



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Mental Health Safety Issues and Credentialing & Privileging Irregularities Alexandria VA Medical Center Pineville, Louisiana

To Report Suspected Wrongdoing in VA Programs and Operations:

Telephone: 1-800-488-8244

E-Mail: vaoighotline@va.gov

(Hotline Information: <http://www.va.gov/oig/contacts/hotline.asp>)

Executive Summary

This review evaluated allegations regarding mental health (MH) safety issues and credentialing and privileging (C&P) irregularities at the Alexandria VA Medical Center in Pineville, LA.

MH Issues: We substantiated that MH inpatients were put at risk because staff did not comply with requirements for suicide risk assessments, suicide safety plans, an interim life safety plan, and MH environmental hazards inspections and training. Additionally, we found inadequate policies related to contraband. We also substantiated that there was insufficient follow up for high risk MH outpatients because of deficiencies with policies and suicide-related issue brief corrective action plans.

We did not substantiate that mixing patients with different privilege levels increased safety risks or that patients with continuous positive airway pressure (CPAP) machines were inappropriately placed on the unlocked MH unit. We were unable to confirm or refute that patients were moved out of locked MH units before they were stable.

We recommended that staff complete suicide risk assessments and safety plans, conduct quarterly inspections of the MH environment, receive training on MH environmental hazards, and develop contraband policies. We also recommended that procedures for follow-up of high-risk MH outpatients be developed, implemented timely, and monitored, and that MH corrective action plans be tracked through resolution.

C&P Program. We substantiated that blank Professional Standards Board (PSB) action forms were given to Service chiefs for signature prior to PSB action. While staff had recently discontinued this practice, monitoring is necessary to ensure compliance. We also substantiated that some renewed licenses were attached to previous license sections in VetPro. Although corrective actions had been taken, monitoring is needed to determine effectiveness.

We did not substantiate that lapses in primary source verification (PSV) exceeding a year had been ongoing and without resolution. We could not confirm or refute that back-dated entries were fraudulently made to VetPro files or that fraudulent entries created misleading information in a compliance report.

We recommended that Board members only sign completed PSB action forms. We also recommended that VetPro license sections be updated timely with appropriate licenses attached and that monitoring is conducted to assure compliance.

The VISN and Medical Center Directors agreed with our findings and recommendations and provided acceptable improvement plans.



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

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

SUBJECT: Healthcare Inspection – Mental Health Safety Issues and Credentialing & Privileging Irregularities, Alexandria VA Medical Center, Pineville, LA

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) received a complaint alleging failure of staff at the Alexandria VA Medical Center (the medical center) in Pineville, LA, to ensure a culture of safety for mental health (MH) patients and to comply with requirements for credentialing and privileging (C&P). The purpose of the review was to determine whether the allegations had merit.

Background

The medical center has 225 inpatient beds and provides acute MH, medicine, surgery, physical rehabilitation, neurology, oncology, dentistry, and geriatric services. The extended care program receives long-term MH referrals from other facilities. Primary and specialized outpatient services are provided at the medical center and two community based outpatient clinics in Lafayette and Jennings, LA. The medical center is part of Veterans Integrated Service Network (VISN) 16.

A complainant contacted the OIG hotline on several occasions during June and July 2009 and voiced concerns regarding retention bonuses, cash awards, the safety of MH patients, and C&P. Allegations related to bonuses and awards were referred to another OIG division and the MH safety and C&P issues were referred to OHI.

MH Safety Issues. Specifically, the complainant alleged issues related to:

- Inpatient MH environmental conditions, procedures, and compliance with procedures.
- Mixing patients with different privilege levels.

- Observation of patients with continuous positive airway pressure (CPAP) machines¹ on the unlocked MH unit.
- Patient transfers out of the locked MH unit.
- Follow-up of high risk MH outpatients.

