MICHIGAN

OFFICE OF THE AUDITOR GENERAL

AUDIT REPORT

PERFORMANCE AUDIT
OF THE

KALAMAZOO PSYCHIATRIC HOSPITAL

BUREAU OF HOSPITALS, CENTERS, AND FORENSIC MENTAL HEALTH SERVICES
DEPARTMENT OF COMMUNITY HEALTH

August 2011

THOMAS H. MCTAVISH, C.P.A.
AUDITOR GENERAL

391-0220-10

The auditor general shall conduct post audits of financial transactions and accounts of the state and of all branches, departments, offices, boards, commissions, agencies, authorities and institutions of the state established by this constitution or by law, and performance post audits thereof.

– Article IV, Section 53 of the Michigan Constitution

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REPORT SUMMARY

Performance Audit

Report Number:
391-0220-10

Kalamazoo Psychiatric Hospital (KPH)

Bureau of Hospitals, Centers, and Forensic Mental Health Services
Department of Community Health (DCH)

Released:
August 2011

KPH operates under the jurisdiction of DCH to provide inpatient psychiatric services for persons with severe mental illness. KPH defines its mission as providing quality inpatient psychiatric services for persons with severe mental illness in a secure and safe environment. KPH provides services for mentally ill patients from 34 counties in the western half of the Lower Peninsula. In addition, in February 2009, KPH established a unit to provide for the care and services of patients transferred to KPH as a result of the closure of the Mt. Pleasant Center.

Audit Objective:

To assess the effectiveness of KPH's efforts to deliver selected patient care services.

Audit Conclusion:

We concluded that KPH was moderately effective in its efforts to deliver selected patient care services. We noted one material condition (Finding 1) and three reportable conditions (Findings 2 through 4).

Material Condition:

KPH needs to improve its monitoring of patient services to help ensure that KPH complies with patient treatment plans, KPH policy, and State law and federal regulations (Finding 1).

Reportable Conditions:

KPH needs to improve its efforts in monitoring and reporting patient elopements to help ensure the safety and security of KPH patients, staff, and other individuals (Finding 2).

KPH needs to improve its process for verifying the identification of patients prior to providing treatment, such as administering medications (Finding 3).

KPH needs to improve its training practices to ensure that its staff are provided the necessary training to deliver care to patients, consistent with the *Code of Federal Regulations (CFR);* the Mental Health Code; and KPH and DCH policies, goals, and objectives (Finding 4).

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Audit Objective:
To assess KPH's efforts to safeguard and efficiently use selected resources.

Audit Conclusion:
We concluded that KPH's efforts were moderately effective in safeguarding and efficiently using selected resources. We noted one reportable condition (Finding 5).

Reportable Condition:
KPH had not established effective inventory controls over its non-controlled substance medications (Finding 5).

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Audit Objective:
To assess the effectiveness of KPH's efforts to investigate and resolve complaints about its operations.

Audit Conclusion:
We concluded that KPH was not effective in its efforts to investigate and resolve complaints about its operations. We noted one material condition (Finding 6).

Material Condition:
KPH, in conjunction with DCH, had not established an effective process to ensure that it properly reported, investigated, and responded to complaints relating to KPH's operations (Finding 6).

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Agency Response:
Our audit report contains 6 findings and 6 corresponding recommendations. DCH's preliminary response indicates that KPH agrees with all of the recommendations.

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A copy of the full report can be obtained by calling 517.334.8050 or by visiting our Web site at: http://audgen.michigan.gov

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THOMAS H. MCTAVISH, C.P.A.
AUDITOR GENERAL

August 25, 2011

Ms. Olga Dazzo, Director
Department of Community Health
Capitol View Building
Lansing, Michigan

Dear Ms. Dazzo:

This is our report on the performance audit of the Kalamazoo Psychiatric Hospital, Bureau of Hospitals, Centers, and Forensic Mental Health Services, Department of Community Health.

This report contains our report summary; description of agency; audit objectives, scope, and methodology and agency responses; comments, findings, recommendations, and agency preliminary responses; four exhibits, presented as supplemental information; and a glossary of acronyms and terms.

Our comments, findings, and recommendations are organized by audit objective. The agency preliminary responses were taken from the agency's responses subsequent to our audit fieldwork. The *Michigan Compiled Laws* and administrative procedures require that the audited agency develop a plan to address the audit recommendations and submit it within 60 days after release of the audit report to the Office of Internal Audit Services, State Budget Office. Within 30 days of receipt, the Office of Internal Audit Services is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

We appreciate the courtesy and cooperation extended to us during this audit.

AUDITOR GENERAL

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DEPARTMENT OF COMMUNITY HEALTH

SUPPLEMENTAL INFORMATION

GLOSSARY

Description of Agency

The Kalamazoo Psychiatric Hospital (KPH) operates under the jurisdiction of the Department of Community Health (DCH) to provide inpatient psychiatric services for persons with severe mental illness*. Section 330.2001a of the *Michigan Compiled Laws* (a section of the Mental Health Code) defines mental illness as a substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life. Admission to the hospital occurs both on a voluntary and an involuntary basis.

KPH defines its mission* as providing quality inpatient psychiatric services for persons with severe mental illness in a secure and safe environment. KPH's comprehensive service delivery system is designed to provide individualized treatment using person-centered planning* processes that support the person's return to the community as appropriate.

KPH provides services for mentally ill patients from 34 counties in the western half of the Lower Peninsula (see Exhibit 1, presented as supplemental information). In addition, in February 2009, KPH established a unit to provide for the care and services of patients transferred to KPH as a result of the closure of the Mt. Pleasant Center.

KPH is accredited by The Joint Commission, which is an independent, not-for-profit organization that accredits 88% of the nation's hospitals and accredits approximately 4,250 general, children's, long-term acute, psychiatric, rehabilitation, and surgical specialty hospitals through a separate accreditation program. Also, KPH is certified as a provider of inpatient psychiatric hospital services under Medicare.

KPH has a capacity of 205 patients (see Exhibit 2, presented as supplemental information). As of May 1, 2010, KPH reported having 489 employees and 179 patients. For fiscal year 2008-09, KPH reported operating expenditures of $41,624,921, of which 87% were personnel costs (see Exhibit 3, presented as supplemental information).

* *See glossary at end of report for definition.*

Audit Objectives, Scope, and Methodology and Agency Responses

Audit Objectives

Our performance audit* of the Kalamazoo Psychiatric Hospital (KPH), Bureau of Hospitals, Centers, and Forensic Mental Health Services, Department of Community Health (DCH), had the following objectives:

1. To assess the effectiveness* of KPH's efforts to deliver selected patient care services.

2. To assess KPH's efforts to safeguard and efficiently* use selected resources.

3. To assess the effectiveness of KPH's efforts to investigate and resolve complaints about its operations.

Audit Scope

Our audit scope was to examine program and other records related to selected operational activities at the Kalamazoo Psychiatric Hospital. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Our audit procedures, conducted from April through August 2010, generally covered the period October 1, 2007 through June 30, 2010.

