways so that their last days would be days of happiness and quality. I try to meet their needs so that their great suffering and loneliness may be eased.

Problems "Just Pushed Aside"

From the very beginning of my chaplaincy, I realized the multitude of problems that existed in this institution. I find so often that problems are not solved, but just pushed aside. This failure to deal with problems has a frustrating effect on the attitude and work of employees and finally comes to rest on the quality of service given to the patients. The causes of the problem are chiefly these:

One: Inadequate training of employees to deal with their own emotional trauma in the face of the chronically ill and lonely, dying patient. Employees are taught how to do things but not how to deal with patients as persons. The hospital is work oriented but not patient oriented.

Two: Low motivation deriving from inadequate salaries and also little recognition for a job well done especially in the case of employees who want to be sensitive to the emotional needs as well as the physical needs of the patient. In other words, individuals are not encouraged to be sensitive and compassionate, and as a result, I feel, they have a sense of guilt and are not able to cope for long. Hence they either leave the institution or build walls between themselves and the patients.

Three: A shortage of help. On Novemebr 26, 1975, the day before Thanksgiving, there were three registered nurses and one supervisor attending 600 patients and approximately one nurses' aide for every 25 patients.

Four: A shortage of supplies, especially the constant lack of clean laundry.

All of these problems combine to alienate the sympathies of employees.

"Some Examples of Suffering"

This trauma has a significant effect on the suffering patient. I would like to cite for you some examples of suffering that have made a deep impression on my mind. But before I begin I now ask myself why did they have to happen.

Some time ago a man phoned me and asked if I would help a friend of his who was a patient get some relief from severe abdominal pain. He told me he went to nurse after nurse trying to find out if someone could do something for his friend and he got nowhere. I promised to help. When I went to the floor, I decided not to see the nurse first, but the patient. I asked the patient what was wrong. He said he had not been able to eat for days; he was in severe pain and his stomach really hurt. I asked if the nurses were helping? He said, "No one helps." I went to talk with the nurse and asked her whether she thought that patient might be having some problems with his bowels, and that might be the cause of some of his problems.

She informed me that she had checked him and that wasn't the problem. I was not satisfied with her observation, so I contacted the doctor on the floor and asked him to see the patient and call me afterwards. The doctor described to me in detail that that was the problem. He said "I have been a doctor for 40 years and that was the worst impaction I have ever seen." He said it was like cement.

I'd like to give you another example, one with regard to the serving of meals. I remember a situation when I went to a floor to assist feeding patients. I asked the nurse what I might do to help. She told me to pass trays in the ward. As I was passing the trays, I took each diet card from the tray and threw it on the top of the cart. My concern was to serve the 25 patients hot feed. When I finished passing all the trays the nurse came in and looked at the diet cards on top of the cart and was very disturbed with me. She started to complain loudly about no one having concern for the diet cards. It seemed to me that her concern was more for diet cards than for the patients who needed to be fed.

At the same time I started to feed an elderly lady who was blind and deaf. This same nurse turned around while fixing her diet cards and said, "Don't feed her." I asked why. She said, "She doesn't eat." But I decided to try. I gave the patient a glass of milk and she drank it right down.

As a result I felt she needed more liquids, so I gave her four glasses of water before I started to feed her. The woman tried to reach out and grab the food before it ever got to her mouth. She ate everything on the tray.

I would like to share with you at this time my true feelings about the kind of food that is served daily. The only way I can relate it to you is in this way. When I was in the seminary, I thought they served the worst food I ever saw . . . until I came to Kane. That usually gets a laugh from people, but it's not a laughing situation . . . I am just trying to clarify.

Many Need To Be Hand Fed

Aside from the good homemade bread and pastry, the diet is too rich in starch. The manner in which the food is served really leaves much to be desired. Sometimes one or other of the utensils is missing. Sometimes the trays are placed at a distance from the patient—they can't reach them. The food is often cold. The units are so inadequately staffed it is difficult to feed personally all those that need help. Sometimes the food carts are taken from the floor too soon; sometimes the patients haven't the opportunity for seconds. There is little done that I can see to make mealtime the enjoyable event it should be in the patient's day. A few weeks ago I received a phone call from a doctor asking me to send, if I could, some of my volunteers to a certain area because six patients on that floor, he said, had not been fed for lack of help. Coming from a doctor, I feel this is strong evidence of the grave needs of this institution.

To give another example: My secretary phoned me one Thursday evening late last July wanting to know what volunteer had cut a patient so badly while shaving him. I asked what unit she was talking about, and she identified the unit. Our volunteers were not shaving

there at all; this was verified by a seminarian. I responded to her call by going to see the patient. Observing the patient, I couldn't believe what I was seeing. Someone had shaved the skin off his cheeks. There was a large gash under his chin. His white gown was spotted with blood. His wife was standing beside him, quite upset. I asked my secretary to call the supervising nurse who came down, and I said, "Look at the condition of this poor man." I could tell by the look on her face that she was shocked. I said to her, "What are you going to do about this?" She said, "What do you want me to do?" "I want an incident report written," I repiled. "The person who did this should be held accountable." She told me that she would write an incident report. I never heard of a followup of the situation. A few days later, I met the wife again in the hospital. In her frustration, she shared with me some very deep thoughts of her heart. She said, "Father, I hate to say this to you, a priest, but someday I am going to come into this institution and kill the nurse that takes care of my husband." She was saying this because of the little care and attention he was receiving.

Nurses Lack Sensitivity

Let me cite just one more example of insensitivity: On one occasion, I was walking down a hall with an R.N., checking patients when both of us glanced into a room and saw one of the volunteers who was ministering to a dying man. The volunteer had her arm around his shoulders. The nurse observed it and said to me, "Look at that. Loving that patient up! She should be out of here; she's a nut." And I said to her, "I don't think so. What you should do is walk into the room and maybe you could learn something from her." The volunteer was simply supporting him compassionately.

These cases are not isolated examples. They could be duplicated many times over. But I point these out to show that in many areas of service there is need of real concern on the part of all of us so that these situations will not be perpetuated.

Some Good Does Emerge

There is a reverse side of this coin, too. Many good things are happening at Kane. The director has given me freedom to create caring programs to meet some of the basic needs of the patients. For this freedom and continued support, I am grateful. These constructive programs have proved effective, not only in the spiritual realm, but have helped to bring comfort to patients generally.

I began these programs by going to the outside community and talking of the great opportunities for service to the elderly at Kane. I invited people to become a part of the newly created volunteer programs. As these people responded, their very presence and involvement has created a new awareness in employees in the areas of gentleness, kindness, and concern for the patient as a person. The volunteer has brought to the patient a new sense of selfworth accomplished through personal interest in his well-being: visiting, feeding, shaving, being a listening companion, performing a variety of little services that break down the barriers of loneliness and isolation.

The volunteer ranges in age from grade school through adulthood. The reason for the existence of such a program is to bring a greater awareness of the concerns of the aged to the public at large and so increase their awareness and sensitivity.

Sometimes when you give a report like this, you want to talk only about the negative conditions you see. But there is a good side too. Thank God for this! For example, over the years, I have watched R.N.'s and aides crying at the death of a patient on the unit. I have watched them work frantically to save a patient. I have watched them become angry over the lack of concern for a patient. I have watched them in anger over abuses that fail to be corrected.

At this moment, I would like to applaud the new era that has been developing over the past few months.

Pilot Program Lends Understanding

Recently, a pilot program has been established in the institution to better help employees understand the worth and dignity of the patients, the losses they have experienced in life, and to reach out to them in their dying moments so that they may be able to live these last few moments in peace. The program is able to assist and aid employees on the unit to better relate with one another, with the patient, and the patient with them. All who have been involved in this program have nothing but the best to say for it; and in working with employees on the unit they are finding better rapport and more effective communication than has ever before existed at Kane.

And so I feel that our presence here today gives great witness to the hope of employees who have continued on at Kane waiting for this moment of change.

I am confident that they will be renewed in the realization that this change will now take place, and their feeling of joy today will be that, having continued on at Kane, they are already part of that change.

I don't know what is going to be accomplished by my being here today. I don't know whether, as members of this committee, you are concerned just about the moneys that are involved in an institution like Kane. I don't know much about the intricate machinery of administration, but I am here on behalf of the aging patients, to say that they need more than they are getting. The suffering that our society has inflicted upon them is our responsibility. Our Government has appropriated millions of dollars to put a man on the moon. We spend billions of dollars for defense. Can't we reach out in support of kindness, tenderness, and healing to these aging people who are helpless and critically in need of our deepest love? Are we afraid to look at them? Do they remind us of our own aging process? Someone once said that aging problems are our No. 1 disgrace. Our challenge now is to make it our No. 1 priority. Now is the time to stand up and give ourselves in full dedication to this pressing need. May I remind you again they are human beings. They are persons. They have feelings the same as you and I. They need us; we need them. We need to share in their lives, in their sufferings, in their wisdom. I beg you, I urge you, to look at Kane Hospital to see its

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good, to eradicate its evil, to care for its people, so that John Kane Hospital can fulfill its great potential to be the leading institution in concern and care for the aged. When I speak of that institution, I speak for all the institutions that house the elderly.

STATEMENT BY SENATOR CHARLES H. PERCY

Senator PERCY. Father, I want to thank you very much indeed, and our other witnesses as well.

Your testimony is about as moving as any I have ever heard. It was the most moving that I have heard in my many years on this committee and subcommittee. Although it is discouraging in some aspects, it does give me hope—hope that there are many like you all, who were brought into this work out of a sense of compassion, a sense of decency, men and women who have a nobility of purpose. I recognize that you can do more here to carry out God's work than probably anyplace else.

I think your comment on the volunteers is so important. I wrote a letter to every high school in the State of Illinois as a result of my impressions after years of going through nursing homes and homes for the aging in the State. What I was struck with, and I want to question you later on how many times you have relatives and friends call on patients at Kane, but I was struck by the fact that in some places my wife and I visited on weekends, we were the only visitors that had been there by Sunday afternoon. Just the fact that someone—anyone comes to see them is exciting. So we encouraged young people, high school students, college students to go to homes in their own community. I think it did a lot for the patients, and for the young people, giving them a sense of usefulness, of being somebody, of being a part of it.

I want to commend you very much indeed, and our other witnesses, for being concerned and coming forward.

Before we question, I would like to ask Dr. Robert Butler, who is in the room, to step up, if he would not mind, and take a chair here.

Dr. Butler is a nationally known author. He is a psychiatrist. I wonder if he could take a few minutes to give us the benefit of his observations.

We will hear from the Doctor, and then we will question our witnesses.

STATEMENT OF DR. ROBERT BUTLER, PSYCHIATRIST, WASHINGTON, D.C.

Dr. BUTLER. Thank you. I am very pleased to be here.

I will make both a comment, and present some observations on the visit made on December 1, to the Kane Hospital.

The physical location was not unusual in that it is far away from the community life, which does not say that the physical plant did not have many things to commend it, but it does express something about our culture's insensibility that the Father was trying to describe of what we do with older people.

At Kane there are 2,200 beds. We were informed that some 1,000 deaths occur annually, and these occur after some period of time in

the hospital, at least for a year, so we know it is not immediate death, but rather deaths that occur in the wake of custodial care. There was precious little evidence of skilled nursing care.

The entrance we made was to a woman's infirmary, which was quite dirty. The patients were mostly in chairs, and not in geri-chairs. There seemed to be ample personnel, which made a number of us, including myself, quite suspicious, as though we had been expected. It would be interesting to see just what the differences were in the number of personnel present on that particular day, compared to other days.

As I say, it was a custodial, not a skilled nursing care institution, and indeed, as the report on the hospital expressed, a place to die.

Motivation Activities Lacking

Specifically, for example, there were no social work histories associated with the medical charts so well-motivated personnel have great difficulty of knowing the person whom they are trying to serve, with regard to family background, interests, whether they were married or not, whether they had children or grandchildren, et cetera.

There are often more than three, often up to six people, in a "room." The beds were often placed against the closets so that it was not even possible to open up those closets to get to one's personal effects.

At least twice I observed drug carts which were unattended. It would only have taken a moment for somebody to obtain the medications.

On the other hand, the medications were delivered, in the appropriate nursing manner, following all procedures. The women were for the most part in dresses, but for some reason on that morning the men were in pajamas and often unshaven and unkempt.

Most people were lining the walls in their chairs, not in any kind of arrangement which would have expedited communication and warmth.

In short, there was no activity, and relatively little use of recreation.

In visiting the dentist's office, we were told the dentist was not yet in, but he would usually be in on Monday, Wednesday, and Friday apparently, and that there was "no oral pathology" ordinarily found on most of these patients. I can assure you, given what we know of the statistics of dentistry in the United States, this can simply not be accurate.

The hygienist and the LPN who assisted could not possibly care for more than 10 or 15 patients a day, when you calculate the number of patients in the institution of some 2,200 beds, and the turnover on an annual basis.

I wanted to particularly point my attention to one patient who had severe bedsores on the buttocks and in his left groin, and to tell you that he was bathed by a hospital aide who may have been well-motivated, but quite untrained. The catheter was on the floor, but attached to the man; in short, it was dirty and unsterile. He had been

wrestled into a bathtub to be bathed down rather than sponge bathed in his own bed, and then brought back to that bed.

He was complaining bitterly, and apparently was regarded as an "uncooperative" patient, although being "treated" to considerable pain and discomfort.

He had a stroke in 1961, 14 years before. He was massively emaciated and without muscle strength, and was unable to defend himself, but absolutely clear of mind, so that it was perfectly possible to get from him a clear picture of what his needs were, and to communicate effectively with him.

There was no evidence, upon examination of his chart, that there had been cultures or sensitivity tests done. Insofar as his catheter was concerned, it was not possible to be certain about any possible infection.

Small Percent Receives Therapy

The recreational therapists said they were about to introduce reality and remotivation therapy techniques, and he estimated that perhaps 670 or more should receive it, but that only about 30 were starting to.

There was no room at all for wheelchairs in the auditorium that would meet some social and recreational needs for these people.

To summarize, having seen numerous nursing homes and homes for the aging in the United States of all types, and under various types of sponsorships—municipal, nonprofit, church related, commercial—despite the obvious possibilities inherent in the physical plant, and despite the obvious interests of a great many of the personnel that work there, it was frightening and disturbing to see the extent to which basic human care and skilled and respectable nursing care was not provided in any kind of a dignified manner. One would simply have to conclude professionally that we found evidence of only minimal custodial care at Kane.

Senator Percy. Thank you very much, Doctor. I appreciate your comments.

Could you answer just one question? I just want to be certain that the testimony that is being given, and that has been given in the past on long-term care facilities, is not overlooking the fact that we are dealing with elderly people.

Dr. Butler. Yes.

Senator Percy. The chronic infirmities of elderly people cannot be compared with those of younger people. Has what you have observed and seen, taken fully into account that even if you went through a perfectly fine facility, with adequate care. and so forth, you might indeed have a saddened feeling in looking at people who were suffering from what the process of aging sometimes brings to people? Taking that fully into account as an expert, are you saying, then, that conditions that can and should have been corrected, and must be corrected, are evident wherever you go?

Dr. Butler. Oh, yes, absolutely.

Family Contacts Important

It is imperative, in fact, as very important as compassion and sentiment are, that we also have to be very hard-headed as to what, in fact, can be done. There are some things that can effectively be done to harness the repair processes, the restorative processes, to

provide recreation, to show human concern, to help people to die peacefully. Inpatients should be given every possible opportunity to communicate with other human beings around the issues that affect one, including especially one's continuing relationships with one's own family, the very point you raised as to why there may or may not be adequate contact with that family. Quite apart from sentiment or compassion, in the most hard-headed way, we could see that the best of medical, social, and nursing care was not present at this institution.

Senator PERCY. I would like to try to reserve some time for our staff members to ask some questions, if they feel so inclined, because I think our staff in this case is so well prepared. The staff has visited the Kane facility many times and I regret that I have not been able to see it myself. The only book I have ever written was about the elderly. I have visited so many homes. I have heard the description of conditions in others, so it is just as if I have been there.

I would first like to make a few summary statements about the problems I feel exist, and then see if we could have some response from our witnesses to those problems.

Senator Moss and I have heard the same story many times. We have heard of places like Kane in New York City, we have heard about it in Springfield, Ill., the home of Lincoln. We heard about it in Chicago, and we have heard about it in every place we have gone.

We have heard about problems in proprietary facilities, we have heard about them in Government-operated facilities, and we have heard about them in voluntary, nonprofit facilities.

ALL ROUTES FAILING?

I wonder, as one Senator, what this really means? We have tried three different routes, and they all seem to be failing. Are we unique in the United States, that we cannot seem to find a way to handle this problem? Are there other countries in this world that any of you have visited where you have seen a good long-term care system?

Can you give us some bright stories? Have you visited other facilities that have really worked? Can you tell us why they seem to work?

It has been implied that the proprietary system suffers because the purpose of a profitmaking facility is to make money, and many times, the way to make money is to deprive the patient of service, to cut down food, and to have inexperienced help, to hire someone like Bill Recktenwald. He was hired when he worked for the Better Government Association, to be a supervisor, when he could not have possibly qualified for that position. He even administered drugs when he was not qualified to do so. Now, we see the same problem in a county facility where there is supposedly no profit motive. Maybe the incentive here is to hold down the costs to the taxpayers and squeeze services so the politicians are not criticized for trying to raise taxes.

Maybe what substitutes for the profit system are the payoffs and the kickbacks, the patronage jobs. Maybe that is the form the ripoff takes in a Government-owned facility.

We obviously have not quite found an answer. We have seen some very good ones, but we have seen some very bad ones.

Do any of you have an answer for us?

We are searching for an answer. We are probing several different routes, but we see failure everywhere. We have seen some good in all three systems, but we cannot establish a pattern. We simply have to find a way to provide the kind of facilities that do serve the people.

"Someone Else's Problem?"

I do not think it could be put more clearly than Father McCormley put it. Someone once said that aging problems are our No. 1 disgrace. This seems to be the case and I am literally ashamed of the United States of America. We have genius for organizing ourselves to conquer outer space, for organizing our military establishment, for organizing our technology and know-how, but when it comes to the simple problem of trying to take care of those we love the most, we seem totally incompetent to be able to do it. Somehow, we do not even have the sense of compassion to want to see what happens. We seem to stay away from it. It is someone else's problem. We have delegated that to the government, we have delegated it to someone else.

So what are the ways that we can go about this? I yield at this point to our distinguished chairman, who feels just the same way I do. I know of no man that I have worked with who wants to do more, and who is more experienced and has more influence and power in the Congress of the United States than Senator Moss. But we are looking for some sense of direction.

You have reported on conditions. Can you now tell us, if you were sitting in our seats, and had our ability and our influence, what you would do? How would you go about this? Tell us what we can do in our capacity as legislators, and tell us what we can do in our capacity as human beings to motivate others who want to do the right thing. That is the purpose of these public hearings, to try to increase our knowledge and that of the public. If there is a way to do it, let us know and we will see if we can move it from the lowest priority to the highest priority.