Concerns regarding MH patient safety are significant because of the recognized risks of suicide in both outpatient and inpatient MH settings. There are more than 33,000 suicides annually in the United States.² While most suicides occur in the community, about 5 percent of suicides occur while patients are hospitalized for medical or MH reasons. From January 1995 through June 30, 2008, 641 inpatient suicides (VA and non-VA facilities) were reported to The Joint Commission (TJC), equating to more than 12 percent of all sentinel events.³ A significant number of inpatient suicides occurred while the patients were on some level of observation; most often the suicides were completed by hanging.⁴ A review of root cause analyses (RCAs) by TJC found that failures in both the environment and staff-related observation were often contributory factors to inpatient suicide.⁵

Evidence-based research and the unique needs of veterans have prompted Veterans Health Administration (VHA) to expand requirements in recent years. MH inpatient environments are evolving to align with MH safe-design guidelines issued by The American Institute of Architects (AIA),⁶ TJC,⁷ National Association of Psychiatric Health Systems (NAPHS),⁸ and VHA.⁹ In addition to the elimination and mitigation of environmental conditions that could pose safety risks to patients, MH practices focus on clinical assessment, ongoing evaluation, and individualized treatment of patients. These aspects of treatment are important as veterans transition from inpatient to outpatient or other types of care.

C&P Issues. Specifically, the complainant alleged issues related to:

- Blank forms given to Service chiefs for signature.

¹ A CPAP machine uses tubes and a mask to provide pressurized air flow for a person who has a condition called sleep apnea, where an airway obstruction interrupts nighttime breathing and causes snoring and restless sleep.

² American Foundation for Suicide Prevention, "[About Suicide: Facts and Figures](#)," accessed on October 21, 2009.

³ A sentinel event is "an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof." [Sentinel Events Policy and Procedure, Updated](#), accessed on October 21, 2009.

⁴ Jeffery Janofsky, "Reducing Inpatient Suicide Risk: Using Human Factors Analysis to Improve Observation Practices," *Journal of the American Academy of Psychiatry and the Law*, Vol. 37, No. 1, March 2009, pp. 15-24.

⁵ TJC, "Sentinel Event Alert, [Issue 7: Inpatient Suicides: Recommendations for Prevention](#)," November 6, 1998, accessed on October 21, 2009.

⁶ American Institute of Architects, "[2006 Guidelines for Design and Construction of Health Care Facilities](#)," June 2006, accessed on October 21, 2009.

⁷ TJC, "Accreditation Process Guide for Hospitals," Oakbrook Terrace, IL, 2009, p. 63.

⁸ National Association of Psychiatric Health Systems, "[Design Guide for the Built Environment of Behavioral Health Facilities](#)," ed. 3.0, Spring 2009, updated August 11, 2009, accessed on October 21, 2009.

⁹ VHA National Center for Patient Safety and VHA Center for Engineering and Occupational Safety and Health, "Mental Health Environment of Care Checklist (MHEOCC)," August 31, 2009.

- Licenses were filed in the wrong section of VetPro.
- Primary source verification (PSV) lapses.
- Fraudulent entries made into VetPro.
- Compliance report.

C&P is a process designed to ensure that practitioners are qualified and competent to practice. Credentials are a practitioner's documentation of education, clinical training, licensure, experience, current competence, health status, and ethical behavior. In order to ensure that credentials are legitimate, PSV is done. For example, a state licensing board attests to the validity of a license, initially and upon renewal.

The privileging process defines what and where providers may practice, taking into consideration the capabilities of the provider, limitations of the facility, availability of support staff, and the mission of the medical center. Every licensed independent practitioner must request and have approved clinical privileges in order to practice independently.

Scope and Methodology

We interviewed the complainant by telephone on August 5, 2009, and conducted a site visit September 14–18. During our site visit, we interviewed clinical and administrative staff knowledgeable about the issues and we toured the MH units. We reviewed patient medical records; staff training records; relevant policies and procedures; incident reports; performance improvement (PI) data; patient satisfaction reports; C&P folders and electronic files; and other documents. We also reviewed the following reports: OIG Combined Assessment Program (CAP) site visit of December 10–14, 2007; TJC Triennial Survey site visit of October 1–30, 2008; TJC Unannounced For-Cause Survey site visit of June 25, 2009; and the VISN 16 MH Product Line Team site visit of August 11–14, 2009. Applicable findings and recommendations from those reviews are referenced in this report.

While other references are footnoted within the report, the following VHA documents are frequently mentioned by the name shown in parentheses.

- VHA National Center for Patient Safety, [*Mental Health Environment of Care Checklist*](#), September 26, 2008 (MHEOCC).¹⁰
- VHA Handbook 1160.01, [*Uniform Mental Health Services in VA Medical Centers and Clinics*](#), September 11, 2008 (MHS Handbook).
- VHA Handbook 1100.19, [*Credentialing and Privileging*](#), November 14, 2008 (C&P Handbook).

