Joint Visitation Team

Western State School and Hospital
Summer Visit

July 2, 1974
3:30 - 6:00 P.M.

TEAM MEMBERS: Joseph H. Rodgers, WSSH's Board of Trustees,
Pat McClain, WSSH's Parent's Group
Eugene Leonard, WSSH's Parent's Group
Ginny Thornburgh, ACC-PARC
Robert Nelkin, ACC-PARC

Purpose:

To compare the care of residents during July 1974 to the care of residents during August 1973. Specifically, the team visited Cedar I, II, III, IV, and Pine II on both visits.

Feeding:

Cedar II residents were fed while lying down. Two CCAS stated they were never told this was wrong.

(1) Is it safe to feed residents while they are reclining horizontally?

(2) What is the WSSH procedure for positioning while feeding?

(3) Why wasn't the WSSH Nursing Director and Superintendent aware of this problem?

(4) What corrective action has been taken since this incident?

(5) What furniture or devices are needed to help feed residents in an upright position?

Resident Feeders:

The following incidents were observed during ten minutes of feeding on Cedar I. One resident feeder poured a large amount of juice down a woman's throat while she held the womans head back. Another resident feeder stuffed bread into a resident's mouth. A third resident feeder poured all of a glass of milk down the shirt and pants of a woman,the feeder was looking away.

(6) What will be done to improve the service provided by resident feeders?

(7) Is closer supervision of resident feeders possible?

Self Feeding:

Some team members observed Cedar I women who might learn to feed themselves but who were being fed by others.

(8) Who evaluates a resident's ability to learn self feeding? How often?

(9) Has the WSSH staff identified Cedar I women who might begin to learn self feeding?

Changing:

The team observed that 17 residents were lying in wet pants on Cedar II.

(10) What action can be taken to insure that children are not in wet pants?

Staff and Residents:

In Cedar I there was no interaction between staff and residents. Similar observations apply to other units.

(11) How will staff members be encouraged or enabled to teach, play, aid, talk with the women?

Clothes:

On Pine II one boy's pants were so loose they were falling off. Most of the residents were not wearing socks or shoes.

(12) What is the reason that the boys and men were not wearing shoes, socks, and belts?

(13) What plans are being made to insure that residents are properly clothed?

Several Pine II young men were stripped fully or partially. One young man, completely naked, ran past the team in the Pine Lodge hallway.

(14) Why are these young men partially or fully unclothed?

(15) What training will occur to have these young men stay dressed?

Staff members informed us that there was a shortage of available clothes: pajama bottoms, shoes, and jumpsuits.

(16) Why is there a shortage of available clothing on Pine II?

(17) What action will be taken to alleviate this clothing shortage?

On Cedar III the team observed many young women sloppily clothed. Many Cedar III residents were not wearing shoes.

(18) What will be done to better the clothing situation on Cedar III?

Furniture:

Several Cedar I young women were slipping forward in their wheelchairs. The restraints were not holding their bodies.

(19) Can the Cedar I wheelchair restraints be re-evaluated and improved?

The team observed furniture needing minor maintenance: chair joints loosened, rough edges on wheelchair trays, bed anchor rods loose through broken, dangerous edge exposed, frayed electrical connection on food warmer.

(20) Could a detailed maintenance inspection be made regularly?

(21) Can the noted maintenance needs be corrected?

In Cedar II, 1/2 of the children were lying on the terrazzo floor, eight others were in play pens.

In Cedar I, a girl from Cedar II had been sleeping on the terrazzo floor in the bathroom.

(22) Is there a plan to acquire more comfortable, usable furniture that will also encourage personal development?

Staff Numbers:

Responding to the question what do you need most, the Cedar I staff member said "we need more staff. We're working a lot with only two aides and 42."

In Cedar II we learned they too are working with only two staff members for 45 residents.

There was only one staff member for most of the 39 young women on Cedar III, while we were visiting the unit. Similar ratios of staff to residents applied in Cedar IV and Pine II. Understaffing is the cause of most of the WSSH's tragedies.

(23) Could the WSSH Administration make DPW officials, the Governor's Office, and legislators aware on a daily basis, the catastrophic effect of understaffing and overcrowding?

(24) What would the WSSH Administration like the parents, trustees, or PARC to do to make these officials aware of these dangers?

Placement:

On Pine II, there are a couple of boys living with very grown men. Team members questioned the appropriateness of these placements.

(25) Will the WSSH staff review and possibly change the placement of boys currently on Pine II?

Restraints:

The team saw a variety of restraints: quiet rooms (sheets not checked or initialed for hours), time out chairs filled (with a waiting list), and parts of day rooms closed off (to segregate one individual).

(26) Could more staff skilled in behavior shaping be assigned to reduce or modify the aggressive behaviors?

Closing off day rooms reduces the already precious living space for for the other residents.

(27) Could an alternative be found to closing off parts of day rooms?

The resident segregated in Pine II was sitting in a urine puddle. Two visitors got locked in the back part of the day room in Cedar III. Neither attendants or other visitors heard their calling or pounding on the door.

(28) If the closing off of quiet rooms continues, will a staff member be assigned to the segregated part to improve supervision?

(29) Are the numerous beds with wooden crib tops and nylon netting necessary?

(30) Is there a plan to train residents to sleep in normal beds?

Flies:

In spite of the air conditioners, there were an over-average number of flies.

(31) What can be done to control or eliminate the flies?

T.V.S

Televisions were operating in all units. Only two residents on Cedar I paid attention to it. No one was watching the television in Cedar II, III, IV, or Pine II. This has been mentioned by the Visitation Team in several past reports.

(32) Could the WSSH Administrator reserve the television for special and selected use?

(33) Could the WSSH Administration plan for greater use of recordings such as storytelling, dancing music, different tempos, etc.?

Personal Possessions:

In Cedar I, one girl clutched her raggedy ann doll. Another women had two catalogues. No one else had personal possessions. Although we were told the girls like radios, none of the women had them with them.

On Cedar IV, there was only a toy doggy and a music box. Very able residents were sleeping on benches. Similar observations were made on Cedar II, III, and Pine II.

(34) Why are residents not allowed more personal or unit possessions?

(35) What plan does the WSSH Administration have to increase the personal and unit possessions for residents?

Outside Play:

Between 4:00 and 4:15 there were five women in the play yard off Cedar IV. There was no one outside on Cedar I, II, III, or Pine II.

(36) Could there be a regularly scheduled period, on every good weather day, when residents are scheduled to get outside?

Interaction Among Residents:

On Cedar I, the only interaction among residents was one women pushing another in a wheelchair. On Cedar II, two children, playing, teasing, and talking were the only two residents interacting with each other.

On Cedar IV, young women very capable of interacting were sleeping or sitting on benches lined against the wall.

(37) How will play, group activity, and talking be encouraged and stimulated more than in the past?

Inspection:

Some team members have expressed concern that so many problems still exist uncorrected a year after our last visit. They also observed that these problems are visible by simple observation.

(38) Does the nursing supervisor visit each unit during their shift?

(39) Does the Director of Nursing inspect units frequently?

(40) Does the Superintendent inspect units frequently?

BN:cp
9/10/74