Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-03668-107

Combined Assessment Program Review of the VA Gulf Coast Veterans Health Care System Biloxi, Mississippi

February 29, 2012

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Glossary

BLS	Basic Life Support
CAP	Combined Assessment Program
CLC	community living center
COC	coordination of care
CRC	colorectal cancer
EOC	environment of care
facility	VA Gulf Coast Veterans Health Care System
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
HF	heart failure
MH	mental health
MSIT	Multidisciplinary Safety Inspection Team
OIG	Office of Inspector General
PR	peer review
PRRC	Psychosocial Rehabilitation and Recovery Center
QM	quality management
RME	reusable medical equipment
RRTP	residential rehabilitation treatment program
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the VA Gulf Coast Veterans Health Care System, Biloxi, MS

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of December 12, 2011.

Review Results: The review covered nine activities. We made no recommendations in the following activity:

- Psychosocial Rehabilitation and Recovery Centers

Recommendations: We made recommendations in the following eight activities:

Quality Management: Initiate and complete Focused Professional Practice Evaluations, and report results. Complete at least two preventive ethics improvement cycles each fiscal year. Ensure committee review of each resuscitation event. Oversee and coordinate the medical record quality review process, and enforce the Basic Life Support training policy.

Colorectal Cancer Screening: Notify patients of positive screening, diagnostic test, and biopsy results. Develop follow-up plans. Ensure patients with positive screening test results receive diagnostic testing. Follow local Tumor Board policy.

Environment of Care: Lock unoccupied rooms with hospital beds on locked units. Properly date multidose medication vials. Conduct and document monthly residential rehabilitation treatment program self-inspections.

Moderate Sedation: Include all required elements in pre-sedation assessment documentation.

Polytrauma: Assign Case Managers to polytrauma outpatients, and develop interdisciplinary team treatment plans. Maintain minimum staffing levels.

Medication Management: Screen patients for vaccinations, and administer them when indicated.

Coordination of Care: Address required elements in discharge instructions, and appropriately schedule follow-up appointments.

Follow-Up on Environment of Care Issues: Ensure that all required team members participate in environment of care rounds and that designated employees receive mental health environmental hazards training.

Comments

The Interim Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

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Objectives and Scope

Objectives

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following nine activities:

- COC
- CRC Screening
- EOC
- Follow-Up on EOC Issues
- Medication Management
- Moderate Sedation
- Polytrauma
- PRRCs
- QM

We have listed the general information reviewed for each of these activities. Some of the items listed might not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2010, FY 2011, and FY 2012 through December 12, 2011, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the VA Gulf Coast Veterans Health Care System, Biloxi, Mississippi,* Report No. 10-00052-10, October 19, 2010). (See Appendix B for further details.) The facility had corrected five of the seven findings.

During this review, we also presented crime awareness briefings for 202 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 226 responded. Survey results were shared with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Results

Review Activities With Recommendations

QM

The purpose of this review was to determine whether VHA facility senior managers actively supported and appropriately responded to QM efforts and whether VHA facilities complied with selected requirements within their QM programs.

We interviewed senior managers and QM personnel, and we evaluated meeting minutes, medical records, and other relevant documents. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	There was a senior-level committee/group responsible for QM/performance improvement, and it included all required members.
	There was evidence that inpatient evaluation data were discussed by senior managers.
	The protected PR process complied with selected requirements.
	Licensed independent practitioners' clinical privileges from other institutions were properly verified.
X	FPPEs for newly hired licensed independent providers complied with selected requirements.
	Staff who performed utilization management reviews met requirements and participated in daily interdisciplinary discussions.
	If cases were referred to a physician utilization management advisor for review, recommendations made were documented and followed.
X	There was an integrated ethics policy, and an appropriate annual evaluation and staff survey were completed.
	If ethics consultations were initiated, they were completed and appropriately documented.
X	There was a cardiopulmonary resuscitation review policy and process that complied with selected requirements.
	Data regarding resuscitation episodes were collected and analyzed, and actions taken to address identified problems were evaluated for effectiveness.
	If Medical Officers of the Day were responsible for responding to resuscitation codes during non-administrative hours, they had current Advanced Cardiac Life Support certification.
X	There was a medical record quality review committee, and the review process complied with selected requirements.
	If the evaluation/management coding compliance report contained failures/negative trends, actions taken to address identified problems were evaluated for effectiveness.
	Copy and paste function monitoring complied with selected requirements.
	The patient safety reporting mechanisms and incident analysis complied with policy.

Noncompliant	Areas Reviewed
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.
X	The facility complied with any additional elements required by local policy.

FPPEs. VHA requires that FPPEs be initiated and completed and that the results be reported to the Clinical Executive Board for consideration in making the recommendation on privileges for newly hired licensed independent practitioners.[1] We reviewed the profiles of 10 newly hired licensed independent practitioners. One of the 10 practitioners did not have an FPPE initiated, 4 FPPEs were not completed, and the results of 2 FPPEs were not reported to the Clinical Executive Board.

Integrated Ethics Improvement Cycles. VHA requires preventive ethics teams at each facility to perform, at a minimum, two improvement cycles each FY.[2] The facility had completed only one improvement cycle during FY 2011.

Resuscitation Event Review. VHA requires that facilities' cardiopulmonary resuscitation committees review each resuscitation event.[3] Although the facility's Critical Care Committee analyzed the aggregate data from resuscitation events, the individual review of each event was delegated to only two individual committee members.

Medical Record Review. VHA requires facilities' medical records committees to provide oversight and coordination of the medical record quality review process that includes all services and programs.[4] The Medical Records Committee did not provide oversight or coordination of the medical record quality review process. Although some medical record quality reviews had been completed, we found that major services, such as medicine and surgery, were not included.

