Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Northern Indiana Healthcare System Fort Wayne and Marion, Indiana

Report No. 04-01740-53 **December 27, 2004**

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General

Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care and benefits services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections, Audit, and Investigations to provide collaborative assessments of VA medical facilities and regional offices 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 and benefits services.
- Determine if management controls ensure compliance with regulations and VA policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- 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 June 7–10, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Northern Indiana Healthcare System (the System). The purpose of the review was to evaluate selected operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness training to 184 employees. The System is under the jurisdiction of Veterans Integrated Service Network (VISN) 11.

Results of Review

The CAP review covered 17 areas. The System complied with selected standards in the following 11 areas:

- Accounts Receivable
- Agent Cashier
- Contracting
- Controlled Substances Accountability
- Government Purchase Card Program
- Information Technology Purchasing
- Information Technology Security
- Medical Care Collections Fund
- Personal Funds of Patients
- Timekeeping for Part-Time Physicians
- Unliquidated Obligations

Based on our review, the following organizational strengths were identified:

- The use of patient restraints had declined significantly.
- Managers implemented an effective method of alerting employees to behavioral emergencies in mental health inpatient and nursing home care units.
- Medical Care Collections Fund (MCCF) procedures were effective.

We identified six areas that needed additional management attention. To improve operations, the following recommendations were made:

- Enforce training and certification policies for the use of moderate sedation, and analyze related adverse patient events.
- Correct environmental deficiencies.
- Strengthen inventory management controls.
- Improve aspects of the QM program.

Suggestions for improvement were made in the following areas:

- Develop policies for the use of Government travel charge cards.
- Improve accountability over security bands used to seal pharmaceutical storage containers.

This report was prepared under the direction of Mr. Freddie Howell, Jr., Director, and Mr. William J. Gerow, Jr., Audit Manager, Chicago Audit Operations Division.

Facility Director Comments

The VISN 11 Director agreed with the CAP review findings, recommendations, and suggestions, and provided acceptable improvement plans. (See Appendix A, pages 12–18 for the full text of the Director's comments.) We will follow up on the implementation of recommended improvement actions until they are completed.

(original signed by:)
RICHARD J. GRIFFIN
Inspector General

Introduction

Facility Profile

Organization. The System is a primary medical care and mental health organization located on two main campuses in Fort Wayne and Marion, Indiana. The two campuses are approximately 50 miles apart. The System provides outpatient health care services at both campuses and at community-based outpatient clinics in South Bend and Muncie, Indiana. The System is part of VISN 11, and serves a veteran population of about 164,500 in a primary service area that includes 15 counties in Indiana and 3 counties in Ohio.

Programs. The System provides primary and secondary medical and surgical care at its Fort Wayne campus. The Marion campus provides chronic and acute psychiatric care, primary medical care, and long-term care. Specialty programs provided by the System include adult day health care, audiology and speech pathology, cardiology, day treatment, dentistry, home health care, oncology, ophthalmology, optometry, physical medicine and rehabilitation, podiatry, post-traumatic stress disorder care, pulmonary, respite care, sub-acute rehabilitation, substance abuse, and urology. The System has 42 medical beds, 201 psychiatry beds, and 180 nursing home care beds.

Affiliations and Research. The System is not affiliated with a school of medicine, but has affiliations with 10 universities, colleges, and technical schools, including Purdue University, Ball State University, Ivy Tech State College, and Tucker Career and Technology Center. Affiliated training programs include pharmacy, nursing, social work, and optometry. The System does not operate a research program.

Resources. The System's projected Fiscal Year (FY) 2004 expenditures are $139 million, a 12 percent increase over FY 2003 expenditures of $124 million. As of May 1, 2004, staffing was 1,102 full-time equivalent employees (FTE), including 48 physician FTE and 390 nursing FTE.

Workload. In FY 2003, the System treated 33,339 unique patients, a 7 percent increase over the FY 2002 figure of 31,131. The FY 2003 inpatient average daily census was 101, and the nursing home care average daily census was 141. In addition, FY 2003 outpatient workload totaled 211,350 visits, a 6 percent increase over the FY 2002 workload of 200,136.

