Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-00001-134

Combined Assessment Program Review of the Kansas City VA Medical Center Kansas City, Missouri

May 29, 2008

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 fraud and integrity awareness training 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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Executive Summary

Introduction

During the week of April 7–11, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the Kansas City VA Medical Center (the medical center), Kansas City, MO. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 206 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 15.

Results of the Review

The CAP review covered five operational activities. We identified the following organizational strengths and reported accomplishments:

- Safety Reporting System.
- Colorectal Cancer Screening Process Improvements.

We made recommendations in three of the activities reviewed. For these activities, the medical center needed to:

- Ensure that clinicians complete peer reviews within required timeframes.
- Fit the outpatient controlled substances storage cabinet with an electronic access system.
- Perform weekly inventories of automated medication dispensing machines.
- Secure access to supplies, medications, utilities, and medical records and limit access to outside contaminants.
- Ensure that all designated environment of care (EOC) team members participate in all EOC rounds and that all community based outpatient clinics (CBOCs) are inspected semi-annually.
- Ensure that all locked inpatient psychiatric unit staff receive training on environmental hazards that pose a threat to suicidal patients.

The medical center complied with selected standards in the following two activities:

- Business Rules.
- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Virginia L. Solana, Director, and Jennifer Kubiak, Healthcare Inspector, Kansas City Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations. (See Appendixes A and B, pages 14–18, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Profile

Organization. Located in Kansas City, MO, the medical center is a tertiary care facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five CBOCs in Belton, Cameron, Nevada, and Warrensburg, MO, and in Paola, KS. The medical center is part of VISN 15 and serves a veteran population of approximately 230,000 throughout 37 counties in Missouri and Kansas.

Programs. The medical center provides medical, surgical, mental health, and advanced rehabilitation services. It has 157 hospital beds and operates several regional referral and treatment programs, including substance abuse, geriatric care, oncology, vascular, and infectious diseases. The medical center does not have a nursing home care unit.

Affiliations and Research. The medical center is affiliated with the University of Kansas' School of Medicine and the University of Missouri-Kansas City's School of Medicine and has 86 medical resident training positions. The medical center also has approximately 40 other health care affiliations for other disciplines, including nursing, pharmacy, and optometry. In fiscal year (FY) 2007, the medical center research program had 154 active projects and a budget of approximately $3.1 million. Important areas of research include cardiovascular diseases, cancer (prostate, breast, and gastric), osteoporosis and other bone disorders, and the award winning blindness and other visual disorders program.

Resources. In FY 2007, the medical care budget was $195.1 million. FY 2007 staffing was 1,172 full-time employee equivalents (FTE), including 91 physician and 295 nursing FTE.

Workload. In FY 2007, the medical center treated 40,985 unique patients, and the inpatient workload totaled 5,927 discharges. The average daily census was 121, and the outpatient workload totaled 420,195 visits.

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 fraud and integrity awareness training 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 work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following five activities:

- Business Rules.
- EOC.
- Pharmacy Operations.
- QM.
- SHEP.

The review covered medical center operations for FY 2007 and FY 2008 through March 31, 2008, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the VA Medical Center, Kansas City, Missouri,* Report No. 05-01654-69, February 1, 2006). The medical center had corrected all findings related to health care from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 206 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.

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. Activities in the "Review Activities Without Recommendations" section have no reportable findings.

Organizational Strengths

Safety Reporting System

To improve reporting of safety concerns, the medical center initiated an intranet site for reporting concerns straight to the Director. Staff submit their concerns using an intranet template and may remain anonymous. QM reports concerns daily in the senior management morning meeting. Each concern is assigned to appropriate leadership staff for immediate review and action. Feedback is posted online as actions are taken. All medical center staff have access to the intranet site and can view the safety concerns and responses. Monetary or other types of rewards/recognition are considered for staff based upon the significance of the submission.