BLS Training. Local policy requires that any employee required to have BLS training face consequences, such as assignment to a non-patient care area, if training is not current. The facility monitored the status of employees' BLS training and reported that compliance through December 2011 was 87 percent. However, there was no evidence that non-compliant employees faced the consequences described in the policy.

[1] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[2] Deputy Under Secretary for Health for Operations and Management, "Integrated Ethics Program Achievement: Goals and Reporting Requirements," memorandum, January 7, 2011.
[3] VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees,* October 17, 2008.
[4] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

Recommendations

1. We recommended that processes be strengthened to ensure that FPPEs are consistently initiated and completed and that results are reported to the Clinical Executive Board.

2. We recommended that processes be strengthened to ensure that at least two preventive ethics improvement cycles are completed each FY.

3. We recommended that processes be strengthened to ensure that the Critical Care Committee reviews each resuscitation event as well as the aggregate data.

4. We recommended that processes be strengthened to ensure that the Medical Records Committee provides oversight and coordination of the medical record quality review process and that all services and programs are included.

5. We recommended that processes be strengthened to ensure that employees required to have BLS training face consequences if training is not current.

CRC Screening

The purpose of this review was to follow up on a report, *Healthcare Inspection – Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (Report No. 05-00784-76, February 2, 2006) and to assess the effectiveness of VHA's CRC screening.

We reviewed the medical records of 20 patients who had positive CRC screening tests, and we interviewed key employees involved in CRC management. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
X	Patients were notified of positive CRC screening test results within the required timeframe.
X	Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe.
X	Patients received a diagnostic test within the required timeframe.
X	Patients were notified of the diagnostic test results within the required timeframe.
X	Patients who had biopsies were notified within the required timeframe.
	Patients were seen in surgery clinic within the required timeframe.
X	The facility complied with any additional elements required by local policy.

Positive CRC Screening Test Result Notification. VHA requires that patients receive notification of CRC screening test results within 14 days of the laboratory receipt date for fecal occult blood tests or the test date for sigmoidoscopy or double contrast barium enema and that clinicians document notification.[5] Seventeen patients' records did not contain documented evidence of timely notification.

Follow-Up in Response to Positive CRC Screening Test. For any positive CRC screening test, VHA requires responsible clinicians to either document a follow-up plan or document that no follow-up is indicated within 14 days of the screening test.[6] Four patients did not have a documented follow-up plan within the required timeframe.

Diagnostic Testing Timeliness. VHA requires that patients receive diagnostic testing within 60 days of positive CRC screening test results unless contraindicated.[7] Twenty patients received diagnostic testing; however, two of these patients requested repeat screening tests prior to diagnostic testing. Six of the remaining 18 patients did not have diagnostic testing completed within the required timeframe.

Diagnostic Test Result Notification. VHA requires that test results be communicated to patients no later than 14 days from the date on which the results are available to the

[5] VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007 (corrected copy).
[6] VHA Directive 2007-004.
[7] VHA Directive 2007-004.

ordering practitioner and that clinicians document notification.[8] Ten of the 20 patients who received diagnostic testing did not have documented evidence of timely notification in their medical records.

Biopsy Result Notification. VHA requires that patients who have a biopsy receive notification within 14 days of the date the biopsy results were confirmed and that clinicians document notification.[9] Of the 15 patients who had a biopsy, 5 records did not contain documented evidence of timely notification.

Tumor Board. Local policy requires that the Tumor Board review newly diagnosed cancer cases. Tumor Board minutes are to include attendance, cancer patient case files, and tumor classifications. The Tumor Board did not keep meeting minutes; therefore, we were unable to determine which cases were discussed.

Recommendations

6. We recommended that processes be strengthened to ensure that patients are notified of positive CRC screening test results within the required timeframe and that clinicians document notification.

7. We recommended that processes be strengthened to ensure that responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.

8. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

9. We recommended that processes be strengthened to ensure that patients are notified of diagnostic test results within the required timeframe and that clinicians document notification.

10. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

11. We recommended that processes be strengthened to ensure that the facility follows local policy for the Tumor Board.

[8] VHA Directive 2009-019, *Ordering and Reporting Test Results,* March 24, 2009.
[9] VHA Directive 2007-004.

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements and whether the facility's Substance Abuse/Post-Traumatic Stress Disorder RRTP was in compliance with selected MH RRTP requirements.

We inspected the medical-surgical, the intensive care, and the MH units; the CLC; a primary care, a multispecialty use, the polytrauma, and the dental clinics; the emergency department; the operating suite; and the Substance Abuse/Post-Traumatic Stress Disorder RRTP. Additionally, we reviewed facility policies, meeting minutes, training records, and other relevant documents, and we interviewed employees and managers. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed for EOC
	Patient care areas were clean.
	Fire safety requirements were properly addressed.
X	Environmental safety requirements were met.
	Infection prevention requirements were met.
X	Medications were secured and properly stored, and medication safety practices were in place.
	Sensitive patient information was protected.
	If the CLC had a resident animal program, facility policy addressed VHA requirements.
	Laser safety requirements in the operating room were properly addressed, and users received medical laser safety training.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for MH RRTP
	There was a policy that addressed safe medication management, contraband detection, and inspections.
X	MH RRTP inspections were conducted, included all required elements, and were documented.
	Actions were initiated when deficiencies were identified in the residential environment.
	Access points had keyless entry and closed circuit television monitoring.
	Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks.
	The facility complied with any additional elements required by local policy.

Environmental Safety. VA requires that rooms containing hospital beds on locked units be locked when not occupied.[10] On the locked MH unit, we found an unoccupied room that contained a hospital bed and had been left open.