Objectives and Scope of the CAP Review

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care and benefits services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility and regional office operations focusing on patient care, QM, benefits, and financial and administrative controls.
- 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, financial, and administrative activities to evaluate the effectiveness of patient care administration, QM, and management controls. 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. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. The review covered medical center operations for FYs 2002, 2003, and 2004 through May 2004, and was conducted in accordance with OIG standard operating procedures for CAP reviews.

In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical, financial, and administrative records. The review covered the following activities:

Accounts Receivable	Information Technology Security
Agent Cashier	Medical Care Collections Fund
Contracting	Moderate Sedation Practices
Controlled Substances Accountability	Personal Funds of Patients
Environment of Care	Pharmaceutical Cache Program
Government Purchase Card Program	Quality Management
Government Travel Charge Card Program	Supply Inventory Management
Information Technology Purchasing	Timekeeping for Part-Time Physicians
	Unliquidated Obligations

As part of the review, we used questionnaires and interviews to survey employee and patient satisfaction with the timeliness of service and the quality of care. We made electronic survey questionnaires available to all System employees with Internet access and 81 responded. We also interviewed 30 patients during the review. The surveys indicated high levels of employee and patient satisfaction and did not disclose any significant issues. The survey results were shared with System managers.

Activities that were particularly effective or otherwise noteworthy are recognized in the Organizational Strengths section of the report (page 4). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 5-11). For these activities, we make recommendations or suggestions. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are

implemented. Suggestions pertain to issues that should be monitored by VISN and System management until corrective actions are completed. For those activities not discussed in the Organizational Strengths or Opportunities for Improvement sections, there were no reportable conditions.

During the CAP review, we also provided fraud and integrity awareness training sessions that were attended by 184 System employees. The briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating benefits fraud, false claims, procurement fraud, and bribery.

Results of Review

Organizational Strengths

Use of Patient Restraints Had Declined Significantly. The use of patient restraints, measured in hours, was monitored by clinical managers and had steadily declined prior to calendar year 2002. However, the System's senior managers identified the further reduction of the use of restraints as an organizational goal. The Chief and the Associate Chief Nurse of Behavioral Science and Mental Health Service asked mental health nursing staff to help develop and implement restraint reduction strategies. The coordinated effort resulted in a dramatic reduction in the hours of patient restraint use as illustrated in the following table.

Time Period	Restraint Use	Decrease from 2002
January-December 2002	48,196 hours	Baseline
January-December 2003	22,045 hours	54%
January-December 2004 (projected)	2,756 hours	94%

An Emergency Alarm System Was Effective. To improve patient, employee, and visitor safety, System managers implemented an effective method of alerting emergency response employees to patient behavioral emergencies. Employees at the Marion campus' inpatient mental health and long term care units carried small transmitters that, when activated, identified the location of an emergency over the facility's pager system. Employees stated that response times for emergency situations had improved dramatically.

Medical Care Collections Fund Procedures Were Effective. MCCF staff accurately identified the validity of bills, properly and timely established accounts receivable, and aggressively pursued collections. As of May 2004, 89 percent of all accounts receivable were less than 90 days old. MCCF staff were recently rated second in collection percentage among all VA MCCF operations. As a result, VISN 11 management tasked the System with providing MCCF services for VA medical centers in Detroit, Saginaw, and Ann Arbor, Michigan.

Opportunities for Improvement

Moderate Sedation Practices – Policies Needed To Be Enforced and Processes Needed To Be Established

Condition Needing Improvement. System managers needed to change System policy to ensure that contract physicians who are privileged to administer moderate sedation receive moderate sedation training and cardiopulmonary resuscitation certification. In addition, processes to analyze adverse patient events resulting from moderate sedation needed to be established.