Colorectal Cancer Screening Process Improvements

The medical center has implemented a Drop-In Group Medical Appointment (DIGMA) for patient education to target no-show rates for colorectal cancer screening appointments. The goal of the clinic is to provide average risk patients with a thorough and broad based education of the available screening options. Since patients are involved with choosing the screening procedure, they are more likely to keep their appointment for the procedure. Clinic staff call patients 1 week prior to the colonoscopy to remind them of their appointment and answer any questions. Since initiating the DIGMA in February 2007, the no-show rates for colonoscopies have been less than one percent.

To reduce the number of repeat colonoscopies due to inadequate bowel preparation, gastroenterology technicians check patients prior to the colonoscopy. If the bowel preparation is inadequate, additional medication is administered, and the patient is scheduled later the same day. The national average repeat colonoscopy rate due to inadequate bowel preparation is 25–30 percent. The medical center repeat rate is now less than 1 percent.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to determine whether the medical center's QM program provided comprehensive oversight of the quality of care and whether senior managers supported the program's activities. We interviewed the medical center's senior management team and QM personnel. We evaluated plans, policies, and other relevant documents.

The QM program was generally effective in providing oversight of the medical center's quality of care, and senior managers supported the program. Appropriate review structures were in place for 14 of 15 program activities reviewed. However, we identified one area that needed improvement.

Peer Review. The peer review process did not meet Veterans Health Administration (VHA) timeliness requirements.[1] Peer review is a protected, non-punitive, medical center process to evaluate the quality of care at the provider level. The peer review process includes an initial review by a peer of the same discipline to determine if most experienced, competent practitioners would have managed the case in a similar fashion or if most experienced, competent providers would have managed one or more aspects of the care differently.

The initial review must be completed within 45 days from the determination that a review is necessary. Once this is completed, the peer review is then forwarded to a multidisciplinary peer review committee for validation of, or changes to, the initial findings. Final reviews are to be completed within 120 days from the determination that a review was needed. The results are then shared with the involved provider in order to give feedback about his or her practice.

The FY 2007 peer review annual summary documented that 15 percent of reviews did not meet the 120-day final completion time requirement. Ten percent of reviews completed in the 1st quarter of FY 2008 did not meet the time requirement. Peer review can result in immediate and

[1] VHA Directive 2004-054, *Peer Review for Quality Management*, September 29, 2004.

long-term improvements in patient care by revealing areas for improvements in individual providers' practices. When peer review feedback is delayed, opportunities to improve practice can be missed.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that clinicians complete all peer reviews within the required timeframes.

The VISN and Medical Center Directors concurred with our findings and recommendation. QM staff have implemented a process that reinforces time requirements, and they will continue to track peer review completion. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Pharmacy Operations

The purpose of this review was to evaluate whether the medical center had adequate controls to ensure the security and proper management of controlled substances and the pharmacies' internal physical environments. We also assessed whether clinical pharmacists had processes in place to monitor patients for polypharmacy, especially in vulnerable populations.

We assessed whether the medical center's policies and practices were consistent with VHA regulations governing pharmacy and controlled substances security.[2] We inspected inpatient and outpatient pharmacies for security, EOC, and infection control (IC) concerns. We interviewed the Controlled Substances Coordinator, the Alternate Controlled Substances Coordinator, and appropriate Pharmacy Service personnel.

Pharmacy Controls. Our review showed that managers needed to improve procedures to ensure the security of controlled substances by electronically tracking employee access to an outpatient storage cabinet and by requiring nurses to complete weekly inventories.

Although the medical center had appropriate policies and procedures to ensure the security of the pharmacies and of controlled substances in the main vaults in the outpatient and inpatient pharmacies, an additional outpatient storage

[2] VHA Handbook 1108.1, *Controlled Substances (Pharmacy Stock),* October 4, 2004; VHA Handbook 1108.2, *Inspection of Controlled Substances*, August 29, 2003; VHA Handbook 1108.5, *Outpatient Pharmacy*, May 30, 2006; VHA Handbook 1108.6, *Inpatient Pharmacy*, June 27, 2006.

cabinet located in the outpatient pharmacy did not comply with VHA regulations. VHA requires that all outpatient controlled substances awaiting patient pickup must be stored in a locked area or a cabinet with electronic access and that documentation of access must be maintained. After prescriptions for outpatient controlled substances are dispensed from the main vault in the outpatient pharmacy, they are transferred to a cabinet in the pharmacy until patient pickup. Although the cabinet is locked, and keys are secured, the cabinet is not controlled by the same electronic security system as the other controlled substances storage areas in the pharmacy. The electronic system consists of a card reader and keypad with unique security codes for each pharmacy employee. This system tracks individual access. Safeguarding and monitoring access to all controlled substances storage is necessary to prevent diversion of pharmaceuticals.