Medication Safety. The Joint Commission requires that all stored medications be labeled with expiration dates. In the CLC, we found one open multidose vial without an

[10] VA National Center for Patient Safety, *Mental Health Environment of Care Checklist (MHEOCC),* http://vaww.ncps.med.va.gov, accessed December 19, 2011.

expiration date and two open multidose vials with illegible expiration dates stored with medications available for administration.

MH RRTP Inspections. VHA requires facilities to conduct and document monthly MH RRTP self-inspections that include safety, security, and privacy.[11] We found that self-inspections were not documented for 5 of the past 6 months.

Recommendations

12. We recommended that processes be strengthened to ensure that rooms containing hospital beds on locked units are locked when unoccupied.

13. We recommended that processes be strengthened to ensure that multidose medication vials are properly dated after opening.

14. We recommended that processes be strengthened to ensure that monthly MH RRTP self-inspections are conducted, include all required elements, and are documented.

[11] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.

Moderate Sedation

The purpose of this review was to determine whether the facility developed safe processes for the provision of moderate sedation that complied with applicable requirements.

We reviewed relevant documents, three medical records, and training/competency records, and we interviewed key individuals. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Staff completed competency-based education/training prior to assisting with or providing moderate sedation.
X	Pre-sedation documentation was complete.
	Informed consent was completed appropriately and performed prior to administration of sedation.
	Timeouts were appropriately conducted.
	Monitoring during and after the procedure was appropriate.
	Moderate sedation patients were appropriately discharged.
	The use of reversal agents in moderate sedation was monitored.
	If there were unexpected events/complications from moderate sedation procedures, the numbers were reported to an organization-wide venue.
	If there were complications from moderate sedation, the data was analyzed and benchmarked, and actions taken to address identified problems were implemented and evaluated.
	The facility complied with any additional elements required by local policy.

Pre-Sedation Assessment Documentation. VHA requires that providers document a complete history and physical examination and/or pre-sedation assessment within 30 days prior to a procedure where moderate sedation will be used.[12] None of the three patients' medical records included all required elements of the history and physical examination, such as a review of current medications and an airway assessment.

Recommendation

15. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

[12] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.

Polytrauma

The purpose of this review was to determine whether the facility complied with selected requirements related to screening, evaluation, and COC for patients affected by polytrauma.

We reviewed relevant documents, 10 medical records of patients with positive traumatic brain injury results, and training records, and we interviewed key staff. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	Providers communicated the results of the traumatic brain injury screening to patients and referred patients for comprehensive evaluations within the required timeframe.
	Providers performed timely, comprehensive evaluations of patients with positive screenings.
X	Case Managers were appropriately assigned to outpatients and provided frequent, timely communication.
X	Outpatients who needed interdisciplinary care had treatment plans developed that included all required elements.
X	Adequate services and staffing were available for the polytrauma care program.
	Employees involved in polytrauma care were properly trained.
	Case Managers provided frequent, timely communication with hospitalized polytrauma patients.
	The interdisciplinary team coordinated inpatient care planning and discharge planning.
	Patients and their family members received follow-up care instructions at the time of discharge from the inpatient unit.
	Polytrauma-Traumatic Brain Injury System of Care facilities provided an appropriate care environment.
	The facility complied with any additional elements required by local policy.

Outpatient Case Management. VHA requires that polytrauma outpatients who need interdisciplinary care have a Case Manager assigned and a specific interdisciplinary treatment plan developed.[13] The plan developed by the interdisciplinary team must address specific elements, including the skills needed to maximize independence and the recommended type of vocational rehabilitation. One of the 10 polytrauma outpatients did not have a Case Manager assigned. In addition, eight treatment plans did not contain all required elements.

Available Services and Staffing. VHA requires that specific services are available for polytrauma patients and that minimum staffing levels are maintained.[14] The facility did

[13] VHA Handbook 1172.04, *Physical Medicine and Rehabilitation Individualized Rehabilitation and Community Reintegration Care Plan*, May 3, 2010.
[14] VHA Directive 2009-028, *Polytrauma-Traumatic Brain Injury (TBI) System of Care*, June 9, 2009.

not have a rehabilitation nurse, physical therapist, occupational therapist, or speech pathologist available.

Recommendations

16. We recommended that processes be strengthened to ensure that Case Managers are appropriately assigned to polytrauma outpatients and that interdisciplinary teams develop treatment plans that contain all required elements.

17. We recommended that processes be strengthened to ensure that all required services are available to polytrauma outpatients and that minimum staffing levels are maintained.

Medication Management

The purpose of this review was to determine whether VHA facilities had properly provided selected vaccinations according to Centers for Disease Control and Prevention guidelines and VHA recommendations.

We reviewed a total of 20 medical records for evidence of screening and administration of pneumococcal vaccines to CLC residents and screening and administration of tetanus and shingles vaccines to CLC residents and primary care patients. We also reviewed documentation of selected vaccine administration requirements and interviewed key personnel.

The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
X	Staff screened patients for pneumococcal and tetanus vaccinations.
X	Staff properly administered pneumococcal and tetanus vaccinations.
	Staff properly documented vaccine administration.
	Vaccines were available for use.
	If applicable, staff provided vaccines as expected by the VISN.
	The facility complied with any additional elements required by local policy.

Vaccination Screening. Through its clinical reminders, VHA requires that clinicians screen patients for pneumococcal and tetanus vaccinations at key points, such as upon admission to a CLC and at clinic visits. Fourteen of 19 records lacked documentation of vaccination screening.

Vaccination Administration. The Centers for Disease Control and Prevention recommends that when indicated, clinicians administer pneumococcal and tetanus vaccinations. Sixteen of 19 records lacked documentation that indicated vaccinations had been administered.

Recommendations

18. We recommended that processes be strengthened to ensure that clinicians screen patients for pneumococcal and tetanus vaccinations upon admission and at clinic visits.

19. We recommended that processes be strengthened to ensure that clinicians administer pneumococcal and tetanus vaccinations when indicated.