Our audit was not directed toward examining clinical decisions made by KPH staff concerning patient treatment identified within a patient's individual plan of service or expressing an opinion on those clinical decisions and, accordingly, we express no opinion on those clinical decisions. Also, we obtained information compiled by KPH (see Exhibits 1 through 4) that relates to our audit objectives. Our audit was not directed toward expressing an opinion on this information and, accordingly, we express no opinion on it.

* *See glossary at end of report for definition.*

Audit Methodology

To establish our audit objectives and obtain an understanding of KPH's operations, we conducted a preliminary review that consisted of interviewing KPH personnel, reviewing applicable policies and procedures and the Mental Health Code (Sections 330.1001 - 330.2106 of the *Michigan Compiled Laws*), analyzing available data and statistics, obtaining an understanding of KPH's internal control*, and conducting limited testing of transactions. Also, we analyzed the composition of the population (see Exhibit 4, presented as supplemental information), toured KPH's buildings, and reviewed the patients' living conditions.

To assess the effectiveness of KPH's efforts to deliver selected patient care services, we reviewed DCH and KPH policies and procedures and met with KPH staff to gain an understanding of the admission process and person-centered planning. We reviewed recent accreditation and Medicare certification survey evaluations and examined patient files for compliance with the *Code of Federal Regulations* (CFR),* the Mental Health Code, and DCH and KPH policies. Also, we analyzed training provided to staff with direct patient contact, reviewed site fire safety procedures, and evaluated safety and security. In addition, we reviewed KPH records of complaints and critical incidents* that occurred during the audit period. We also reviewed the criminal background check and drug testing processes used by KPH for its employees.

To assess KPH's efforts to safeguard and efficiently use selected resources, we interviewed KPH staff and reviewed various DCH and KPH policies and procedures. We obtained an overall understanding of and tested controls related to inventory procedures and pharmacy practices and reviewed pharmacy inventories.

To assess the effectiveness of KPH's efforts to investigate and resolve complaints about its operations, we interviewed KPH staff and reviewed applicable policies and procedures. We obtained an overall understanding of and tested controls related to KPH's complaint process. We assessed the appropriateness of KPH complaint investigations, responses, and changes implemented as a result of concerns or complaints related to KPH operations.

When selecting activities or programs for audit, we use an approach based on assessment of risk and opportunity for improvement. Accordingly, we focus our audit efforts on activities or programs having the greatest probability for needing improvement

* *See glossary at end of report for definition.*

as identified through a preliminary review. Our limited audit resources are used, by design, to identify where and how improvements can be made. Consequently, we prepare our performance audit reports on an exception basis.

Agency Responses

Our audit report contains 6 findings and 6 corresponding recommendations. DCH's preliminary response indicates that KPH agrees with all of the recommendations.

The agency preliminary response that follows each recommendation in our report was taken from the agency's written comments and oral discussion subsequent to our audit fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and State of Michigan Financial Management Guide (Part VII, Chapter 4, Section 100) require DCH to develop a plan to address the audit recommendations and submit it within 60 days after release of the audit report to the Office of Internal Audit Services, State Budget Office. Within 30 days of receipt, the Office of Internal Audit Services is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

COMMENTS, FINDINGS, RECOMMENDATIONS, AND AGENCY PRELIMINARY RESPONSES

EFFORTS TO DELIVER SELECTED PATIENT CARE SERVICES

COMMENT

Background: Section 330.1708 of the *Michigan Compiled Laws* requires that patients receive mental health services, suited to their condition, in the least restrictive setting that is appropriate and available.

The Kalamazoo Psychiatric Hospital (KPH) provides a variety of continuous care services to its patients, including treatment and clinical services, vocational/educational activities, and discharge planning. Patient assessments are used at the time of admission to determine which care services would benefit the patients the most.

During the period October 1, 2007 through June 30, 2010, KPH reported 348 instances of self-harm (347) or suicide (1) by patients, 380 acts of aggression by patients on other patients that resulted in injuries, and 294 acts of aggression by patients on staff that resulted in injuries. It should be noted that KPH patients can be unpredictable and inherently dangerous. Therefore, compliance with the policies, procedures, and other requirements may not entirely eliminate safety and security risks.

Audit Objective: To assess the effectiveness of KPH's efforts to deliver selected patient care services.

Audit Conclusion: We concluded that KPH was moderately effective in its efforts to deliver selected patient care services. Our audit disclosed one material condition*. KPH needs to improve its monitoring of patient services to help ensure that KPH complies with patient treatment plans, KPH policy, and State law and federal regulations (Finding 1).

Our audit also disclosed three reportable conditions* related to patient elopements*, patient identification, and training practices (Findings 2 through 4).

* *See glossary at end of report for definition.*

FINDING

1. Monitoring of Patient Services

KPH needs to improve its monitoring of patient services to help ensure that KPH complies with patient treatment plans, KPH policy, and State law and federal regulations. Improved monitoring of patient services would also help KPH identify and resolve patient service deficiencies on a timely basis and help ensure that it provides services to patients in a safe environment.

KPH operates under requirements specified in the Mental Health Code, the *Michigan Administrative Code*, and the *Code of Federal Regulations* (*CFR*), as well as policies established by the Department of Community Health (DCH) and internal KPH operating procedures. These policies, procedures, and other requirements were designed to have a positive impact on the services provided to KPH patients; to ensure that KPH provides services to patients in the least restrictive environment; and to help ensure that KPH provides a safe and secure environment for KPH patients, staff, and other individuals.

During our audit period, several critical incidents occurred at KPH. Also, KPH underwent one accreditation survey and five Medicare Conditions of Participation surveys during our audit period. These incidents and surveys indicated that KPH had been in noncompliance with various requirements and/or had weaknesses in its monitoring of patient services. We noted:

a. Four critical incidents occurred at KPH that resulted in the assault, injury, or death of KPH patients. These incidents involved noncompliance with patient treatment plans, KPH policies, or requirements of the Mental Health Code or the *CFR:*

   (1) A patient was found dead in a laundry room with a plastic bag pulled over his head. The cause of death was presumed suicide by asphyxiation.

   This patient had recently been transferred to KPH from a local jail, and the jail's records (which had been reviewed by KPH) indicated that jail personnel had observed and taken precautions regarding suicide and self-abuse by the patient.