¹⁰ The MHEOCC originated in August 2007 and has been updated multiple times; however, the September 26, 2008, MHEOCC is applicable to the timeframe referenced in this report.

This review was performed in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

Issue 1: MH Safety Issues

Complaint (a): MH inpatients were put at risk because of unsafe environmental conditions, inconsistent and incomplete procedures, and inadequate compliance with procedures.

We substantiated complaint (a). We found that safety risks existed on the locked MH unit because staff did not fully comply with requirements for an interim life safety plan (ILSP), EOC inspections, and MHEOCC training. In addition, we found concerns related to contraband policies and practices as well as suicide prevention compliance.

ILSP. Unit staff did not conduct ILSP-required 15-minute checks on MH inpatients between February and October 2009. During this time, the locked MH unit was undergoing renovation and the patients were housed on a temporary locked unit that only partially met MH safe-design guidelines. To maintain the safety of patients, the ISLP called for 15-minute head counts for all patients. After our visit, staff began the 15-minute checks on October 7 and continued them until patients were returned to the locked MH unit on November 23.

EOC Inspections. Medical center managers and staff members conducted MHEOCC inspections in October 2007 and October 2008, but not quarterly as required.¹¹ We were told that a team, led by the Associate Director, conducted the, required¹² semi-annual environmental rounds in all areas, including the MH units; however, there was no documentation of these inspections.

During our tour of the temporary locked MH unit on September 14, we noted a need for general cleaning. Further, we identified several hazards that could potentially result in injury to patients:

- Wooden tables and chairs were in use in the third floor dayrooms even though MH safe-design furniture sat unused on the second floor.
- A free-standing mobile metal cart, used for collecting soiled food trays, stood outside the nursing station.
- An unlocked housekeeping cart, holding unsecured cleaning products and a long-handled broom, was unattended in a hallway.
- An interview room had a window that opened and blinds with long rope cords.

¹¹ Deputy Undersecretary for Health for Operations and Management Memorandum, "*Mental Health Environment of Care Checklist*," August 27, 2007.

¹² Deputy Undersecretary for Health for Operations and Management Memorandum, "*Environmental Rounds*," March 5, 2007.

- Plastic zippered covers were used to protect pillows.
- A bed, wheelchair, other equipment, and needle boxes were inappropriately stored in a biohazard room.

We communicated our concerns, as well as the need for cleaning, to medical center staff and corrective actions were promptly initiated. Medical center managers are responsible for MHEOCC compliance and ensuring that MH inpatients are provided an environment that is safe, therapeutic, and inviting. Without ongoing environmental inspections, managers cannot ensure that risks are minimized and that the environment is clean and safe.

MHEOCC Training. Appropriate staff had not received required training regarding identification of environmental hazards that represent a threat to suicidal patients. We reviewed the training records of locked inpatient MH unit staff and found no evidence of MH environmental hazards training during the previous 24 months. The MHEOCC instructions require that the training be completed initially and annually for all locked inpatient MH unit staff and MHEOCC inspection team members. Without training, employees may not have the understanding and skills necessary to ensure a safe MH inpatient environment.

Contraband. The medical center did not have adequate contraband policies or practices, and staff did not consistently comply with policies related to contraband and patient safety. For example, there was no policy specific to visitors on the locked MH unit, even though visitation is a known source of contraband transfer. Further, a metal detection wand provided to staff could not detect non-metal contraband such as glass, plastic utensils, matches, or cigarettes.

One inpatient injured himself after obtaining plastic utensils and, later, a military can opener, while on 1:1 observation in the special observation area (SOA).¹³ On other occasions, the same patient acquired razor blades and a 7-foot section of speaker wire while on 1:1 observation in the SOA. We were told that when unit staff became aware that the patient had the wire, they did not check the area for additional speakers or wire. Two days later, safety staff went to investigate the incident, searched the area, found a second speaker, and removed all remaining wire.