COC

The purpose of this review was to determine whether patients with a primary discharge diagnosis of HF received adequate discharge planning and care "hand-off" and timely primary care or cardiology follow-up after discharge that included evaluation and documentation of HF management key components.

We reviewed 22 HF patients' medical records and relevant facility policies, and we interviewed employees. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	Medications in discharge instructions matched those ordered at discharge.
X	Discharge instructions addressed medications, diet, and the initial follow-up appointment.
X	Initial post-discharge follow-up appointments were scheduled within the providers' recommended timeframes.
	The facility complied with any additional elements required by local policy.

Discharge Instruction Components. VHA requires that discharge instructions address medications, diet, and the initial follow-up appointment.[15] Four records did not include one or more of the required components.

Follow-Up Appointments. VHA requires that discharge instructions include recommendations regarding the initial follow-up appointment.[16] Of the 16 patients whose providers requested specific follow-up timeframes, 3 appointments were not scheduled as requested.

Recommendations

20. We recommended that processes be strengthened to ensure that discharge instructions address medications, diet, and the initial follow-up appointment.

21. We recommended that processes be strengthened to ensure that follow-up appointments are consistently scheduled within the timeframes requested by providers.

[15] VHA Handbook 1907.01, *Health Information Management and Health Records,* August 25, 2006.
[16] VHA Handbook 1907.01.

Review Activity With Previous CAP Recommendations

Follow-Up on EOC Issues

As a follow-up to recommendations from our prior CAP review, we reassessed facility compliance with EOC rounds attendance and MH training.

EOC Rounds Attendance. VHA requires that weekly EOC rounds led by the Director or Associate Director include participation by managers in nursing, building management, engineering, and safety; representatives from patient safety and infection control; and others, as required.[17] The facility's Safety Officer is monitoring attendance compliance. We reviewed EOC rounds attendance for the previous 2 months and found that a representative from patient safety had not attended two of the six rounds.

MH Training. VHA requires employees of locked inpatient MH units and members of the MSIT to complete training on environmental hazards that represent a threat to suicidal patients.[18] This training should occur initially during orientation and annually thereafter. After our last CAP, all designated employees received this training. However, during our follow-up review, we found that 42 (70 percent) of 60 employees from the acute locked inpatient MH unit and members of the MSIT were not current with annual training.

Recommendations

22. We recommended that processes be strengthened to ensure that EOC rounds include participation by all required team members or their representatives.

23. We recommended processes be strengthened to ensure that acute locked inpatient MH unit employees and members of the MSIT receive annual training on environmental hazards that represent a threat to suicidal patients.

[17] Deputy Under Secretary for Health for Operations and Management, "Environmental Rounds," memorandum, March 5, 2007.
[18] VA National Center for Patient Safety, *Mental Health Environment of Care Checklist (MHEOCC).*

Review Activity Without Recommendations

PRRCs

The purpose of this review was to determine whether the facility had implemented a PRRC and whether VHA required programmatic and clinical elements were in place. VHA directed facilities to fully implement PRRCs by September 30, 2009, or to have a Deputy Under Secretary for Health for Operations and Management approved modification or exception. Facilities with missing PRRC programmatic or clinical elements must have an Office of MH Services' approved action plan or Deputy Under Secretary for Health for Operations and Management approved modification.

We reviewed facility policies and relevant documents, inspected the PRRC, and interviewed employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	A PRRC was implemented and was considered fully designated by the Office of MH Services, or the facility had an approved modification or exception.
	There was an established method for soliciting patient feedback, or the facility had an approved action plan or modification.
	The PRRC met space and therapeutic resource requirements, or the facility had an approved action plan or modification.
	PRRC staff provided required clinical services, or the facility had an approved action plan or modification.
	The facility complied with any additional elements required by local policy.

Comments

The Interim VISN Director and Facility Director agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 23–34, for the full text of the Directors' comments.) We consider Recommendation 12 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[19]		
Type of Organization	Tertiary care	
Complexity Level	2	
VISN	16	
Community Based Outpatient Clinics	Mobile, AL Pensacola, FL Eglin Air Force Base, FL Panama City, FL	
Veteran Population in Catchment Area	244,999	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial RRTP**	114	
• **CLC/Nursing Home Care Unit**	101	
• **Other**	N/A	
Medical School Affiliation(s)	81st Medical Group/Keesler Air Force Base Tulane University University of South Alabama	
• **Number of Residents**	108	
	Prior FY (2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$349	$327
• **Medical Care Expenditures**	$349	$327
Total Medical Care Full-Time Employee Equivalents	1,812.2	1,783.0
Workload:		
• **Number of Station Level Unique Patients**	60,756	59,592
• **Inpatient Days of Care:**		
o **Acute Care (RRTP)**	18,263	15,747
o **CLC/Nursing Home Care Unit**	30,001	28,682
o **RRTP**	11,546	5,715
Hospital Discharges (excludes RRTP and CLC/Nursing Home Care Unit)	2,163	2,323
Total Average Daily Census (including all bed types)	164	148
Cumulative Occupancy Rate (in percent)	76.3	74.7
Outpatient Visits	573,056	545,853

[19] All data provided by facility management.