A subsequent investigation into the death by DCH's Office of Recipient Rights (ORR) concluded that the resident care aide (RCA) assigned to account for the patient that day failed to provide appropriate supervision, which contributed to the death by suicide. KPH records indicated that the RCA was dismissed as a result of the incident.

The ORR investigation also concluded that a nursing manager failed to appropriately assess and provide for appropriate supervision, which contributed to the death by suicide. KPH records indicated that the nursing manager retired in lieu of dismissal as a result of the incident.

KPH Consumer Care and Treatment Policy and Procedure 03-04-002 requires that suicide and self-abuse precautions be initiated whenever a patient has indicated by word or action that suicide or self-harm is intended, including thinking about, planning, or talking about suicide or making gestures or attempts to terminate life.

(2) A patient attacked three other patients who suffered severe injuries. The attacks consisted of two separate critical incidents that occurred over a five-month period.

The first attack resulted in two injured patients. The first injured patient was treated at the hospital for injuries. The second injured patient was hospitalized in intensive care with traumatic brain injury, internal bleeding, lacerations, and swelling.

A Medicare certification survey team found that KPH had not conducted a formal investigation into the circumstances of these two assault and battery incidents or the appropriateness of the treatment program that the patient who attacked the two other patients was receiving. The survey team also determined that KPH had not notified law enforcement of the assault and battery as required by Section 330.1723 of the *Michigan Compiled Laws* and DCH Policy and Procedure 10.3.2.

(3) A female patient experienced inappropriate sexual contact initiated by a male patient.

The hospital investigator and a Medicare certification survey team determined that the three RCAs who accompanied the female patient had not provided the level of supervision that was expected and that had been documented as having been provided in the incident reports that each RCA completed regarding the incident. In addition, the survey determined that the incident had not been reviewed by the male patient's psychologist or treatment team.

(4) A KPH patient was physically abused during an altercation with two RCAs. According to the Medicare certification survey of the incident, the surveillance video tape showed that, while the patient was being held down, an RCA struck the patient in the head with his knee and elbow. The survey also indicated that the video tape showed that another RCA had also struck the patient in the vicinity of his head at least three times with a hand or a fist.

A subsequent investigation of the incident by ORR concluded that the RCAs had physically abused the patient. The ORR investigation reported that the RCAs were no longer employed by KPH.

b. KPH may have been able to prevent instances of noncompliance with the *CFR* and KPH policy, which included the critical incidents described in parts a.(2), a.(3), and a.(4), by improving its monitoring of patient services. Our review of surveys completed during our audit period disclosed:

(1) On August 5, 2009, KPH was notified by the Centers for Medicaid and Medicare Services (CMS), U.S. Department of Health and Human Services (HHS), that a July 31, 2009 survey of KPH operations disclosed that KPH was out of compliance with Medicare Conditions of Participation for Hospitals involving patient rights, including deficiencies so serious that they constituted an immediate threat to patient health and safety.

KPH is subject to certification surveys to ensure that KPH is in compliance with the Medicare Conditions of Participation requirements of the *CFR* in order to receive federal Medicare reimbursement for eligible patients. HHS is authorized under the Social Security Act to terminate a hospital's participation in Medicare if the hospital cannot achieve compliance by the termination date.

The survey found that KPH did not use safe and appropriate restraint and seclusion techniques, had not established a process for prompt resolution of grievances, and had not informed each patient of whom to contact to file a grievance. As a result, CMS notified KPH of its intention to terminate its Medicare agreement on August 23, 2009 unless KPH achieved compliance by that date.

(2) On September 2, 2009, CMS notified KPH that DCH had resurveyed KPH on August 20, 2009 and found that the immediate jeopardy to patient health and safety was removed. Therefore, the Medicare termination date of August 23, 2009 was rescinded. However, other deficiencies remained and KPH remained out of compliance with Medicare Conditions of Participation regarding patient rights. As a result, CMS extended its termination date for KPH's Medicare agreement to October 29, 2009.

(3) On October 6, 2009, DCH performed a full survey of KPH and found KPH was not in compliance with Medicare Conditions of Participation regarding patient rights; physical environment; and organ, tissue, and eye procurement.

(4) On November 3, 2009, CMS notified KPH that, based on the surveys from July 31, 2009 and October 6, 2009, CMS was terminating KPH's Medicare agreement on December 17, 2009 unless KPH achieved compliance by that date.

(5) On December 23, 2009, CMS notified KPH that it received KPH's December 17, 2009 revised plan of corrective action and found it acceptable. As a result, CMS administratively extended its projected date for terminating KPH's Medicare agreement to February 1, 2010 to allow DCH time to conduct a follow-up survey.

(6) On February 22, 2010, CMS notified KPH that DCH had conducted a revisit survey of KPH on January 5, 2010 that revealed KPH was now in compliance with Medicare Conditions of Participation. As a result, CMS rescinded its decision to terminate KPH's participation in Medicare, and KPH was again deemed to meet applicable Medicare requirements based on accreditation by The Joint Commission (TJC).

As a result of the conditions identified in the certification surveys, KPH has made some changes to its monitoring activities. However, KPH needs to ensure that it monitors patient services functions in a timely manner to effectively prevent or detect patient critical incidents and other conditions to comply with Medicare Conditions of Participation requirements of the *CFR*.

RECOMMENDATION

We recommend that KPH improve its monitoring of patient services to help ensure that KPH complies with patient treatment plans, KPH policy, and State law and federal regulations.

AGENCY PRELIMINARY RESPONSE

KPH agrees that there are always opportunities for improvement in the monitoring of patient services. KPH informed us that it conducted a root cause analysis where appropriate and immediately developed corrective actions to mitigate risks of unfortunate events like this from occurring in the future. KPH also informed us that follow-up surveys by CMS and internal monitoring by KPH ensured that these plans of correction were implemented and resolved the safety and security risks to the satisfaction of CMS. KPH indicated that it will continue its efforts to improve its monitoring of patient services to help ensure compliance with patient treatment plans, KPH policy, and State law and federal regulations.

However, KPH also indicated that given the nature of these patients, as the finding describes, there is no level of monitoring possible that would ensure the complete elimination of incidents involving patients. The Office of the Auditor General acknowledges this in the background comments of this report, stating that ". . . KPH patients can be unpredictable and inherently dangerous. Therefore, compliance with the policies, procedures, and other requirements may not entirely eliminate safety and security risks."

FINDING

2. Patient Elopements

KPH needs to improve its efforts in monitoring and reporting patient elopements to help ensure the safety and security of KPH patients, staff, and other individuals.

Proper reporting and documentation of missing patients provide a detailed record of the event at the time it occurred. This ensures that such occurrences are identified and reported to law enforcement, DCH, and other individuals with an interest in the patients' whereabouts, as well as to the oversight bodies responsible for KPH accreditation and certifications.

