



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 08-02601-131

Combined Assessment Program Review of the North Chicago VA Medical Center North Chicago, Illinois



May 20, 2009

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 February 2–6, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the North Chicago VA Medical Center (the medical center), North Chicago, IL. 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 171 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 12.

Results of the Review

The CAP review covered eight operational activities. We identified the following organizational strength:

- Joint venture provides services for VA and Department of Defense (DoD) beneficiaries.

We made recommendations in three of the activities reviewed. One finding was a repeat finding from the prior CAP review. For these activities, the medical center needed to:

- Complete peer reviews (PRs) within the timeframes specified in Veterans Health Administration (VHA) policy.
- Ensure that medical center policy delineates the requirements for all employees who must complete cardiopulmonary resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) training and that there is a tracking mechanism in place to assure compliance with the policy.
- Correct identified patient safety and infection control (IC) deficiencies.
- Ensure compliance with VHA regulations regarding medical record documentation for patients deemed at high risk for suicide.

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

- Contracted/Agency Registered Nurses (RNs).
- Coordination of Care.
- Emergency/Urgent Care Operations.

- Medication Management.
- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Verena Briley-Hudson, Director, Chicago and Kansas City Offices of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 13–17, 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. The medical center is located in North Chicago, IL, and provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at three community based outpatient clinics (CBOCs) in Evanston and McHenry, IL, and in Kenosha, WI. The medical center is part of VISN 12 and serves a veteran population of about 79,000 in a primary service area that includes three counties in Illinois and one county in Wisconsin. The medical center also serves DoD beneficiaries affiliated with the Naval Station Great Lakes.

Programs. The medical center provides mental/behavioral health, surgical, primary/ambulatory, medical, specialty, and extended care services. It has 161 hospital beds and 195 community living center (CLC)¹ beds.

Affiliations and Research. The medical center is affiliated with Rosalind Franklin University of Medicine and Science, Loyola University Chicago, and the University of Illinois and provides training for 134 residents and for students of other disciplines, including social work and psychology. In fiscal year (FY) 2008, the medical center research program had 81 projects and a budget of \$428,000. Important areas of research included intensive care, cardiology, gastroenterology, oncology, pulmonary disease, podiatry, endocrinology, and optometry.

Resources. In FY 2008, medical care expenditures totaled more than \$206 million. The FY 2009 medical care budget is about \$210 million. FY 2008 staffing was 1,309.8 full-time employee equivalents (FTE), including 291 physician and 275 nursing FTE.

Workload. In FY 2008, the medical center treated 35,401 unique patients of which 11,214 were DoD beneficiaries. The medical center provided 22,791 inpatient days in the hospital, which included 7,009 days for DoD beneficiaries, and 57,873 inpatient days in the CLC. The hospital had 2,606 VA and 1,587 DoD admissions, and the average daily census was 61. The CLC had 467 admissions, and the average daily census was 158.

¹ A CLC (formerly called a nursing home care unit) provides compassionate, person-centered care in a safe and homelike environment to eligible veterans who require a nursing home level of care.

Outpatient workload totaled 252,662 visits of which 13,240 were DoD beneficiaries.

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 eight activities:

- Contracted/Agency RNs.
- Coordination of Care.
- Emergency/Urgent Care Operations.
- Environment of Care (EOC).
- Medication Management.
- QM Program.
- SHEP.
- Suicide Prevention Program.

The review covered medical center operations for FY 2008 and FY 2009 through January 30, 2009, 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 North Chicago VA*

Medical Center, North Chicago, Illinois, Report No. 05-03219-103, March 14, 2006). We had one repeat EOC finding from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 171 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.