We determined that controlled substances inspections were conducted according to VHA regulations. Training records showed that the Controlled Substances Coordinator and inspectors received appropriate training to execute their duties. Monthly summaries of inspection results were submitted to senior managers. However, the last 6 months of these reports noted that nursing personnel did not consistently perform weekly inventories of automated medication dispensing machines. VHA requires that nurses conduct weekly inventories to verify that the pharmacy has accurately filled the machines.

We determined that managers reported all controlled substance diversions or suspected diversions to the OIG. The pharmacies' internal environments were secure, clean, and well maintained. However, we did note an IC concern. After use in patient care areas, nursing personnel returned emergency resuscitation carts to the inpatient pharmacy. Pharmacy personnel removed any medications prior to transferring the carts to Supply, Processing, and Distribution (SPD) for final cleaning. This process introduced contaminated articles into the clean pharmacy environment. A multidisciplinary group met while we were onsite and revised the policy and procedures so that only medications are returned to the pharmacy after resuscitation events. The carts are now taken directly to SPD.

Polypharmacy. Pharmacological regimens involving multiple medications are often necessary to prevent and maintain

disease states; however, excessive use of medications can result in adverse reactions and increased risks of complications. Polypharmacy is more complex than just the number of drugs that patients are prescribed. The clinical criteria to identify polypharmacy are the use of: (a) medications that have no apparent indication, (b) therapeutic equivalents to treat the same illness, (c) medications that interact with other prescribed drugs, (d) inappropriate medication dosages, and (e) medications to treat adverse drug reactions.[3] Some literature suggests that elderly patients and mental health patients are among the most vulnerable populations for polypharmacy.[4]

Our review showed that managers had developed effective processes to ensure that clinical pharmacists reviewed all patients' medication regimens to avoid polypharmacy and advised providers as appropriate.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that the outpatient controlled substances storage cabinet be fitted with an electronic access system.

The VISN and Medical Center Directors concurred with our finding and recommendation. An outside contractor is building a new storage cabinet that will have an electronic monitoring system tied into the existing pharmacy security system. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director enforces the requirement that nurses perform weekly inventories of the automated medication dispensing machines.

The VISN and Medical Center Directors concurred with our finding and recommendation. Nursing Service has initiated weekly checks of the dispensing machines, and pharmacy personnel conduct weekly oversight reviews to ensure compliance. We find this action plan appropriate and

[3] Yvette C. Terrie, BSPharm, RPh, "Understanding and Managing Polypharmacy in the Elderly," *Pharmacy Times,* December 2004.
[4] Terrie, *Pharmacy Times*, December 2004; Vijayalakshmy Patrick, M.D., et al., "Best Practices: An Initiative to Curtail the Use of Antipsychotic Polypharmacy in a State Psychiatric Hospital," *Psychiatric Services*, 57:21–23, January 2006.

will follow up on reported implementation actions to ensure completion.

Environment of Care

The purpose of this review was to determine whether the medical center complied with selected IC standards and maintained a clean and safe health care environment. Medical centers are required to provide a comprehensive EOC program that fully meets VHA National Center for Patient Safety, Occupational Safety and Health Administration (OSHA), and Joint Commission standards.

We evaluated the IC program to determine compliance with VHA directives that require management to collect and analyze data to improve performance. IC staff appropriately monitored, trended, analyzed, and reported infection data to clinicians for implementation of quality improvements to reduce infection risks for patients and staff.