The TJC Specifications Manual for Joint Commission National Quality Core Measures defines a patient elopement as an unauthorized leave of absence when a patient wanders away, walks away, runs away, escapes, or otherwise leaves the hospital unsupervised, unnoticed, and/or prior to his or her scheduled discharge.

During our review of KPH's efforts in monitoring and reporting patient elopements, we noted:

a. According to KPH records, there were 21 occasions during our audit period in which KPH patients walked away, ran away, escaped, or otherwise left the hospital unsupervised, unnoticed, and/or prior to their scheduled discharge. Those incidents included the following:

   (1) A KPH patient left the hospital unsupervised and unnoticed by KPH staff. The patient's absence remained unnoticed by KPH staff despite two separate checks purporting to confirm the patient's whereabouts.

   (2) A patient, who had three days earlier attempted to escape by hiding in a pizza delivery vehicle, successfully escaped by breaking a glass window and cutting through a window screen.

   After the first escape attempt, KPH had put the patient on escape precautions requiring monitoring every 15 minutes. However, the precautions neither prevented nor detected the escape. Instead, the escape was detected by a KPH employee who happened to be outside and noticed a broken window and an individual running away. The

employee alerted KPH staff, who proceeded to check patient rooms and discovered that the patient was missing. Approximately 3.5 hours after the escape, the patient called KPH with his location, asking to be picked up. The patient was then transferred the following day to the Center for Forensic Psychiatry.

An administrative review of the escape by KPH found that the patient had planned his escape over a period of time. The administrative review was never able to determine how the patient acquired the scissors used to cut through the window screen, but it did find that on the day prior to the escape, the patient successfully misled KPH staff regarding sustaining an injury to his right thumb resulting from breaking the window to his private room. The patient, who was admitted to a hospital and received eight sutures to his thumb, reported to KPH staff that he had injured himself in a bathroom. Although KPH staff doubted that the injury had occurred in the bathroom, there was no search of the patient's room for other possible causes for the injury.

The administrative review concluded that the patient was monitored and supervised in accordance with KPH policies and procedures. However, the administrative review also identified several factors that played a role in the patient's escape. The administrative review recommended that KPH staff receive training to address these factors.

b. KPH did not report and document all instances of patients discovered missing, discovered absent, or placed on unauthorized leave status.

KPH's accreditation process requires that KPH accurately report these instances to TJC, its accreditation agency. TJC accreditation meets federal certification requirements, qualifying KPH for Medicare reimbursement. In addition, KPH Consumer Registration Policy and Procedure 02-04-003 governs KPH's response to the unauthorized absence of patients from the hospital.

During our review of KPH's reporting of patient elopements, we noted:

(1) KPH did not complete an incident report for 8 (47%) of the 17 instances in which KPH recognized a patient's absence as unauthorized during our audit period.

KPH Consumer Registration Policy and Procedure 02-04-003 requires that whenever a patient is discovered missing, either on or off grounds, KPH employees shall complete an incident report of the event, regardless of whether the incident is ultimately deemed unauthorized by a KPH psychiatrist.

(2) KPH did not report all instances of patients discovered missing or absent to TJC.

KPH is required to report to TJC all elopements, not just those deemed by KPH to be an unauthorized leave, whenever a patient wandered away, walked away, ran away, escaped, or otherwise left KPH unsupervised, unnoticed, and/or prior to the patient's scheduled discharge. However, KPH reported only 17 of the 21 instances that we identified from KPH records in which an elopement occurred.

RECOMMENDATION

We recommend that KPH improve its efforts in monitoring and reporting patient elopements to help ensure the safety and security of KPH patients, staff, and other individuals.

AGENCY PRELIMINARY RESPONSE

KPH agrees that there are opportunities for improvement in its efforts to monitor and report patient elopements.

KPH informed us that it has revised KPH Consumer Registration Policy and Procedure 02-04-003 to more clearly define staff reporting responsibilities as soon as a patient is unaccounted for and that a definition of elopement has been added which is consistent with current reporting requirements of TJC. DCH and KPH also indicated that management will continue to monitor compliance with the revised

policy and procedure to help ensure the safety and security of KPH patients, staff, and other individuals.

FINDING

3. Patient Identification

KPH needs to improve its process for verifying the identification of patients prior to providing treatment, such as administering medications.

Proper identification of patients is necessary to help prevent errors during treatment, such as the dispensing of medication to the wrong patient.

The Accreditation Program for Hospitals by TJC established National Patient Safety Goal 01.01.01, which requires the use of at least two patient identifiers when providing care, treatment, and services such as administering medications. Also, KPH Standard Operations Procedure Manual Chapter 1 requires nursing staff to make positive identification of patients using two patient identifiers before administering treatment or medication. In addition, KPH's Medication Administration Procedure further requires KPH nursing staff to use at least two of the following identifiers prior to administering medication: asking the patient his or her name, asking the patient his or her date of birth, comparing the patient's face with picture identification, comparing information provided by the patient with information contained in the medication administration record, and/or enlisting the aid of a KPH staff person who knows the patient to assist in the identification process.

Our review of KPH's patient identification practices disclosed:

a. KPH did not consistently use at least two identifiers when dispensing medication to patients.

   We observed medication being distributed to patients in four separate hospital units. KPH staff did not use at least two identifiers when dispensing medications to 15 (27%) of 56 patients.

b. KPH did not optimize the use of photographic identification as a patient identifier.

We determined that as of June 17, 2010, 37 (22%) of 168 KPH patients did not have a photographic identification. Section 330.1724 of the *Michigan Compiled Laws* requires that KPH have the written consent of the patient or the patient's guardian prior to taking a photograph. However, KPH records did not indicate how many of the 37 patients or their guardians had affirmatively refused to be photographed, rather than simply not provided the proper written consent upon admission. Such a determination and follow-up would optimize the use of photographic identification by acquiring the proper consent from any additional patients or guardians who were not affirmatively opposed to the patient being photographed, but whose consent may not have been obtained previously.

Patient misidentification can be particularly problematic in psychiatric care because mental impairment can affect communication with staff and the ability to accurately self-identify. Photographic identification represents an effective identifier because it does not rely on patients to self-identify. Photographic identification also ensures the safety of patients, staff, and other individuals when a patient becomes lost or otherwise leaves the facility without proper authorization or supervision.

RECOMMENDATION

We recommend that KPH improve its process for verifying the identification of patients prior to providing treatment, such as administering medications.