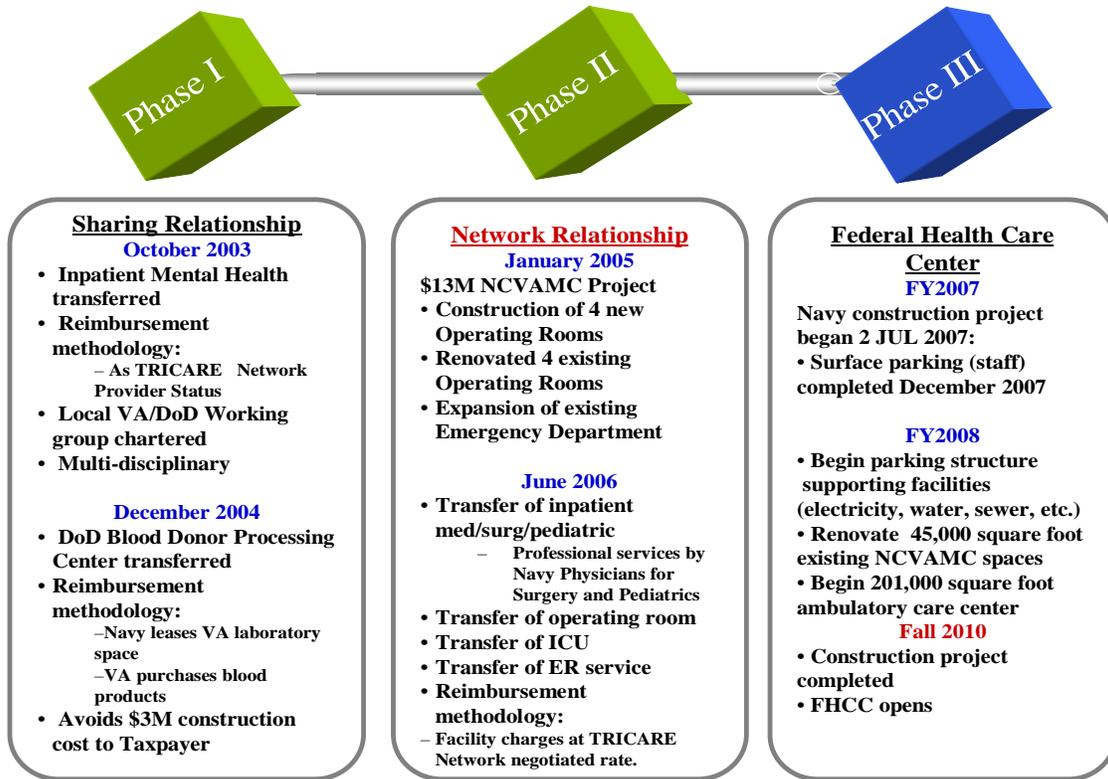
In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the "Review Activities Without Recommendations" section have no reportable findings.

Organizational Strength

Joint Venture Provides Services for VA and DoD Beneficiaries

On October 1, 2010, the medical center will integrate with Naval Health Clinic, Great Lakes to become the Captain James A. Lovell Federal Health Care Center (FHCC), a unique collaborative effort with the DoD. This integrated facility will operate under a single chain of command to manage care for veterans, active duty service members, dependents, and naval recruits in northeastern Illinois and southern Wisconsin. The FHCC will encompass all Federal health care provided at the main campus (on the existing medical center grounds), at the Naval Station Great Lakes branch clinics, and at the three CBOC locations. Collaborative efforts for this venture began in 2003.

The diagram on the next page summarizes collaborative actions taken regarding this venture.



Results

Review Activities With Recommendations

Quality Management Program

The purpose of this review was to evaluate whether the medical center had a comprehensive and effective QM program designed to monitor patient care activities and coordinate improvement efforts and whether senior managers actively supported the program's activities. We interviewed medical center senior managers, the Chief of Organizational Performance Improvement (PI), and key staff. We evaluated policies, PI data, 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 through participation in and evaluation of PI initiatives and through allocation of resources to the program. Appropriate review structures were in place for 12 of the 14 program activities reviewed. We identified two areas that needed improvement.

Peer Review. Once the need for a PR is determined, VHA policy² requires that initial reviews be completed within 45 days and that final reviews be completed by the PR Committee within 120 days. Of the 147 PRs completed during FY 2008, 13 (9 percent) exceeded the 45-day timeframe, and 13 (9 percent) exceeded the 120-day timeframe. The medical center had identified the need for improvement in this area and had made procedural changes prior to our visit. Although all PRs conducted during quarter 4 of FY 2008 met the timeframes, there had not been a sufficient amount of time between implementation of the revised procedures and our inspection to determine whether the procedural changes would be effective in fully resolving the issues.