During the unannounced TJC June 2009 survey, reviewers cited the medical center for failure to minimize environmental safety risks because of some of the patient incidents described above. In response, the medical center revised its SOA policy, implemented a utensil-count form, and trained staff. However, we found that staff members had not counted patient utensils for 11 (26 percent) of 42 meals during the weeks of August 1–7 and September 23–29. When contraband policies and staff compliance or practices are

¹³ A patient is admitted to the SOA when confused, combative, or threatening harm. Frequently, one SOA patient is observed by one staff member; this is referred to as 1:1 observation.

inadequate, there is increased risk of patients acquiring contraband which could lead to injury.

Suicide Prevention. Medical center managers and staff had not fully complied with VHA requirements regarding suicide prevention. In the unannounced TJC June 2009 survey report, reviewers noted that inpatient MH staff failed to complete suicide risk assessments. We found that suicide safety plans were not provided or documented in 12 (32 percent) of 37 medical records of inpatients at high-risk for suicide who were treated and discharged from the locked MH unit during July 2009. The MHS Handbook requires that inpatients be evaluated for suicidal risk. Further, as outlined by VHA guidance,¹⁴ safety plans provide veterans with pre-determined lists of potential coping strategies and individuals to contact when there is risk of suicidal behavior. Without assessment of suicide risk and provision of suicide safety plans, high-risk patients may not receive appropriate treatment or have the resources needed to help avert a suicidal crisis.

Complaint (b): Mixing patients with different privilege levels increased safety risks of elopement, suicide, assaultive behavior, and/or acquisition or transfer of contraband.

We did not substantiate complaint (b). Medical center policy defines privilege levels based on the functional status of MH patients. For example, Level 2 patients may leave the unit with escorts; Level 3 patients are restricted to the unit; and Level 4 patients are placed in the SOA. These levels reflect desirable incremental steps of improvement in behavior and thinking that serve as positive goals for patients and promote transition towards the post-acute setting.

We interviewed staff and we reviewed police reports, PI documents, and patient advocate reports from the last 12 months; however, we found no evidence to support that mixing patients with different privilege levels increases safety risks. Although there was one elopement from the locked MH unit during the previous 12 months, it was due to an error in staff judgment. An RCA was conducted after the elopement and appropriate actions were taken. Having more than one privilege level in a locked unit is consistent with practices at other medical centers as well as private-sector MH facilities. We made no recommendations.

Complaint (c): Some patients who required 1:1 observation while on CPAP machines were inappropriately placed on the unlocked non-acute MH unit, resulting in misuse of resources.

¹⁴ Barbara Stanley and Gregory K. Brown, "Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version," August 20, 2008.

We did not substantiate complaint (c). Most patients housed on the unlocked MH unit function adequately during the waking hours and do not require daytime observation; however, nighttime disturbances can occur. For example, research¹⁵ suggests that one in four veterans with post traumatic stress disorder may have disturbing trauma-related nightmares. Therefore, the risk of injury during a night disturbance may warrant 1:1 observation when CPAP cords, tubing, or other hazards are available. The decision to prescribe CPAP, as well as 1:1 observation, was a clinical judgment made by the attending physician. We made no recommendations.

Complaint (d): Leadership, in response to utilization review¹⁶ and other pressures, knowingly allowed the movement of patients out of locked MH units before they were stable.

We were unable to confirm or refute complaint (d). Although an April 22, 2009, e-mail from the Chief of Staff implies that some patients may have been transferred out of the locked MH unit before they were stable, we were unable to confirm that such was the case. We reviewed the medical records of 10 patients transferred from the locked MH unit to the non-acute unit between October 2008 and June 2009 and found documentation that the patients met transfer criteria in all cases. Further, throughout their stay on the non-acute unit, none of the patients had behavior changes that required transfer back to the locked MH unit. Nursing and other staff did not report or confirm such issues during interviews. We also found no evidence from police, patient advocate, or other reports to support this complaint. We made no recommendations.

Complaint (e): Insufficient follow up regarding high risk MH outpatients.

We substantiated complaint (e). We found that responsible staff members did not fully implement policies and procedures to ensure the follow up of outpatients at high-risk for suicide. Medical center managers and staff identified this need through monitors and issue briefs. A draft procedure was written in April 2009 to assure follow up and documentation in the clinical record when veterans miss scheduled appointments. However, at the time of our visit, the policy had not been finalized or implemented. Further, we found that suicide-related issue brief corrective action plans were not always implemented or tracked through resolution. For example, some peer reviews were planned but not initiated.