AGENCY PRELIMINARY RESPONSE

KPH agrees that there are opportunities for improvement in its process for verifying the identification of patients prior to providing treatment and has taken the appropriate corrective action as follows. KPH informed us that:

a. KPH policy now requires nursing management and/or their designees to observe the medication administration process. If it is determined that KPH medication administration policies/procedures are not being followed, appropriate corrective action will be taken. During the first half of 2011, the

monitoring was conducted by the KPH risk manager during medication administration on all units with results in the expected range.

b. KPH developed a consent form specifically for patients' photographic identification. The form has a section to be signed if the patient refuses to have his or her photograph taken at admission. Photographic identification consent forms will be forwarded through the medical records department to appointed guardians of patients admitted to KPH for approval to take their photographs. A copy of the consent form will be kept in the patient's medical record for auditing and verification purposes.

FINDING

4. Training Practices

KPH needs to improve its training practices to ensure that its staff are provided the necessary training to deliver care to patients, consistent with the *CFR;* the Mental Health Code; and KPH and DCH policies, goals, and objectives.

Properly trained staff are essential in order to effectively care for patients and to enhance the safety of patients, staff, and other individuals. The development and completion of required training help KPH improve employees' skills and safety, familiarize employees with new developments and techniques, and reinforce employees' knowledge and understanding of their job responsibilities.

Federal regulation 42 *CFR* 482.13, Medicare Conditions of Participation for Hospitals, requires hospitals such as KPH to protect and promote patient rights, including the right to receive care in a safe setting and the right to be free from all forms of abuse or harassment. Proper training for KPH employees provides the guidance and instruction necessary to ensure that KPH meets these standards of care.

Our review of KPH's training practices disclosed:

a. KPH had not established policies and procedures to ensure that direct care staff received training that met KPH's operational needs. For example, our review of the CMS certification survey of KPH disclosed that KPH had not used safe and appropriate restraint and seclusion techniques on a patient.

Federal regulation 42 *CFR* 482.13, Medicare Conditions of Participation for Hospitals, requires that appropriate KPH staff must have education, training, and demonstrated knowledge in such restraint and seclusion techniques.

The CMS certification survey also disclosed an incident of physical abuse of a patient by KPH staff. CMS declared that the incident constituted an immediate threat to patient health and safety. KPH uses Non-Abusive Psychological and Physical Intervention* (NAPPI) guidelines for interacting with aggressive patients. The CMS certification survey reported that KPH staff are expected to have refresher training in NAPPI annually. However, the CMS certification survey found that two KPH staff members involved in the incident had not received such training for two years and a third staff member involved had not received such training for four years.

b. KPH had not developed an overall training strategy to help implement an effective training program.

KPH's training activities are decentralized. The Education and Training Department conducts and documents a majority of the hospital's training activities. However, additional training is conducted and documented outside of the Education and Training Department. For example, the Nursing Department conducts training that is specific to nursing. Similarly, training occurs during staff meetings and housing unit meetings and is documented within those meetings' minutes.

Training was not coordinated among the outside training sessions and the Education and Training Department. In addition, training outside of the Education and Training Department did not get reported to or documented by the Education and Training Department. As a result, individual staff training records maintained by the Education and Training Department were not updated to reflect the completion of such training. Consequently, employee training records were incomplete and employee training could not be monitored, tracked, or properly evaluated.

* *See glossary at end of report for definition.*

RECOMMENDATION

We recommend that KPH improve its training practices to ensure that its staff are provided the necessary training to deliver care to patients, consistent with the *CFR;* the Mental Health Code; and KPH and DCH policies, goals, and objectives.

AGENCY PRELIMINARY RESPONSE

KPH agrees that there are opportunities for improvement with its training practices but feels that it effectively delivered care to patients consistent with the *CFR*, the Mental Health Code, and KPH and DCH policies. KPH informed us that:

a. KPH has restructured the Education, Training and Staff Development Department with new leadership and additional staffing to help ensure that all direct care staff receive necessary training to meet KPH's operational needs. KPH acknowledges that there were three staff out of 489 employees (less than 1%) that were not up to date with their annual NAPPI training. Since 2009, the Education, Training and Staff Development Department has scheduled and trained all staff in NAPPI. Education and transcripts of the training are up to date. On March 18, 2009, CMS found KPH to be in compliance with the Medicare Conditions of Participation.

b. KPH is in the process of developing a Comprehensive Training Policy. This policy requires that any training conducted outside of the Education, Training and Staff Development Department must be reported to the education and training coordinator so that training records are appropriately updated.

EFFORTS TO SAFEGUARD AND EFFICIENTLY USE SELECTED RESOURCES

COMMENT

Audit Objective: To assess KPH's efforts to safeguard and efficiently use selected resources.

Audit Conclusion: We concluded that KPH's efforts were moderately effective in safeguarding and efficiently using selected resources. Our audit disclosed one reportable condition related to the inventory of non-controlled substance medications (Finding 5).

FINDING

5. Inventory of Non-Controlled Substance Medications

KPH had not established effective inventory controls over its non-controlled substance medications. As a result, KPH could not adequately account for its purchases and use of non-controlled substance medications in order to ensure that these pharmaceuticals were safeguarded against theft, loss, waste, and misuse.

The State of Michigan Financial Management Guide (Part II, Chapter 12, Section 100) requires that KPH establish and maintain an inventory control system over its medications. The accuracy of the inventory must be verified at least annually by a physical count.

To accommodate patients' medication needs, KPH operates an on-site pharmacy that orders, receives, and stocks hundreds of different prescription and over-the-counter medications, including both controlled and non-controlled substances. During fiscal year 2008-09, KPH's non-controlled medication purchases totaled $2,049,113, which represented 99% of KPH's total medication purchases of $2,074,873.

Our review of KPH's inventory controls over non-controlled substance medications disclosed that KPH had not established and maintained an inventory control system over its non-controlled substance medications. Also, KPH had not performed an annual physical count of these medications and, when we requested documentation to support the disposition of non-controlled substance medications purchased and dispensed to patients, KPH informed us that supporting documentation for medications dispensed to patients was retained for only three months. As a result, KPH could neither document its current stock of non-controlled substances on hand nor document the disposition of its purchases of non-controlled substances during the audit period.

RECOMMENDATION

We recommend that KPH establish effective inventory controls over its non-controlled substance medications.

AGENCY PRELIMINARY RESPONSE

KPH agrees that currently there is no system to maintain an inventory control system over non-controlled substances. KPH indicated that DCH is implementing a new pharmacy computer system scheduled to be implemented in August 2011 which will include a perpetual inventory system. KPH informed us that this new system will allow for the complete tracking of all pharmaceuticals, from purchase to medication disposition.

EFFORTS TO INVESTIGATE AND RESOLVE COMPLAINTS

COMMENT

Background: KPH has received numerous complaints relating to its operations from patients and related parties, KPH staff, and the community. The exact number of complaints received by KPH could not be determined because of weaknesses in KPH's controls and processes for tracking complaints (see Finding 6).