Cardiopulmonary Resuscitation and Advanced Cardiac Life Support Training. VHA policy³ requires that each medical facility have a local policy governing training for CPR and ACLS and a mechanism in place to assure compliance with the policy. Although the medical center had a policy that addressed CPR and ACLS training for employees, it did not adequately specify the training requirements. Prior to our visit, the medical center identified the need to revise its policy in order to clearly delineate the training requirements; however, the policy had not been finalized at the time of our visit. Also, managers need to establish mechanisms for tracking training compliance once the policy is finalized.

Recommendation 1

We recommended that the VISN Director ensure that the Medical Center Director requires that PRs be completed within the timeframes specified in VHA policy.

The VISN and Medical Center Directors concurred with our findings and recommendation. The Credentialing and PR Committee was divided into two distinct committee structures. The committees were reorganized, and new policies were developed. The occurrence screen spreadsheet was revised to track and trend potential timeline issues, and the PR Committee met weekly to address the occurrence screen backlog. A PR manual outlining all PR processes and procedural changes was developed. Each service chief received a copy of the manual and was educated on the new process related to timeline

² VHA Directive 2008- 004, *Peer Review for Quality Management*, January 28, 2008.

³ VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.

requirements. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 2

We recommended that the VISN Director ensure that the Medical Center Director requires that medical center policy delineates the requirements for all employees who must complete CPR and ACLS training and that there is a tracking mechanism in place to assure compliance with the policy.

The VISN and Medical Center Directors concurred with our findings and recommendation. The resuscitative education and training policy has been revised to specify which employees are required to have Basic Life Support (BLS) and ACLS training. Approval of the revised policy by the CPR Committee is pending. Also, a database has been created to track and report compliance with BLS and ACLS certification. Supervisors will be responsible for assuring appropriate certification of their employees. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Environment of Care

The purpose of this review was to determine if the medical center complied with selected IC standards and maintained a safe and clean patient care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VA National Center for Patient Safety, Occupational Safety and Health Administration, and Joint Commission (JC) standards.

We inspected seven inpatient units, including medical/surgical, intensive care, two locked mental health (MH), and three CLC units. We also inspected several common areas.

We evaluated the IC program to determine compliance with VHA directives. IC staff appropriately collected, trended, and analyzed data related to infections, and they involved clinicians in improvement initiatives to reduce infection risks for patients and staff.

The medical center was generally clean and effectively maintained. Managers and employees were responsive to environmental concerns identified during our inspection. We identified the following conditions that needed improvement.

Patient Safety. On four of the seven units inspected, we observed that some of the emergency call system cords

were tied to handrails next to commodes. This did not allow the system to alarm when the cords were pulled from under the handrails. This was a repeat finding from our prior CAP review.

Infection Control. On four of the seven units inspected, we observed emergency call system cords in congregate bathrooms and in patient restrooms that were made of rope. Some of the cords were so long that they lay on the floor surface. Emergency call system cords should be made of a material that can be cleaned and disinfected and should be accessible from the floor but not on the floor surface.

Recommendation 3

We recommended that the VISN Director ensure that the Medical Center Director requires that identified patient safety and IC deficiencies be corrected.

The VISN and Medical Center Directors concurred with our findings and recommendation. Nursing and housekeeping staff were educated regarding not tying emergency call system cords to handrails. The rope cords were replaced, and the new cords are 6 inches from the ground. The corrective actions are acceptable, and we consider this recommendation closed.

Suicide Prevention Program

The purpose of this review was to determine whether the medical center had implemented a suicide prevention program that was in compliance with VHA regulations. We assessed whether senior managers had appointed Suicide Prevention Coordinators (SPCs) at facilities and very large CBOCs,⁴ and we evaluated whether SPCs fulfilled all required functions. Also, we verified whether medical records of patients determined to be at high risk for suicide contained Category II PRFs,⁵ documented safety plans that addressed suicidality, and documented collaboration between MH providers and SPCs.

We interviewed the SPCs and the MH manager, and we reviewed pertinent policies. We found that the medical center had appointed two full-time SPCs who fulfilled the required functions of the position. We identified one area that needed improvement.

⁴ Very large CBOCs are defined as clinics with more than 10,000 unique patients enrolled.

⁵ A Category II PRF is an alert mechanism that is displayed prominently in medical records.