Veterans Health Administration (VHA) policy requires that health care facilities establish guidance for providing care to patients who received any type of anesthesia, including moderate sedation. Moderate sedation is a drug-induced depression of consciousness used to control pain and discomfort associated with minor surgical procedures and diagnostic examinations. Patients who receive moderate sedation retain their ability to respond to verbal and tactile commands unlike patients who receive general anesthesia. No special measures are required to maintain the patients' cardiovascular functioning or spontaneous ventilation during the procedures.

Training and Certification Requirements. The System's policy governing moderate sedation requires that employees who administer sedation or monitor patients during and after sedation receive annual moderate sedation training. We reviewed scopes of practice and training records of two registered nurse (RNs) employees and training and credentialing and privileging (C&P) records of one physician employee. We also reviewed training and C&P records of two contract physicians who were clinically privileged to administer moderate sedation.

Documentation in the employees' training records showed that they had completed annual moderate sedation training within the year preceding our review. However, the two contract physicians' training records showed that they had not completed this training. Clinical managers stated that they believed that the contract physicians did not need to complete the training because they were not System employees. In addition, there was no evidence to show that the contract physicians had obtained cardiopulmonary resuscitation certification.

To ensure that all patients receive the same level of care, contract physicians who are clinically privileged to administer moderate sedation need to complete the same training and receive the same certification as System employees. The System's policy on moderate sedation needed to be changed to include contract physicians.

Adverse Patient Events. A formalized process was needed to capture information on adverse patient events related to moderate sedation. Although informal data collection

processes were in place for analyzing adverse patient events, they were not sufficient to ensure that clinical managers captured all of them.

Recommended Improvement Action(s) 1. We recommended that the VISN Director ensure that the System Director requires that: (a) System policy is changed to ensure that contract physicians who are privileged to administer moderate sedation meet the same requirements for training and certification as System employees and (b) a formal process is established to capture and analyze adverse patient events related to moderate sedation.

The VISN Director agreed with the findings and recommendations and reported that Surgical Service will work with Education Service to ensure that Licensed Independent Practitioners performing moderate sedation will receive annual training. In addition, a form has been developed to assist nursing staff in reporting adverse patient events related to moderate sedation. Focused reviews will be performed to ensure that adverse events related to moderate sedation are captured. The implementation plans are acceptable, and we will follow up on planned actions until they are completed.

Environment of Care – Safety and Environmental Deficiencies Needed To Be Corrected

Condition Needing Improvement. Managers needed to ensure that sharp instruments and hazardous cleaning products were secured and that patient medication and nourishment refrigerator temperatures were appropriately monitored. System managers also needed to ensure that infection control practices were employed to reduce the risk of infections and doors were secured to restrict access to unauthorized areas.

Security of Sharp Instruments and Hazardous Cleaning Products. There were scissors in unlocked utility rooms and drawers on inpatient units at both the Fort Wayne and Marion campuses. There were hazardous cleaning products that were not secured on a dementia unit and in an outpatient area. Sharp instruments and hazardous cleaning products should be secured in patient care areas to prevent accidental or purposeful injury to patients, visitors, and employees.

Monitoring of Refrigerator Temperatures. According to medication and nourishment refrigerator temperature logs, refrigerator temperatures were not consistently monitored on three inpatient units at the Marion campus. Refrigerator temperatures should be monitored daily to ensure that the medications and nourishments they contain are maintained at safe temperatures.

In addition, the refrigerator temperature on an outpatient unit was below the acceptable range during 3 days in June 2004. There was no documentation to show that action had been taken to correct the condition, although the temperature on the day of our inspection was within the acceptable range.

Infection Control Practices. There were pillows with damaged surfaces on three inpatient units at both the Fort Wayne and Marion campuses. There were cracked and torn surfaces on furniture in the dayrooms on two inpatient units at the Marion campus. Nursing supervisors stated that housekeeping and nursing staff, who clean and maintain patient care areas, are required to inspect items that patients may use and report damage so that items can be replaced. Pillows and furniture with compromised surfaces are infection control risks to patients.

Security. There was an unlocked door in an Intensive Care Unit (ICU) waiting area at the Fort Wayne campus that allowed unrestricted access to the roof. The nurse manager for the ICU was unaware that the door was unlocked. This condition posed a safety risk for patients, visitors, and employees.