Audit Objective: To assess the effectiveness of KPH's efforts to investigate and resolve complaints about its operations.

Audit Conclusion: We concluded that KPH was not effective in its efforts to investigate and resolve complaints about its operations. Our audit disclosed one material condition. KPH, in conjunction with DCH, had not established an effective process to ensure that it properly reported, investigated, and responded to complaints relating to KPH's operations (Finding 6).

FINDING

6. Complaints

KPH, in conjunction with DCH, had not established an effective process to ensure that it properly reported, investigated, and responded to complaints relating to

KPH's operations. As a result, KPH could not ensure that complaints, including those involving allegations of patient abuse or neglect, were identified and properly resolved on a timely basis.

Federal regulation 42 *CFR* 482.13, Medicare Conditions of Participation for Hospitals, requires hospitals such as KPH to protect and promote patient rights, which includes establishing a process for the filing and resolution of patient complaints. KPH receives notification of complaints from various sources, including patients and related parties, KPH staff, and other individuals. As required under Section 330.1776 of the *Michigan Compiled Laws* and DCH Policy and Procedure 10.3.2, complaints involving patient rights are required to be forwarded to DCH's on-site ORR investigators. Other non-patient rights complaints may be forwarded to other KPH administrative staff for investigation and resolution as appropriate.

Our review of KPH's processes for handling complaints disclosed:

a. KPH, in conjunction with DCH, had not developed and used a consistent practice for reporting and resolving complaints. As a result, some incidents were never properly reported or forwarded for investigation.

   KPH utilizes four separate forms and related processes to document and resolve various events occurring at KPH, including complaints:

   - Administrative reports are completed to report property damage, illegal acts, or misconduct by individuals other than patients.

   - Incident reports are completed to report, investigate, and review unusual incidents involving patients.

   - Unusual incident report logs are used to report all incidents of abuse, neglect, assault, or serious injury involving a patient.

   - Recipient rights complaint forms are used to document and review apparent or suspected violations of recipient rights, abuse or neglect of patients, or an assault by one patient upon another.

The outcome of having four different processes and forms related to complaints and critical incidents not only produced duplication or overlap, but also resulted in incidents involving recipient rights going uninvestigated because they were not reported on a particular form. Our review disclosed:

(1) KPH did not require administrative report forms to be forwarded to ORR, even though misconduct by individuals other than patients may have also involved patient rights.

During the period December 25, 2007 through May 6, 2010, KPH reported 32 patient-related incidents on an administrative report form, even though those incidents did not involve property damage, illegal acts, or misconduct by individuals other than patients. Of the 32 incidents, 18 (56%) were also reported separately on an incident report form and thus properly forwarded to ORR for investigation on that basis. However, the remaining 14 incidents were not forwarded to ORR because KPH did not require administrative report forms to be forwarded to ORR.

(2) KPH did not consistently report incidents involving patients on an incident report form as required.

We identified eight patient-related incidents that were reported on an administrative report form instead of an incident report form. Unlike KPH's Consumer Care and Treatment Policy and Procedure involving patient-related incident report forms, KPH's Administrative Report Procedure did not address patient rights or an ORR review. Therefore, KPH could not ensure that incidents involving patient rights were properly investigated and resolved by ORR when reported on an administrative report form.

(3) KPH did not always document its review and resolution of incidents reported on administrative report forms.

KPH's Administrative Report Procedure required KPH management to evaluate administrative report forms for administrative action, including conducting an administrative review. However, KPH's Administrative

Report Procedure did not require KPH to record what administrative action or review it conducted.

We reviewed 10 KPH administrative report forms and found 4 incidents that had no administrative review; no explanation why an administrative review was not warranted; and no indication regarding when, where, or how the administrative action in response to the incident had been carried out.

b. KPH had not logged each reportable incident in its unusual incident report log. As a result, KPH did not ensure that an immediate record was made of all reports of abuse, neglect, assault, and serious injury involving patients and that all such reports were appropriately investigated and resolved.

In response to significant deficiencies identified in Medicare certification surveys of KPH conducted during our audit period, KPH's plan of corrective action included the development of the unusual incident report log, to be used in conjunction with incident reports completed by KPH staff. According to KPH's plan of corrective action submitted to CMS, the incidents and immediate actions taken by KPH staff in response to such incidents were to be documented in the log to ensure that an immediate record was made and followed up for all reports of abuse, neglect, assault, or serious injury involving patients.

We reviewed a sample of 15 incident report forms at KPH and found that 6 of the 15 incidents reviewed, all of which involved injuries or neglect to patients, had not been documented in the KPH unusual incident report log.

c. KPH, in conjunction with DCH, had not developed an effective process to track and monitor all allegations of abuse and/or neglect that were forwarded to ORR to ensure that all allegations were appropriately reviewed, investigated, and resolved.

Section 330.1776 of the *Michigan Compiled Laws* requires each recipient rights complaint to be recorded upon receipt by ORR and an acknowledgment of the recording and a copy of the complaint to be sent to a complainant within five business days. In addition, if ORR determines that an investigation into a

complaint is not warranted, ORR is required, within five business days of receiving a complaint, to document that determination and to notify a complainant of that determination.

Our review of KPH's unusual incident report log disclosed 3 incidents involving allegations of abuse and/or neglect that ORR did not investigate. Those incidents consisted of the following:

(1) A KPH patient alleged that KPH staff assaulted him in a quiet room during a one-on-one observation. ORR's telephone log indicated that ORR had received notification of the incident, but ORR did not document an investigation or a determination that an investigation was not warranted.

(2) A KPH patient alleged that she was assaulted by three security guards and several RCAs. ORR's telephone log indicated that ORR had received notification of the incident, but ORR did not document an investigation or a determination that an investigation was not warranted.

(3) A KPH patient alleged that she was given Vicodin and a cigarette by KPH staff. KPH's unusual incident report log indicated that ORR was notified by telephone. However, ORR's telephone log contained no record that ORR had received notification of this incident, and ORR did not document an investigation or a determination that an investigation was not warranted.

Although ORR did not document whether an investigation was warranted for these incidents, ORR subsequently acknowledged upon our review that all three incidents either should have been investigated or should have had a determination of why no investigation was warranted.

d. KPH, in conjunction with DCH, did not identify, document, and track the number of incident reports filed at KPH.

KPH Policy 03-01-001 requires the KPH central nursing office supervisor to forward all incident report forms filed at KPH to ORR for review. In accordance with Section 330.1776 of the *Michigan Compiled Laws*, ORR then reviews each incident report form and follows up on those incident reports

containing allegations of abuse and/or neglect in order to determine whether an investigation will be initiated.