Medical Record Review. VHA regulations⁶ require that all medical records of patients at high risk for suicide have a Category II PRF and a safety plan and show evidence of collaboration. We reviewed the medical records of six medical center patients and four CBOC patients determined to be at high risk for suicide. Required Category II PRFs were not present in 9 (90 percent) of the 10 records. In addition, 4 (40 percent) of the records did not have a documented safety plan, and none of the records in our sample reflected collaboration between the SPCs and MH providers.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires compliance with VHA regulations regarding medical record documentation for patients deemed at high risk for suicide.

The VISN and Medical Center Directors concurred with our findings and recommendation. All patients identified as being at high risk for suicide now have a Category II PRF in their medical record and a suicide prevention safety plan. The medical center is now fully compliant with VHA Handbook 1160.01 and has established ongoing monitoring to ensure continued compliance. The corrective actions are acceptable, and we consider this recommendation closed.

Review Activities Without Recommendations

Contracted/Agency Registered Nurses

The purpose of this review was to evaluate whether RNs working in the medical center through contracts or temporary agencies met the same entry requirements as RNs hired as part of the medical center's staff. These requirements include documentation of current licensure, completed competencies, completed background checks, and VA information security and privacy training.

We found required documentation for the four contracted RNs who worked at the medical center during the past 12 months. We made no recommendations.

Coordination of Care

The purpose of this review was to evaluate whether consultations, intra-facility (ward-to-ward) transfers, and discharges were coordinated appropriately over the continuum of care and met VHA and JC requirements.

⁶ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.

Coordinated consultations, transfers, and discharges are essential to optimal patient outcomes.

We reviewed the medical records of 13 inpatients that had consultations ordered and performed internally. In general, we found that inpatients received consultative services within acceptable timeframes.

We determined that clinicians appropriately managed all 12 intra-facility transfers reviewed. We found appropriate hand-off communication between providers and between nursing staff. Sending and receiving unit nursing documentation was completed timely and in accordance with medical center policy.

We reviewed the medical records of 12 discharged patients and found that all patients received appropriate written discharge instructions that included current medications, diet, activity level, and recommendations for follow-up care. We also found that the discharge instructions and discharge orders were generally consistent with providers' discharge summaries. There was evidence that patients or their family members understood and received copies of discharge instructions. We made no recommendations.

Emergency/Urgent Care Operations

The purpose of this review was to evaluate whether the medical center's emergency department (ED) complied with VHA guidelines related to hours of operation, clinical capability, staffing adequacy, and nursing staff competency. In addition, we inspected the ED environment for cleanliness and safety.

The ED is located in the main hospital building at the medical center and operates 24 hours per day, 7 days per week, as required for an ED. Under a joint venture with the Naval Station Great Lakes, this ED also serves active duty military personnel and their dependents. We determined that emergency services provided are within the medical center's patient care capabilities.

We reviewed the medical records of five patients who were admitted to acute care from the ED and found that patients were appropriately managed. We also reviewed the medical records of five patients who were transferred to another facility or released from the ED and found that discharge and inter-facility transfer documentation was complete.

We found that ED physicians are emergency medicine specialists. Other ED staff have specialized training as Sexual Assault Nurse Examiners or emergency medical technicians or have training in pediatric life support. We found completed competency assessments for ED nursing staff.

We conducted EOC tours and found that the environment was clean, secure, and safe and that equipment was appropriately maintained. We made no recommendations.