We conducted onsite inspections of ambulatory care areas, inpatient units, intensive care units, the dialysis unit, and the radiology area. We inspected the locked inpatient psychiatric unit to determine if managers identified environmental hazards that pose a threat to suicidal patients. We also reviewed documentation to ensure that all required staff received training on identifying these hazards. Medical center managers conducted quarterly mental health EOC assessments for the locked unit, as required by VHA. We confirmed that the medical center had identified environmental vulnerabilities, and managers told us that the unit is scheduled for a renovation project that will correct the deficiencies.

The medical center maintained a generally clean and safe environment, and managers were responsive to identified environmental concerns. Nurse managers expressed high satisfaction with the responsiveness of housekeeping staff on their units. However, we identified three areas that needed improvement.

Security, Safety, and Privacy Issues. During our inspection, we found multiple doors equipped with automatic locking mechanisms that could be opened without using a key or entering an access code. The doors were entrances to supply storage rooms, medication rooms, and a utility room. The rooms contained supplies, medications, and access to utilities and needed to be secured to prevent theft or injury.

We found an unlocked medication cart even though medical center policy requires that medication carts be secured when not in use. Open access to the cart could result in theft or in injury to patients and visitors.

We found an open window on one of the inpatient units, which could allow contaminants to enter from the outside. Staff told us that windows are to be closed and locked at all times and are designed to be opened only with a specialized tool. There were multiple windows on the inpatient units that could be opened manually.

We were able to open a wall-mounted cabinet used to store an individual patient's paper medical information even though the cabinet was equipped with an integrated locking device. The Health Insurance Portability and Accountability Act of 1996 requires that patient health information be protected from unauthorized disclosure.

Environment of Care Rounds. Attendance at weekly EOC rounds by required staff varied. EOC rounds by the medical center inspection team allow management-level staff to identify and correct sanitation discrepancies, unsafe working conditions, and OSHA regulatory violations. Also, semi-annual inspections of the CBOCs were not consistently conducted. According to local policy, the inspection team, with representation from all required disciplines, is to conduct semi-annual inspections of all CBOCs.

Locked Inpatient Psychiatric Unit Training. Some staff members working on the locked inpatient psychiatric unit did not receive training on identifying and correcting environmental hazards. The medical center provided us with information that 7 of 44 unit staff had not received this training. A memorandum issued on August 27, 2007, by the Deputy Under Secretary for Health for Operations and Management requires that all staff who work on locked inpatient psychiatric units and staff who participate in EOC safety rounds receive training on environmental hazards that pose a threat to suicidal patients.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires staff to secure access to supplies, medications, utilities, and medical records and to limit access to outside contaminants.

The VISN and Medical Center Directors concurred with our findings and recommendation. The medical center repaired or replaced malfunctioning locks. Windows are now locked to prevent outside contaminants. The security issues will be included in semi-annual inspections and the preventive maintenance schedule. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires that all designated EOC team members participate in all EOC rounds and that all CBOCs are inspected semi-annually.

The VISN and Medical Center Directors concurred with our findings and recommendation. Managers modified the EOC rounds policy to include the requirements that all designated EOC team members or their alternates participate in all rounds and that all offsite patient treatment locations are inspected semi-annually. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires that all locked inpatient psychiatric unit staff receive training on environmental hazards that pose a threat to suicidal patients.

The VISN and Medical Center Directors concurred with our finding and recommendation. The medical center submitted training record documentation showing that mental health employees on the locked inpatient psychiatric unit have completed the required training. Therefore, we consider this recommendation closed.

Review Activities Without Recommendations

Business Rules

The purpose of this review was to determine whether business rules governing the computerized patient record system (CPRS) comply with VHA policy. CPRS business rules define what functions certain groups or individuals are allowed to perform in the health record.

The health record includes the combined electronic and paper medical record and is also known as the legal health

record.[5] It includes items, such as physician orders, chart notes, examinations, and test reports. Once notes are signed, they must be kept in unaltered form. New information, corrections, or different interpretations, may be added as further entries to the record, as addenda to the original notes, or as new notes—all accurately reflecting the times and dates recorded.