The MHS Handbook requires that staff follow up and document when veterans miss scheduled appointments. Without procedure implementation and compliance, medical center managers and staff cannot ensure that timely and effective care is provided for

¹⁵ Murray A. Raskind et al., "A Parallel Group Placebo Controlled Study of Prazosin for Trauma Nightmares and Sleep Disturbance in Combat Veterans with Post-Traumatic Stress Disorder," *Biological Psychiatry*, Vol. 61, No. 8, April 15, 2007, pp. 925-927.

¹⁶ Utilization review is a process that uses criteria to evaluate the appropriateness of admissions and continued stay.

high risk MH outpatients. Further, improvements cannot be made, nor lessons learned, when corrective actions are not implemented or tracked through resolution.

Issue 2: C&P Irregularities

The medical center has a Professional Standards Board (PSB) which reviews and approves C&P requests for the medical staff; then, PSB decisions are documented on PSB action forms. By policy, all documentation and records are to be maintained in hard-copy files as well as in VetPro. The complainant did not provide us with names, dates, or other specific examples supporting the allegations; therefore, we evaluated VetPro files for 31 staff to determine if there were C&P irregularities.

We substantiated some of the allegations related to C&P violations. The complainant presented five primary complaints in support of the allegation.

Complaint (a): Blank PSB action forms were given to Service chiefs for signature prior to PSB action.

We substantiated complaint (a). During our interviews with knowledgeable staff, we confirmed that Board members had been provided blank PSB action forms to sign during the PSB meetings. We determined that Board members signed the blank PSB action forms immediately following Board discussion and recommendations in order to improve the timeliness of final approval of actions. We were told that following the PSB meeting, the C&P coordinator documented discussions and actions in the PSB meeting minutes and typed the recommendations onto the signed PSB action forms. Packets containing the PSB minutes and action forms were then provided to the Medical Center Director for final approval.

By signing completed PSB action forms, Board members attest to the accuracy of the PSB discussions, decisions, and actions as documented on the PSB action forms. When PSB action forms are signed before completion, the accuracy and legitimacy of the information could not be ensured. While we were told that the C&P staff had recently discontinued this practice, not enough time had elapsed to determine that the revised practice has been fully adopted and implemented. Therefore, further monitoring is necessary to ensure compliance.

Complaint (b): Licenses were filed in the wrong section of VetPro.

We substantiated complaint (b). Clinical staff members are required to update their VetPro files upon license renewal, thus creating a new section for the most recent license information.¹⁷ We were told that clinical staff who did not update license information in VetPro timely would not have the new section. Without a new section, the C&P staff would attach the renewed license to a previous license section. We determined that in

¹⁷ VetPro, "[Credentialing Coordinators Users Manual](#)," October 2007.

27 (87 percent) of the 31 files, a renewed license was attached to the previous license section in VetPro.

We were told that C&P staff increased communication with the clinical staff to ensure timely updates to their license information in VetPro. We determined that since corrective actions had only recently been implemented, monitoring was needed to determine effectiveness. When current licensure information is attached to previous license information in VetPro, the files could reflect that a license is not current and compromise the value of the national electronic database.

Complaint (c): Lapses in PSV exceeding a year have been ongoing and without resolution, despite awareness at both the Medical Center Director and VISN levels.

We did not substantiate complaint (c). The C&P folders that we reviewed contained documents to confirm PSV completion and that all VetPro files reflected the PSV date. Four files reflected delayed PSV for periods between 1 and 29 days; however, there were no year-long lapses as alleged. All four PSVs were completed during calendar year 2008, and the more recent files had been completed prior to license expiration, as required.

We confirmed that medical center and VISN leaders were informed of the assertions and took appropriate actions to ensure compliance with the C&P Handbook regarding PSV. Interviews with staff confirmed that improvements had been made to ensure VetPro accuracy including entry of PSV information. Because we validated the accuracy and timeliness of the PSV documented in the C&P folders as well as VetPro, we made no recommendations.

Complaint (d): Back-dated entries were fraudulently made to VetPro files as an attempt to cover-up lapses in PSV.

We were unable to confirm or refute complaint (d). All of the C&P folders that we reviewed contained documented PSVs that matched the information contained in VetPro files. Since we were unable to identify fraudulent or back-dated entries in VetPro files, we made no recommendations.

Complaint (e): The fraudulent entries created misleading information in a compliance report which is distributed by the Office of Quality & Performance.