Medication Management

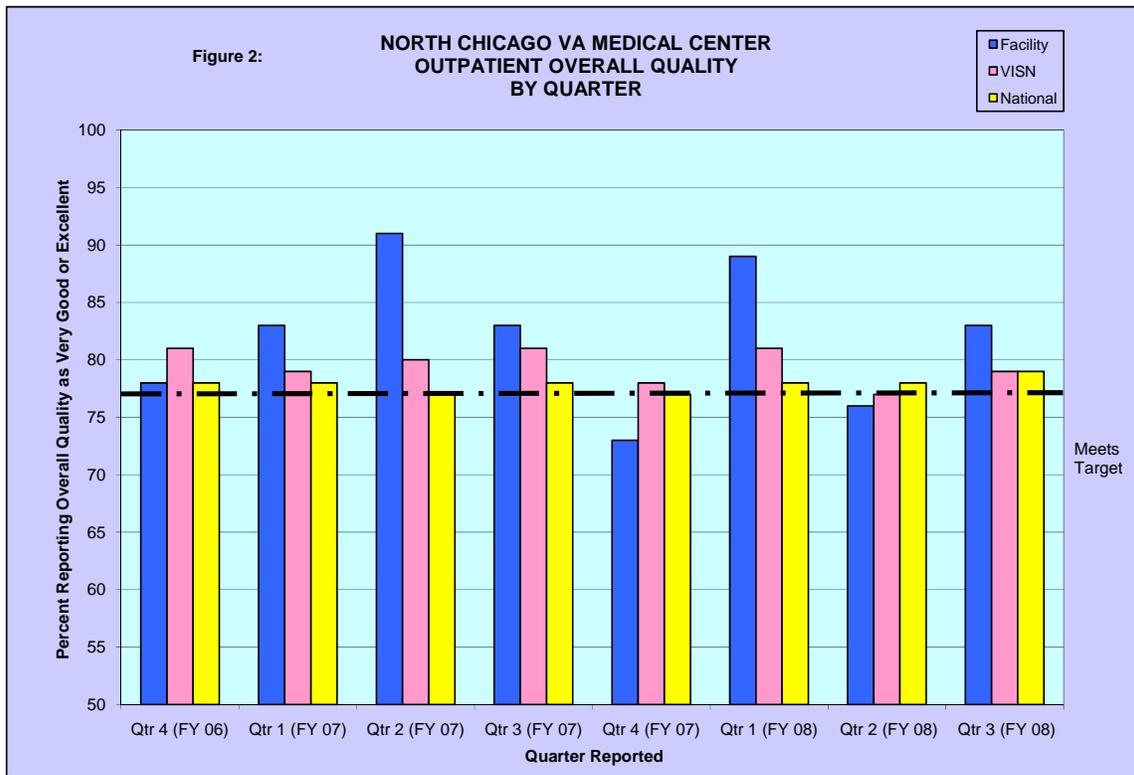
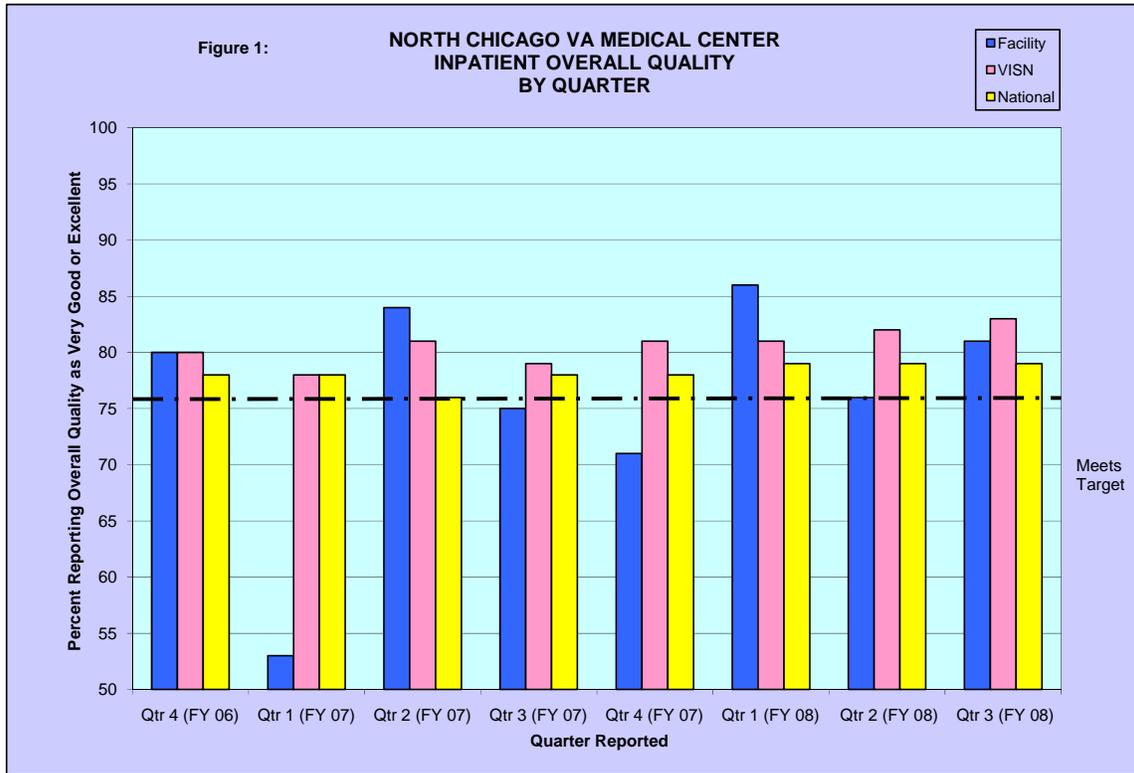
The purpose of this review was to evaluate whether the medical center had adequate medication management practices. A safe medication management system includes medication ordering, administering, and monitoring.