One thing is certain: We will all be older when we walk out that door than when we came in. The alternative to aging is not good to contemplate.

Father, I wanted to ask you. Would you put your mother in Kane? Would you want her there?

How strongly do you feel about that, and then let us open it up for discussion. First, let's have you answer that question, and then I will yield to the chairman.

Senator Moss. You are doing fine.

Father McCormley. Before I answer that, I would like to give a little background information. My mother is an invalid. She had a stroke 4 years ago, and we have been able to maintain her at home. At present, however, we are just running on a shoestring in our situation. We are inches away from making a decision. At times, we felt compelled to make the decision to put her in an institution. The only thing I can say is that I would rather bury my mother than ever put her in an institution, especially Kane.

Senator Moss. That is a powerful comment there. That is a question all of us should ask ourselves. I can understand what you are saying, Father. You say you are on a shoestring, almost on the verge,

but many people are pushed over the edge, they do not know where else to turn. So they simply place their loved ones in Kane Hospital or someplace like that, and the Senator from Illinois expressed our great frustration. We have been pursuing these hearings for a long time.

"Why Have You Not Got the Answer?"

In fact, some of my people ask me, in a sort of derogatory way, why have you not got the answer? We have seen much progress, but we still have far to go.

We make some efforts, by legislation, to try to bring about better care, but we neglect other basic needs of human beings, that is what always gets to me. The lack of medical attention is terrible, of course, but it seems worse to me to strip a person of all human dignity and treat him just as a thing, like a piece of furniture. This is what came through in a lot of testimony that we have heard in this hearing today, and that is one of the reasons I admire what you are trying to do for these people; to bring back to them a little sense of dignity and concern.

Well, I did not want to intercede. Senator Percy was doing a very good job in his questioning. He asked the ultimate question, and if any of you have any comments, I would welcome them.

Dr. Butler. I think, Senator Percy has put his finger on human imperfections, which we all have, and we possibly have very imperfect ways of trying to respond, but I would begin with about four or five points briefly. One is education, inservice education at its best within any given institution.

I think that medical institutions have some reforming to do regarding elderly people. We do have 1.2 million people in nursing homes in the United States, and if we do more socializing with them, they would all be much better off, and could die in dignity.

There is not one medical school in the United States that requires a student to go to a nursing home. Doctors, nurses, social workers, recreational therapists, everyone has something to offer an older person, but the kind of education which such personnel need just does not exist, so education is one important route.

Senator Percy. Would it be possible for federally assisted medical students to be required to put a certain amount of time into this field during their residency or internship, or some time during their training?

Dr. Butler. I wonder a little bit about the word "require" but in the sense of arrangements, yes.

Educating the Young on Aging Problems

So often I will hear educators teaching medical students or residents in training, that aging is not interesting. They are only supposed to be interested in younger people. In my own experience, if you can get your hands on the students and have an opportunity to present to them effectively, they do become interested.

It is true in Great Britain that the national health service encourages care of older patients through incentives. We could accomplish the same ends through departments of geriatrics medicine.

We do not yet have a specialty of geriatrics medicine.

Senator PERCY. My concern with the problem is that of the person always going out for the fast buck. Why could we not ask medical schools across the country to set up volunteer programs? We could provide incentives, underwrite some of the costs of the administration of these programs, so that we could encourage those who want to gravitate into this field early in their medical experience. The same thing could be done in nurse's training. We would at least create knowledge early in training about the impact they can make, even before they graduated, and even before they become proficient in this profession.

Dr. BUTLER. Provisionally, we need a change, not only in medicine, but in nursing, social work, recreational therapy, occupational therapy; we need to expose students to the possibilities of being able to help people.

The myth of senility: We very casually write people off as "senile," when we fail to recognize the fact that there are significant numbers of treatable patients. We must create a new flavor in the medical schools to change the models presented by teachers to excite the interest of students.

It is very important to require systematic exposure of the medical student in hospitals, homes for the aged, nursing homes; to see for himself or herself the kinds of things that can be effectively done.

HIGH TURNOVER RATE

There is the need for decent pay and career ladder incentives among the personnel. As the Senator pointed out, there is a high turnover rate which shows us the extent to which people working directly in patient care often are doing very distasteful work and are not rewarded with a sense of real appreciation through decent pay and educational opportunities to further advance themselves in the hierarchy.

There is the very definition of the term "institution." When the Father said he would not want his mother to be in an institution, it occurred to me to remind us all again how we need to redesign an institution to be a complex of services and facilities that go far beyond the traditional walls and reach out into the community and provide services.

We certainly did not see outreach at Kane Hospital. At the Philadelphia Geriatrics Center, in the same State, there are studies wherein one-half of a random sampling of prospective admissions to the center were provided with various types of services in their homes rather than admitted into the institution. Thus, it was possible for them to remain outside.

There is research. This may turn out to be the No. 1 cost containment of all, more than cost controls, I do not mean those are not important, but when you think back to the observation of the late Alexander Fleming of England, in the 1920's, out of which came penicillin, and therefore control in considerable measure of infectious diseases. In fact, this breakthrough gave us increased survivorship into old age. It seems patently clear that we will have to support research in the chronic diseases and in aging.

It is not traditional in most nursing homes and in most hospitals to take advantage of technology for the elderly. For instance, it is

possible for me to sit in this chair, as a paralyzed person or to have severely disabling arthritis, and through the movements of my eyes, to be able to cook a meal on the stove. If I have a clear head, and through the use of modern technology, I could live at home and have a realistic kind of independence, certainly with enormous savings to the country.

Community Participation Needed

I would like to see consumers, which means the families of older people, and the providers, which means nurses and others, working together in systematic ways, for example, volunteers. I am impressed, for instance, with the Organization of Friends and Families of Nursing Home Patients, in Oregon and with the Better Care Association in Detroit, instances of ways of trying to galvanize the interest of people in the community. There is perhaps no better way to enforce changes in care than for people coming in and out of an institution all the time, and particularly families making contact with the patient.

We can never have enough inspectors to enforce the regulations which we try to establish. I think changes in our culture's sensibility to older people, would make the biggest difference of all.

Senator Moss. Thank you.

Father McCormley?

Father McCormley. I would like also to address myself to some ideas of what could be done.

We have to, in some way, change the whole attitude of our country with respect to the aged. We think so much about the youth, yet we think very little about older people. We are not really looking at their qualities as persons.

I am reminded of this attitude so often when I go out and give talks in order to enlist more volunteers. I usually go out on Sunday morning and talk at all of the masses in a particular church. I went to a church about a month and a half ago, and I preached to 4,000 people. Twenty people signed up to volunteer, and only 10 came for an orientation. People could not even look at me while I was standing at the door. The apathy which I observed was unbelievable.

I would suggest that we begin teaching children at the elementary level to value all human life in order to acquire a balanced attitude toward all persons of our society, regardless of age.

Another area I think we should look at is television programing. The exposure the elderly in our communities receive on television is terrible. I remember watching a talk show on which a dirty old man technique was being portrayed, and it was just horrible.

I felt like kicking my foot right through the television set. At the same time, the audience burst into uncontrollable laughter. We are perpetuating this negative attitude towards old people, because we do not look at them as valued persons.

Preparing the Young as Volunteers

Senator Percy. Let me ask whether or not you feel that we have a better chance to appeal to young people than to preoccupied middle-aged Americans to get them into this movement and to have them

care for someone else in a volunteer capacity? These young people may be more realistic and less materialistic than their parents.

Father McCormley. Yes, I do, but I think they have to be prepared for it. From my limited experience, when I ask young people to come to Kane to volunteer, I have found out that it is better to prepare them before they come to the hospital. Then I would speak to them again about the kind of people they would be working with, since they are not used to seeing old people.

Senator Percy. Now, let me ask about those who have elderly parents, who also are raising their own children, who may be faced with the choice of taking care of aging parents or meeting the pressing needs of their own children. These people may have the tendency to turn their parents over to an institution where they have the care provided.

In your judgment, if financial assistance were offered to a family so that they could then have the ability to care for their own parents, in their own home, to keep them in an atmosphere that is more familiar to them, would they do so? If they had some assistance, and if that assistance were substantially less than the cost of institutionalizing the parents, would we not be better off all around?

Father McCormley. Yes, I think that could be helpful. I know from my experience with my mother, if my dad died tomorrow, it would be all over for us if we did not receive any financial assistance.

High Costs Force Institutionalization

In our own case, with medicare cutting back funding, we now have to provide almost everything. People are being forced to institutionalize members of their family. They do not want to do this, and I think if they did receive some help, not only financial help, they could be encouraged to maintain their loved one in their family setting. Everyone has the right to die in their own home. No one has the right to inflict an institution on another person.

Senator Percy. I would like to ask Ms. Frenchik a question. In your statement you indicated that the report is an accurate reflection of the conditions at Kane Hospital.

Have you had experience in other facilities, and can you tell us if the problems of those long-term care facilities are any different from the ones at Kane with which you are familiar?

Ms. Frenchik. No, I have worked in no other long-term care facility.

Senator Percy. You have not worked in any other?

Ms. Frenchik. No. Is that what you are asking?

Senator Percy. Yes.

Ms. Frenchik. I have worked in no others.

Senator Percy. Ms. Kiefer, could you answer that question for us?

Ms. Kiefer. I have not worked in any other institution either. I have worked in other general hospitals.

If you want to make a comparison there, there just is not any comparison. The general hospital runs very efficiently. You never have any shortages of supplies, you always have enough staff, and if there is not enough staff present, say, due to illness or absences, they call people into work who are on their day off and they ask them to work.

I have never run into the situation that I did at Kane. It is unique.

Senator PERCY. To the best of your knowledge, can you tell us whether the county commissioners visited the facility to observe it first hand?

RARE VISITS BY COUNTY COMMISSIONERS

Ms. KIEFER. To the best of my knowledge, I personally only know of one time that I knew of a county commissioner being in the facility.

Senator PERCY. And he was there how long?

Ms. KIEFER. I do not know. I did not see him entering the facility. I saw him on the first floor, relatively close to where the offices are.

Senator PERCY. Ms. Frenchik, could you comment on that?

Have any county commissioners visited Kane? I would appreciate also your comment.

Ms. FRENCHIK. I do not know of any from first-hand experience. I did hear one time that Commissioner Staisey was out for a lunch.

Also, I believe Mr. Forrester was out at one time that I heard of. Dr. Hunt, I heard was out at the hospital one time also, but I did not see these people.

Senator PERCY. Father, can you answer that?

Father MCCORMLEY. I have seen the county commissioners there on occasions, mostly for ceremonial events, and that would be Commissioner Staisey and Commissioner Forrester.

I was never aware of Commissioner Hunt ever being in the hospital. I would like to point out at this time, that in my own opinion, I feel that Commissioner Forrester has shown the deepest concern for the patients of the hospital.

Senator PERCY. I wonder if you have been subjected to pressure, or have been offered advice about your testimony by the Kane Hospital administration, or by anyone else officially connected with the Kane Hospital?

Ms. KIEFER. When I called in to say that I was going to be here, my immediate supervisor told me that I was to tell the truth as I saw it.

Senator PERCY. You were told to tell the truth?

Ms. KIEFER. Yes.

Senator PERCY. You had no other advice?

Ms. KIEFER. No, nothing.

Senator PERCY. I am very pleased to hear that.

I indicated that I would ask the members of the staff, who were intimately involved, if they have any further questions, but obviously we will defer to the distinguished Senator from Pennsylvania first. I have no further questions myself.

Senator SCHWEIKER. I pretty well asked my questions earlier, Senator. Thank you. I will let the staff go ahead.

Mr. HALAMANDARIS. Thank you very much.

I have a couple of questions that I would like to ask all of you, particularly Father McCormley.

We had the testimony of Eileen Frenchik, and Senator Percy just asked whether her day-to-day experience confirmed what we have in this report. I would like to ask Father McCormley, does the report

confirm your day-to-day experiences at Kane Hospital? Is the report we have basically accurate?

Father McCormley. Yes, it is accurate. For instance, I knew which patients were described in the report, even though they weren't named.

Senator Schweiker. You are saying the personal stories of human degradation are accurate, that you saw them, particularly? Is that correct?

Father McCormley. Yes; I have seen patients mistreated, but I was not a witness to the examples contained in the report.

Mr. Halamandaris. I have a couple of other questions.

Ms. Kiefer. I have to say the same thing, when the report recites these horrid stories, I knew the patients.

Drug Administration Regulations

Mr. Halamandaris. It has been suggested to us that the hospital administration was not responsive to the requests from the Pennsylvania Department of Health. I'm speaking of the requirement that unlicensed personnel not administer medication. Do unlicensed personnel give injections? Are you aware of hospital officials disregarding orders from the Pennsylvania Department of Health, and ignoring regulations relating to drug administration.

Ms. Frenchik. There was a staff meeting held in the inservice department, and we had a lengthy discussion in reference to this.

Mr. Halamandaris. As far as you know, are aides still continuing to pass medication? Do you know of instances in which aides and unlicensed personnel, are giving injections?

Ms. Frenchik. Nurses' aides are classified as three stripes. They give injections at Kane Hospital, they give intramuscular injections, however, they cannot give intravenous injections.

Mr. Halamandaris. In respect to patients' rights and requirements, are families informed of any changes in the hospital rules and regulations? Are you aware of any unusual administrative actions in this regard?

Father McCormley. I attended a department head meeting a month ago and a proposed bill of rights for the patients was discussed. The general discussion centered on the issue of how the bill of rights would be formulated and how the signature would be obtained from the patient.

I got the impression that the bill of rights should not be made known to the family of a patient before admittance since they would clearly know of their rights.

The bill of rights is required by law, therefore, the hospital will comply. But, in my opinion, the patients' well-being will not be the primary concern.

Personal Hygiene Care Needed

Mr. Halamandaris. Father, earlier you discussed some of the problems with personal hygiene of the patients at Kane Hospital.

Will you relate to the committee the incident you described to the committee staff concerning the Kane resident known as Porkie?

Father McCormley. Four Saturdays ago, with a group of volunteers, I went to shave some patients on a particular unit in the hos-

pital. While looking in one of the rooms to see if there was a patient that needed to be shaved, I found a little man whom I had seen many times before. I would say he had a few week's growth of beard on his face. So I walked over to him, and I said, "Porkie, would you like to have a shave?" He said, "I would like to have one very much." I started with barber clippers in order to get his beard closer to his face. Only then was I able to give him a close shave with a regular razor.

I then decided to wash his face and clean his ears; I could not believe the junk that came out of his ears. I was sick to the stomach. There were huge chunks of stuff in his ears. It was not only in the lower part, but in the upper part also. When I was finished, Porkie thanked me, and he said, 'No one ever cleans my ears, and I cannot do it myself." My emotion changed from one of almost wanting to vomit to wanting to cry, just because he was so appreciative.

Mr. HALAMANDARIS. Again, Father, if you would, please, could you give us some sort of judgment, are these isolated instances, that happen once in awhile, or are they fairly frequent occurrences or occurrences that happen every day?

UNIT "IS A ZOO"

Father McCORMLEY. The only way I can describe this particular unit to you is to say it is a zoo. I have been on that unit often and have seen urine all over the floor. I have observed people covered with BM from head to toe, while the staff sits at the desk, waiting to pass the food trays. Ironically, the registered nurse in charge of this floor thinks she runs the best unit in the hospital.

Mr. HALAMANDARIS. I take it that you have a similar problem with podiatry. Is there some sort of foot care given?

Father McCORMLEY. I had better let a nurse answer that one.

Ms. FRENCHIK. There is a podiatrist on the staff who works part time. He is, to the best of my knowledge, working 9 a.m. to 12 noon, Monday through Friday.

There is another podiatrist that comes in part time, two mornings a week. However, the nursing personnel are instructed to cut the toenails and fingernails of patients, and they are told not to cut diabetics' fingernails and toenails. That is up to the registered nurse.

Senator PERCY. I did neglect to ask for an answer to the question I put to you on the question of visitors.

Here is something that the government really cannot do anything about. It does not involve money, but it does involve someone reaching out and doing something for someone, in many cases for someone they are close to.

At Kane, do the patients have frequent visitors? In how many cases do the patients there have relatives or friends who could visit them but never do, or do so very, very infrequently? Did people make phone calls to patients there? Was there much mail that came in to keep them in contact by letter?

What more could people do, that they are not doing now, for their own who are in the institutions? Or, is there a satisfactory level of human contact with the outside world?

No Visistors for 75 Percent

Ms. Kiefer. People are going to visit, they will always visit.

By and large, I would have to say that probably 75 percent of the patients never get any visitors at all, never receive any mail. We do get a large volume of mail at Christmas, a token of Mother's Day and Father's Day cards.

Very rarely do they even get gifts at Christmas or Mother's Day or Father's Day gifts, just a card. I do not know why.

We try to encourage, when they do come in, to take part in the care. We feel that they should want to feed the patients, maybe help a little bit with them. It would make the patients feel better that their families really care. But they seemed filled with guilt; they seem to not want to come in. They feel guilty for having them there, and they cannot face up to the reality of seeing them in that situation.

Senator Percy. Any other comment? Father?

Father McCormley. I will confirm Ms. Kiefer's report in the sense of this guilt.

My staff and I have interviewed many patients' families. I cannot begin to describe the feelings of guilt which people have concerning institutionalizing their loved one. I would say that almost all of the families I have interviewed personally have broken down in tears.

Senator Percy. I want to read a 30-second statement by Mr. Silverstein. Really, this should not be read with reference to patients at Kane Hospital. As we approach the holiday season, there are millions and millions of Americans of all ages who have so much to be grateful for. We are not in a war for the first time in a long time.

We have the most blessed Nation on earth from a standpoint of the bountiful nature of our harvest, the largest harvest on earth this year. We ought to reach out to some nursing home, some home for the aged, some long-term care facility near our homes and do something this particular season for someone. It will do more to bring the Christmas spirit to all of us than anything we could do.

Could we not say that of the many, many facilities that we have visited, that this is the home of the living dead?

Mr. Silverstein states: "Hitler was less cruel. He gave hope, albeit false, with death—Kane gives despair and creates a desire to die."

For Kane we could substitute the name of any other institution that we have investigated. We can do something about it.

I think your testimony is excellent. I must leave now, but I think your testimony today, all of it, has been invaluable, in helping us to overcome this problem.

Thank you.

Mr. Halamandaris. I have a couple of more questions I would like to pose.

Before you leave, Senator, I would like your permission to have entered in the record a copy of the medicare-medicaid inspection report completed by the Pennsylvania State Department of Health.

It lists a long series of violations of standards, and I would like to have it made a part of the record, with your permission.

Senator Percy. Without objection, it will be made a part of the record.