Recommended Improvement Action(s) 2. We recommended that the VISN Director ensure that the System Director requires that: (a) sharp instruments and hazardous cleaning products be secured; (b) patient medication and nourishment refrigerator temperatures be monitored and maintained within an acceptable range; (c) pillows and furniture in patient care areas be regularly inspected and replaced if damaged; and (d) doors to restricted access areas be secured.

The VISN Director agreed with the findings and recommendations and reported that policies regarding the storage and security of cleaning products and sharp instruments have been reinforced to nursing staff. Nursing Service will complete a focused review on the monitoring of medication refrigerator temperatures. A follow-up review will be conducted by the end of the first quarter of FY 2005. The need for additional reviews will be determined by the results of these reviews. Housekeepers and supervisors will routinely check furniture and bedding for damage and wear and submit work orders for repair. Nursing staff will conduct a review of pillow and furniture surfaces and will take appropriate remedial action. Hardware on the door to the roof access will be adjusted to make it easier to secure by deadbolt. The implementation plans are acceptable, and we will follow up on planned actions until they are completed.

Supply Inventory Management – Inventory Controls Needed To Be Strengthened

Condition Needing Improvement. VHA policy establishes a goal that medical facilities carry no more than a 30-day supply of medical, prosthetic, and other types of supplies. To assist medical facilities in meeting the goal, VHA policy also requires use of the automated Generic Inventory Package (GIP) for medical supplies and recommends its use for other types of supplies. The policy also recommends use of the automated Prosthetics Inventory Package (PIP) for prosthetic supplies. Inventory managers can use GIP and PIP to analyze usage patterns, establish normal stock levels, determine optimum order quantities, and help conduct physical inventories.

In FY 2003, the System spent $4.3 million on medical, prosthetic, and building management supplies. Business Support Services staff used GIP to manage medical supplies, and Medical Business Office (MBO) staff used PIP to manage prosthetic supplies. To determine the accuracy of the quantities and values of supplies reported in the two systems and to test the reasonableness of inventory levels, we reviewed inventory data and a judgment sample of line items recorded in each system.

Use of GIP. GIP was fully implemented for medical supplies maintained by Supply Processing and Distribution (SPD) staff at both the Fort Wayne and Marion campuses and by warehouse staff at Marion. However, GIP was not implemented for three inventory control points: engineering supplies at Marion and dental and laboratory supplies at Fort Wayne. At the time of our review, GIP was scheduled to be implemented by August 2004 for engineering supplies and by January 2006 for dental and laboratory supplies. In addition, GIP was not fully implemented for five other inventory control points. Business Support Services staff had not implemented bar coding and scanning procedures for dental, laboratory, and radiology medical supplies at Marion and radiology and janitorial supplies at Fort Wayne. The use of bar coding and scanning procedures is critical for identifying items, determining restocking levels, and updating inventory.

Reported Stock Quantities. Information in GIP and PIP did not accurately reflect supply levels on hand of medical and prosthetic supplies. Business Support Services and MBO staff had not correctly recorded transactions in GIP and PIP when removing items from inventory. Inaccuracies in inventory data can lead to unexpected shortages of needed supplies or premature replenishment.

Excess Inventory. Business Support Services staff needed to monitor supply usage rates and reduce stock levels to achieve VHA's 30-day supply goal. The warehouse and SPD functions at Fort Wayne and Marion had significant numbers of medical supply items that were in excess of a 30-day supply. Fifty-five percent of the inventory in the Marion warehouse (140 of 257 line items) exceeded 30-day supply levels. Seventy-three percent of the inventory maintained in Fort Wayne's SPD (461 of 635 line items) exceeded 30-day supply levels. Thirty-three percent of the inventory maintained in Marion's SPD (257 of 779 line items) exceeded 30-day supply levels. The value of all excess supplies totaled about $48,000. Excess supply inventories tie up funds that could be put to other uses.

