

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 010001	(X3) Date Survey Completed 08/24/2017
Name of Provider or Supplier Southeast Health Medical Center	Street Address, City, State 1108 Ross Clark Circle, Dothan, AL	
For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.		

(X4) ID Prefix Tag	Summary Statement of Deficiencies (Each deficiency should be preceded by full regulatory or LSC identifying information)
A0309	<p>QAPI EXECUTIVE RESPONSIBILITIES CFR(s): 482.21(e)(1), (e)(2), (e)(5)</p> <p>The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: 1) That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained. (2) That the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety and that all improvement actions are evaluated. (5) That the determination of the number of distinct improvement projects is conducted annually.</p> <p>This STANDARD is not met as evidenced by: Based on review of facility policy, Minutes Houston County Health Care Authority Quality Committee, medical records and interviews, it was determined the hospital's governing body failed to: 1. Review the sentinel event involving Patient Identifier (PI) # 1, a patient who successfully committed suicide while a patient in the Behavioral Medicine Unit (BMU). 2. Conduct monthly meetings for the months of July 2017 and as of the date of this survey (8/24/17) August 2017. 3. Ensure staff completed occurrence reports for PI # 2 with documented self-destructive behaviors. 4. Patient occurrences that were reported were investigated, analyzed and preventative measures were implemented to prevent further occurrences. This affected 2 of 3 medical records (Patient Identifier (PI) # 1, PI # 2) and 3 of 6 patients with adverse occurrences (PI # 4, PI # 6 and PI # 7). This also has the potential to negatively affect all patients admitted to this facility. Findings include: Facility Policy: Quality Plan Effective Date: 1/1/2002 Policy: ... The hospital's governing body will provide oversight that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and</p>

services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. Purpose: 1. To establish organizational guidelines for developing, implementing and maintaining an ongoing system for managing quality and patient safety... 3. To reflect the oversight mechanism of the governing body, regarding direct supervision, support, and participation of the quality activities performed by the hospital and its affiliates and network ... 5. To demonstrate a consistent endeavor to deliver safe, effective, optimal patient care and services in an environment of minimal risks The Governing Board has defined the scope of organizational performance improvement as an overall assessment of the efficacy of performance improvement activities with a focus on continually improving care provided, and promoting patient safety practices throughout the Hospital and its entities... 1. The Governing Board monitors quality and safety through a monthly dashboard of quality/safety indicators and a quarterly report discussing specific issues related to quality and safety... ..Quality Improvement minutes should contain conclusions that have been reached as result of quality investigations, recommendations that the committee makes to address the conclusions reached, actions taken to follow through on the recommendations made and evaluations of the effectiveness of the actions taken... Every member of the organization has a role in providing quality, safe care. Leaders play a role in fostering improvement. 1. At Southeast Alabama Medical Center ... leaders including the governing board, the chief executive officer, and other senior management, the elected officers of the medical staff, department directors, and directors of nursing units. 2. Leaders may foster performance improvement through planning, educating, setting priorities, providing support such as time and resources, and empowering staff as appropriate. 3. Department managers and their staff ... under the direction of their administrative contact are responsible for quality activities ... 5. The department manager or his/her designee should review and report the status and results of quality activities to the Quality Management Department Clinical Practice Guidelines, based on evidenced based medicine, are considered when designing or improving processes. The hospital leaders identify criteria for the selection and implementation of clinical practice guidelines ... Collections and analysis of certain data is required. These are: 1. Threats to patient safety (i.e. falls, patient identification, injuries) a. Quality Management monitors all reported falls and falls with injury... 7. Adverse events/ near misses a. Quality Management monitors level of harm and near misses as it relates to reported medication variances... 15. Physical Environment Management Systems... .. Certain analyses have specific defined timeframes such as Root Cause Analysis, 30 days from event. Quality indicators on the organization scorecard are reported to the Governing Board... The Houston County Healthcare Authority Governing Board is ultimately responsible for the provision of the performance improvement process at Southeast Alabama Medical Center The hospital's executive team's primary responsibility is to plan, review, analyze data, approve and evaluate quality and safety activities that relate to patient care provided throughout the organization. The hospital's executive team responds to performance improvement team requests and recommendations, quality measurement reports and other issues from the clinical practice improvement teams, hospital departments, clinical benchmarking and team tracking ... The hospital has the following committees that provide oversight of the quality requirements by reviewing and acting on reports and recommendations from: 1. Quality Safety Council is to incorporate the organization's Mission... Responsibilities is to assist with determining targets and ensure corrective and preventive actions are taken by the organization are implemented, measured and monitored... 2. Adverse Outcomes is to provide a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety. This is