[The report follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

(1)

Medicaid inspection dated

Form Approved.
OMB No. 72-R0931

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

DATE SURVEY COMPLETED: 7/22,23,25 & 28/1975

NAME OF FACILITY AND PROVIDER NUMBER: John J. Kane Hospital (Skilled Program) M.C. 39-5057 M.A. 0201 / SNF/ICF

STREET ADDRESS, CITY, STATE ZIP CODE: Vanadium Road, Pittsburgh, Pa. 15243

This document contains a listing of the deficiencies cited by the surveying State Agency as requiring correction. The Summary Statement of Deficiencies is based on the surveyor's professional knowledge and interpretation of Medicare and/or Medicaid requirements. In the column Provider's Plan of Correction, the statements should reflect the facility's plan for corrective action and anticipated time for correction. Copies of this form will be kept on file at local Social Security and Public Assistance Offices, to be made available to the public, upon request.

SUMMARY STATEMENT OF DEFICIENCIES NOTED BY SURVEYING STATE AGENCY WITH REFERENCE CITATION	PROVIDER'S PLAN OF CORRECTION WITH TIME TABLE
1. The Inservice Training Program has not included Prevention & Control of Infections, Confidentiality of Patient Information, Accident Prevention, Preservation of Patient Dignity, Psychosocial needs and Restorative Nursing Techniques. F 51 - 405.1121 (h)	1. The In-Service Education Department is developing programs which will be implemented within the next three months which will include the items listed.
2. Patient Personal & Property Rights have not been delineated in writing. F 62 - 405.1121 (K) F 84 - 405.1121 (L)	2. This procedure is presently detailed in writing through Patient Care Policy Manual and a copy will be provided upon admission to the patient or responsible relative (see A Attached).
3. There is no written acknowledgement that patients have been informed of services available in the facility or of related charges including any charges for services not covered under Titles XVIII & XIX or not covered	3. The basic per diem rate is all inclusive for medical, surgical, social nursing care in this facility and no additional billing will be involved for services rendered. Costs for extra-ordinary items of the patient' choice may be paid for through a monthly allowance of $25.00 which is received by all Kane Hospital patients

LICENSING, SCHEDULING & TRACKING UNIT
SEP 1975
NURSING HOMES
DIVISION OF LICENSURE
DEPT. OF HEALTH

*Any deficiency statement ending with an asterisk (*) denotes a condition which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. The asterisk means that the surveying State Agency has recommended that the deficiency be waived for this reason. If the State Agency recommendation has been accepted, this will be noted in the right hand column opposite the deficiency statement.

PROVIDER REPRESENTATIVE'S SIGNATURE: [signature]
DATE: 9/11/75

Form SSA-2567

3. STATE AGENCY

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

(2)

Form Approved.
OMB No. 72-R0931

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
Continuation Sheet

DATE SURVEY COMPLETED: 7/22,23,25, & 26/1975

NAME OF FACILITY AND PROVIDER NUMBER: John J. Kane Hospital (Skilled Program) M. A. 39-5057 M.A. 0201 /SN/ICF

STREET ADDRESS, CITY, STATE, ZIP CODE: Vanadium Road, Pittsburgh, Pa. 15243

SUMMARY STATEMENT OF DEFICIENCIES NOTED BY SURVEYING STATE AGENCY WITH REFERENCE CITATION	PROVIDER'S PLAN OF CORRECTION WITH TIME TABLE
3. Con't. by the facility's basic per diem rate. F 68 - 405.1121 (K)	3. Con't This information will be provided to all patients in writing upon admission. Implementation 60 days. Effective 7/1/75
4. In the Skilled Infirmary Unit, less than 2.0 patients hours were provided on 7/6, 7/18, 7/19, & 7/20 as indicated on the three week time schedule reviewed. Professional nurse supervision is shared with the ICF unit on the 3-11 and 11-7 tours of duty. F 135 - 405.1124 (C)	4. An increase in the number of nursing personnel authoriz was approved by the County Commissioners. Personnel ar being employed which will meet the required number of patient hours provided in the Skilled Infirmary Units within the next three months (see B Attached). Completion date 12/31/75
5. A Licensed Nurse is not available at each nurse's station in the Skilled Units according to the 3 week time schedule reviewed as follows: Tower - On July 13 for 3-11 tour of duty and July 20 for 11-7 tour of duty, 11 licensed nurses were available and twelve are required.	5. A heavy vacation schedule and shift change took place during the period of inspection. An active recruitment program is also being conducted for the employment of Licensed Nurses. The coverage of Skilled Units by Licensed Nurses should be acquired within the next three months. Completion by 12/31/75

LICENSING, SCHEDULING & TRACKING UNIT
SEP 25 1975
NURSING HOMES DIVISION OF LICENSURE DEPT. OF HEALTH

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

(3)

Form Approved.
OMB No. 72-R0931

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
Continuation Sheet

DATE SURVEY COMPLETED: 7/22,23,25 & 28/1975

NAME OF FACILITY AND PROVIDER NUMBER: John J. Kane Hospital (Skilled Program) M.A. 0001 / SNF/ICF M.C. 39-5057

STREET ADDRESS, CITY, STATE, ZIP CODE: Vanadium Road, Pittsburgh, Pa. 15243

SUMMARY STATEMENT OF DEFICIENCIES NOTED BY SURVEYING STATE AGENCY WITH REFERENCE CITATION	PROVIDER'S PLAN OF CORRECTION WITH TIME TABLE
5. Con't. Infirmary - 7-3 tour of duty on July 6. 3-11 tour of duty on July 6,8,9,11,12,13,16,17,20,21, & 26. 11-7 tour of duty for all three weeks. Convalescent - 3-11 tour of duty on July 6,7,12,13,18 & 23. 11-7 tour of duty on July 11,12,14, & 24. F 137 - 405.1124 (C)	LICENSING, SCHEDULING & TRACKING UNIT SEP 25 1975 NURSING HOMES DIVISION OF LICENSURE DEPT. OF HEALTH
6. Nursing care plans do not include bowel and bladder retraining programs that are in effect for incontinent patients in the Tower Section. F 171 - 405.1124 (D)	6. Nursing Supervisors have taken action to include [illegible]e and bladder retaining programs in Nursing Care Plans. This will be implemented immediately. - as of 9/[illegible]
7. A program of Rehabilitative Nursing was not in evidence in the Convalescent area as observed during the survey. F 175 & F 176 - 405.1124 (E)	7. In-Service Education and Nursing Supervisors are dev[illegible]ing a plan to implement Rehabilitative Nursing throu[illegible] the facility. Implementation three months. Effective 12/19/75.

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

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Form Approved.
OMB No. 72-R0931

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Continuation Sheet

DATE SURVEY COMPLETED: 7/22,23,25 & 2[illegible]/1975

NAME OF FACILITY AND PROVIDER NUMBER: John J. Kane Hospital (Skilled Program) M.A. C[illegible] /[illegible]/ICF — M.C. 39-5057

STREET ADDRESS, CITY, STATE, ZIP CODE: Vanadium Road, Pittsburgh, Pa. 15243

SUMMARY STATEMENT OF DEFICIENCIES NOTED BY SURVEYING STATE AGENCY WITH REFERENCE CITATION	PROVIDER'S PLAN OF CORRECTION WITH TIME TABLE
8. Written Stop Order Policies do not include the use of Anti-coagulants. F 191 - 405.1124 (H)	8. Stop order policy has been ammended to include anti-coagulants.
9. The procedure for disposing of drugs has not been established by the Pharmaceutical Committee. F 202 - 405.1124 (i)	9. A written procedure for disposing of drugs is being prepared by our Pharmaceutical and Therapeutic Committee. Implementation 60 days.
10. Medicine carts, refrigerators and dressing carts, all containing oral or external medications, were located in the unlocked medicine rooms in the Convalescent unit. F 203 - 405.1124 (i)	10. Personnel have been instructed to lock Medicine Rooms when unused. Immediate implementation.
11. The Pharmacist does not review the drug regimen at least monthly for each patient in the Skilled units. F 20[illegible] - 405.1127 (A)	11. A new system of maintaining current drug profile for each patient will be maintained in the pharmacy beginning within 60 days.
12. The Pharmacist has not submitted at least a quarterly report to the Pharmaceutical Services Committee on the	12. A quarterly report will now be given to the Pharmaceutical and Therapeutic Committee.

[Stamp:] [illegible]NG, SCHEDULING & TRACKING UNIT SEP [illegible] 1975

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Form SSA-2567A (6-73)

3. STATE AGENCY

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

(5)

Form Approved.
OMB No. 72-R0231

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
Continuation Sheet

DATE SURVEY COMPLETED: 7/22,23,25, & 28/1975

NAME OF FACILITY AND PROVIDER NUMBER: John J. Kane Hospital (Skilled Program) M.C. 39-5057 M.A. 0201 /SNF/ICF

STREET ADDRESS, CITY, STATE, ZIP CODE: Vanadium Road, Pittsburgh, Pa. 15243

SUMMARY STATEMENT OF DEFICIENCIES NOTED BY SURVEYING STATE AGENCY WITH REFERENCE CITATION	PROVIDER'S PLAN OF CORRECTION WITH TIME TABLE
12. Con't. status of the facility's pharmacy service and staff performance. F 269 - 405.1127 (a)	LICENSING, SCHEDULING & TRACKING UNIT SEP 25 1975 NURSING HOMES
13. Procedures dated 7/1/75 for control and accountability of drugs are in need of further revision to insure effective control of all drugs and biologicals. F 273 - 405.1127 (b) F 280 - 405.1127 (d)	13. A statement detailing procedures and policies in compliance with regulations where control and accountability drugs and biologicals will be issued to departments involved and included in the Pharmacy manual. Implementation 60 days. Effective 11/19/75.
14. All medicines are dispensed in stock bottles. The labels on stock bottles of medicine do not include the dispensing pharmacist's initials. Individual prescriptions are not utilized. F 278 - 405.1127 (C)	14. All medicines that are currently being dispensed in stock bottles carry the pharmacists initials as well as the date dispensed. Individual prescriptions are written for all control drugs, however, compliance with this regulation is not feasible in a 2100 bed facility. We request a variance to this regulation and will adapt our procedures in a reasonable manner proposed for non-control drugs.
15. The administrator is listed as a member of the pharmaceutical services committee but does not attend	15. In the absence of the Executive Director, the Superintendent of Clinical Services acts as his designee on the Pharmaceutical and Therapeutic Committee.

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

(6)

Form Approved.
OMB No. 72-R0931

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
Continuation Sheet

DATE SURVEY COMPLETED: 7/22,23,25, & 28/1975

NAME OF FACILITY AND PROVIDER NUMBER: John J. Kane Hospital (Skilled Program) M.C. 39-5057 M.A. 0201/ SNF/ICF

STREET ADDRESS, CITY, STATE, ZIP CODE: Vanadium Road, Pittsburgh, Pa. 15243

SUMMARY STATEMENT OF DEFICIENCIES NOTED BY SURVEYING STATE AGENCY WITH REFERENCE CITATION	PROVIDER'S PLAN OF CORRECTION WITH TIME TABLE
15. Con't. meetings. F 281 - 405.1127 (d)	
16. The committee is not monitoring the pharmaceutical service to ensure accuracy and adequacy. F 282 - 405.1127 (d)	16. The Pharmaceutical and Therapeutic Committee will immediately begin to monitor services to insure pharmaceutical accuracy and will document same. Effective as of 9/22/75.
17. Fifty-six medical records were reviewed and the following information was lacking: (A) Ten Medicaid Certifications were not signed by the attending physician. (B) Six records lacked documentation when a medication was not given as ordered. (C) Four doses of Syndavite were not recorded as being administered as ordered. (D) Daily and monthly nurses' summaries are inconsistent as to the frequency of recording in the	17. These deficiencies will be emphasized by the Nursing Administrator and the Nursing Supervisors. Repeated briefings concerning these deficiencies will lead to correction of these problems by the personnel involved Correction - immediately - as of 9/22/75.

LICENSING, SCHEDULING & TRACKING UNIT
SEP 25 1975
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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

(7)

Form Approved.
OMB No. 72-R0931

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
Continuation Sheet

DATE SURVEY COMPLETED: 7/22,23,25 & 28/1975

NAME OF FACILITY AND PROVIDER NUMBER: John J. Kane Hospital (Skilled Program) M.C. 39-5057 M.A. [illegible]/SNF/ICF

STREET ADDRESS, CITY, STATE, ZIP CODE: Vanadium Road, Pittsburgh, Pa. 15243

SUMMARY STATEMENT OF DEFICIENCIES NOTED BY SURVEYING STATE AGENCY WITH REFERENCE CITATION	PROVIDER'S PLAN OF CORRECTION WITH TIME TABLE
17. Con't. Convalescent and Tower units. (E) Monthly summaries are frequently omitted for the 3-11 & 11-7 tours of duty in the Convalescent units. F 346 - 405.1132 (C)	LICENSING, SCHEDULING & TRACKING UNIT SEP [illegible] 1975 NURSING HOMES [illegible]
18. All closed records are not indexed according to name of patient and final diagnoses. F 359 - 405.1132 (E)	18. A closed index system is in the process of being established and should be completed within 90 days. Completion date 12/19/75.
19. An electrical call system is not available in patient toilet and bathing areas. F 395 - 405.1134 (D)	19. Hospital is presently involved in Life Safety Code construction which will eventually result in an electrical call bell system in all areas. Projected time - one year. Completion date 9/19/76
20. Cubicle curtains are not available in all patient bedrooms and bathrooms. F 397 - 405.1134 (c)	20. Cubicle curtains in the Infirmary areas will require ceiling tracks, but ceilings must be disrupted in many of these areas in conjunction with the Life Safety Code modifications. When this critical work is completed ceiling tracks can then logically be added. Estimated time of completion - one year. Completion date 9/19/76

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

(8)

Form Approved.
OMB No. 72-R0931

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
Continuation Sheet

DATE SURVEY COMPLETED: 7/22,23,25 & 28/1975

NAME OF FACILITY AND PROVIDER NUMBER: John J. Kane Hospital (Skilled Program) M.C. 39-5057 M.A. 0201 /SNF/ICF

STREET ADDRESS, CITY, STATE, ZIP CODE: Vanadium Road, Pittsburgh, Pa. 15243

SUMMARY STATEMENT OF DEFICIENCIES NOTED BY SURVEYING STATE AGENCY WITH REFERENCE CITATION	PROVIDER'S PLAN OF CORRECTION WITH TIME TABLE
21. A written preventive maintenance program is not available. F 417 - 405.1134 (i)	21. Position has been created by the Executive and Administrative Officers for a professional engineer whose initial assignment will be to develop a preventi[ve] maintenance plan. At this time an on-going maintenanc[e] program is daily in effect. Projection for written program - eight months.
22. Corridor walls are cracked and soiled in the Infirmary and Convalescent units. Floor tile is missing and/or cracked in the female Infirmary. Walls in bathrooms and patient rooms are soiled and paint is peeling in the Convalescent unit. Bathrooms in the Convalescent unit were in need of cleaning. Water fountains in male Infirmary were rusty. Commode stall walls and doors were rusty in the male Infirmary and Tower 5 B & 6 B. F 418 - 405.1134 (i)	22. Extensive remodeling due to Life Safety Code construct[ion] is taking place throughout this institution. At this time, the Tower and Convalescent areas are in the last phase of construction. Basic construction in the Infirmary as well as certain maintenance projects ie. painting of water fountains, cleaning of bathrooms, et[c.] has already begun. Projection time - one year.

LICENSING, SCHEDULING & TRACKING UNIT
SEP 2 3 1975
NURSING HOME ... LICENSURE
... DEPT. OF HEALTH

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

(9)

Form Approved.
OMB No. 72-R0931

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
Continuation Sheet

DATE SURVEY COMPLETED: 7/22,23,25, & 28/1975

NAME OF FACILITY AND PROVIDER NUMBER: John J. Kane Hospital (Skilled Program) M.C. 39-5057 M.A. 0801 /SNF/ICF

STREET ADDRESS, CITY, STATE, ZIP CODE: Vanadium Road, Pittsburgh, Pa. 15243

SUMMARY STATEMENT OF DEFICIENCIES NOTED BY SURVEYING STATE AGENCY WITH REFERENCE CITATION	PROVIDER'S PLAN OF CORRECTION WITH TIME TABLE
23. Assist bars at toilets are loose in the female Convalescent unit. Cracked window panes observed throughout the facility. F 419 - 405.1134 (i)	23. Toilet bars being checked and tightened immediately. Window panes in all patient areas are at this time being replaced where necessary. Completion 60 days. Completion date 11/19/75.
24. The Infection Control Committee has not established policies and procedures for investigating, controlling, and preventing infections. F 431 - 405.1135 (a)	24. Development of policies, procedures and re-vamping of Infection Control Committee now taking place. Projection time 90 days. Completion date 12/19/
25. Physicians employed by the facility are members of the Utilization Review Committee. The Physicians who function as the physician delegate for Medicaid continued stay reviews are not part of the Utilization Review Committee according to the written plan. F 465 - 405.1137 (b)	25. New Utilization Review Plan has been submitted to the regulatory state agencies and we are presently awaiting their recommendation. Projection - indeterminate based on information which is forthcoming from State.
26. Utilization review minutes do not include the following information:	

FORM SSA-2567A (6-73) 3. STATE AGENCY

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

(10)

Form Approved.
OMB No. 72-R0931

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
Continuation Sheet

DATE SURVEY COMPLETED: 7/22,23,25 & 28/1975

NAME OF FACILITY AND PROVIDER NUMBER: John J. Kane Hospital (Skilled Program) M.C. 39-5057 M.A. [illegible] /SNF/ICF

STREET ADDRESS, CITY, STATE, ZIP CODE: Vanadium Road, Pittsburgh, Pa. 15243

SUMMARY STATEMENT OF DEFICIENCIES NOTED BY SURVEYING STATE AGENCY WITH REFERENCE CITATION	PROVIDER'S PLAN OF CORRECTION WITH TIME TABLE
26. Con't.	26. Con't
(A) A description of the medical care evaluation studies.	A. Is in progress at the present time. Effective [illegible]
(B) Summary of continued study cases for Medicaid patients.	B. Is in progress at the present time. Effective 9/1/[illegible]
F 509 - 405.1137 (c)	

LICENSING, SCHEDULING & TRACKING UNIT
SEP [illegible] 1975
NURSING HOMES
DIVISION OF LICENSURE
DEPT. OF HEALTH

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FORM SSA-2567A (8-73)

3. STATE AGENCY

NAME OF FACILITY

John J. Kane Hospital [illegible] 0301

Governing Body (continued)

	YES	NO	N/A		EXPLANATORY STATEMENTS
F43	✓			Personnel records are current and available for each employee and contain sufficient information to support placement in the position to which assigned.	Personnel policies revised 5/20/75. There is a job description manual which includes 458 class specifications for personnel.
F44	✓			Written policies for control of communicable disease are in effect to ensure that employees with symptoms or signs of communicable disease or infected skin lesions are not permitted to work,	
F45	✓			that a safe and sanitary environment for patients and personnel exists, and	
F46	✓			incidents and accidents to patients and personnel are reviewed to identify health and safety hazards.	
F47	✓			Employees are provided, or referred for, periodic health examinations, to ensure freedom from communicable disease.	
F48				☐ MET ☒ NOT MET	
				(h) Standard: Staff development.	
F49	✓			An ongoing educational program is planned and conducted for the development and improvement of skills of all the facility's personnel, including training related to problems and needs of the aged, ill, and disabled.	
F50	✓			Each employee receives appropriate orientation to the facility and its policies, and to the employee's position and duties.	
F51		✓		Inservice training includes at least prevention and control of infections, fire prevention and safety, accident prevention, confidentiality of patient information, and preservation of patient dignity, including protection of the patient's privacy and personal and property rights.	F 51. Inservice Programs did not include Prevention & Control of Infections, Confidentiality of Patient Information, Accident Prevention, Preservation of Patient Dignity, Psychosocial needs, Restorative Nursing Techniques.
F52	✓			Records are maintained which indicate the content of, and attendance at, such staff development programs.	