Follow-Up on Previous Recommendations		
Recommendations	**Current Status of Corrective Actions Taken**	**Repeat Recommendation? Y/N**
QM		
1. Approve all PR extensions in writing as required.	Rates for the 120-day completion of PRs for FY 2010 have consistently exceeded 90 percent. Since February 2010, three PRs have required an extension. Letters were submitted to and approved by the Director.	N
2. Implement a local policy regarding the appropriate use and monitoring of copy and paste entries in medical records.	A local policy was published August 5, 2010. Routine monitoring began in May, and retrospective reviews were completed for all of FY 2011.	N
3. Implement a process to monitor BLS training compliance and ensure local policy includes consequences for not maintaining certification.	A revised BLS policy was published March 7, 2011. Evidence of monitoring compliance was provided.	N
EOC		
4. Date and initial multidose vials when opened.	There have been 10 multidose vial audits completed since November 2010. There were no findings in 9 of the 10 audits. The one finding was on November 22, 2010. Current compliance rate is 90 percent, which meets the established benchmark.	N
5. Include participation by all required team members or their representatives in EOC rounds.	Attendance compliance is monitored by the Safety Officer. Safety will continue to monitor participation until the established benchmark is met for all areas.	Y (see page 15)
6. Ensure that acute locked inpatient MH unit employees and members of the MSIT receive required training on environmental hazards that represent a threat to suicidal patients.	Not all employees assigned to the inpatient MH unit have completed the required training. Not all inspection team members have completed the training.	Y (see page 15)

Recommendations	Current Status of Corrective Actions Taken	Repeat Recommendation? Y/N
RME		
7. Report the results of monitoring RME processes quarterly to the Clinical Executive Board.	Quarterly reporting by the RME Committee to the Clinical Executive Board has been instituted. Monitoring of RME processes continues.	N

VHA Satisfaction Surveys

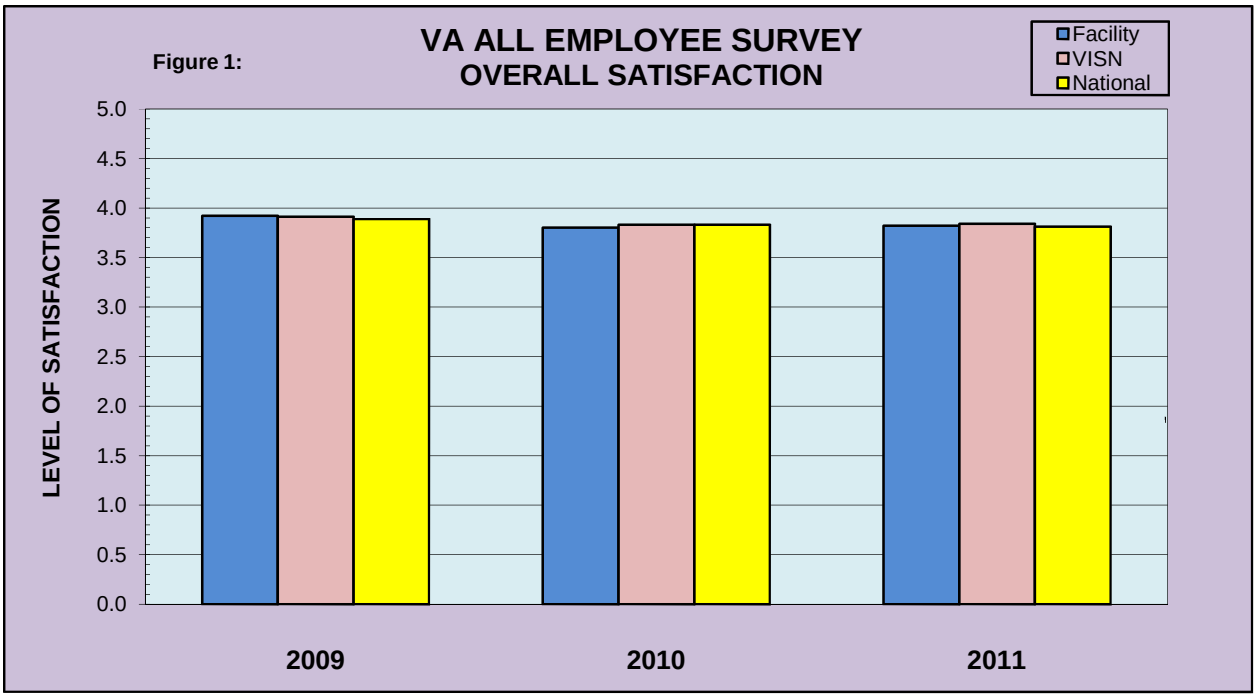
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient satisfaction scores and targets for quarters 3–4 of FY 2010 and quarters 1–2 of FY 2011 and overall outpatient satisfaction scores and targets for quarter 4 of FY 2010 and quarters 1–3 of FY 2011.

Table 1

	FY 2010		FY 2011			
	Inpatient Score Quarters 3–4	Outpatient Score Quarter 4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3
Facility	62.0	48.9	61.1	56.0	52.0	51.4
VISN	62.4	50.8	65.3	52.4	53.2	52.8
VHA	64.1	54.4	63.9	55.9	55.3	54.2

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[20] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2007, and June 30, 2010.[21]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	**	9.4	10.5	**	23.8	17.0
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

** The number of cases is too small (fewer than 25) to reliably tell how well the facility is performing.

[20] A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Congestive HF is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[21] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

Interim VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 13, 2012

From: Director, South Central VA Health Care Network (10N16)

Subject: **CAP Review of the VA Gulf Coast Veterans Health Care System, Biloxi, MS**

To: Director, Dallas Office of Healthcare Inspections (54DA)

Director, Management Review Service (VHA 10A4A4 Management Review)

Attached is the response to the CAP Draft Report for the VA Gulf Coast Veterans Health Care System, Biloxi, MS, conducted the week of December 12, 2011. As requested, the report includes an implementation plan showing specific corrective actions and target completion dates for each recommendation.

If you have questions, please contact Reba Moore, VISN 16 Accreditation Specialist, (601) 206-7022.