On October 20, 2004, VHA's Office of Information (OI) provided guidance that advised VHA facility managers to review their business rules and delete any rules that allowed editing of signed medical records. In accordance with this guidance, OI has recommended that any editing of signed records be limited to a facility's Privacy Officer. On June 7, 2006, VHA issued a memorandum to all VISN Directors instructing all VA medical centers to comply with the informational patch sent in October 2004.

We reviewed VHA and medical center information and technology policies and interviewed Information Technology (IT) staff. We found that IT staff had reviewed local business rules to assess compliance with VHA policy and had updated or deleted rules that were not applicable. As a result, all of the business rules the medical center provided for our review complied with VHA requirements. We made no recommendations.

Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that VHA medical centers use the quarterly/semi-annual survey report results of patients' health care experiences with the VHA system to improve patient care, treatment, and services. The Performance Analysis Center for Excellence of the Office of Quality and Performance within VHA is the analytical, methodological, and reporting staff for SHEP. VHA set performance measure (PM) goals for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients.

We reviewed the inpatient and outpatient survey results for each quarter in FY 2007. Figures 1 and 2 on the next page show the medical center's SHEP PM results for inpatients and outpatients, respectively.

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

Figure 1:

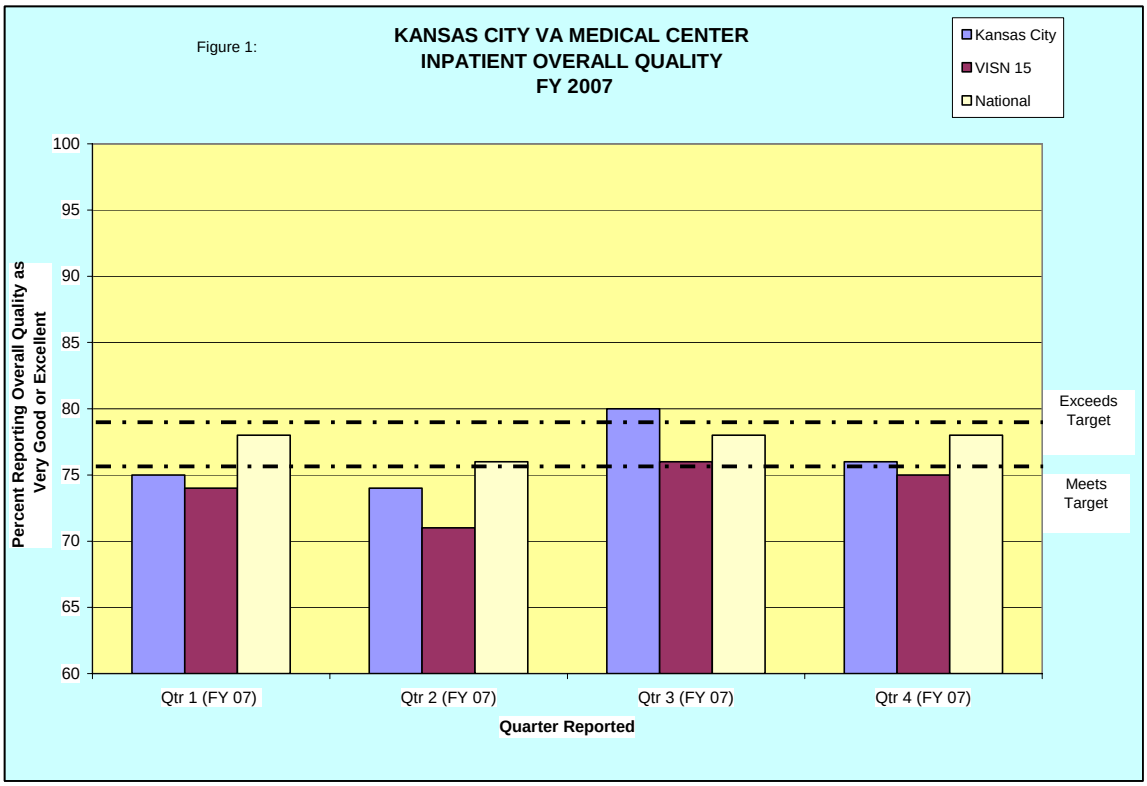
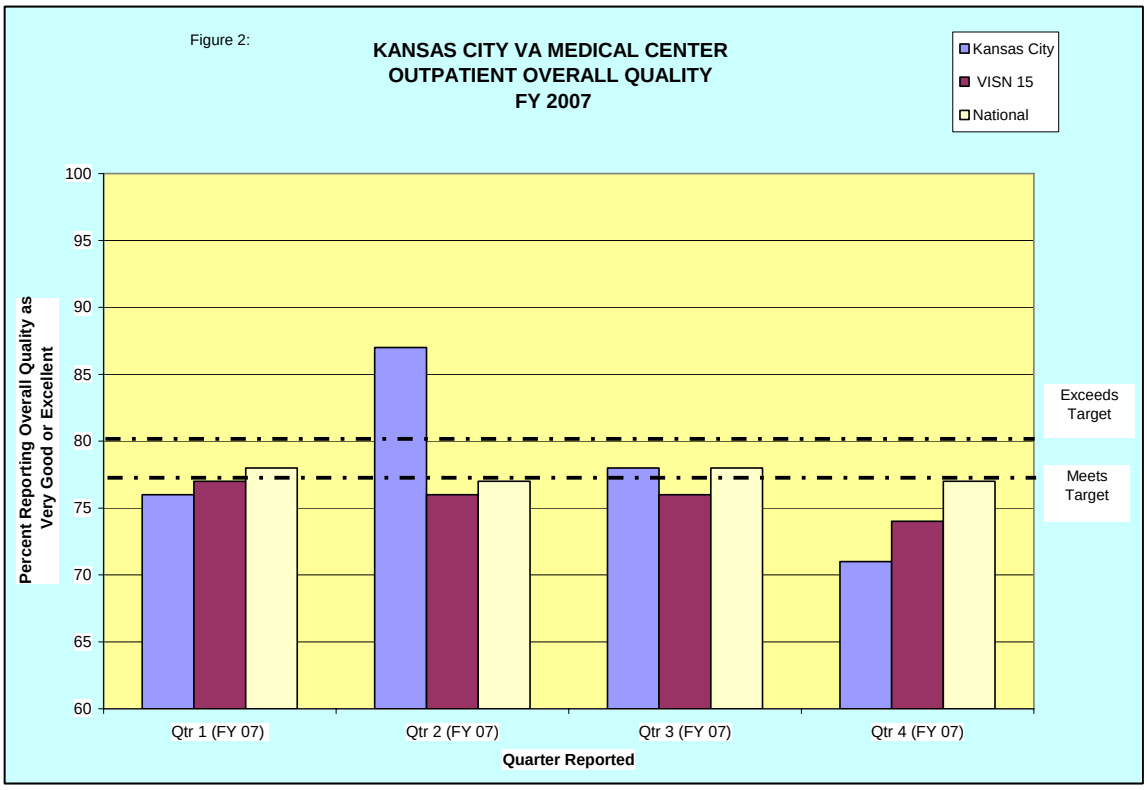


Figure 2:



The medical center met or exceeded the target in 2 of the 4 quarters for both inpatients and outpatients. Managers had identified opportunities for improvement and had developed an action plan targeting specific services and departments. Because the medical center implemented an action plan, demonstrated evidence of ongoing activities, and evaluated the plan for effectiveness, we made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 13, 2008

From: Director, Veterans Integrated Service Network (10N15)

Subject: **Combined Assessment Program Review of the Kansas City VA Medical Center, Kansas City, MO**

To: Director, Kansas City Regional Office of Healthcare Inspections (54KC)

Director, Management Review Service (10B5)

I have reviewed the draft report of our Combined Assessment Program (CAP) review of the Kansas City VA Medical Center and concur with the plans of corrective action to the recommendations outlined in this report.