FORM SSA-1569 (10-74)

(12)

NAME OF FACILITY

John J. Kane Hospital 39-5057 C201

Governing Body (continued)

	YES	NO	N/A		
F59				☑ MET ☐ NOT MET	EXPLANATORY STATEMENTS
F60	✓			*(j) Standard: Notification of changes in patient status.* The facility has appropriate written policies and procedures relating to notification of the patient's attending physician and other responsible persons in the event of an accident involving the patient, or other significant change in the patient's physical, mental, or emotional status, or patient charges, billings, and related administrative matters.	
F61	✓			Except in a medical emergency, a patient is not transferred or discharged, nor is treatment altered radically, without consultation with the patient or, if the patient is incompetent, without prior notification of next of kin or sponsor.	
F62				☐ MET ☑ NOT MET *(k) Standard: Patients' rights.*	F 62. Written policies regarding the rights of patients have not been formulated.
F63		✓		The governing body of the facility establishes written policies regarding the rights and responsibilities of patients and,	
F64		✓		through the administrator is responsible for development of, and adherence to, procedures implementing such policies.	
F65		✓		These policies and procedures are made available to patients, to any guardians, next of kin, sponsoring agency(ies), or representative payees selected pursuant to section 205(j) of the Social Security Act, and Subpart Q of Part 404 of this chapter, and to the public.	
F66		✓		The staff of the facility is trained and involved in the implementation of these policies and procedures.	

FORM SSA-1569 (10-74)

3482

NAME OF FACILITY

John J. Kane Hospital [illegible] [illegible]

Governing Body (continued)

	YES	NO	N/A	These patients' rights policies and procedures ensure that, at least, each patient admitted to the facility:	EXPLANATORY STATEMENTS
F67		✓		(1) Is fully informed, as evidenced by the patient's written acknowledgment, prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct and responsibilities;	
F68		✓		(2) Is fully informed, prior to or at the time of admission and during stay, of services available in the facility, and of related charges including any charges for services not covered under titles XVIII or XIX of the Social Security Act, or not covered by the facility's basic per diem rate;	Policy & procedure for informing patients of available services & related charges have not been formulated.
F69		✓		(3) Is fully informed, by a physician, of his or her medical condition unless medically contraindicated (as documented, by a physician, in the medical record), and is afforded the opportunity to participate in the planning of his or her medical treatment and to refuse to participate in experimental research;	
F70		✓		(4) Is transferred or discharged only for medical reasons, or for his or her welfare or that of other patients, or for nonpayment for his or her stay (except as prohibited by titles XVIII or XIX of the Social Security Act), and is given reasonable advance notice to ensure orderly transfer or discharge, and such actions are documented in the medical record;	
F71		✓		(5) Is encouraged and assisted, throughout the period of stay, to exercise rights as a patient and as a citizen, and to this end may voice grievances and recommend changes in policies and services to facility staff and or to outside representatives of his or her choice, free from restraint, interference, coercion, discrimination, or reprisal;	

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(14)

NAME OF FACILITY

John J. Kane Hospital 39-5057 0201

Governing Body (continued)

	YES	NO	N A		EXPLANATORY STATEMENTS
F72		✓		(6) May manage his or her personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his or her behalf should the facility accept his or her written delegation of this responsibility to the facility for any period of time in conformance with State law;	
F73		✓		(7) Is free from mental and physical abuse; and free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician for a specified and limited period of time, or when necessary to protect the patient from injury to self or to others;	
F74		✓		(8) Is assured confidential treatment of personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in case of transfer to another health care institution, or as required by law or third-party payment contract;	
F75		✓		(9) Is treated with consideration, respect, and full recognition of his or her dignity and individuality, including privacy in treatment and in care for personal needs;	
F76		✓		(10) Is not required to perform services for the facility that are not included for therapeutic purposes in the plan of care;	
F77		✓		(11) May associate and communicate privately with persons of his or her choice, and send and receive personal mail unopened, unless medically contraindicated (as documented by his or her physician in the medical record);	This is done but written policy not established.

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NAME OF FACILITY

John J. Kane Hospital [illegible]

Governing Body (continued)

	YES	NO	N/A		EXPLANATORY STATEMENTS
F78		✓		(12) May meet with, and participate in activities of, social, religious, and community groups at his or her discretion, unless medically contraindicated (as documented by his or her physician in the medical record);	This is done but written policy not established.
F79		✓		(13) May retain and use personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients, and unless medically contraindicated (as documented by his or her physician in the medical record); and	This is done but written policy not established.
F80		✓		(14) If married, is assured privacy for visits by his her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician in the medical record).	This is done but written policy not established.
				All rights and responsibilities specified in paragraphs (k)(1) through (4) of this section — as they pertain to (a) a patient adjudicated incompetent in accordance with State law, (b) a patient who is found, by his or her physician, to be medically incapable of understanding these rights, or (c) a patient who exhibits a communication barrier — devolve to such patient's guardian, next of kin, sponsoring agency(ies), or representative payee (except when the facility itself is representative payee) selected pursuant to section 205(j) of the Social Security Act and Subpart Q of Part 404 of this chapter.	

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(16)

NAME OF FACILITY

John J. Kane Hospital 39-50[illegible]7 0[illegible]0[illegible]

Governing Body (continued)

	YES	NO	N/A	
F81				☐ MET ☑ NOT MET *(l) Standard: Patient care policies.* The skilled nursing facility has written policies to govern the continuing skilled nursing care and related medical or other services provided.
F82	✓			The facility has policies, which are developed by the medical director or the organized medical staff (see §405.1122), with the advice of (and with provision for review of such policies from time to time, but at least annually, by) a group of professional personnel including one or more physicians and one or more registered nurses, to govern the skilled nursing care and related medical or other services it provides.
F83	✓			The policies, which are available to admitting physicians, sponsoring agencies, patients, and the public, reflect awareness of, and provision for, meeting the total medical and psychosocial needs of patients, including admission, transfer, and discharge planning, and the range of services available to patients, including frequency of physician visits by each category of patients admitted.
F84		✓		These policies also include provisions to protect patients' personal and property rights.
F85	✓			Medical records and minutes of staff and committee meetings reflect that patient care is being rendered in accordance with the written patient care policies.
F86	✓			And that utilization review committee recommendations regarding the policies are reviewed and necessary steps taken to ensure compliance.

EXPLANATORY STATEMENTS

Patient personal & property rights have not been formulated in writing.

FORM SSA-1569 (10-74)

3486

NAME OF FACILITY

John J. Kane Hospital 39-50[illegible]7 0201

Nursing Services (continued)

	YES	NO	N A		EXPLANATORY STATEMENTS
F129				[✓] MET [ ] NOT MET	
				(b) Standard: Charge nurse.	
F130	✓			A registered nurse, or a qualified licensed practical (vocational) nurse, is designated as charge nurse by the director of nursing services for each tour of duty	
F131	✓			Is responsible for supervision of the total nursing activities in the facility during each tour of duty.	
F132	✓			The director of nursing services does not serve as charge nurse in a facility with an average daily total occupancy of 60 or more patients.	
F133	✓			The charge nurse delegates responsibility to nursing personnel for the direct nursing care or specific patients during each tour to duty, on the basis of staff qualifications, size, and physical layout of the facility, characteristics of the patient load, and the emotional, social, and nursing care needs of patients.	
F134				[ ] MET [✓] NOT MET	
				(c) Standard: Twenty-four-hour nursing service.	
F135		✓		The facility provides 24-hour nursing services which are sufficient to meet total nursing needs and which are in accordance with the patient care policies developed as provided in 405.1121(l).	In the skilled infirmary unit, less than 2.0 hrs. were provided on 7/6, 7/1[illegible], 7/19 & 7/20. In addition, professional nurse supervision is shared with the I.C.F. units on the 3-11 & 11-7 tours of duty.
F136	✓			The policies are designed to ensure that each patient receives treatments, medications, and diet as prescribed, and rehabilitative nursing care as needed; receives proper care to prevent decubitus ulcers and deformities, and is kept comfortable, clean, well-groomed, and protected from accident, injury, and infection; and encouraged, assisted, and trained in self care and group-activities.	The overall staffing pattern for the skilled unit meets the State requirements of 2.0 hours. However, the distribution of staff in the Infirmary on the above mentional days was not adequate & resulted in a staffing deficiency.

(18)

NAME OF FACILITY

John J. [illegible] Hospital [illegible] 0201

Nursing Services (continued)

	YES	NO	N/A	
F137		✓		Nursing personnel, including at least one registered nurse on the day tour of duty 7 days a week, licensed practical (vocational) nurses, nurse aides, orderlies, and ward clerks, are assigned duties consistent with their education and experience, and based on the characteristics of the patient load.
F138	✓			Weekly time schedules are maintained and indicate the number and classifications of nursing personnel including relief personnel, who worked on each unit for each tour of duty.

(If a distinct part certification, in an ICF or uncertified facility, show the staffing for the DP, and if appropriate, the entire facility and explain any sharing of nursing personnel.)

LIST THE NUMBER OF FULL-TIME EQUIVALENTS OF RN'S, LPN'S, AIDES, ORDERLIES ASSIGNED TO NURSING DUTY FROM THE LAST 3 COMPLETE WEEKS AVAILABLE:

	SHIFT		SUN. 7/6			MON. 7			TUES. 8			WED. 9			THURS. 10			FRI. 11			SAT. 12		
			RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A
F139	DP	DAY	23	5	57	21	10	51	26	12	60	30	10	[illegible]	31	10	47	26	7	57	20	[illegible]	49
F140	ENTIRE FAC.	DAY	38	15	[illegible]	42	32	[illegible]	45	35	[illegible]	51	32	[illegible]	53	32	[illegible]	46	22	[illegible]	35	26	141
F141	DP	EVENING	[illegible]	7	25	6	7	39	9	8	38	9	9	37	9	7	40	7	5	42	8	[illegible]	40
F142	ENTIRE FAC.	EVENING	12	17	91	12	21	[illegible]	13	24	[illegible]	[illegible]	26	[illegible]	14	2	[illegible]	[illegible]	16	[illegible]	14	16	108
F143	DP	NIGHT	7	9	17	[illegible]	10	22	6	9	23	6	11	17	7	10	19	5	9	20	6	6	25
F144	ENTIRE FAC.	NIGHT	[illegible]	20	60	11.5	22	73	[illegible]	21	65	13	23	61	13	21	68	9	20	66	10	19	68

SHIFT		7 SUN. 13			MON. 14			TUES. 15			WED 16			THURS 17			FRI. 18			SAT 19		
		RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A
DP	DAY	20	6	42	28	8	43	28	8	48	35	6	56	25	5	56	24	8	46	22	7	36
ENTIRE FAC.	DAY	34	27	[illegible]	48	29	130	50	29	[illegible]	56	22	[illegible]	45	25	[illegible]	42	26	141	37	26	120
DP	EVENING	5	6	38	6	8	40	6	9	43	7	7	33	8	7	43	8	8	41	5	8	35
ENTIRE FAC.	EVENING	10	10	100	11.5	27	96	12	20	114	13	21	86	14	21	115	[illegible]	21	102	25	27	89
DP	NIGHT	6	6	19	6	7	19	7	11	10	6	10	10	5	10	21	5	9	20	5	7	19
ENTIRE FAC.	NIGHT	12.5	16	62	11.5	16	63	[illegible]	25	62	11	23	59	12	23	67	10	21	62	10	18	56

EXPLANATORY STATEMENTS

Insufficient licensed staff available to insure that a licensed nurse is available at each nurses station in the skilled units.

Tower - 12 nurses stations. On 7/13 for 3-11 and 7/20 for 11-7 only 11 licensed nurses were available.

Infirmary - 14 nurses stations
Insufficient licensed staff on
7-3 - 7/6
3-11 - 7/6, 7/8, 7/9, 7/11, 7/12, 7/13, 7/16, 7/17, 7/20, 7/21 & 7/26.
11-7 - all three weeks had insufficient licensed staff scheduled.

Convalescent - 10 nurses stations
Insufficient licensed staff on
3-11 - 7/6, 7/7, 7/12, 7/13, 7/18 & 7/23.
11-7 - 7/11, 7/12, 7/14, & 7/24
The above staffing requirement is a new State regulation effective 3/1/75.

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(19)

NAME OF FACILITY

John J. Kane Hospital 39-5059 0201

Nursing Services (continued)

		YES	NO	N/A		SHIFT	SUN. 20 RN	PN	A	MON 21 RN	PN	A	TUES. 22 RN	PN	A	WED. 23 RN	PN	A	THURS. 24 RN	PN	A	FRI 25 RN	PN	A	SAT. 26 RN	PN	A
F145					DP	DAY	22	7	73	23	5	57	26	8	60	25	8	47	27	8	60	21	7	51	23	5	53
F146					ENTIRE FAC.	DAY	36	23	154	45	20	140	48	26	167	49	20	145	52	27	165	59	27	160	55	27	150
F147					DP	EVENING	6	7	30	[illegible]	[illegible]	33	[illegible]	7	[illegible]	9	7	30	8	8	25	[illegible]	[illegible]	[illegible]	7	[illegible]	30
F148					ENTIRE FAC.	EVENING	11	21	90	15	24	92	11	29	116	14	24	97	13	25	114	15	27	107	13	21	103
F149					DP	NIGHT	[illegible]	[illegible]	20	5	8	22	5	8	23	6	7	22	5	7	22	6	7	[illegible]	[illegible]	7	22
F150					ENTIRE FAC.	NIGHT	10	10	50	10	21	60	11	22	72	12	20	[illegible]	9	21	[illegible]	11	20	69	10	19	66

EXPLANATORY STATEMENTS

Patients hours required.
Tower - Census 545 - Pts. hrs. 1080
Convalescent - Census 570 Pt. hrs. 1140
Infirmary - Census 434 - Pt. hrs. [illegible]
Entire facility - Census 1547
Pt hours 3094

F151 Is Director of Nursing included in above schedule? 1. ☐ YES 2. ☑ NO

	NUMBER	
F152	1547	PATIENT CENSUS ON DATE OF SURVEY.
F153	36	NUMBER OF COMPLETELY BEDFAST PATIENTS.
F154	109	NUMBER OF PATIENTS REQUIRING NO ASSISTANCE WITH AMBULATION
F155	1042	NUMBER OF PATIENTS REQUIRING ASSISTANCE WITH AMBULATION (I.E. WHEELCHAIR, WALKER, CANE, ETC.).
F156	172	NUMBER OF PATIENTS REQUIRING FULL ASSISTANCE IN EATING.
F157	366	NUMBER OF PATIENTS REQUIRING SOME ASSISTANCE IN EATING.
F158	307	NUMBER OF PATIENTS WITH INDWELLING CATHETERS
F159	620	NUMBER OF INCONTINENT PATIENTS (BOWEL AND/OR BLADDER).
F160	145	NUMBER OF PATIENTS WITH DECUBITI.
F161	60	NUMBER OF PATIENTS ON INDIVIDUALLY WRITTEN BOWEL AND BLADDER RETRAINING PROGRAM.
F162	247	NUMBER OF PATIENTS RECEIVING SPECIAL SKIN CARE
F163	851	NUMBER OF CONFUSED OR DISORIENTED PATIENTS
F164	9	NUMBER OF PATIENTS RECEIVING INTRAVENOUS THERAPY AND/OR BLOOD TRANSFUSION.
F165	254	NUMBER OF BED-TO-CHAIR PATIENTS.

PATIENT CENSUS:

F166 MEDICARE 21

F167 MEDICAID 1526

F168 OTHER 0

FORM SSA-1569 (10-74)

(20)

NAME OF FACILITY [illegible] 39-5057 0201

Nursing Services (continued)

	YES	NO	N/A	
F169				☐ MET ☒ NOT MET *(d) Standard: Patient care plan.*
F170	✓			In coordination with the other patient care services to be provided, a written patient care plan for each patient is developed and maintained by the nursing service consonant with the attending physician's plan of medical care, and is implemented upon admission.
F171		✓		The plan indicates care to be given and goals to be accomplished and which professional service is responsible for each element of care.
F172	✓			The patient care plan is reviewed, evaluated, and updated as necessary by all professional personnel involved in the care of the patient.
F173				☐ MET ☒ NOT MET *(e) Standard: Rehabilitative nursing care.*
F174	✓			Nursing personnel are trained in rehabilitative nursing.
F175		✓		The facility has an active program of rehabilitative nursing care which is an integral part of nursing service and is directed toward assisting each patient to achieve and maintain an optimal level of self-care and independence.
F176		✓		Rehabilitative nursing care services are performed daily for those patients who require such service, and are recorded routinely.
F177				☒ MET ☐ NOT MET *(f) Standard: Supervision of patient nutrition.*
F178	✓			Nursing personnel are aware of the nutritional needs and food and fluid intake of patients and assist promptly where necessary in the feeding of patients.
F179	✓			A procedure is established to inform the dietetic service of physicians' diet orders and of patients' dietetic problems.
F180	✓			Food and fluid intake of patients is observed, and deviations from normal are recorded and reported to the charge nurse and the physician.

EXPLANATORY STATEMENTS

F 171. Nursing care plans did not indicate bowel and bladder routines that are in effect for incontinent patients in the Tower Section.

F 175 & F 176.
A program of rehabilitative nursing was not in evidence in the Convalescent area during the survey.