We reviewed selected medication management processes in the intensive care, medical/surgical, MH, and CLC units. We found adequate management of medications brought into the facility by patients or their families. Nurses appropriately scanned patient armbands and used personal identifiers to correctly identify patients prior to medication administration. We found that reconciliation of controlled substances discrepancies at the unit level was adequate.

We reviewed 47 doses of PRN (as needed) pain medication given to patients January 18–20, 2009. Clinicians documented the effectiveness of these medications within the timeframe required by medical center policy in 44 (94 percent) of the doses. We made no recommendations.

Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that the medical center used quarterly SHEP results 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 results for patients reporting overall satisfaction of “very good” or “excellent” at 76 percent for inpatients and 77 percent for outpatients. Figures 1 and 2 (on the next page) show the medical center’s SHEP performance measure results for inpatients and outpatients, respectively.



We reviewed survey results for quarter 4 of FY 2006 through quarter 3 of FY 2008. The medical center's inpatient results

met or exceeded the target in 5 of the 8 quarters reviewed. The medical center's outpatient results exceeded the target in 6 of the 8 quarters reviewed. Managers had analyzed survey results, identified opportunities for improvement, initiated an action plan, and evaluated the plan for effectiveness. We made no recommendations.

VISN Director Comments

Department of
Veterans Affairs

Memorandum

Date: May 5, 2009

From: Director, VA Great Lakes Health Care System (10N12)

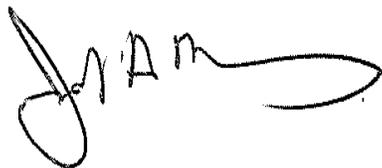
Subject: **Combined Assessment Program Review of the North Chicago VA Medical Center, North Chicago, Illinois**

To: Director, Chicago and Kansas City Offices of Healthcare Inspections (54CH)
Director, Management Review Service (10B5)

Attached please find the Combined Assessment Program (CAP) draft response from North Chicago VA Medical Center.

I have reviewed the draft report for North Chicago VA Medical Center and concur with the findings and recommendations.

I appreciate the Office of Inspector General's efforts to ensure high quality of care to veterans and the active duty patients and families at the North Chicago VAMC.



Jeffrey A. Murawsky, M.D.

Medical Center Director Comments

Department of
Veterans Affairs

Memorandum

Date: April 17, 2009

From: Director, North Chicago VA Medical Center (556/00)

Subject: **Combined Assessment Program Review of the North Chicago VA Medical Center, North Chicago, Illinois**

To: Director, VA Great Lakes Health Care System (10N12)
Director, Chicago and Kansas City Offices of Healthcare Inspections (54CH)

I want to express my appreciation to the Office of Inspector General (OIG) Survey Team for their professional and comprehensive Combined Assessment Program (CAP) review conducted on February 2–6, 2009. The results of their review validate the efforts of this Medical Center in providing high quality health care to our nation's veterans and the transition to providing high quality care to Department of Defense (DoD) beneficiaries. Our DoD partnership was considered an organizational strength.

I have reviewed the draft report for North Chicago VA Medical Center and concur with the findings and recommendations.

I appreciate the opportunity for this review as a continuing process to improve the care to our veterans and DoD patients.



Patrick L. Sullivan, FACHE

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 PRs be completed within the timeframes specified in VHA policy.