PETER L. ALMENOFF, MD, FCCP

Attachment

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 9, 2008

From: Director, Kansas City VA Medical Center (589/00)

Subject: **Combined Assessment Program Review of the Kansas City VA Medical Center, Kansas City, MO**

To: Director, Veterans Integrated Service Network (10N15)

Concur.

KENT D. HILL
Director

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires that clinicians complete all peer reviews within the required timeframes.

Concur

To insure timeliness, the following measures have been put in place:

1. Initial review

a. Primary reviewers are informed they have 2 weeks to complete the peer review when the case is first assigned to the reviewer. This is the same time that we include in our letter when we send out cases for outside review.

b. After 2 weeks, if review has not been received, an administrative person follows up with the provider or the service AO if unable to reach the provider once a week.

c. If review is still not completed after 30 days, the Service Chief is informed of the delay. COS is also informed.

d. If the initial reviewer is unable to meet the desired timeline, request for extension will be referred to the COS (prior to 45 days) for approval. This will be entered in a log for tracking.

2. Final Review

a. Upon receipt of the initial review, providers of cases assigned Levels 2 and 3 are sent a memo requesting their input regarding issues identified by the initial reviewer before the case is sent to the committee for second level review. Providers are given at least a week to provide their response or are given the option to provide a verbal response at the meeting. If the provider does not meet the deadline for submission of input, the case will be reviewed by the committee without the provider's input. Should the committee agree with the initial reviewer, the provider is given another one-time opportunity to respond to the issue(s) identified. The case will be taken back to the committee meeting the month following

the initial discussion to close out whether or not a response is received from the provider.

b. All cases assigned Levels 2 and 3 by the committee will be on the agenda for follow-up and closure the month following the initial peer review committee discussion.

c. If completion of a case review is anticipated to go beyond 120 days for any reason, a request for extension will be obtained from the Director before the deadline. A log of all requests for extension will be maintained and reviewed quarterly.

3. We're going to remind peer reviewer again of the VHA requirements.

Target date for Completion: System in place May 2008

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that the outpatient controlled substances storage cabinet be fitted with an electronic access system.

Concur

Facilities are working with an outside contractor to manufacture a storage cabinet to meet specifications agreed upon between Pharmacy and Facilities. Upon completion of the cabinet being built, Siemens Security will be notified by Facilities to install a card reader and scramble pad to the new cabinet to electronically monitor the cabinet access. The cabinet security will be tied into the existing security system in the pharmacy.

Target Completion Date: October 2008

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director enforces the requirement that nurses perform weekly inventories of the automated medication dispensing machines.

Concur

Nursing has initiated a weekly check of the pyxis and has changed policy to reflect these changes. We've also put in place a monitor where pharmacy conducts a weekly run on the pyxis to ensure the inventory is done.

Target Completion Date: May 2008

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires staff to secure access to

supplies, medications, utilities, and medical records and to limit access to outside contaminants.

Concur

We have repaired or replaced all locks where hardware was determined to be malfunctioning on doors securing supplies, medications, and utilities.

Batteries were also replaced on the locking medical record wall cabinet (Wall-a-Roo).

Windows that were either found open or were able to be opened without a special tool have been locked to limit access to outside contaminants.

To reduce the likelihood of recurrence in the above deficiencies, we have asked staff to report via engineering work order any sensitive security irregularities that arise. In addition, these security items will be included during future EOC rounds. Lastly, by June 1, 2008, we will be adding semi-annual inspections and servicing of sensitive window/door hardware and wall cabinets (to include battery exchange) to our routine preventive maintenance schedule.

Target Completion Date: May 2008

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that all designated EOC team members participate in all EOC rounds and that all CBOCs are inspected semi-annually.

Concur

The policy has been modified and is in the process of concurrence.

Completion Date: Policy modification: Completed April 10, 2008
Policy approval: May 30, 2008

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that all locked inpatient psychiatric unit staff receive training on environmental hazards that pose a threat to suicidal patients.

Concur

One hundred percent of MH employees assigned to the inpatient acute unit have received the training in MHEOC.

Target Completion Date: May 2008

OIG Contact and Staff Acknowledgments

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