However, our review of the KPH incident report process disclosed that KPH had not individually prenumbered or otherwise identified each incident report form that was prepared. Therefore, KPH and DCH could neither determine how many incident report forms had been filed at KPH nor ensure that each incident report form that was filed had been forwarded, investigated, and resolved as appropriate by ORR.

RECOMMENDATION

We recommend that KPH, in conjunction with DCH, establish an effective process to ensure that it properly reports, investigates, and responds to complaints relating to KPH's operations.

AGENCY PRELIMINARY RESPONSE

KPH agrees that there are opportunities for improvement over the processes to report, investigate, and respond to complaints relating to KPH operations. KPH indicated that it has taken the actions noted below to help ensure that all complaints are identified and properly resolved on a timely basis:

a. KPH revised its Administrative Report Procedure to require any incidents involving patients to also be recorded on an incident report form to ensure that ORR is notified of any patient-related incidents. KPH's revised Administrative Report Procedure requires that KPH management document its review and resolution of all administrative report forms.

b. KPH has revised the procedure for the routing of incident reports to incorporate the logging and numbering of all patient-related incidents in the unusual incident report log. This new procedure ensures accountability that reports are appropriately investigated and resolved.

c. KPH, in conjunction with DCH, will work with ORR to establish an effective process to ensure that it properly reports, investigates, and responds to complaints and critical incidents relating to KPH's operations and to ensure that all allegations are appropriately addressed.

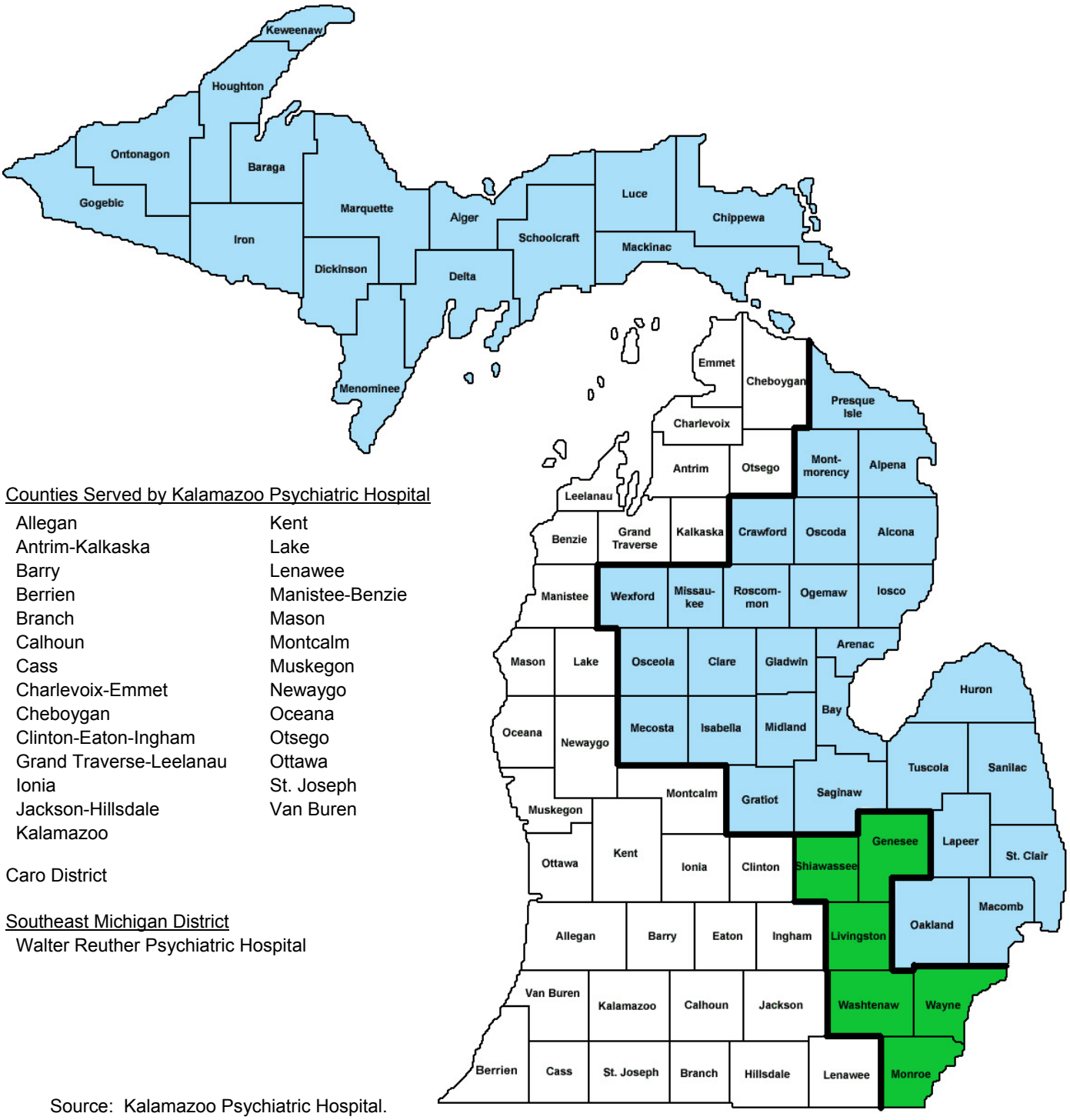
d. KPH has revised the procedure for the routing of incident reports to incorporate the logging and numbering of all patient-related incidents in the unusual incident report log. This new procedure ensures accountability that reports are appropriately investigated and resolved.

SUPPLEMENTAL INFORMATION

UNAUDITED
Exhibit 1

KALAMAZOO PSYCHIATRIC HOSPITAL

Department of Community Health
Map of Service Area
As of June 30, 2010



Counties Served by Kalamazoo Psychiatric Hospital

Allegan	Kent
Antrim-Kalkaska	Lake
Barry	Lenawee
Berrien	Manistee-Benzie
Branch	Mason
Calhoun	Montcalm
Cass	Muskegon
Charlevoix-Emmet	Newaygo
Cheboygan	Oceana
Clinton-Eaton-Ingham	Otsego
Grand Traverse-Leelanau	Ottawa
Ionia	St. Joseph
Jackson-Hillsdale	Van Buren
Kalamazoo	

Caro District

Southeast Michigan District
Walter Reuther Psychiatric Hospital

Source: Kalamazoo Psychiatric Hospital.