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NAME OF FACILITY

John J. [illegible] Hospital [illegible]

Nursing Services (continued)

	YES	NO	N/A	
F181				☑ MET ☐ NOT MET *(g) Standard: Administration of drugs.*
				Drugs and biologicals are administered only by physicians, licensed nursing personnel, or by other personnel who have completed a State-approved training program in medication administration.
F182	✓			Procedures are established by the pharmaceutical services committee (see 405.1127(d)) to ensure that drugs are checked against physicians' orders.
F183	✓			
F184	✓			The patient is identified prior to administration of a drug.
F185	✓			Each patient has an individual medication record.
F186	✓			The dose of a drug administered to that patient is properly recorded therein by the person who administers the drug.
F187	✓			Drugs and biologicals are administered as soon as possible after doses are prepared.
F188	✓			Administered by the same person who prepared the doses for administration, except under single unit dose package distribution systems. (See 405.1101(h).)
F189				☐ MET ☑ NOT MET *(h) Standard: Conformance with physicians' drug orders.*
F190	✓			Drugs are administered in accordance with written orders of the attending physician.
F191		✓		Drugs not specifically limited as to time or number of doses when ordered are controlled by automatic stop orders or other methods in accordance with written policies.
F192	✓			Physicians' verbal orders for drugs are given only to a licensed nurse, pharmacist, or physician and are immediately recorded and signed by the person receiving the order. (Verbal orders for Schedule II drugs are permitted only in the case of a bona fide emergency situation.)
F193	✓			Such orders are countersigned by the attending physician within 48 hours.
F194	✓			The attending physician is notified of an automatic stop order prior to the last dose so that the physician may decide if the administration of the drug or biological is to be continued or altered.

EXPLANATORY STATEMENTS

The Drug Administration Course offered in this facility was approved by the State [illegible]/13/74.

F 183. R.N.s' check doctors' orders and are responsible for ordering medications on a daily basis.

F 191.
The written stop order policies do not include anti-coagulants.

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(22)

NAME OF FACILITY: [illegible] Hospital 39-5057 0201

Nursing Services (continued)

	YES	NO	N/A	
				Stop-order policies for following are:
F195				Narcotics 2 days
F196				Anti-coagulants not in - days writing
F197				Antibiotics 10 days
F198				Barbituates 14 days (2 days, if convulsive)
F199				Review of (No.) 6 charts indicates stop-order policies are observed: 1. ☑ YES 2. ☐ NO
F200				
F201				☐ MET ☑ NOT MET
				(i) Standard: Storage of drugs and biologicals.
F202		✓		Procedures for storing and disposing of drugs and biologicals are established by the pharmaceutical services committee.
F203		✓		In accordance with State and Federal laws, all drugs and biologicals, are stored in locked compartments under proper temperature controls.
F204	✓			Only authorized personnel have access to the keys.
F205	✓			Separately locked, permanently affixed compartments are provided for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention & Control Act of 1970 and other drugs subject to abuse, except under single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
F206	✓			An emergency medication kit approved by the pharmaceutical services committee is kept readily available.

EXPLANATORY STATEMENTS

F 202. The procedure for disposing of drugs has not been established by the pharmaceutical committee.

F 203. Medicine carts, refrigerators & dressing carts, all containing oral or external medications, were located in the unlocked medicine rooms in the Convalescent Unit.

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FORM SSA-1569 (10-74)

(23)

NAME OF FACILITY: John J. Kane Hospital 39-5057 0201

Pharmaceutical Services

	YES	NO	N/A	Requirement	Explanatory Statements
F263				[✓] MET [ ] NOT MET **VIII. Pharmaceutical services. (405.1127)** — The skilled nursing facility provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals. Whether drugs and biologicals are obtained from community or institutional pharmacists or stocked by the facility, the facility is responsible for providing such drugs and biologicals for its patients, insofar as they are covered under the programs, and for ensuring that pharmaceutical services are provided in accordance with accepted professional principles and appropriate Federal, State, and local laws. (See 405.1124 (g), (h), and (i).)	Licensed Pharmacy within the facility. Pharmacy Permit #41006 BNDD # AJ 6239936 Pharmacy hours are 8 am to 4 pm Monday thru Friday A pharmacist is on call 24 hours daily. Saturday hours 8 am to 1 pm.
F264				[ ] MET [✓] NOT MET *(a) Standard: Supervision of services.*	
F265	✓			The pharmaceutical services are under the general supervision of a qualified pharmacist	
F266	✓			The pharmacist is responsible to the administrative staff for developing, coordinating, and supervising all pharmaceutical services.	
F267	✓			The pharmacist (if not a full-time employee) devotes a sufficient number of hours, based upon the needs of the facility, during regularly scheduled visits to carry out these responsibilities.	
F268		✓		The pharmacist reviews the drug regimen of each patient at least monthly, and reports any irregularities to the medical director and administrator.	F 268. A pilot program has been initiated in the Tower Section only to review the drug regimen of every patient. The program will be implemented for the remaining patients when the pilot program is evaluated & approved.
F269		✓		The pharmacist submits a written report at least quarterly to the pharmaceutical services committee on the status of the facility's pharmaceutical service and staff performance.	F 269. A written pharmaceutical report on the status of the service of the pharmacy is not submitted quarterly to the pharmaceutical committee.
				NAME OF PHARMACIST: Paul Geinzer, RPH #24931 Chief Pharmacist	R. L. Mancione, RPH #20157 - full time Sr. M.E. Hypaver, RPH #22765 - full time There are two intern pharmacists, a pharmacy technician, clerk typist and a pharmacy aide.
F270				(1) [✓] FULL TIME (2) [ ] PART TIME	
F271				IF PART TIME HOURS PER MONTH SPENT IN FACILITY: NA	

FORM SSA-1569 (10-74)

3493

NAME OF FACILITY

John J. [illegible] Hospital [illegible] 0201

	YES	NO	N/A	
F272				☐ MET ☑ NOT MET *(b) Standard: Control and accountability.*
F273		✓		The pharmaceutical service has procedures for control and accountability of all drugs and biologicals throughout the facility.
F274	✓			Only approved drugs and biologicals are used in the facility.
F275	✓			They are dispensed in compliance with Federal and State laws.
F276	✓			Records of receipt and disposition of all controlled drugs are maintained in sufficient detail to enable an accurate reconciliation.
F277	✓			The pharmacist determines that drug records are in order and that an account of all controlled drugs is maintained and reconciled.
				NAME AND POSITION OF PERSON RESPONSIBLE FOR CONTROLLED DRUG RECORD Mr. Paul Geinzer
F278				☐ MET ☑ NOT MET *(c) Standard: Labeling of drugs and biologicals.* The labeling of drugs and biologicals is based on currently accepted professional principles and includes the appropriate accessory and cautionary instructions as well as the expiration date when applicable.
F279				☐ MET ☑ NOT MET *(d) Standard: Pharmaceutical services committee.*
F280		✓		A pharmaceutical services committee (or its equivalent) develops written policies and procedures for safe and effective drug therapy, distribution, control and use.
F281		✓		The committee is comprised of at least the pharmacist, the director of nursing services, the administrator, and one physician.
F282		✓		The committee oversees pharmaceutical service in the facility, makes recommendations for improvement, and monitors the service to ensure its accuracy and adequacy.
F283	✓			The committee meets at least quarterly and documents its activities, findings and recommendations.

Pharmaceutical Services (Continued)

EXPLANATORY STATEMENTS

F 273. Procedures of 7/1/75 are being further revised for control and accountability of all drugs and biologicals, other than the schedule II drugs.

The medicine nurse on each shift is responsible for auditing the controlled drug record for her unit.

F 278. All medicines are dispensed in stock bottles and the label does not always include the dispensing pharmacist initials. Individual prescriptions are not utilized.

F 280. No written policies & procedures used to insure effective control of non-scheduled drugs.

F 281. The administrator is listed as a member of pharmaceutical committee but does not attend meetings.

F 282. Monitoring of all pharmaceutical services is not being performed by pharmaceutical committee.

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NAME OF FACILITY
John J. Lane Hospital 39-5057 0203

	YES	NO	N/A
F344			
F345	✓		
F346		✓	
F347			
F348			
F349			
F350			
F351	✓		
F352	✓		

☐ MET ☑ NOT MET

(c) Standard: Content.

The medical record contains sufficient information to identify the patient clearly, to justify the diagnosis and treatment, and to document the results accurately.

All medical records contain the following general categories of data: documented evidence of assessment of the needs of the patient, of establishment of an appropriate plan of treatment, and of the care and services provided; authentication of hospital diagnoses (discharge summary, report from patient's attending physician, or transfer form), identification data and consent forms, medical and nursing history of patient, report of physical examination(s), diagnostic and therapeutic orders, observations and progress notes, reports of treatments and clinical findings, and discharge summary including final diagnosis and prognosis.

NUMBER OF RECORDS EXAMINED
[illegible]

CURRENT INPATIENT
5[illegible]

DISCHARGED PATIENTS
17

METHOD OF SELECTION OF CASES FOR EXAMINATION
Random [illegible]

LIST TYPE OF DATA WHICH IS LACKING
See above breakdown.

ON HOW MANY RECORDS
See above breakdown.

☑ MET ☐ NOT MET

(d) Standard: Physician documentation.

Only physicians enter or authenticate in medical records opinions that require medical judgment (in accordance with medical staff bylaws, rules, and regulations, if applicable).

All physicians sign their entries into the medical record.

Medical Records (Continued)

EXPLANATORY STATEMENTS

Of the 5[illegible] current records reviewed the following deficiencies were:

1. [illegible] A. certification sheets were not signed by the physician on ten (10) records.
2. The reason why medication was not given to a patient was not explained on six (6) records.
3. Medication order for 4 doses of Synkavite was not recorded as given on 1 record.
4. Daily and monthly summaries are inconsistent as to frequency of recording. Monthly summaries are frequently absent from 3-11 & 11-7 shifts.

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(26)

NAME OF FACILITY

John J. Kane Hospital 39-5157 0201

Medical Records (Continued)

EXPLANATORY STATEMENTS

	YES	NO	N/A	Standard	Explanatory Statements
F353				[x] MET [ ] NOT MET	
				(e) Standard: Completion of records and centralization of reports.	
F354	✓			Current medical records and those of discharged patients are completed promptly.	
F355	✓			All clinical information pertaining to a patient's stay is centralized in the patient's medical record.	
F356				[x] MET [ ] NOT MET	
				(f) Standard: Retention and preservation. Medical records are retained for a period of time not less than that determined by the respective State statute, the statute of limitations in the State, or 5 years from the date of discharge in the absence of a State statute, or, in the case of a minor, 3 years after the patient becomes of age under State law.	Medical Records are maintained in fire resis- tant cabinets in a secure record room for 7 years. Micro filming is permitted in 5 years. Minors records are retained to age of maturity (18).
F357				[ ] MET [x] NOT MET	
				(g) Standard: Indexes. Patients' medical records are indexed according to name of patient and final diagnoses to facilitate acquisition of statistical medical information and retrieval of records for research or administrative action.	Records of patients "discharged" by death are filed by patient name and final diagnosis. However, records of patients discharged by physician's order are only alphabetically [illegible]
F358				[x] MET [ ] NOT MET	
				(h) Standard: Location and facilities. The facility maintains adequate facilities and equipment, conveniently located, to provide efficient processing of medical records (reviewing, indexing, filing, and prompt retrieval).	

3496

NAME OF FACILITY: John J. Kane Hospital 39-5057 0201

Physical Environment (Continued)

	YES	NO	N/A	
F388	✓			5.11 Does the facility provide appropriate means for the blind to identify rooms, facilities, and hazardous areas?
F389	✓			5.12 Does the facility provide simultaneous audible and visual warning signals? (LSC-SRF 6-1)
F390	✓			5.13 Does the facility exercise safeguards to eliminate hazards for the handicapped?
F391				Are patient closets accessible to and usable by the physically handicapped? 1. [✓] YES 2. [ ] NO
F392				Are patient beds of a height that permits an individual in a wheel chair to get in and out of bed unassisted? 1. [✓] YES 2. [ ] NO
F393				[ ] MET [✓] NOT MET *(d) Standard: Nursing unit.*
F394	✓			Each nursing unit has at least the following basic service areas: Nurses station, storage and preparation area(s) for drugs and biologicals, and utility and storage rooms that are adequate in size, conveniently located, and well lighted to facilitate staff functioning.
F395		✓		The nurses station is equipped to register patients' calls through a communication system from patient areas, including patient rooms and toilet and bathing facilities.
F396				[ ] MET [✓] NOT MET *(e) Standard: Patient rooms and toilet facilities.*
F397		✓		Patient rooms are designed and equipped for adequate nursing care and the comfort and privacy of patients.
F398	✓			They have no more than four beds, except in facilities primarily for the care of the mentally ill and or retarded where there shall be no more than 12 beds per room. (An institution primarily engaged in the care of the mentally retarded or in the treatment of mental diseases cannot qualify as a participating skilled nursing facility under Medicare.)

EXPLANATORY STATEMENTS

F 395. An electrical call system is available in patient bedrooms in the Tower, Convalescent and Infirmary areas. However, handbells are available in patient toilet and bathing areas. An electrical call system for toilet and bathing facilities is included in the Capital Expenditure Plan. The material for this installation is expected within 6 weeks and at that time the contract will be signed.

F 397. Cubicle curtains are not available in the Skilled Infirmary Units in bedrooms and bathrooms.

F 398. Tower, Convalescent and Infirmary areas have five, nine, twelve, twenty-four, twenty-five or twenty-seven bed wards on most units. However, more than adequate space is provided for nursing care and to facilitate wheelchairs.

NAME OF FACILITY

John J. Kane Hospital 39-5057. 0001

Physical Environment (Continued)

	YES	NO	N/A	[✓] MET [ ] NOT MET
F413 →				*(h) Standard: Kitchen and dietetic service areas.*
F414	✓			The facility has kitchen and dietetic service areas adequate to meet food service needs.
F415	✓			These areas are properly ventilated, and arranged and equipped for sanitary refrigeration, storage, preparation, and serving of food as well as for dish and utensil cleaning and refuse storage and removal.
F416 →				[ ] MET [✓] NOT MET *(i) Standard: Maintenance of equipment, building, and grounds.*
F417		✓		The facility establishes a written preventive maintenance program to ensure that equipment is operative
F418		✓		The interior and exterior of the building are clean and orderly.
F419		✓		All essential mechanical, electrical, and patient care equipment is maintained in safe operating condition.
F420 →				[✓] MET [ ] NOT MET *(j) Standard: Other environmental considerations.*
F421	✓			The facility provides a functional, sanitary, and comfortable environment for patients, personnel, and the public.
F422	✓			Provision is made for adequate and comfortable lighting levels in all areas.
F423	✓			There is limitation of sounds at comfort levels.
F424	✓			A comfortable room temperature is maintained
F425	✓			There are procedures to ensure water to all essential areas in the event of loss of normal water supply.
F426	✓			Adequate ventilation through windows or mechanical means or a combination of both.
F427	✓			Corridors are equipped with firmly secured handrails on each side.

EXPLANATORY STATEMENTS

F 417. The facility has no written preventive maintenance program.

F 418. Corridor walls are chipped and soiled in the Infirmary and Convalescent units. Floor tile missing and cracked in Female Infirmary [illegible]. Walls in both areas as well as patient rooms are soiled and paint is peeling in Female Convalescent areas. Water fountains in Male Infirmary were rusted. Commode stall walls were rusted in Male Infirmary, [illegible]
Cracked panes of glass noted throughout facility.

F 419. [illegible] in the Convalescent unit were in need of [illegible].
Loose [illegible] in Female Convalescent area.

F 425. Water is supplied by South Pittsburg Water Supply Company. There are 2 main feed lines into Hospital - East and West. Either line capable of full capacity of use. If these become inoperable - there is a 250,000 gallon underground emergency tank capable of 24 hour emergency coverage. Pumps are activated automatically. In an extreme emergency after 24 hours, Volunteer Fire Dept. in the area, 7 tank trucks, and 20 pumper [illegible]

3498

NAME OF FACILITY: [illegible] 15-5057 0201

Infection Control

	YES	NO	N/A		EXPLANATORY STATEMENTS
F428				☑ MET ☐ NOT MET XVI. **Infection control (405.1135)** — The skilled nursing facility establishes an infection control committee of representative professional staff with responsibility for overall infection control in the facility. All necessary housekeeping and maintenance services are provided to maintain a sanitary and comfortable environment and to help prevent the development and transmission of infection.	
F429				☐ MET ☑ NOT MET *(a) Standard: Infection control committee.*	[illegible list of committee members and positions]
F430	✓			The infection control committee is composed of members of the medical and nursing staffs, administration, and the dietetic, pharmacy, housekeeping, maintenance, and other services.	
F431		✓		The committee establishes policies and procedures for investigating, controlling, and preventing infections in the facility.	[illegible]
F432	✓			Monitors staff performance to ensure that the policies and procedures are executed.	
				(a) Members of infection control committee. NAME / POSITION: [illegible]	
F433				FREQUENCY OF MEETINGS: (1) ☐ WEEKLY (2) ☑ MONTHLY (3) QUARTERLY	
F434				DATE OF LAST MEETING: ?/11/75?	
F435				☑ MET ☐ NOT MET *(b) Standard: Aseptic and isolation techniques.*	
F436	✓			Written effective procedures in aseptic and isolation techniques are followed by all personnel.	
F437	✓			Procedures are reviewed and revised annually for effectiveness and improvement.	

NAME OF FACILITY

Utilization Review (Continued)

	YES	NO	N/A		EXPLANATORY STATEMENTS
F464				☐ MET ☑ NOT MET *(b) Standard: Composition and organization of utilization review committee.*	
F465		✓		The committee or group responsible for utilization review is composed of two or more physicians and optionally, other professional personnel.	Physicians [illegible] are [illegible] of the U. R. Committee. There are [illegible] physicians who function as physician delegates for [illegible] continued stay reviews. These physicians are not included as part of the U. R. Committee.
F466	✓			All medical determinations are made by the physician members of the committee.	
F467	✓			No physicians review any case in which they were professionally involved.	
F468				COMMITTEE IS: (1) ☑ IN-HOUSE (2) ☐ LOCAL MEDICAL SOCIETY (3) ☐ OTHER (SPECIFY)	
				INDICATE THE PROFESSIONAL DISCIPLINES REPRESENTED ON THE UTILIZATION REVIEW COMMITTEE AND GIVE NUMBER OF EACH:	
F469				PHYSICIANS	
F470				NURSES	
F471				ADMINISTRATORS	
F472				MEDICAL RECORD ADMINISTRATOR	
F473				SOCIAL WORKER	
F474				OTHER (SPECIFY)	
F475				☑ MET ☐ NOT MET *(c) Standard: Medical care evaluation studies.*	
F476	✓			Medical care evaluation studies are performed to promote the most effective and appropriate use of available health facilities and services consistent with patient needs and professionally recognized standards of health care.	
F477	✓			Studies which could include assessment of findings resulting from periodic medical review, emphasize identification and analysis of patterns of patient care and changes indicated to maintain consistent high quality of services.	