We could not confirm or refute complaint (e). Medical center staff provided us with the relevant VetPro report entitled *Licenses within 45 days of Expiration, by Date*, dated September 16, 2009. This report identifies clinical staff members who have licenses which are due to expire within the next 45 calendar days. One clinical staff member, who held a current Louisiana license, appeared on the list because of an expired license from

another state. The C&P Handbook requires that clinical staff have only one current and valid license; therefore, the secondary expired license was not a problem. Since we were able to validate that VetPro license information was current for each clinical staff member included in our review, we made no recommendations.

Conclusions

We substantiated that medical center managers and staff failed to consistently ensure a culture of safety for MH patients. Responsible staff did not fully comply with requirements of an ILSP, MHEOCC inspections, and MH environmental hazards training. We found inadequate policies, practices, and staff compliance for restricting contraband. Staff also did not fully comply with VHA requirements for suicide risk assessments and suicide safety plans.

We did not substantiate the allegation that mixing patients with different privilege levels increased safety risks. We also did not substantiate that patients with CPAP machines were inappropriately placed on the unlocked MH unit. We were unable to confirm or refute that patients were moved out of locked MH units before they were stable; however, we did not find evidence to support the complaint.

We substantiated that responsible staff members did not fully implement policies for follow-up of outpatients at high-risk for suicide. In addition, some suicide-related issue brief corrective action plans were not implemented or tracked through resolution.

We partially substantiated allegations regarding irregularities with the C&P program. We substantiated that PSB members signed blank PSB action forms; however, we were told that the practice was discontinued. We also substantiated that some renewed licenses were attached to previous license sections in VetPro. We did not substantiate that year-long lapses occurred in PSV. We were unable to confirm or refute fraudulent or back-dated VetPro entries or that these alleged entries created a misleading compliance report.

Recommendations

Recommended Improvement Action(s) 1. The VISN Director should ensure that the Medical Center Director requires that staff complete quarterly environmental inspections of the MH areas and comply with all requirements of the MHEOCC Memorandum.

Recommended Improvement Action(s) 2. The VISN Director should ensure that the Medical Center Director requires that all appropriate staff receive training on MH environmental hazards, as required by the MHEOCC instructions.

Recommended Improvement Action(s) 3. The VISN Director should ensure that the Medical Center Director requires that policies and procedures for contraband be developed and monitored for staff compliance.

Recommended Improvement Action(s) 4. The VISN Director should ensure that the Medical Center Director requires that the locked MH unit staff complete suicide risk assessments and provide suicide safety plans.

Recommended Improvement Action(s) 5. The VISN Director should ensure that the Medical Center Director requires that a procedure for follow-up of high-risk MH outpatients be developed, implemented in a timely manner, and monitored for effectiveness.

Recommended Improvement Action(s) 6. The VISN Director should ensure that the Medical Center Director requires that MH corrective action plans be tracked through resolution and monitored for effectiveness.

Recommended Improvement Action(s) 7. The VISN Director should ensure that the Medical Center Director requires that Board members only sign completed PSB action forms.

Recommended Improvement Action(s) 8. The VISN Director should ensure that the Medical Center Director requires that VetPro license sections be updated timely with appropriate licenses attached and that monitoring is conducted to assure compliance.

Comments

The VISN and Medical Center Directors agreed with our findings and recommendations. Management submitted appropriate implementation plans; we will follow up until the planned actions are completed.

(original signed by:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: March 10, 2010

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

Subject: **Healthcare Inspection – Mental Health Safety Issues and
Credentialing & Privileging Irregularities, Alexandria VA
Medical Center, Pineville, Louisiana**

To: Director, Atlanta Office of Healthcare Inspections (54AT)

Thru: Director, Management Review Office (10B5)

1. The SCVAHCN 16 has reviewed and concurs with the medical center's response to the Healthcare Inspection report for the VAMC, Alexandria, LA.
2. If you have questions or need additional information, please contact Mary Jones, Health System Specialist at 601-206-6974.

(original signed by:)

George H. Gray, Jr.

