STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

RICK SNYDER
GOVERNOR

OLGA DAZZO
DIRECTOR

December 15, 2011

Mr. Doug Ringler
Office of Internal Audit Services
Office of the State Budget
George W. Romney Building
111 South Capitol, 6th Floor
Lansing, Michigan 48913

Dear Mr. Ringler:

In accordance with the State of Michigan, Financial Management Guide, Part VII, attached is the final summary table identifying our responses and corrective action plans to address recommendations contained within the Office of the Auditor General's Performance Audit of the Kalamazoo Psychiatric Hospital, Department of Community Health.

Questions regarding the summary table or corrective action plans should be directed to me at (517) 373-1508 or Myerspa@michigan.gov.

Sincerely,

PAM MYERS

Pam Myers, Director
DCH Office of Audit

Enclosure

cc: Office of the Auditor General
House Fiscal Agency
Senate Fiscal Agency
Executive Office
DCH, Olga Dazzo
DCH, Lynda Zeller
House Appropriations Committee
House Standing Committee
Senate Appropriations Committee
Senate Standing Committee
DCH, Nick Lyon

PERFORMANCE AUDIT OF THE KALAMAZOO PSYCHIATRIC HOSPITAL

DEPARTMENT OF COMMUNITY HEALTH

AUGUST 2011

AUDIT RESPONSE

Approved: [signature]
Olga Dazzo, Director
Department of Community Health

Date: 11/10/11

AUDIT REPORT SUMMARY

DEPARTMENT: Community Health

AUDIT PERIOD: October 1, 2007 through June 30, 2010

REPORT DATED: August 2011

DISPOSITION OF AUDIT RECOMMENDATIONS

CITATIONS COMPLIED WITH	CITATIONS TO BE COMPLIED WITH	CITATIONS DCH DID NOT AGREE WITH
Finding 1		
Finding 2		
Finding 3		
Finding 4a	Finding 4b (December 2011)	
	Finding 5*	
Finding 6		

*Compliance date is dependent upon the resolution of current implementation issues.

Audit Response
Performance Audit
Kalamazoo Psychiatric Hospital
Department of Community Health
October 1, 2007 through June 30, 2010

<u>Recommendation 1:</u> <u>Monitoring of Patient Services</u>

OAG recommended 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.

<u>Response:</u>

KPH agreed that there are always opportunities for improvement in the monitoring of patient services. KPH continues its efforts to improve its monitoring of patient services to help ensure compliance with patient treatment plans, KPH policy, State law, and federal regulations. KPH has revised documentation processes and provided additional training to nursing staff as part of the Performance Improvement Process currently taking place within the entire Hospitals and Centers Bureau. In addition, when incident reports identify issues, nurse administrators are investigating and initiating corrective action.

<u>Recommendation 2:</u> <u>Patient Elopements</u>

OAG recommended 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.

<u>Response:</u>

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

KPH 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 a definition of elopement has been added which is consistent with current reporting requirements of The Joint Commission. DCH and KPH 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. Subsequent to the policy revision there have been two elopements, an investigative review by the Safety Director found that the revised policies/procedures were followed.

<u>Recommendation 3:</u> <u>Patient Identification</u>

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

<u>Response:</u>

KPH agreed that there are opportunities for improvement in its processes for verifying the identification of patients prior to providing treatment and have taken the appropriate corrective action as follows.

a. KPH policy now requires nursing management and/or their designees to observe the medication administration process. Ongoing monitoring indicates improved compliance with the revisions to treatment policies. Training and disciplinary action are used to improve performance when necessary.

b. KPH developed a consent form specifically for patient's photo identification. The form has a section to be signed if the patient refuses to have their photo identification taken at admission. Photo identification consent forms will be forwarded through the medical records department to appointed guardians of patients admitted to KPH for approval to take their photos. A copy of the consent form will be kept in the patient's medical record for auditing and verification purposes. The numbers of consumers participating has increased, unit social workers are following up with guardians when necessary. Risk managers are reviewing compliance twice per month.

Recommendation 4: Training Practices

OAG recommended 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.

Response:

KPH agreed 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 the OAG 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 receives 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 Non-Abusive Physical & Psychological Intervention (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, the Center for Medicare & Medicaid Services (CMS) found KPH to be in compliance with the Medicare Conditions of Participation. KPH training transcripts continue to be up to date.

b. KPH has developed a Comprehensive Training Policy that has gone to the Executive Planning Committee for final approval. This policy requires that any training conducted outside of the Education, Training and Staff Development Department must be reported to the Education & Training Coordinator so that training records are appropriately updated. The policy has been partially implemented pending final approval of the committee.

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Recommendation 5: Inventory of Non-Controlled Substance Medications

OAG recommended that KPH establish effective inventory controls over its non-controlled substance medications.

Response:

KPH agreed that currently there is no system to maintain an inventory control system over non-controlled substances. The Department of Community Health began implementation of a new pharmacy computer system in August 2011 which includes a perpetual inventory system. This new system, once fully implemented will allow for the complete tracking of all pharmaceuticals. Currently DCH and DTMB are working together to resolve software issues identified during implementation.

Recommendation 6: Complaints

OAG recommended 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.

Response:

KPH agreed that there are opportunities for improvement over the processes to report, investigate and respond to complaints relating to KPH operations. KPH 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 the Office of Recipient Rights (ORR) is notified of any patient related incidents. KPH management continue to document their review and resolution of all Administrative Report forms.

b. KPH has revised the procedure for 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. All incident reports are now logged in the Unusual Incident Report Log, follow-up is done to ensure appropriate investigation and resolution.

c. KPH, in conjunction with DCH, will work with the 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. KPH has strengthened its processes; all administrative reports involving a patient are reported to ORR.

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d. KPH has revised the procedure for routing of Incident Reports to incorporate the logging and numbering of all patient related incidents in the Unusual Incident Report Log. All incident reports are now logged in the Unusual Incident Report Log, follow-up is done to ensure appropriate investigation and resolution.