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(31)

NAME OF FACILITY

John J. Kane Hospital [illegible] 0201

Utilization Review (Continued)

	YES	NO	N/A	☐ MET ☑ NOT MET	EXPLANATORY STATEMENTS
F506				*(g) Standard: Utilization review records.*	
F507	✓			Written records of committee activities are maintained.	
F508	✓			Appropriate reports, signed by the committee chairman, are made regularly to the medical staff, administrative staff, governing body, and sponsors (if any).	
F509		✓		Minutes of each committee meeting are maintained and include at least: (1) Name of committee. (2) Date and duration of meeting. (3) Names of committee members present and absent. (4) Description of activities presently in progress to satisfy the requirements for medical care evaluation studies, including the subject and reason for study, dates of commencement and expected completion, summary of studies completed since the last meeting, conclusions, and followup on implementation of recommendations made from previous studies, and (5) Summary of extended duration cases reviewed, including the number of cases, case identification number, admission and review dates, and decisions reached, including the basis for each determination and action taken for each case not approved for extended care.	Minutes do not include: 1. [illegible] description of the medical care evaluation studies including the subject [illegible] reason for study, dates of commencement [illegible] expected completion, summary of studies completed, conclusions, recommendations or follow up [illegible] implementation of recommendations. 2. Summary of continued stay cases are recorded for Medicare patients only. The continued stay reviews for Medicaid patients are not recorded in the minutes. The only verification of continued stay review to M.A. is the U. R. form maintained on each patients' records.

3501

FORM SSA-1569 (10-74)

(32)

NAME OF FACILITY

John J. Kane Hospital

Utilization Review (Continued)

	YES	NO	N/A				
				THE COMMITTEE RECORDS INCLUDE			
F510				✓ LIST OF PATIENT CASES REVIEWED			
F511				✓ DECISIONS ON PATIENT CASES REVIEWED			
F512				✓ ADMINISTRATIVE ACTIONS RECOMMENDED BY THE COMMITTEE			
				HOW OFTEN ARE MEETINGS OF THE FULL UR COMMITTEE HELD, AS VERIFIED BY THE SURVEYOR?			
F513				(1) WEEKLY (2) ✓ MONTHLY (3) QUARTERLY			
				INTERNAL RECORDS OR METHODS WHICH ARE USED BY THE UR COMMITTEE FOR REVIEW OF EXTENDED DURATION CASES AND MEDICAL CARE EVALUATION STUDIES INCLUDE: (CHECK ALL APPROPRIATE BOXES FOR EACH TYPE OF CASE)			
					CASES		
				METHOD OR RECORD	EXTENDED DURATION (1)	MCE STUDY (2)	BOTH (3)
F514				COMPLETE MEDICAL RECORD			
F515				ABSTRACT OF MEDICAL RECORD			
F516				FACE SHEET OF MEDICAL RECORD			
F517				UTILIZATION REVIEW CHECK-LIST	✓		
F518				INTERVIEW WITH ATTENDING PHYSICIAN	✓		✓
F519				OBSERVATION OF PATIENT	✓		✓
F520				OTHER (SPECIFY) Questionnaire Worksheet			✓
				MIF Form	✓		

EXPLANATORY STATEMENTS

F 510, 511 & 512 Recorded for Medicare patients only.

?/30/75, 5/30/75, 4/30/75, 3/31/75, 2/28/75 & 1/31/75.

FORM SSA-1569 (10-74)

3502

Senator PERCY. I should like also to state for our witnesses today that you are here at the request of this committee, and of the Congress of the United States. Should you ever at any time have any kind of reprisal, you should just get in touch with your Senator, and he will have the full backing of the Congress of the United States in enforcing and protecting your rights.

Mr. HALAMANDARIS. Father McCormley, you were the chairman of the snack shop committee. Will you tell the committee under what circumstances you resigned from that position?

SNACK SHOP PRICES CAUSE COMPLAINTS

Father MCCORMLEY. I questioned the snack shop board many times, during my years on the board, why the snack shop had the same prices as the outside community, or even why we charge more. Why could not Kane have the same kind of privileges as the Veterans' Hospital receive? This question never seemed to be answered adquately. I was told it could not be done.

The patients complained to me over and over again about the prices in the snack shop, and while I was chairman, I tried to find out what the profits were so that prices could be reduced. Whenever I tried to correct some of the bad situations that I found in the snack shop, I found myself in a helpless predicament. After being thoroughly disgusted with the whole operation, I walked out of a meeting and submitted by resignation as chairman of the board.

Mr. HALAMANDARIS. Thank you very much for that response.

I have one brief comment, and then we will hear our last witness. The brochure* that Kane Hospital publishes, which we have here, depicts in grand style the facilities and the services, that allegedly are offered at Kane Hospital. Some services exist only on paper. For example, the report stresses that the facility specializes in rehabilitative services, and yet, as we have been told, there are over 2,000 patients in the facility, and each year 1,000 of them die and only 200 are discharged.

That is a rather devastating indictment of the rehabilitation services at that facility.

"A TERMINAL ILLNESS CENTER"

I would like you to comment, and to tell me to what extent is there an effort being made to rehabilitate people. The broader question is, you know, the discrepancy between the brochure and the report** we have received this morning.

It could not be any more startling. It is as if we are talking about two totally different facilities.

Do you want to give us any sort of reaction or comment to that question?

Father MCCORMLEY. I do not know whether Kane Hospital should be called a rehabilitation center. I think the hospital should adopt in its title that it is also a terminal illness center.

Mr. HALAMANDARIS. Would you repeat that?

*See p. 3505.
**See p. 3471.

Father McCORMLEY. It is also a terminal illness center, since it deals with people in the process of dying. I would say that rehabilitation is not being done in the convalescent areas. If it is, I am not aware of it. The rehabilitation programs are quite inadequate for the vast numbers of patients that we have in the hospital.

Mr. HALAMANDARIS. You remember Dr. Butler's testimony a little while ago, in which he stated the care being offered was primarily custodial.

We have in the record a statement* from a registered nurse that accompanied us on our visit on December 1, in which she stated, the patients primarily received custodial care.

We have that on the record.

We now have your statement.

I would add a third piece of evidence, that is a report** prepared by the Allegheny County Human Services Commission, prepared in November 1974, in which it says that "the hospital's largely long-term population belies its claim as a rehabilitative facility." That is the point I was trying to make, and I would be interested in reaction from the nurses.

Ms. KIEFER. I would like to tell you, like I tell new employees when they start, I feel the hospital has two objectives. It is rehabilitation for some, and second, it is care of the terminally ill, and another problem facing our society is the fact that terminally ill patients have nowhere to go.

The hospitalization runs out; the families cannot take them to their homes, so this, as maybe Kane started out taking care of the elderly, but we have now become a long-term care center for the terminally ill patients, those that need much, much care.

This is a part of our problem. Our patients need more care, and it is not completely a rehabilitative center.

"ANOTHER SIDE TO THIS STORY"

Mr. HALAMANDARIS. We have received a lot of testimony today. It is all stacked up on one side, indicating the quality of care offered at Kane. There have been some financial questions raised, and we hope to have those settled when the General Accounting Office completes its audit of Kane Hospital. We expect a further hearing to be held, when that report is ready, and we would hope to do this in Pennsylvania. At that time we want to give an opportunity to those people who would like to respond and to present a complete detailed response. If there is another side to this story, we would like to hear it. We would like to be able to interview other witnesses who work at the facility who can give us their perspective.

That is something we will plan to do. and before we close, we want to hear briefly from James M. McLean from the Allegheny County Law Department.

I am grateful to you for appearing today. Senator Schweiker may have a question or two before we dismiss you.

[The brochure referred to follows:]

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*See p. 3444.
**Retained in committee files.

Kane Hospital Cares

(3505)

70-080 O - 76 - 13

JOHN J. KANE
HOSPITAL
CARES ABOUT
EACH PATIENT'S...

PHYSICAL HEALTH
ENVIRONMENTAL NEEDS
EMOTIONAL HEALTH
SPIRITUAL LIFE
SOCIAL LIFE

WELCOME!

We wish to extend a most cordial invitation to you to participate by means of this brochure in a descriptive and pictorial visit to *your* John J. Kane Hospital. It is our hope that the information presented will stimulate enough interest to motivate personal visits to this facility.

For the convenience of relatives and friends of our patients, visiting hours have been made most liberal. Visitors have a definite beneficial effect since they help to dispell the feeling of isolation and even abandonment which some patients experience.

Most patients at Kane Hospital suffer from multiple systems diseases associated with old age and chronic illness. Our mission is dedicated to the scientific, and above all, *compassionate* effort to alleviate as best we can the degenerative diseases associated with the ravages of time. *"Time — the stealthy equalizer moves softly on padded feet."* We all age imperceptibly, but — *"suddenly, we're old"* and burdened with time's destructive legacy.

In our youth oriented society, the society of the *beautiful people*, the visage of old age creates anxiety. The observer sees in the aged sick the mirror image of himself "X" number of years in the future. Anxiety converts easily to anger which is frequently directed toward the hospital, the physicians, the nurses and others. Many people are emotionally incapable of dealing with the repellent aspects of terminal illness and this leads to difficulty in recruiting and retaining personnel. Frequently, excellent employees become depressed and resign.

On the other hand, Kane Hospital has many positive and optimistic aspects. The concept of rehabilitation with the return of the patient to community living is an all pervasive orientation of our personnel. Occupational Therapy, Recreational Therapy, Social Service, Volunteer Service and Spiritual Support are all major positive efforts here.

Each year we strive to improve our services and each year we succeed to a significant degree. The enlightened and progressive attitude of our Board of County Commissioners in conjunction with the support of the people of Allegheny County make this progress possible. We are deeply grateful for this support.

Sincerely,
ALLEGHENY COUNTY INSTITUTION DISTRICT

Edward R. Deverson

Edward R. Deverson, M.D.
Executive Director

THESE TIRED OLD HANDS HAVE...

Toiled long in sacrifice and love.

Diapered and comforted generations of babies.

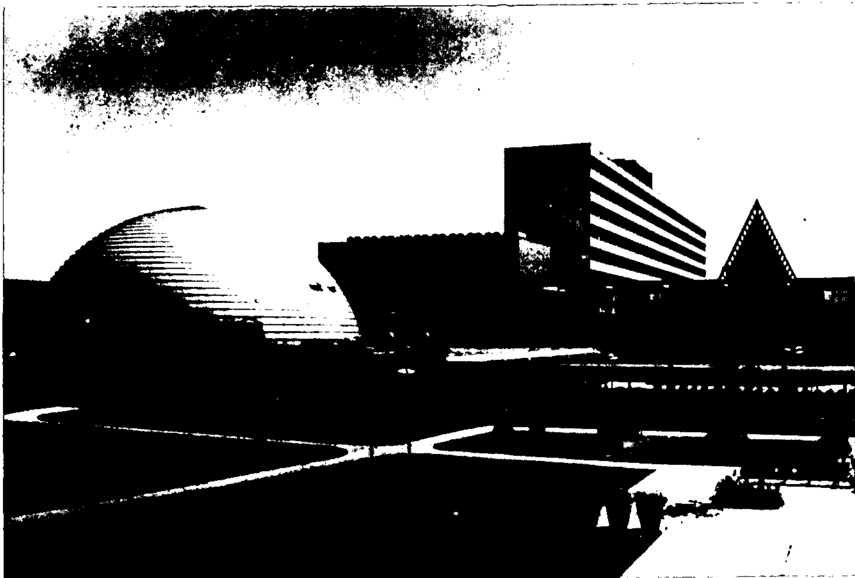
Touched the rosy cheeks of children and smoothed away the tears of childhood fears.

Released a loving grip on sons in time of war and Counted beads in prayer for safe return.

THUS...

It is our sacred duty to hold these tired Old hands in ours, comfort and gently Lead them through the twilight of a Long days journey.

JOHN J. KANE
HOSPITAL CARES
ABOUT EACH
PATIENT'S
PHYSICAL HEALTH



MEDICAL SERVICES

John J. Kane Hospital is nationally recognized as one of the most advanced hospitals in the United States today for the care of the chronically ill and aging. Supported by Allegheny County taxpayers, John J. Kane Hospital may well be a source of pride to local citizens. It has achieved a national reputation for excellence in the field of rehabilitation and restorative care, and serves as a guide for similar programs in hospitals nationally. Caring for 2,187 patients today, it is the second largest geriatric hospital in the United States. The goal of Kane Hospital is the restoration to health of the geriatric and chronically ill patient and his return to the community.

Kane Hospital opened in February, 1958 to provide restoration and terminal illness care for the medically indigent and chronically ill. It offers service to patients who need long term rehabilitation; care and comfort of the ill, handicapped, and aging so that they may return to community living whenever possible. The term chronic illness includes all categories of illness which do not respond to immediate treatment.

John J. Kane Hospital is "people"... the physicians, the nurses, the Board of County Commissioners, and Advisory Board, administrative staff, social workers, technicians, therapists, aides, volunteers, clergymen, maintenance crews, and many others whose only goal is to serve the patient.

Many staff personnel see the patient every day. Some, the patient never sees, but nevertheless they are all working together behind the scenes to provide the best possible care.

Kane Hospital "is" a competent qualified medical staff and well trained, experienced registered nurses who staff diagnostic and therapeutic facilities.

The entire staff of more than 1,700 cooperates for the benefit of the patient and keeps the hospital operating at top efficiency while maintaining an atmosphere of cleanliness and cheerfulness.

The consultants participate in operating the many specialty clinics at Kane Hospital. The major clinics are: General Surgery, Orthopedic Surgery, Neurology, Ophtholmology, Dermatology, Urology, Otolaryngology, Hematology, Dentistry, Cardiology and Pacemaker Monitoring, Gynecology, Podiatry.

The associate medical staff includes psychiatrists, sociologists, pharmacists, psychologists, and pharmacologists. The associate staff provides specialized services beyond those offered by the attending physicians and consulting staff.

Accurate and complete records on every patient admitted are maintained in the **MEDICAL RECORDS DEPARTMENT**. The physician writes a detailed case history as well as results of physical examinations, diagnostic tests, and treatments for each patient so that records are complete for future reference. Complete records can be a life-saving factor in the event that the patient is re-admitted and his condition is such that his past medical history contains information essential to proper therapy.

THE NURSING SERVICES

The backbone of Kane Hospital is a large NURSING STAFF, assisted by licensed practical nurses and hospital aides.

The long-term geriatric patient requires intensive nursing care which is an essential requirement for his recovery. Many geriatric patients are admitted to Kane Hospital without next-of-kin. Approximately 30-40 percent of the patients do not have regular

visitors. The Kane Hospital staff becomes "his family" and he relies heavily on his nurses for his daily care and human contact.

The non-professional nursing staff includes nurses assistants, medicine girls, licensed practical nurses, and nurses aides.

Every hospital faces a nursing shortage and Kane Hospital has been attempting to solve this problem in many ways.

The Allegheny County Commissioners initiated a program to employ 150 high school and college students to serve as part-time hospital aides. Only worthy students with adequate scholastic records who also need financial assistance were accepted, and consequently the program is proving mutually beneficial.

A close working relationship between Kane Hospital and the Visiting Nurse Association (VNA) aids patients who return to their homes. Many patients regress unless their rehabilitation program at the hospital is continued in the home. The VNA nurse assists the patient at home and helps prevent the unnecessary return to Kane.

Continuity of the patients' occupational and physical therapy programs are an important key to successful discharge.

Kane Hospital maintains three main areas for its 2,187 patients on 129 acres of rolling countryside in Allegheny County, in the Southwestern area of Pennsylvania. After admission to the hospital, those patients requiring intensive medical care are placed in the main eight-story Kane Hospital Tower Building. Patients assigned to the Infirmary section are usually ambulatory patients requiring routine medical care and nursing supervision. Convalescent area patients are those not requiring intensive hospital care, but are too ill to be placed in ambulatory facilities of the Infirmary.

The average age of the patient today is 76.3 years with more than 1,800 of them over the age of 65. The oldest patient is 102 years. The youngest is 22 years of age.

Many elderly patients admitted to Kane Hospital are suffering from terminal illnesses. The personnel of Kane Hospital are carefully trained in the application of special care designed to lend dignity to their final days.

The average length of stay of patients who were discharged during the past year was 304.6 days.

Since the opening of Kane Hospital in February, 1958, there has been a progressive increase in the feminine population. At the beginning approximately a third of the patients were women, but today 62 percent of the patients are women.

Under the guidance of two certified roentgenologists the X-RAY DEPARTMENT of Kane Hospital operates 24 hours a day. Modern equipment for the geriatric patient offers automatic processing and drying of films to speed procedures. A modern tilt-table fluoroscopic combination equipped with image amplifier and remote control television monitoring are particularly adaptable to elderly and disabled patients since they can be examined under ordinary light and moved during procedures with little difficulty.

The clinics which operate at John J. Kane Hospital with a full complement of medical staff are: Dental,

Dermatology, Ear, Nose and Throat, Cardiology, Eye, Genito-Urinary, Gynecology, Hematology, Neurology, Orthopedic, Podiatry, Surgical, and Pacemaker Monitoring Clinic.

The extensive diagnostic services and care offered at the 13 Kane Hospital clinics can only be touched on here briefly.

The Dental Clinic was recently outfitted with a special lift which enables the patients to be raised for treatment while remaining in their wheelchairs. Oral surgery and prosthetics demand the greatest attention of the dentist and restorations, prophylactic treatment and denture insertions are major areas of care offered. The Dental Clinic is open daily.

Kane Hospital Eye Clinic is open four days a week. Diseases of the eyes are treated and the great gift of vision is given to those whose eye condition is suitable for cataract extraction. Eye glasses are prescribed to improve vision and broken glasses are replaced.

Pap smears are routine in the Gynecological Clinics and are performed on all female patients admitted.

The Neurology Clinic for the geriatric patient deals mostly with organic brain syndromes, strokes, Parkinsonism, and various less common neurological syndromes.

The Orthopedic Clinic is one of the busiest clinics at Kane Hospital and cares for hundreds of fractures. The elderly are particularly susceptible to hip fractures.

Podiatry (foot care) is especially important for the elderly patient. Foot care aids in rehabilitation and exercise. It also allows the patient to be more independent and self-reliant, and less inclined to be inactive.

Readers interested in care of the chronically ill are welcome to contact the hospital for more detailed information on specialized clinic services to the geriatric patient.

THE CLINICAL LABORATORY

The CLINICAL LABORATORY personnel includes a supervisor who is a Registered Medical Technologist and also registered in the field of Cytology. He is supported by two Registered Medical Technologists, three Certified Laboratory Assistants, one Medical Technician and one Electrocardiographer.

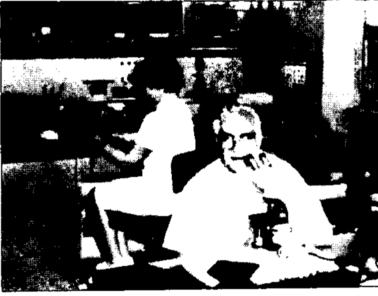
Clinical Laboratory services are available 24 hours a day.

The scope of work offered by the Clinical Laboratory includes Urinalysis, Hematology, Biochemistry, Bacteriology, Serology, Blood Banking, Cytopathology, Electrolyte Determinations, Spinal Fluid Analysis, and Food Service Sanitation and Bacteriological Monitoring.