Attachment

Medical Center Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: March 10, 2010

From: Medical Center Director (502/00), VAMC, Alexandria, LA

Subject: **Revised OIG Draft Report – Mental Health Safety Issues and Credentialing & Privileging Irregularities, Alexandria VA Medical Center, Pineville, Louisiana**

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

1. In the facility's original response, we concurred with all recommendations except #8. Since the original submission dated February 12, 2010, the facility and the VISN staff have been in negotiations with the OIG staff regarding the content in the report. The OIG agreed to remove the terms inaccurate and misfiling which were noted in the discussion of findings related to licenses. As a result the facility will concur with recommendation #8. The revised document, which is attached, contains the facility's responses to recommendations in the report. Please note that many actions were complete prior to the visit.
2. If you should have any questions, please contact Portia McDaniel, RN, BSN, Chief of Performance Improvement at (318) 466-2370.

(original signed by:)

Bryan T. Bayley, MHA, FACHE

Attachment

cc: Margaret Ponder, VISN 16

Director's 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's report:

OIG Recommendations

Recommendation 1. The VISN Director should ensure that the Medical Center Director requires that staff complete quarterly environmental inspections of the MH areas and comply with all requirements of the MHEOCC Memorandum.

Concur **Completed:** October 23, 2009.

The Alexandria VAMC had been conducting frequent (at least monthly) Mental Health Environment of Care "Rounds" on the locked inpatient acute psychiatry unit since June 2007. Upon issue of the MHEOCC Checklist, the initial rounds were performed using the Mental Health Environment of Care Checklist for Locked Units. Many environment of care improvements have been made to the unit to reduce the risk of inpatient suicides since this time. Unfortunately, all of the rounds performed were not documented utilizing the Mental Health Environment of Care Checklist for Locked Units. However, each month the facility did report its findings from these Rounds on the Mental Health Environment of Care Checklist Tracking Sheet to VISN 16.

In fiscal year 2010, the Alexandria VAMC will utilize the Mental Health Environment of Care Checklist for Locked Units to perform quarterly surveys on the locked inpatient acute psychiatry unit. The first of these surveys was performed on October 23, 2009, and submitted to VISN 16 on November 13, 2009. The second quarterly survey using this checklist was completed on February 3, 2010, and will be submitted to the VISN. The facility will continue to perform and report these quarterly surveys until it is no longer required to do so.

Recommendation 2. The VISN Director should ensure that the Medical Center Director requires that all appropriate staff receive training on MH environmental hazards, as required by the MHEOCC instructions.

Concur **Completed:** October 16, 2009

All staff working in mental health areas received training on MH environmental hazards as required by the MHEOCC instructions. On October 12, 2009, a PowerPoint was distributed electronically to appropriate staff. The training tool was sent to all service chiefs that have staff working in mental health areas. The Administrative Officer of Psychiatry Service will ensure that annual training occurs. Training records are available along with the PowerPoint that was used as the training tool.

Recommendation 3. The VISN Director should ensure that the Medical Center Director requires that policies and procedures for contraband be developed and monitored for staff compliance.

Concur **Completion Date:** February 23, 2010

Psychiatry Service has begun development of a policy for contraband. The draft policy will be finalized by February 23, 2010, with an approved electronic version posted on-line by March 15, 2010. Pertinent staff will be educated on its content. The Chief, Psychiatry Service will develop the procedure for monitoring compliance with the policy. This monitor will go into effect after final approval of the policy by the facility's leadership.

Recommendation 4. The VISN Director should ensure that the Medical Center Director requires that the locked MH unit staff complete suicide risk assessments and provide suicide safety plans.

Concur **Completed:** November 18, 2009

Suicide Risk Assessment templates have been implemented and staff educated on their use. Education was provided on November 18, 2009, and is ongoing for all staff.

Mental Health Service Chiefs have instructed staff to complete suicide safety plans when applicable. Suicide Prevention Coordinators review admissions daily. Two processes have been implemented:

1. On the inpatient mental health unit, during the daily interdisciplinary session, the team leader makes assignments to the disciplines responsible for completing the suicide safety plans.
2. On the inpatient medical/surgical care units, the Suicide Prevention Coordinator contacts the Primary Mental Health Social Worker to complete the suicide safety plan.

The compliance with completion of suicide safely plans is being monitored by the Suicide Prevention Coordinator. Reports are presented to and tracked monthly by the Mental Health Council. Improvements have been noted with completion of the plans for the month of January 2010.