(original signed by:)
Michael R. Winn
Interim Director, South Central VA Health Care Network (10N16)

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 13, 2012

From: Director, VA Gulf Coast Veterans Health Care System (520/00)

Subject: **CAP Review of the VA Gulf Coast Veterans Health Care System, Biloxi, MS**

To: Director, South Central VA Health Care Network (10N16)

I concur with the recommendations of the draft CAP Review conducted during the week of December 12, 2011.

Attached is the action plan addressing the recommendations.

Thomas Wisnieski, MPA FACHE
Director, VA Gulf Coast Veterans Health Care System (520/00)

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that FPPEs are consistently initiated and completed and that results are reported to the Clinical Executive Board.

Concur

Target date for completion: June 30, 2012

All Focused Periodic Performance Evaluations (FPPEs) for applicable Licensed Independent Practitioners (e.g., newly hired, those requesting new privileges, those with clinical practice issues) are to be submitted by the identified Service Chief prior to the Committee convening. The FPPEs will then be reviewed for thoroughness, completion and accuracy by staff of the Professional Credential's Office and Quality & Performance Management. Inadequate or incomplete FPPEs will be returned to the Service Chief for modification prior to presentation. Acceptable FPPEs will be presented to the Committee by the Service Chief and captured in Committee minutes. Results of the FPPEs, which are now a part of the Credentials Committee record, will then be reported to Clinical Executive Board. The minutes of the Clinical Executive Board will reflect the FPPE information as reported by the Credentials Committee.

To ensure compliance, data will be compiled monthly by Quality & Performance Management staff and presented to the Quality & Performance Management Board. The monitor will continue until three consecutive months of compliance is demonstrated with the above process.

Recommendation 2. We recommended that processes be strengthened to ensure that at least two preventive ethics improvement cycles are completed each FY.

Concur

Target date for completion: September 30, 2012

The Integrated Ethics Chair and the Preventative Ethics Coordinator will review the process for completing issue cycles and the required timeline. The progress of both required issue cycles will be tracked monthly in the Integrated Ethics Committee to assure they are completed prior to the end of the fiscal year.

Recommendation 3. We recommended that processes be strengthened to ensure that the Critical Care Committee reviews each resuscitation event as well as the aggregate data.

Concur

Target date for completion: July 31, 2012

A subcommittee of the Critical Care Committee will be established specifically to review each resuscitation event that occurs at the healthcare facility. This subcommittee will meet on a monthly basis and will be comprised of staff from various disciplines (e.g., Nursing, Medicine, Respiratory, and Education) that are also represented on the Critical Care Committee. After their review of individual episodes is completed, the subcommittee will summarize their findings and report to the full Critical Care Committee. Members of the Critical Care Committee will be provided both individual and aggregate data for review and discussion. This information will be recorded in Committee minutes.

To ensure compliance, minutes of the Critical Care Committee will be monitored by Quality & Performance Management until three consecutive months reflect the improved reporting process.

Recommendation 4. We recommended that processes be strengthened to ensure that the Medical Records Committee provides oversight and coordination of the medical record quality review process and that all services and programs are included.

Concur

Target date for completion: August 31, 2012

The current quality review process is under review by members of the Medical Records Committee, Risk Management, and Quality & Performance Management. The quality reviews that are currently being completed by such services as Physical Medicine and Rehabilitation and Nursing will continue to be completed but the outcomes will now be reported to the Medical Records Committee instead of the Peer Review Committee. In addition, all other services will be included.

To ensure compliance, minutes of the Medical Records Committee will be monitored by Quality & Performance Management until three consecutive months of minutes reflect the improved reporting process.

Recommendation 5. We recommended that processes be strengthened to ensure that employees required to have BLS training face consequences if training is not current.

Concur

Target date for completion: August 31, 2012

The current station memorandum on BLS training will be revised to strengthen the language associated with consequences employees are to face when they do not maintain a current certification for the required training. Education on the new memorandum will be provided to Service Chiefs, supervisory staff and affected front line employees. Non-compliant employees will face appropriate disciplinary action as outlined in the new policy. Training compliance will be tracked utilizing Talent Management System (TMS) and disciplinary actions will be tracked by Human Resources Management Service. Quality & Performance Management will provide a summary report to the Critical Care Committee on a quarterly basis.

To ensure compliance, training rates and associated disciplinary actions will be tracked by Quality & Performance Management until three consecutive months of compliance is achieved.

Recommendation 6. We recommended that processes be strengthened to ensure that patients are notified of positive CRC screening test results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: August 31, 2012

A previously chartered System Redesign team will reconvene to review the recommendations made for improving CRC processes that were made last year. As needed, the interdisciplinary team will modify and expand it's scope to assure that all required elements of the CRC process (including those that cross service/discipline lines – Medicine, Medical Administration, Primary Care, Surgery) have been addressed in the redesign. This includes CRC screening, patient notification, provider documentation, the development of plans for follow-up, required diagnostic testing, communication of testing results, and biopsy completion and notification. The Team will review required elements with the services and service providers to implement improved processes. Required elements will be tracked until fully implemented.

To ensure compliance, the System Redesign Team will facilitate the development of a monitor to track the implemented CRC processes that meet the required standards of care. Thirty outpatient charts will be audited each month. The monitor will continue until there are three consecutive months of demonstrated compliance.

Recommendation 7. We recommended that processes be strengthened to ensure that responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.

Concur

Target date for completion: August 31, 2012

A previously chartered System Redesign team will reconvene to review the recommendations made for improving CRC processes that were made last year. As

needed, the interdisciplinary team will modify and expand its scope to assure that all required elements of the CRC process (including those that cross service/discipline lines – Medicine, Medical Administration, Primary Care, Surgery) have been addressed in the redesign. This includes CRC screening, patient notification, provider documentation, the development of plans for follow-up, required diagnostic testing, communication of testing results, and biopsy completion and notification. The Team will review required elements with the services and service providers to implement improved processes. Required elements will be tracked until fully implemented.