391-0220-10

UNAUDITED
Exhibit 2

KALAMAZOO PSYCHIATRIC HOSPITAL
Patient Admissions, Discharges, and Average Daily Census Data
For Fiscal Years 2001-02 through 2008-09

Fiscal Year	Admissions	Discharges	Average Daily Census
2001-02	361	366	114
2002-03	440	365	109
2003-04	491	508	178
2004-05	531	543	176
2005-06	458	462	165
2006-07	476	466	160
2007-08	406	412	163
2008-09	439	454	158
8-Year Average	450	447	153

Note: Kalamazoo Psychiatric Hospital has a capacity of 205 patients.

Source: Kalamazoo Psychiatric Hospital.

KALAMAZOO PSYCHIATRIC HOSPITAL
Expenditures and Average Cost Per Patient
For Fiscal Years 2004-05 through 2008-09

	Fiscal Year					Five-Year
	2004-05	2005-06	2006-07	2007-08	2008-09	Average
Average number of patients	176	165	160	163	158	164
Personnel costs	$30,172,514	$30,487,250	$31,499,889	$33,504,307	$36,137,438	$32,360,280
Average cost per patient	$ 171,435	$ 184,548	$ 197,371	$ 205,231	$ 228,275	$ 196,754
Food services costs	$ 285,510	$ 287,343	$ 302,792	$ 332,241	$ 335,320	$ 308,641
Average cost per patient	$ 1,622	$ 1,739	$ 1,897	$ 2,035	$ 2,118	$ 1,882
Medications and medical supplies costs	$ 1,952,807	$ 1,914,596	$ 1,849,833	$ 2,216,787	$ 2,197,471	$ 2,026,299
Average cost per patient	$ 11,095	$ 11,590	$ 11,591	$ 13,579	$ 13,881	$ 12,347
Fuel and utilities costs	$ 720,385	$ 761,354	$ 780,000	$ 778,872	$ 781,823	$ 764,487
Average cost per patient	$ 4,093	$ 4,609	$ 4,887	$ 4,771	$ 4,939	$ 4,660
Travel costs	$ 57,601	$ 53,034	$ 55,099	$ 48,098	$ 50,626	$ 52,892
Average cost per patient	$ 327	$ 321	$ 345	$ 295	$ 320	$ 322
Materials, supplies, and equipment costs	$ 1,591,215	$ 2,010,550	$ 2,041,547	$ 1,940,864	$ 2,122,243	$ 1,941,284
Average cost per patient	$ 9,041	$ 12,170	$ 12,792	$ 11,889	$ 13,406	$ 11,860
Total agency costs	$34,780,032	$35,514,127	$36,529,160	$38,821,169	$41,624,921	$37,453,882
Average cost per patient	$ 197,614	$ 214,977	$ 228,883	$ 237,800	$ 262,938	$ 227,723

Source: Kalamazoo Psychiatric Hospital.

KALAMAZOO PSYCHIATRIC HOSPITAL
Patient Census Breakdown
As of June 14, 2010

	Number of Patients	Percentage of Total
Patient Location:		
Edwards Unit	31	18.5%
Flunt Unit	15	8.9%
Holder Unit	20	11.9%
Linda Richards Unit	17	10.1%
MH Roll Unit	30	17.9%
Morter Unit	19	11.3%
Schrier Unit	17	10.1%
Gero-Psych and Medical Unit	15	8.9%
Unauthorized leave of absence	1	0.6%
Community hospital	3	1.8%
Total	168	100.0%
Year of Admission:		
1960 - 1970	0	0.0%
1971 - 1980	1	0.6%
1981 - 1990	2	1.2%
1991 - 1995	0	0.0%
1996 - 2000	3	1.8%
2001 - 2005	12	7.1%
2006 - 2009	63	37.5%
2010	87	51.8%
Total	168	100.0%
Gender:		
Male	130	77.4%
Female	38	22.6%
Total	168	100.0%
Race:		
White	105	62.5%
Black	53	31.5%
Other	10	6.0%
Total	168	100.0%
Legal Status:		
Guardian admitted patient	3	1.8%
Court ordered	98	58.3%
Voluntary admission	3	1.8%
Incompetent to stand trial	29	17.3%
Not guilty by reason of insanity	35	20.8%
Total	168	100.0%

Source: Kalamazoo Psychiatric Hospital.

GLOSSARY

Glossary of Acronyms and Terms

CMS	Centers for Medicaid and Medicare Services.
Code of Federal Regulations **(***CFR***)**	The codification of the general and permanent rules published by the departments and agencies of the federal government.
critical incident	An occurrence involving a patient that results in a disruption of, or has an adverse effect upon, the normal routine of treatment or care of a patient, the management of the living unit, or the administration of KPH.
DCH	Department of Community Health.
effectiveness	Success in achieving mission and goals.
efficiently	Achieving the most outputs and outcomes practical with the minimum amount of resources.
elopement	An unauthorized leave of absence when a patient wanders away, walks away, runs away, escapes, or otherwise leaves the hospital unsupervised, unnoticed, and/or prior to his or her scheduled discharge.
HHS	U.S. Department of Health and Human Services.
internal control	The plan, policies, methods, and procedures adopted by management to meet its mission, goals, and objectives. Internal control includes the processes for planning, organizing, directing, and controlling program operations. It includes the systems for measuring, reporting, and monitoring program performance. Internal control serves as a defense in safeguarding assets and in preventing and detecting errors; fraud; violations of laws, regulations, and provisions of contracts and grant agreements; or abuse.

KPH	Kalamazoo Psychiatric Hospital.
material condition	A reportable condition that could impair the ability of management to operate a program in an effective and efficient manner and/or could adversely affect the judgment of an interested person concerning the effectiveness and efficiency of the program.
mental illness	A substantial disorder of thought or mood that significantly impairs an individual's judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life.
mission	The main purpose of a program or an agency or the reason that the program or the agency was established.
Non-Abusive Psychological and Physical Intervention (NAPPI)	A behavioral response technique with the focus on actively keeping the assaultive person safe while at the same time keeping everyone else safe.
ORR	Office of Recipient Rights.
performance audit	An economy and efficiency audit or a program audit that is designed to provide an independent assessment of the performance of a governmental entity, program, activity, or function to improve program operations, to facilitate decision making by parties responsible for overseeing or initiating corrective action, and to improve public accountability.
person-centered planning	A process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and honor the individual's preferences, choices, and abilities.
RCA	resident care aide.

reportable condition	A matter that, in the auditor's judgment, falls within any of the following categories: an opportunity for improvement within the context of the audit objectives; a deficiency in internal control that is significant within the context of the objectives of the audit; all instances of fraud; illegal acts unless they are inconsequential within the context of the audit objectives; significant violations of provisions of contracts or grant agreements; and significant abuse that has occurred or is likely to have occurred.
TJC	The Joint Commission.


STATE OF MICHIGAN
OFFICE of the AUDITOR GENERAL