Recommendation 5. The VISN Director should ensure that the Medical Center Director requires that a procedure for follow-up of high-risk MH outpatients be developed, implemented in a timely manner, and monitored for effectiveness.

Concur **Completion Date:** February 19, 2010

Each Mental Health Service Chief (Psychiatry, Psychology, and Social Work) developed a standard operating policy (SOP) for documentation of no-shows and educated staff during monthly meetings. SOP 116-13 is Psychiatry Service's policy, SOP 09-11-122 is Social Work Service's policy, and SOP 116B-01 is Psychology Service's Policy. All SOP's were implemented by February 8, 2010. Staff education and training began prior to implementation and has been ongoing.

Medical Center Memorandum (MCM) 116-1, *Managing High Risk Mental Health Patients*, was published on January 22, 2010. Staff education and training has been initiated and will be ongoing.

The effectiveness of processes outlined in Service-level SOP's will be evaluated through random monitoring by the clerical and administrative staff assigned to the services. The first report is scheduled to be presented to the Mental Health Council on February 19, 2010.

The effectiveness of processes related to outpatients described in MCM 116-1 is monitored monthly through the external peer review program. The most recent results revealed 6 out of 7 patients (77 percent compliance) received follow-up and timely evaluation. Outcomes for the first reporting period will be reported to the Mental Health Council on February 19, 2010.

Recommendation 6. The VISN Director should ensure that the Medical Center Director requires that MH corrective action plans be tracked through resolution and monitored for effectiveness.

Concur **Completion Date:** February 19, 2010

The Medical Center has implemented processes to improve tracking and monitoring of the effectiveness of corrective actions plans related to Mental Health.

1. All recommended actions from RCA's, peer reviews, and issue briefs regarding mental health concerns will be forwarded to the Mental Health Council for monitoring and tracking. The Council will follow-up on the concerns and issues until they are resolved and closed.
2. A mail group has been established whose membership is made up of key staff that is involved in follow-up actions assigned from issue briefs. This improved notification process for suicidal behavior now alerts Risk Management to those needing peer reviews. A shared tracking tool has been implemented. Access to the tracking tool has been granted to Risk Management. The tracking tool provides the status of actions related to issue briefs. It is reviewed regularly and at each time notification is received of a new event by staff assigned to the Risk Management Program.

Recommendation 7. The VISN Director should ensure that the Medical Center Director requires that Board members only sign completed PSB action forms.

Concur **Completed:** June 10, 2009

Effective June 10, 2009, support staff assigned to the Credentialing and Privileging program received counseling and re-education on the process for completing PSB action forms and presenting them to board members for signature. Members of the board have validated that the current process is in place. The facility will continue to monitor for compliance.

The current process is:

1. Professional Standards Board meets and agenda items are discussed and recommendations made by the committee members.
2. The Credentialing staff member makes notes of the recommendations and then types minutes and board action forms.
3. Minutes and board action forms are routed to each committee member who was present at the meeting for signature and date.
4. Once all members have signed the board action form it is sent to the Director for review and approval.

Recommendation 8. The VISN Director should ensure that the Medical Center Director requires that Vet Pro license sections be updated

timely with appropriate licenses attached and that monitoring is conducted to assure compliance.

Concur

Completion Date: Completed May 29, 2009

Effective May 2009, staff began opening Vet Pro files for update by the providers. E-mails were sent to the providers to update their license, controlled dangerous substances, and Drug Enforcement Administration information, as appropriate. The providers are responding and completing the updates in Vet Pro.

Weekly reports of provider activities are submitted to the leadership at the Director's morning meeting. The report includes the number of providers that are currently enrolled, the number in processing, and the number of licensed independent practitioners that are at the appointed status in Vet Pro.

OIG Contact and Staff Acknowledgments

OIG Contact	Victoria H. Coates, Director Atlanta Office of Healthcare Inspections (404) 929-5962
-------------	--

Acknowledgments	Melanie Cool Tishanna McCutchen Toni Woodard Kathleen Shimoda Deborah Howard
-----------------	--

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, South Central VA Health Care Network (10N16)
Director, Alexandria VA Medical Center, Pineville, Louisiana (502/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and
Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and
Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Mary L. Landrieu and David Vitter
U.S. House of Representatives: Rodney Alexander, Charles W. Boustany, Jr., and John
Fleming

This report is available at <http://www.va.gov/oig/publications/reports-list.asp>.