Two members of the Laboratory staff and one staff physician serve as the Infection and Environmental Control Committee. This committee inspects sanitary conditions, checks for bacterial contamination and verifys sterility of appropriate articles from the Central Supply Room that are distributed throughout the hospital. Control of the Central Supply sterile material is accomplished daily by means of the "Attest" method.

The Hematology and Chemistry Departments are operated under complete quality control standards.

A new Three Channel Electrocardiographic machine has been added to the Clinical Laboratory. This instrument is also equipped with phonocardographic attachments.



IN-SERVICE EDUCATION

The Kane Hospital IN-SERVICE EDUCATION program provides comprehensive understanding and increased competence in nursing skill in relation to changing methods and new techniques in caring for the chronically ill and aging.

An extensive orientation program is given to the newly assigned staff nurses. This program is designed to assist each nurse in development of an awareness of responsibilities, activities and functions in nursing service, as well as relationships to other departments in order to promote continuity of patient care.

Kane's nursing in-service education department conducts a training program for all new hospital aides. Orientation and basic training techniques are covered in the first four weeks concerning care of the geriatric patient, ethics, safety, and care of the patient's unit.

Hospital aides represent the largest category of non-professional personnel offering services and play a major role in the bedside care of the patient. They work under the supervision of registered nurses after receiving extensive training in the nursing in-service education department.

KANE HOSPITAL AS A TEACHING CENTER

The John J. Kane Hospital cares for more than 2,100 chronically ill patients presenting a vast variety of diagnoses both common and rare. Many of these illnesses and their nursing requirements are not usually seen in general hospitals. For this reason, Kane Hospital presents an excellent opportunity for

training of medical and nursing students. Some university faculties recognize the wealth of material available at Kane and have involved their students in tours, demonstrations and classes at Kane Hospital. The aim is to make Kane Hospital an institution for teaching and research in Geriatrics, Gerontology, and Rehabilitation Medicine.

To stimulate university involvement, the John J. Kane Hospital has developed a program with the Graduate School of Social Service of the University of Pittsburgh. This joint effort has made possible the use of the Kane Hospital for training University of Pittsburgh Social Service students and has involved the Kane Hospital Social Service staff in teaching at the University School of Social Work.

Students from three general hospital Schools of Nursing gain broader experience in geriatric care through training at Kane. More than 150 students annually received educational training. These student nurses were from the Schools of Nursing at University of Pittsburgh, Presbyterian-University Hospital and St. John's Hospital.

The purpose of this program is to have students learn to understand the changes that occur in the aged patient physically, socially, and psychologically.

The John J. Kane Hospital also has negotiated a contract with Physiatrists (physician specialists in physical medicine) involved in Rehabilitation programs at St. Francis Hospital, Mercy Hospital and other local general hospitals. As a public institution, the John J. Kane Hospital has encouraged the use of its facilities and the study of its patients in the training curriculum for undergraduate and graduate training of medical, nursing and para-medical personnel.

JOHN J. KANE HOSPITAL CARES ABOUT EACH PATIENT'S ENVIRONMENTAL NEEDS

FOOD SERVICES

The diet and preparation of food for the more than 2,100 ill, handicapped and aged patients at Kane Hospital is a complicated and colossal job for the medical staff, the dietitian, the kitchen crew and the nurses aides.

The attending physician orders a special diet for each patient depending on his needs. The dietitian visits the patient to discuss his likes and dislikes.

The dining room overlooks both the Mirror Lake Court and the large central court and can serve 900 people, cafeteria style, in two sittings. Those patients who are ambulatory come to the dining hall. However, about 40 per cent of the patients have feeding problems and need help.

Supplemental feeding such as egg nog, milk shakes, or juice, are available under physicians orders. The food is placed in refrigerators on the patient's floor to meet his needs at the appropriate time.

Kane Hospital operates its own bakery and bakes approximately 500 loaves of bread per day. All meat is served boneless due to the difficulties of chewing of many of the patients.

More than 175 kitchen personnel and dietary aides will prepare about 500 pounds of mashed potatoes for one meal; 200 pounds of fresh vegetables; 800 pounds of turkey; serve 450 gallons of whole milk per day; or use 1,260 dozen fresh eggs a week.

Visiting hours have been extended to encourage families and visitors to help feed these patients. Volunteer groups have been organized to help feed patients.

All patients receive a prescribed diet. Visitors are asked not to bring food.

ELIGIBILITY AND ADMISSION

John J. Kane Hospital opened its doors in February, 1958 to the chronically-ill or long-term patient unable to purchase such care in private or voluntary agencies.

Eligibility requirements include a physician's statement indicating need for skilled nursing and medical care; medical indigency, a referral from a general hospital, or extended care facility.

Indigency is interpreted as "without sufficient funds to pay for care in other institutions." Therefore, to be eligible for admission an applicant must be unable to pay for care in other facilities. He is definitely permitted to retain his home and property because provision must be allowed for his return to the community after discharge.

Patients come to Kane Hospital from three major sources: general hospitals, nursing homes and public institutions.

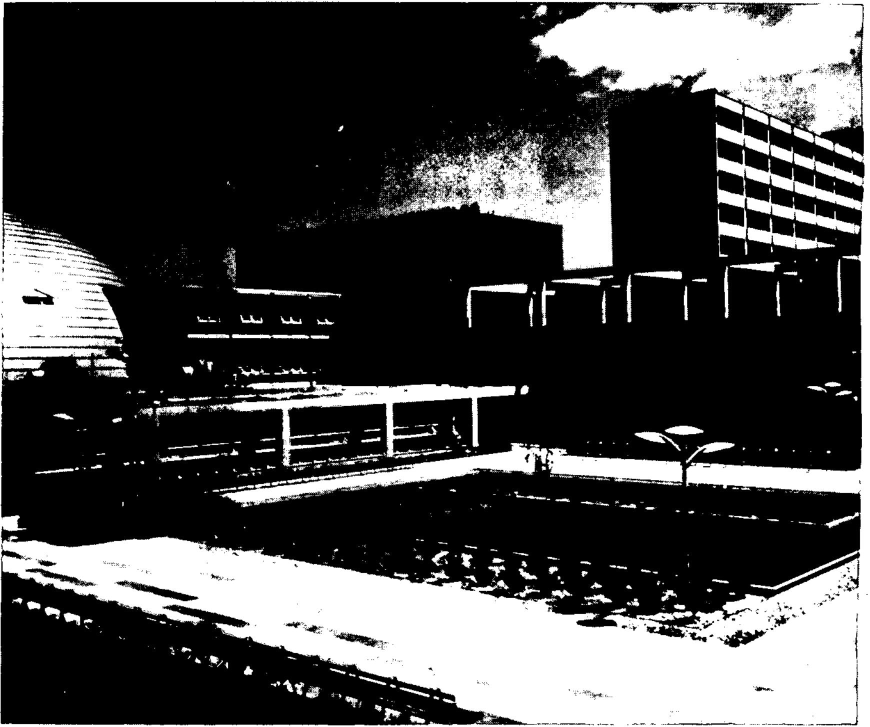
It is planned that discharge and placement services (such as foster homes) be accelerated so that beds can be vacated; thus permitting a more liberal intake of those on the waiting list and thus make Kane Hospital services available to a greater number of patients.

WHO'S INVOLVED AT KANE HOSPITAL

GROUNDS AND BUILDINGS

THE KANE HOSPITAL FIRE DEPARTMENT, working on two shifts, keeps a 24 hour watch for emergencies. The 17 man fighting crew schedules and practices fire drills and evacuation of patients. It conducts inspections, including the fire alarm system, and does preventive maintenance on all fire fighting equipment at the fire house, on the grounds, in the hospital and in adjoining and employees' quarters.

Its equipment includes a 750-gallon pumper, a 65-foot ladder truck, and an emergency cart loaded with a hose and fire extinguisher for use inside the hospital. The emergency cart, designed by one of the Kane firemen, is able to travel through corridors and enter elevators.



The Kane Hospital Fire Department serves in several important capacities. It is the focal nerve center for a radio system over which area hospitals and fire departments may be alerted in cases of emergencies and disasters in Allegheny County. The radio transmitter can establish contact with area hospitals instantly to tell them when ambulances are on their way with casualties.

The Kane Fire Department also serves as headquarters for the South Hills Volunteer Firemen's Association, and acts as the base for the fire band radio and telephone system. Through this network, Kane can contact approximately 204 community fire departments which are part of the operation. It can summon assistance from any of these volunteer groups in case of an emergency at the hospital or at either of the two Allegheny County airports.

The Kane radio system is an essential part of the disaster plan for Greater Pittsburgh Airport. Kane Hospital maintains a fully equipped disaster hospital in the fire alert building at the airport. The radio system ties in rescue personnel from Kane, Sewickley Valley, Ohio Valley and Mercy Hospitals.

HOUSEKEEPING

An executive housekeeper supervises a staff of 96 to establish and maintain a high standard of cleanliness and sanitation in patient areas, staff facilities, and public areas throughout Kane Hospital.

Mechanized housekeeping is in constant operation as are 1500 mops and buckets to cleanse the acres of rooms and hallways; 496 bathrooms and 23,000 windows.

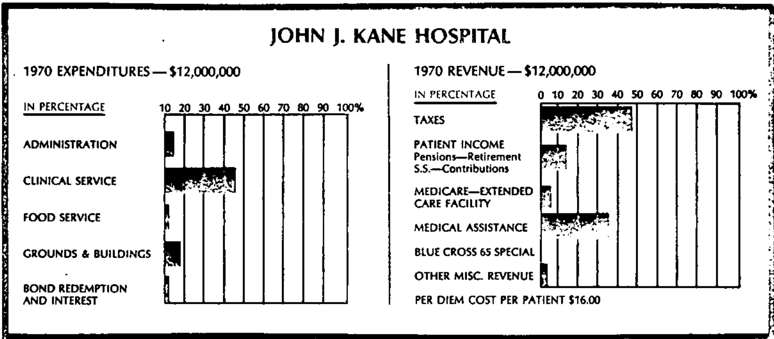
HOUSEKEEPING has a direct bearing on the welfare of the staff, the patient, and the visitors. Housekeeping employees, like food service and maintenance people are offered instructional programs of training.

PHARMACEUTICAL SERVICES

A well stocked **PHARMACY** operated by 3 registered pharmacists has facilities for storing, preparing and dispensing medicines as prescribed by the attending staff physician.

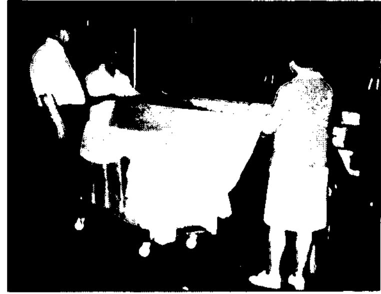
ADMINISTRATION

An important recent addition to the hospital has been the installation of computer equipment. All information concerning a patient is punched on his individual card at his nursing station. This allows for completion of statistical data relevant to chronic illness research. It also allows for rapid accounting procedures and inventory control.



LAUNDRY

In the Laundry Department an average of 30,000 sheets are processed weekly. In one year, 4½ million pounds of material including linen and patient apparel are laundered, ironed and supplied to appropriate hospital areas.



JOHN J. KANE HOSPITAL CARES ABOUT EACH PATIENT'S EMOTIONAL HEALTH

REHABILITATION SERVICES

An unknown author stated "Medicine and surgery have added more years to life; rehabilitation adds more life to years."

REHABILITATION is the restoration of the handicapped to the fullest physical, mental, emotional, social, vocational, and economic usefulness of which they are capable.

Rehabilitation restores something special to the life of the aged, ill and handicapped . . . dignity and independence.

The Rehabilitation program at Kane Hospital is one of the most advanced programs for the geriatric patient in the nation.

The staff here feels that almost every patient benefits to some degree from rehabilitation. The aim is to re-train patients to live and work within the limits of their disabilities and to achieve greater independence . . . always working toward the day the patient can be discharged and returned to his community.

The Rehabilitation Department at John J. Kane Hospital is composed of Physical Therapy, Occupational Therapy, Inhalation Therapy and Services to the Blind.

Playing a vital role in rehabilitation services are the Physical and Occupational Therapy Departments. Their principle goal is to overcome or minimize an individual's disability and to restore him to useful living.

PHYSICAL THERAPY applies to the procedures and techniques used for restoration of the aged and chronically ill. Here patients are taught exercises, especially with parallel and traction bars, to improve balance or to coordinate movements. Main objective, however, is ambulation or learning to walk with various devices.

Services in the Physical Therapy area include thermal therapy; therapeutic exercise and muscle re-education; massage or manipulation of body tissues; training in the use of prostheses; electro-therapy for the purpose of producing heating effects; ultra violet sun ray therapy and therapeutic use of cold to minimize the initial reaction of tissues to local traumatic injuries such as contusions and sprains.

Patients who participate in the Physical Therapy Department on recommendations of the medical staff are orthopedic cases; amputees; arthritis cases; neurological cases; and general medical cases.

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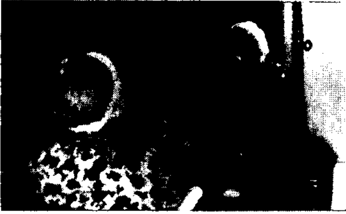


OCCUPATIONAL THERAPY works closely with the Physical Therapy Department. Occupational Therapy is defined as an activity—mental or physical—medically prescribed and professionally guided to aid the patient in recovery from disease or injury. Basically, in Occupational Therapy the patient achieves the ability to perform the usual activities of daily living, such as dressing, feeding, and performing requirements of his occupation.

Diversional programs also are part of Occupational Therapy. Many pieces of beautiful workmanship are turned out by patients despite major physical handicaps. These include art needlework, paintings, leathercraft, copper tooling, mosaics and woodshop work. Projects are undertaken on either a group or individual basis. Sanding of wood may restore strength to an arm; weaving may help a deformed hand; typing may aid coordination.

Occupational Therapy's goal on the functional level is to increase muscle strength; develop coordination, motor skills and work tolerance; and to increase the range of motion of affected joints.

Vocationally oriented Occupational Therapy aims to adjust the patient to regain lost skills and work tolerance, or develop new skills for the patient who may need to change vocation.

The advent of Medicare and its demands for rehabilitation services along with the cognizance of the value and need for such services in long term care hospitals caused a great personnel shortage. Because of this, Kane Hospital initiated an educational and training program for new employees.

The Rehabilitation In-Service Training program at Kane Hospital is under the direction of the Chief Physiatrist and the Coordinator of Rehabilitation.

In cooperation with the Rehabilitation Department, the Social Service Department established discharge planning conferences on patients who have obtained optimum recovery and no longer need the services of Kane Hospital.

Future plans include employing a Speech Therapist on a part time basis to work with stroke patients who have speech disabilities secondary to neurological damage.

The **INHALATION THERAPY** Department's services encompass a broad spectrum dealing with respiratory problems. The therapist's primary function is to administer intermittant positive pressure breathing treatments to emphysematous, asthmatic, and other patients in acute and chronic respiratory distress. This department is also responsible for the administration of oxygen via tents, cannula, face masks, aerosols, and ultrasonic devices.

Persons with chronic lung problems are treated here. By the use of special pressure equipment, medications are administered directly into the lungs, and inhalation treatments are given as well as routine oxygen therapy.

TREATING THE BLIND

In 1946, having pioneered in rehabilitation of the chronically ill and aging and in 1959, initiating foster home placement for adults in Pennsylvania, Kane Hospital was again "first" in designing specific services for those who are chronically ill, aging, handicapped and BLIND.

The Blind population represents 6% of Kane Hospital patients. Since their average age is 85 years, a complete evaluation is done on all new blind patients to determine their needs. Although Physical Therapy and other rehabilitation services were available to this group, specific training in orientation, and mobility, for the blind was developed.

Kane Hospital has a trained permanent staff to maintain the blind patients' interest in the use of talking books and tape recorders, and to assist the blind in the daily use of human guide technique thus enabling them to mentally visualize their surroundings by means of repetitive exposure.

After learning personal grooming techniques, they move about the hospital freely and participate in many activities.

Volunteers play an important part in the lives of the blind and handicapped. They exercise the patients, play games, chat, write letters and provide companionship.

Blind patients who are ambulatory exercise daily and take walks using human guide technique or walkettes.

The Greater Pittsburgh Guild for the Blind began, under contract, a program in the technique of mobility and orientation of blind people at Kane Hospital.

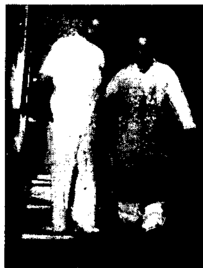
Under the contract, the Guild provides a coordinator of services for blind patients for 30 hours a week, a mobility specialist for 20 hours a week; and specialists who will teach techniques of daily living, activities programs and counseling.

Orientation and mobility programs of the Rehabilitation Services instruct the blind, handicapped elderly patients in a method of travel that is safe and as independent as their physical and mental capabilities permit. This instruction includes travel with the human guide technique; independent travel (with or without a cane) in the patients' immediate area such as the bathrooms, dining rooms; independent travel (with or without cane) to certain locations of prime interest to the patient — Snack Bar, Chapel, another wing of the building, hospital patios, etc,; independent travel (with or without cane) in a foster home and its immediate outside area.

Modified courses in exercise, braille, techniques of daily living and mobility are offered. As a result of this training, several aged blind patients have been able to leave the hospital setting and have been placed in foster homes.

Recently a Licensed Practical Nurse has been added to the staff to specifically instruct the blind in feeding techniques.

Some patients are blind and DEAF and these patients are provided a rehabilitation program with a teacher from the Pennsylvania State Office for the Blind. Communication with the blind and deaf patient is done through several methods. Hospital staff and volunteers spell out words on his hand. These patients also understand by means of a special glove with the alphabet printed on the hand.



SOCIAL SERVICES

In cooperation with the Graduate School of Social Work, University of Pittsburgh, the Social Service Department was established to offer a comprehensive social work service to all chronically ill patients at Kane Hospital.

The Social Service Department is oriented to the problems and resources for chronic illness care and is involved in three main phases of patient care:

Admissions: Includes social work assessment of the patient and his family and his resources. This is an important phase because many admissions and readmissions are due to social factors rather than medical.

Restorative Services: Through individualized counselling techniques and the utilization of group discussions for mutual support and encouragement, patients reach a level of self-esteem with dignity and self-respect.

Discharge Planning and Follow-Up: Change creates anxiety and distortions of reality to different degrees in everyone. Therefore, placement of severely handicapped adults in home of strangers creates difficulties for both which at the outset requires considerable discussion and clarification of the purpose, rights and responsibilities of each.

The Social Service Department is able to arrange the discharge of patients in the following ways: 1. Return to their own families, 2. Discharge to other chronic care facilities, 3. Placement in private family boarding homes, 4. Placement in group living or licensed boarding homes, 5. Assignment to foster homes.

The Social Service Department guides families on caring for the elderly in their homes after discharge.