To ensure compliance, the System Redesign Team will facilitate the development of a monitor to track the implemented CRC processes that meet the required standards of care. Thirty outpatient charts will be audited each month. The monitor will continue until there are three consecutive months of demonstrated compliance.

Recommendation 8. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

Concur

Target date for completion: August 31, 2012

A previously chartered System Redesign team will reconvene to review the recommendations made for improving CRC processes that were made last year. As needed, the interdisciplinary team will modify and expand its scope to assure that all required elements of the CRC process (including those that cross service/discipline lines – Medicine, Medical Administration, Primary Care, Surgery) have been addressed in the redesign. This includes CRC screening, patient notification, provider documentation, the development of plans for follow-up, required diagnostic testing, communication of testing results, and biopsy completion and notification. The Team will review required elements with the services and service providers to implement improved processes. Required elements will be tracked until fully implemented.

To ensure compliance, the System Redesign Team will facilitate the development of a monitor to track the implemented CRC processes that meet the required standards of care. Thirty outpatient charts will be audited each month. The monitor will continue until there are three consecutive months of demonstrated compliance.

Recommendation 9. We recommended that processes be strengthened to ensure that patients are notified of diagnostic test results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: August 31, 2012

A previously chartered System Redesign team will reconvene to review the recommendations made for improving CRC processes that were made last year. As

needed, the interdisciplinary team will modify and expand its scope to assure that all required elements of the CRC process (including those that cross service/discipline lines – Medicine, Medical Administration, Primary Care, Surgery) have been addressed in the redesign. This includes CRC screening, patient notification, provider documentation, the development of plans for follow-up, required diagnostic testing, communication of testing results, and biopsy completion and notification. The Team will review required elements with the services and service providers to implement improved processes. Required elements will be tracked until fully implemented.

To ensure compliance, the System Redesign Team will facilitate the development of a monitor to track the implemented CRC processes that meet the required standards of care. Thirty outpatient charts will be audited each month. The monitor will continue until there are three consecutive months of demonstrated compliance.

Recommendation 10. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: August 31, 2012

A previously chartered System Redesign team will reconvene to review the recommendations made for improving CRC processes that were made last year. As needed, the interdisciplinary team will modify and expand its scope to assure that all required elements of the CRC process (including those that cross service/discipline lines – Medicine, Medical Administration, Primary Care, Surgery) have been addressed in the redesign. This includes CRC screening, patient notification, provider documentation, the development of plans for follow-up, required diagnostic testing, communication of testing results, and biopsy completion and notification. The Team will review required elements with the services and service providers to implement improved processes. Required elements will be tracked until fully implemented.

To ensure compliance, the System Redesign Team will facilitate the development of a monitor to track the implemented CRC processes that meet the required standards of care. Thirty outpatient charts will be audited each month. The monitor will continue until there are three consecutive months of demonstrated compliance.

Recommendation 11. We recommended that processes be strengthened to ensure that the facility follows local policy for the Tumor Board.

Concur

Target date for completion: September 30, 2012

Tumor Board composition, processes and functions are currently under review by Medicine and Quality & Performance Management. Once the review is completed, functions of the Board will meet the established guidelines of the local policy or a new

policy will be drafted. Documentation of Board activities will be maintained with clearly defined topics and cases discussed for action and/or review.

To ensure compliance, documentation of Board activities and discussions will be submitted to Quality & Performance Management for review and comparison against station policy. Unacceptable documentation or documentation that lacks clarity, definition or purpose of work will be returned to the Board for further enhancement. The monitor will continue until the Board provides acceptable documentation of activities for three consecutive months.

Recommendation 12. We recommended that processes be strengthened to ensure that rooms containing hospital beds on locked units are locked when unoccupied.

Concur

Target date for completion: Completed

The hospital bed has been removed from the unit. Prior to its removal, all unit staff had been educated on safety and security measures pertaining to unlocked doors to unoccupied rooms containing hospital equipment on the locked unit. Staff is fully aware that if the bed were to be returned to the unit for patient use, the door to the patient care room is to be locked when unoccupied and remain locked until the time the room requires usage by the patient. Once the patient exits the room, the door is to be immediately locked by unit staff.

Recommendation 13. We recommended that processes be strengthened to ensure that multidose medication vials are properly dated after opening.

Concur

Target date for completion: July 31, 2012

Nursing Service and Pharmacy Service have received education on the proper usage and labeling of multi-dose vials. To improve compliance with dating and disposal practices, date labels have been purchased for staff use and 28-day calendars have been placed in medication rooms. In addition, multi-dose vials are inspected for appropriate labeling and dating during Environment of Care rounds.

To ensure compliance, a monitor has been developed for usage during the inspection of areas currently utilizing multi-dose vials. Monitor results are collected by Quality & Performance Management and shared with staff and appropriate leadership. The monitor will continue until there are three consecutive months of demonstrated compliance.

Recommendation 14. We recommended that processes be strengthened to ensure that monthly MH RRTP self-inspections are conducted, include all required elements, and are documented.

Concur

Target date for completion: July 30, 2012

The Clinical Coordinator, MH PRRTP has established a monthly self-inspection tool for the residential program. The tool will be used by staff in making rounds to assess the safety/security of the unit and to comply with the VHA directive.

To ensure compliance, the Clinical Coordinator, MH PRRTP will submit the results of the self-inspection monitor to Quality & Performance Management for review upon completion. The monitor will continue until there are three consecutive months of demonstrated compliance.

Recommendation 15. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

Concur

Target date for completion: July 31, 2012

The documentation tool utilized by Anesthesiology/Surgery Service has been modified to include all required elements of the pre-sedation assessment. Staff have been educated on the modification and required documentation.