Concur **Target Date of Completion: Completed**

Several procedural changes have occurred for the Peer Review Process during FY 2008. These changes are as follows:

- A. During the 2nd quarter of FY 2008, there was a huge backlog of occurrence screens that had not been processed through the Peer Review Committee, creating problems in meeting the expected timelines. To correct this issue, weekly, versus monthly, meetings occurred until the backlog was corrected.
- B. During the 2nd quarter of FY 2008, it was also noted that the peer review process did not meet the current Joint Commission (JC) standards and the VHA corrected Peer Review Directive dated January 2008. Several actions were taken to correct this problem:
 - (1) Credentialing and Peer Review Committee was divided into two distinct committee structures: Peer Review Committee and Credentialing and Privileging. These committees were reorganized, membership reviewed, and new committee policies developed to fully reflect the intended interdisciplinary nature of the process as outlined in the new Directive.
 - (2) A revised occurrence screen spreadsheet was developed to easily track and trend any potential timeline issues so they could be easily identified and corrected before they became deficient.
 - (3) A Peer Review Manual was developed that outlined all of the peer review processes and procedural changes as required by the Directive and JC. This manual was reviewed and approved by the newly organized Peer Review Committee in March of 2008 and by the Executive Committee of the Medical Staff. The manual was signed off by the Chief of Staff and the Medical Center Director. Each Service Chief received a manual and was educated on the

new process reinforcing specific requirements related to the 45-day and 120-day timelines.

- (4) Quarterly reports show a gradual increase in compliance with timelines from 83% in the 2nd quarter of FY 2008 to 100% compliance for the 2nd quarter of FY 2009.
- (5) 4th quarter of FY 2008 also demonstrated that our peer reviewer and health care workers had completed the required peer review training.
- (6) We have developed a matrix related to our level 2 and 3 occurrence screens to further identify potential system issues. The committee members are currently in process of reviewing and analyzing this data.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that medical center policy delineates the requirements for all employees who must complete CPR and ACLS training and that there is a tracking mechanism in place to assure compliance with the policy.

Concur

Target Date of Completion: July 1, 2009

The Resuscitative Education and Training Policy has been revised to specify what classification of employee is required to have Basic Life Support (BLS) and ACLS. This policy is awaiting approval by the CPR Committee.

A database has been created to track and report compliance with BLS and ACLS certification. This database is in the process of being populated. The Education and Training Department is responsible for creating and maintaining the database, as well as reporting employee certification status to the supervisors. Each supervisor is responsible for assuring appropriate certification for their employees.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that identified patient safety and IC deficiencies be corrected.

Concur

Target Date of Completion: Completed

Patient Safety: The nursing and housekeeping staffs have been educated regarding not typing call cords to handrails. The housekeepers have been educated to notify the housekeeping supervisor or the unit charge nurse if they find a call cord tied to a handrail.

Infection Control: By February 28, 2009, the emergency cords were replaced with cords that could be cleaned and disinfected. The length of the cords is 6 inches from the ground.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires compliance with VHA regulations regarding medical record documentation for patients deemed at high risk for suicide.

Concur

Target Date of Completion: Completed

The list (of patients at high risk for suicide) provided to the OIG in December of 2008 reflected the beginning stage of implementation of the protocol for high risk patients at the North Chicago VAMC. At that time, only one individual on the high risk list for suicide had a Category II Flag in their medical record. Since then, all patients identified as being high risk for suicide had a Category II Flag entered in their records and their suicide safety plans updated. By the time the OIG review was done on February 2, 2009, all reviewed medical records has these flags, but the time of completion of the flags was outside the timeframe selected for review. This was noted by the OIG reviewer at the briefing to the leadership, even though it is not mentioned in the final OIG report. Also, on the date of the review (February 2, 2009), all but six patients (out of 48) identified as being high risk for suicide had in their record a Suicide Prevention Safety Plan. These six patients, identified as not having Safety Plans, were sought out, and Suicide Prevention Safety Plans were developed with each individual by February 6, 2009. Currently, all individuals (100%) identified as being high risk for suicide have a Patient Record Category II Flag in their medical record and have a Suicide Prevention Safety Plan developed with the individual. A copy of the Suicide Prevention Safety Plan has been placed in their record, and one has been provided to the patient. At this time, we are fully compliant with the VHA regulations and VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, with regards to care of patients at high risk for suicide. Ongoing monitoring is in place to ensure continued compliance.

OIG Contact and Staff Acknowledgments

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