FOSTER HOME CARE

Kane Hospital was intended to be used exclusively as a hospital where maximum treatment and rehabilitation would lead to early discharge of patients and to their return to normal community living. Kane Hospital was not to be a permanent residence for patients after treatment had been completed.

Many patients could be discharged if suitable supportive and home care were available in Allegheny County.

It would appear that the original goal—to utilize the John J. Kane Hospital solely as a hospital—will be achieved when adequate placement facilities are available.

A large percentage of patients, treated at the John J. Kane Hospital, lack homes or relatives able to care for them when discharge is indicated. Therefore, the hospital is confronted with the arduous task of finding suitable placement. Kane Hospital presently sponsors a Foster Home Placement Program in which patients are provided community living in private residences at Institution District and Department of Welfare expense. The Kane Hospital is currently advocating the use of public housing for the 2,000 patients in institutions in Allegheny County who could and deserve to be living normally outside County and State Institutions.

Presently, more than 100 patients are benefiting from Foster Home Placement, but more could be included if greater recruitment of foster homes would be effected.

A PATIENT ELIGIBLE FOR FOSTER HOME CARE is one who has improved to the extent that he no longer requires hospital services and who, in the opinion of the medical staff, is suitable for Foster Home Placement.

What is a Foster Home? It is a private family-type abode used as a residence by the owner or leasee wherein a patient of the John J. Kane Hospital might be placed for board, room, personal needs and other requirements as designated for such care under regulations as established by the Department of Welfare of the Commonwealth of Pennsylvania, the Allegheny County Health Department, and the Allegheny County Institution District. These regulations specifically define these homes as those limited to the care of two persons not members of their immediate family.

Under the supervision of the Social Service Department Kane Hospital provides foster homemakers with $158 per month for board and room plus $29 which the patient receives for clothing and incidentals. This money is made available from the patient's funds and the Department of Public Assistance.

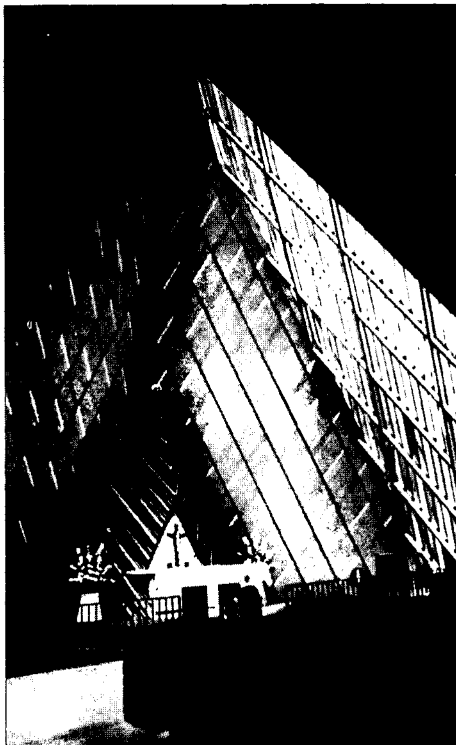
All medical, nursing and social work services are provided to help homemaker and patient establish and maintain a comfortable association.

Homes where foreign languages are spoken are especially needed for the various nationality groups who are found in Allegheny County.

Registered nurses visit the patient in the foster home. Trial visits for three or four days are arranged first. Compatability of religion, social and cultural backgrounds and personal interests are carefully weighed before placements are made.

In addition to supervising and observing the homemakers, the R.N. is also responsible for teaching the homemakers special nursing procedures such as giving insulin, medicine, special diets, etc. Patients visit the Kane Hospital clinics for regular checkups.

John J. Kane Hospital is striving to establish an effective discharge and placement program which will assure availability of Kane facilities to all chronically ill of Allegheny County as a long-term hospital for treatment, research and training in care of the chronically ill.



JOHN J. KANE HOSPITAL CARES ABOUT EACH PATIENT'S SPIRITUAL LIFE

GLORY TO GOD

The biggest challenge facing those who care for the chronically ill and aging here at John J. Kane Hospital is to put new life and spirit into their hearts, and to change despair and apathy of sick old people with limited funds into a new desire to live healthy lives again.

To meet this challenge, a great deal of attention has been given to those things that nourish people's souls as well as their bodies. Excellent medical care alone will not effect recovery of patients whose illness and old age have caused them to lose all desire to live.

RELIGIOUS SERVICES AND CHAPLAIN COUNSELING ARE RECOGNIZED AS ESSENTIAL TO THE REHABILITATION OF PATIENTS.

Two full time chaplains as well as part time clergical personnel representing all religious faiths, visit each and every patient and offer spiritual aid.

Worship services are conducted regularly by the chaplains in the hospital chapel with patients, volunteers, employees, and visiting choirs assisting in presenting the programs.

Unique about the Kane Hospital Chapel is the revolving altar for Protestant, Catholic, Eastern Orthodox and Hebrew faiths. The chapel accommodates 250 and is designed for use by wheelchair and litter patients as well as ambulatory patients.

A Protestant Chaplain and a Catholic Chaplain are residents at the hospital and are available 24 hours a day to assist patients during admission and orientation days; during times of illness, recovery or discharge from the hospital; or during times of readjustment or placement in foster homes. Since many patients are admitted to Kane Hospital terminally, the Chaplains are often called upon to minister to the comfort of the patient and his family at the time of death.

Evening and Sunday Catholic masses are served by altar boys from the various community churches. Special prayer services, Rosary Devotions, and Bible Study programs are scheduled weekly.

The number of patients attending Mass and receiving Holy Communion has doubled, thanks to the hundreds of hours donated by volunteers from surrounding communities who assist in transporting wheelchair patients to the Chapel.

Patients of the Eastern Orthodox religion and the Hebrew faith are ministered by part-time staff. The Eastern Orthodox Chaplain offers liturgy in the chapel and distributes Holy Communion on a regular basis. The Ladies Aid Society of the neighboring Eastern Orthodox churches act as volunteers giving further service to the approximately 45 of the patients who are of the Orthodox faith.

Protestant church worship services are held weekly and Holy Communion is offered four times a year to all patients, employees and volunteers.

Special attention is given to the ministry for the deaf patients by chaplain aides who are able to read and speak in the sign language. Protestant prayer classes, Bible study, and hymn concerts are held by volunteer church groups.

Patients are visited daily and those placed on the critical list are visited day and night. Private prayer and consultation periods are held for patients who request this.

The American Bible Society provides patients with Bibles in both large and regular print. Devotional booklets are issued regularly.

JOHN J. KANE HOSPITAL CARES ABOUT EACH PATIENT'S SOCIAL LIFE

One of the most difficult problems of a long term care hospital is the prevention of apathy and inactivity among the patients.

John J. Kane Hospital maintains an extensive recreational program in an attempt to minimize the institutional problems of idleness, loneliness and worry. Recreation for the ill, the handicapped, and aged is a comparatively new service in the history of rehabilitation in medical progress.

Recreation is a vigorous and direct attack on an important aspect of rehabilitation. Recreation for rehabilitation is scheduled as part of the overall prescription for treatment and is determined by the physician. All recreational activity is medically and administratively approved, since complete cooperation of the hospital staff is essential.

Recreation is not an extra-curricular activity, but a necessity for improvement of the health of the patient. Deterioration takes place in inactive hospitalized patients. Inactivity leads to the development of potential blood hypercoagulability, with thrombosis and embolism as a possibility. The basic thesis is that inactivity, indolence and immobilization slow the heart action. Any program of daily recreation that offers regularly increased heart action will help prevent this.

Inactivity results in muscle weakness, stiffness, fatigue, heart inefficiency and mental deterioration. In the chronically ill and aging these patterns are often difficult to reverse. To prevent rapid deterioration, activity must be encouraged to the tolerance point of the patient. The experienced staff at Kane

Hospital effectively guides and encourages patients to be physically active.

Beside having a recreational program medically approved, each patient has a voice in his own rehabilitation. Each patient's background is considered. He is asked his preference and interest and past talents. His age, physical condition, and language is taken into consideration. To encourage patient activity, a Patient's Council of 30 members meets monthly to discuss patients needs and interests. The goal of recreation is to keep patients active and busy through imaginative recreational programs that give the patient a feeling of pride and self importance.

The recreation program at Kane Hospital is operated daily and includes both individual activity and group participation.

Social recreation such as dances, parties, hobby clubs, and special event parties are enjoyable group situations.

Regularly scheduled programs include weekly viewing of modern movies, stage productions, concerts, musical revues and fashion shows.

Monthly parties are held to celebrate birthdays with refreshments, special entertainment, and decorations. No one's birthday is forgotten. Each patient, on his birthday, receives a card and a small gift from the hospital.

The financial costs of the recreation department are met almost entirely by the profits of the hospital Snack Shoppe which is partially staffed by volunteers.

A newspaper, published monthly, is written by the patients about all hospital activities. A recreational bulletin announcing all activities is published by patients.

Television sets are maintained by the Recreation Department and are placed throughout the hospital.

Musical therapy eases emotional stress and restlessness, and is used extensively. Tapes and records called "Recordings for Recovery" and strolling musicians are successful tools in rehabilitation.

An extensive Art Program is held five days a week with morning and afternoon sessions. Painting techniques are discussed, demonstrated and practiced in the various mediums of charcoal, acrylics, oils and pastels. Lectures with slides illustrating the various schools of painting, history of painters and style technique concerning composition and drawing are taught. Painting is not confined to the art class alone, and every bed patient is encouraged in this therapy.

Kane Hospital auditorium seats 750 and is designed not only for ambulatory patients. Wheelchair and litter patients attend movies, lectures, and stage productions. Solariums are designed throughout the hospital to accommodate classes, shuffleboard courts, and arts and crafts programs.

Outdoor summer festivities include picnics, an annual Folk Festival and Kane Karnival, Hawaiian luau, pop band concerts, club meetings and hobby shows.

Care is taken that the chronically ill young patient at Kane Hospital is not overlooked in a hospital where the average age of the patient is 76.3 years (two percent of the hospital population is under 40 years of age).

Local Pittsburgh college age students volunteer their time weekly to bring fresh companionship to the young ill and handicapped.

Weekly Current Events Classes are staffed jointly by the Occupational Therapy Department and volunteers. This fills a need for the psycho-social and resocialization outlets of young patients ranging in age from 22 to 35.

The Kane Hospital LIBRARY provides reading material for all patients. Reading material is especially important to long term care patients because it helps to keep them mentally alert, abreast of world affairs, and allows them to utilize time wisely. Daily newspapers, magazines and over 2500 books are available. Staff and volunteers take talking book machines to the bedside of those who cannot travel to the library.

The talking books program provides condensed book and magazine material on phonograph discs and are available to physically and visually handicapped patients. Earphones are provided so the patients may listen individually without distraction. Tape recorder casettes are especially adaptable to the physically handicapped with minimal muscular control.

Through the Library of Congress, talking book machines and records are provided free of charge. Patients select records from bi-monthly reading lists issued for the Library of Congress by the American Foundation for the Blind. Interests cover music, poetry, plays, current events, sports, and the space program. Physically and visually handicapped patients are referred to the program by the medical staff and the Rehabilitation Services department on the basis of need and value anticipated through this type of therapy.

Numbered among John J. Kane Hospital's greatest assets are the hundreds of VOLUNTEERS who give unstintingly of their time and energy to assist the 2,187 patients daily.

The "companionship therapy" and services performed by the volunteers play an important role in the rehabilitation, recovery and comfort of the patient.

Since the average age of the patient here is 76.3 years, many lack relatives and friends, and therefore depend heavily on the volunteers for companionship. Several thousand hours annually are donated by the volunteers for the welfare of patients.

The volunteer program is designed to add stimulation and personal services to the patients. They make purchases for the patients, write letters, read to them, and keep them informed on community activities.

Volunteers help operate the snack shop and snack carts. They circulate the library cart which brings all the library services to the bed patient. They perform numerous duties in the recreation program. Under the direction of Kane Hospital personnel, volunteers work in the Admission Department, in the blind patient program and occupational therapy workshops.

The junior aides who work in the summer months are very popular with the chronically ill and aging.

Volunteer aides to the Protestant and Catholic Chaplains devote thousands of hours annually ministering to patients, helping to feed those who need this service, and escorting wheelchair and litter patients to many functions.

The decision to take the story of Kane Hospital to the public resulted in the establishment of the PUBLIC INFORMATION OFFICE for the purpose of developing a better understanding and closer association between the patients at Kane Hospital and the community.

News releases concerning hospital activities are prepared regularly for daily and weekly newspapers; television and radio coverage of all events are encouraged; and a narrated color slide program describing all phases of Kane Hospital, has proved very popular with local church, civic, and social organizations.

Through the assistance of the Occupational Therapy Department, public exhibits of the patient's art work; tapestry designs; and exquisite handmade Christmas ornaments are held annually.

The results of such programs are immeasurable both to the public and the patient. As a better understanding grows, hundreds of local citizens come to Kane Hospital yearly to perform volunteer services.

March 9, 1971

Dear Sir:-

I must take time out to "thank you" and everyone that took care of my mother "Mrs. Helena Ertman."
At times before taking my mother to "Kane Hospital" I would hear reports that things were terrible there. This is completely wrong, as each and everytime I visited my Mother, I have yet to hear anyone talk or treat a patient unkindly.
Everyone that I have seen or heard taking care of patients was always kind, pleasant, and very patient, so they have to be angels of Mercy, as most of the ones that are there, especially in my Mothers case, are the hardest to take care of.
My mother entered October 19th, 1970, and passed away February 18th, 1971. She lasted longer than we had ever expected.
So many many thanks to everyone that helped in any way, and nothing but good reports will be coming from the family of "Mrs. Helena Ertman.

Sincerely
Mrs. Emilia P. Christopher
Daughter.

7535 Dickson St.
Pittsburgh, Pa. 15218

THE JOHN J. KANE HOSPITAL

Vanadium Road

Pittsburgh, Pennsylvania 15243

EDWARD R. DEVERSON, M.D.

Executive Director

Telephone: 412/923-2000
412/276-1600

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County of Allegheny

PITTSBURGH, PA. 15219

OFFICE OF THE COUNTY COMMISSIONERS
THOMAS S. CARPENTER
CHIEF CLERK

May 1, 1971

It is my earnest wish that this brochure will introduce you to the wonderful things that are being accomplished at John J. Kane Hospital. I do not believe that county government has a more essential duty than to care at the highest level for our aged and chronically ill citizens of Allegheny County.

Top rate medical services are provided, but more than that is the emphasis that is placed on the way in which they are administered. The medical executive director, the staff, and the volunteers have been instructed that in the carrying-out of their duties, compassion for the patient must be the first order of everyday. Sympathy and understanding are essential ingredients in treating and prescribing for these older women and men who may well have a feeling that society has forgotten them. At John J. Kane Hospital, one of the finest of its kind in the nation, these patients are not forgotten people.

I do hope you will find time to visit this outstanding institution which really belongs to you, the taxpayer. I think you will find it worthwhile and I am certain the patients will welcome your interest.

Sincerely,

Leonard C. Staisey

Leonard C. Staisey, chairman

Allegheny County Board of

Commissioners.

LCS/rc

ALLEGHENY COUNTY INSTITUTION DISTRICT
JOHN J. KANE HOSPITAL

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Senator SCHWEIKER. I would just like to take a moment to ask Father McCormley, what in his judgment needs to be done to rectify the situation?

In other words, what do we really have to do to get a fair shake for the inpatients at the hospital, and what kind of changes do you think it would take to rectify this condition?

Father McCORMLEY. That is a loaded question. I think our first move should be this: We should meet with the incoming county commissioners and give them the report. We can discuss the accuracy of it and solicit from them their support, so that they will begin to make changes whenever necessary. Thus, this will give the patients the care and dignity they deserve.

Senator SCHWEIKER. I think that is a very constructive suggestion, and I think that is a very valid point.

That is all I have.

Mr. HALAMANDARIS. Thank you very much.

Again, we appreciate your testimony.

Dr. Butler, I appreciate your accompanying us on that tour, and for your comments here today. They have been very useful.

We dismiss you all now.

We now call Mr. James H. McLean, from the Allegheny County Law Department.

A group of people have been invited here today, they have been provided the opportunity to appear on behalf of the hospital, and Senator Moss has sent a letter to them with the outline of the charges presented here today and we talked several times on the phone with hospital personnel.

I understand that they did not wish to appear, but that Mr. McLean will appear on their behalf.

STATEMENT OF JAMES H. McLEAN, ALLEGHENY COUNTY LAW DEPARTMENT, PITTSBURGH, PA.

Mr. McLEAN. I would like to thank the committee for giving me a chance to appear.

I would like to preface my short remarks with a statement that the present county commissioners have not, to my knowledge, ever been informed about the conditions that were testified to here today.

I think that is very important to understand.

If they are willing to give the benefit of their testimony as to the conditions that were testified to here today in the future, I think that is a step in the right direction, but I think we have to understand from the beginning that first, the present commissioners have not heard of this.

I have been designated as spokesman for the other commissioners, and authorized by the people at Kane Hospital to speak on their behalf today.

The report to which you referred to earlier, which is Kane Hospital, I first saw last night at 10 p.m. I received a copy this morning, and I have not had an opportunity to read it or to study it, therefore, I would certainly appreciate an opportunity to study this report, and to study the testimony that you have taken today before testifying.

Certainly, I would like another committee meeting set up where we may, at the appropriate time, respond to the things that were presented here today.

I wish you would keep an open mind and not prejudge, and I ask that a copy of the transcript be provided to my office.

Thank you very much.

Mr. HALAMANDARIS. Of course, we will do that. We will make a transcript available to you, at the earliest possible opportunity, along with all of the exhibits, and presumably, you have copies of the inspection reports that have come from the State Health Department,* but we will take nothing for granted, and send you all of the exhibits.

Mr. McLEAN. I appreciate that very much.

COMMISSIONERS TO RESPOND TO CHARGES

Mr. HALAMANDARIS. And as I said awhile ago, we would be glad to hear not only from the county commissioners, but other employees of the facility. If you would give the committee a list of those that you would like us to call, we would be very pleased to schedule a hearing, and to make sure that they are heard.

Mr. McLEAN. We appreciate that opportunity.

Senator SCHWEIKER. Do I understand from what you just said, that the new commissioners, as well as the incumbent commissioners, would be very responsive to a meeting along the lines that Father McCormley suggested—to sit down and try to work some of these problems out?

Mr. McLEAN. Absolutely.

Senator SCHWEIKER. Is that the import of what you are telling us?

Mr. McLEAN. Absolutely.

We will make every person available at the meeting, to try to eliminate the conflicts that apparently have existed.

Mr. HALAMANDARIS. Thank you for coming here to testify before the subcommittee. We will probably see you again in the near future.

Mr. McLEAN. I appreciate your courtesy.

Mr. HALAMANDARIS. Thank you.

Senator PERCY. The subcommittee is adjourned subject to the call of the Chair.

[Whereupon, the subcommittee was adjourned at 6:15 p.m.]

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*See p. 3471.

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