accomplished through mechanisms that support effective response to potential or actual Patient Safety concerns or near misses or hazardous conditions, ongoing proactive reduction in medical/health care errors, and integration of patient safety priorities into new design and redesign of relevant organization processes, functions, and services. 3. Patient Safety Committee is to improve patient safety and reduce risks to patients through an environment that encourages: recognition and acknowledgement of risks to patient safety... and initiation of actions to reduce these risks. The internal reporting of possible risks and any action taken. A focus on processes and systems ... 4. Physical Environment Committee is to adopt, implement and monitor a comprehensive hospital wide safety program, designed to produce safe characteristics and practices for the elimination and/or reduction, to the greatest extent possible, hazards to patients, visitors and staff... A root cause analysis (RCA) shall be conducted on all incidents that impact or threaten patient safety and close calls involving a recipient of care... A patient safety concern is an unexpected occurrence involving death, permanent harm or severe temporary harm of a patient or the risk thereof... The phrase "risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. To identify, analyze for root cause, and improve to the extent possible, the following events will always have a root cause analysis: 1. Suicide of a patient in a setting where the patient receives around the clock care, treatment or services or within 72 hours of discharge... 12. Any elopement (that is, unauthorized departure) of a patient from a staffed around-the clock care setting (including the ED), leading to death, permanent harm, or severe temporary harm to the patient... Upon notification of a patient safety concern or near miss, an administrative leader or his/her designee will initiate an immediate investigation involving appropriate department head and appropriate personnel. The basics of the RCA are: 1. Assign a team, including personnel closest to the occurrence along with supervisory staff to investigate the event immediately. 2. Set the goal of thirty (30) days for completion of the RCA. 3. Clearly define the event or near miss and brainstorm all possible causes. Focus on processes, not people... 5. Redesign the process that will eliminate the risk of the root cause occurrence. 6. Complete the RCA form and submit to Quality Management within 30 days of the event. Include the number, skill mix and competency of all staff on duty in the area of the occurrence. 7. Quality Management staff will assign a date and time for the team to meet and discuss the RCA with Adverse Outcomes Committee. 8. Follow up to the RCA will be required by the Adverse Outcomes Committee. Follow up should address the interventions put into place to avoid another occurrence. The Quality Management staff will assign dates for follow up ... The organization recognizes the impact of effective communication in the promotion of safety and quality. Effective communication is measured by timeliness, accuracy and use by the audience. Leadership roles in providing effective communication are: ... 2. Assessment of internal and external needs ... 4. Assess environmental changes as they relate to communication needs of the patients, community, physicians, staff and management... ... The organization will adhere to all requirements for mandatory reporting of adverse events and will meet requirements for voluntary program for patient safety concern reporting ... The Governing Board, Senior Leadership and the organized Medical Staff will collaborate and manage conflicts that may hinder the delivery of quality safe patient care The Adverse Outcomes Committee reviews the organization's initial management of Patient Safety concerns... Occurrence reporting is a key part of the management information system, provides support and assistance in the overall institutional objective of improved patient care ... Any hospital employee who becomes aware of an incident must report that incident by completing an Occurrence Report. The Occurrence Report consists of two components, an Incident Report and a Quality Assurance narrative, which provided in-depth detail. The Occurrence Report

is to be completed online... To complete an on-line Occurrence Report you must access Inside SAMC and do the following: ... 7. Complete the Incident Report by filling in all required fields ... 8. The next section is the Quality Assurance Narrative; this section provides in-depth details about the incident ... 10. Quality Management will receive immediate notification that an incident report has been submitted. 11. After being reviewed by Quality Management the occurrence Report will be forwarded to the appropriate Department Head for follow up/investigation by placing it on the Department Head's Midas work list. The Department Head will receive notification by e-mail that an incident report had been placed on their work list. The Department Head should complete the follow up/investigation within 72 hours ... 14. Department Investigations - The extent of investigation will depend on the seriousness of the event. The department head or designee shall investigate all incidents. Based on severity or trend direction, formal investigation will be performed by the department head or designee and/or Risk Management. 15. Analysis - The Quality Management Department is responsible for producing a monthly analysis of incidents by type, location and time to appropriate committees and administration for review. Refer to A144 and A286 for individual information related to PI # 1, PI # 2, PI # 4, PI # 6 and PI # 7. 30952 On 8/24/17 at 1:00 PM the surveyor reviewed a facility document titled, "Minutes Houston County Health Care Authority Quality Committee, June 14, 2017. Included in the June 2017 Quality Committee (QC) Meeting was documentation a DNV (Det Norske Veritas) (accrediting organization) survey visit occurred in May at the end of Southeast Alabama Medical Centers' optimization process (\$30 million operating expense reduction). The documented finding was the Safety Council failed to meet to evaluate Quality Improvement of corrective action plans during the optimization process. Further review of the June 2017 QC Meeting documentation was QPRC (Quality Peer Review Committee) /Adverse Outcomes Case Presentation by the Chief Medical Officer concerning 2 patients with suspected cancer and questionable biopsy reports. Pathology was notified, results reviewed and confirmed as reported. The physician remained unconvinced, repeated the biopsies. The repeat biopsy results confirmed the mistake. Additionally, the QC meeting documentation revealed the pathologists attended the June QC meeting, reported on the root cause analysis results and new process implemented. There was no documentation the 5/30/17 patient suicide in the 3 North Behavioral Medical Unit was reviewed during the June 14, 2017 in the Quality Committee meeting. In an interview on 8/24/17 at 1:29 PM, the surveyor requested the July 2107 Quality Committee Meeting documentation from Employee Identifier (EI) # 1, Director of Quality Management. EI # 1 confirmed the QC Committee meetings were monthly. EI # 1 reported the committee did not meet in July and had not met in August as of August 24. The surveyor asked EI # 1 why the QC committee had not met in July? EI # 1 responded, I honestly do not know.