To ensure compliance with the directive, Anesthesiology/Surgery Service will establish a monitor and randomly audit 30 charts a month for adherence to assessment practices. Audit results will be provided to Quality & Performance Management. The monitor will continue until there are three consecutive months of demonstrated compliance.

Recommendation 16. We recommended that processes be strengthened to ensure that Case Managers are appropriately assigned to polytrauma outpatients and that interdisciplinary teams develop treatment plans that contain all required elements.

Concur

Target date for completion: July 31, 2012

The Polytrauma Clinic Team has reviewed their practice of enrollee assignments to case management. The program social worker is now appropriately added to patient progress notes and picks them up for case management at that time. Currently, all program participants are under case management. A case management/enrollee list has been provided to Quality & Performance Management to demonstrate compliance.

Treatment plans are currently being revised to reflect the interdisciplinary care and required elements of the VHA directive. Once the revisions have been completed, the new plans will be implemented.

To ensure compliance with treatment planning, 15 treatment plans will be audited each month by the Program Manager. All plans are to contain the required elements as outlined in the directive and reflect interdisciplinary involvement in patient care. Audit results will be provided to Quality & Performance Management. The monitor will continue until there are three consecutive months of demonstrated compliance.

Recommendation 17. We recommended that processes be strengthened to ensure that all required services are available to polytrauma outpatients and that minimum staffing levels are maintained.

Concur

Target date for completion: September 30, 2012

The Polytrauma Clinic Team has reviewed their staffing mix and other disciplines are being added in accordance with the VHA directive. Speech, Occupational Therapy and Physical Therapy are now a part of the program. In addition, a rehabilitation nurse vacancy has been announced and Nursing Service is preparing to interview a list of candidates to fill this position.

To demonstrate that an appropriate staffing mix has been established for the Team, a staffing list will be provided to Quality & Performance Management. The list will reflect a staffing level that meets the guidance outlined in the VHA directive. This item will remain open until all required staff positions are filled.

Recommendation 18. We recommended that processes be strengthened to ensure that clinicians screen patients for pneumococcal and tetanus vaccinations upon admission and at clinic visits.

Concur

Target date for completion: September 30, 2012

The clinical reminder for pneumococcal and tetanus vaccinations will be utilized to screen patients admitted to the acute care unit and those who present for clinic visits in Primary Care.

To ensure compliance, Quality & Performance Management will randomly select 30 charts a month for an audit of documented pneumococcal and tetanus vaccination screening opportunities. The monitor will continue until there are three consecutive months of demonstrated compliance.

Recommendation 19. We recommended that processes be strengthened to ensure that clinicians administer pneumococcal and tetanus vaccinations when indicated.

Concur

Target date for completion: September 30, 2012

The clinical reminder for pneumococcal and tetanus vaccinations will be utilized to screen patients admitted to the acute care unit and those who present for clinic visits in Primary Care. Appropriate candidates for vaccination will be identified and vaccinations administered accordingly.

To ensure compliance, Quality & Performance Management will randomly select 30 charts a month for an audit of appropriately administered vaccinations. The monitor will continue until there are three consecutive months of demonstrated compliance.

Recommendation 20. We recommended that processes be strengthened to ensure that discharge instructions address medications, diet, and the initial follow-up appointment.

Concur

Target date for completion: September 30, 2012

A workgroup is currently reviewing discharge instructions written by inpatient providers on the acute care unit for thoroughness and communicated expectations (e.g., physical restrictions and outpatient diet). Feedback from the group's work will be provided to the appropriate Service Chiefs (e.g., Medicine, Surgery) to improve documentation practices.

To ensure compliance, Quality & Performance Management will randomly select 20 charts a month for an audit of discharge instructions. The monitor will continue until there are three consecutive months of demonstrated compliance in provider documentation of discharge medications, diet and initial plans for a follow-up appointment.

Recommendation 21. We recommended that processes be strengthened to ensure that follow-up appointments are consistently scheduled within the timeframes requested by providers.

Concur

Target date for completion: September 30, 2012

A workgroup is currently reviewing discharge instructions written by inpatient providers on the acute care unit for thoroughness and communicated expectations (e.g., physical restrictions and outpatient diet). In addition, the team is reviewing the timeframes for follow-up appointments to determine if the appointments are scheduled within the

timeframe requested by the provider. Feedback from the group's work will be provided to the appropriate Service Chiefs (e.g., Medicine, Surgery, Medical Administration Service) to improve scheduling practices as needed.

To ensure compliance, Quality & Performance Management will randomly select 20 charts a month for an audit of discharge instructions and the scheduling of follow-up appointments. The monitor will continue until there are three consecutive months of demonstrated compliance with provider orders for the scheduling of appointments.

Recommendation 22. We recommended that processes be strengthened to ensure that EOC rounds include participation by all required team members or their representatives.

Concur

Target date for completion: May 30, 2012

A rounds schedule is utilized by the Safety Office in scheduling Environment of Care rounds in the health care system. All team members have a copy of the schedule to facilitate their participation. If a required team member is not available, a designee or representative is allowed to stand in.

To ensure compliance, participation by the required team member or their designee will be tracked and reported to the Environment of Care Committee. The monitor will continue until there are three consecutive months of demonstrated compliance.

Recommendation 23. We recommended processes be strengthened to ensure that acute locked inpatient MH unit employees and members of the MSIT receive annual training on environmental hazards that represent a threat to suicidal patients.

Concur

Target date for completion: May 30, 2012

A tracking list of all employees assigned to the inpatient mental health unit has been created. Each employee's training date has been recorded and training is current at this time.

To ensure continued compliance, training dates will be monitored by Patient Safety and Quality & Performance Management. Results will be reported to the Environment of Care Committee. The monitor will continue until there are three consecutive months of demonstrated compliance.

OIG Contact and Staff Acknowledgments

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