Physical Inventory. VHA policy requires that a complete physical inventory of medical supplies be conducted annually. Business Support Services staff could not recall when complete physical inventories of dental, laboratory, and radiology medical supplies at Fort Wayne were last conducted.

Recommended Improvement Action(s) 3. We recommended that the VISN Director ensure that the System Director takes action to: (a) fully implement GIP; (b) improve the

accuracy of GIP and PIP by ensuring that transactions are correctly recorded into these systems; (c) reduce inventory levels to a 30-day supply; and (d) conduct annual physical inventories of dental, laboratory, and radiology medical supplies.

The VISN Director agreed with the findings and recommendations and reported that as of September 2, 2004, barcoding and scanning was being used for all functioning GIP inventories including dental, laboratory, and radiology medical supplies on both System campuses. Full implementation of GIP for engineering inventory is planned for February 1, 2005. The System instituted process changes and increased accountability to maintain an accurate accounting of inventory including establishing positions in SPD responsible for entering receipts and posting stocks. Supplies issued from SPD stock use GIP scanning. As of September 2, 2004, PIP had been fully implemented. A review of inventory items for adjustment and potential removal from stock will be completed. As of September 2, 2004, procedures had been established to ensure that annual physical inventories of GIP stock are completed. The implementation plans are acceptable, and we will follow up on planned actions until they are completed.

Quality Management – Aspects of the Program Needed To Be Improved

Condition Needing Improvement. The System's QM program, referred to as Performance Improvement (PI), was effective. Senior managers demonstrated support for PI by participating in PI activities and providing necessary resources to accomplish initiatives. However, there were aspects of the program that needed to be improved.

Implementation and Monitoring. We reviewed one health failure mode and effects analysis (HFMEA™)[1] and four aggregated root cause analyses (RCA). Recommendations for corrective actions from the reviews were not always implemented, even though senior managers had agreed with the recommendations. For example, recommendations that proposed strategies to improve searches for missing patients were not implemented because managers were waiting for a new VHA missing patient policy to be approved. This condition existed for over 1 year. In addition, even though corrective actions deriving from the four aggregated RCAs were implemented, processes were not established to ensure that corrective actions were effective.

Analysis of Collected Assault Data. PI staff collected extensive data on patient assaults and regularly reported the data at committee meetings. However, System managers did not analyze or use the data to develop and implement strategies that could reduce incidents of assault and improve patient, employee, and visitor safety.

Recommended Improvement Action(s) 4. We recommended that the VISN Director ensure that the System Director requires that: (a) recommendations from HFMEA™ and

[1] HFMEA™ is a systematic approach that identifies and prevents product and process problems before they occur.

RCA reviews are implemented timely and corrective actions are monitored for effectiveness; and (b) System managers analyze and use patient assault data to develop and implement strategies to reduce such incidents and improve patient, employee, and visitor safety.

The VISN Director agreed with the findings and recommendations and reported that, as of September 2, 2004, delinquent HFMEA™ and RCA action items were being reviewed monthly by the Senior Leadership and Joint Conference Council. Senior managers are sent summary information that distinguishes between delinquent and pending items and that allows them to reinforce an expectation of timeliness. By October 1, 2004, System management planned to initiate quarterly aggregate RCA reviews of assault data. The Patient Safety Report will display data that will indicate the effectiveness of RCA action items related to patient assaults. The implementation plans are acceptable, and we will follow up on planned actions until they are completed.

Government Travel Charge Card Program – Policy Covering Misuse of Charge Cards Was Needed

Condition Needing Improvement. VA policy prohibits the use of Government travel charge cards when cardholders are not traveling on Government business. According to VA policy, misuse of a Government travel charge card subjects a cardholder to disciplinary action ranging from reprimand to removal. Because the System did not have local policy governing the use of Government travel charge cards, supervisors did not appropriately discipline two employees for misuse of their cards.

MBO records showed that in January, February, and March 2004, an employee used a Government travel charge card while not in travel status for 16 cash advances totaling $725.35, including fees. In March 2004, the MBO manager, who was not the employee's supervisor, sent the employee a counseling memorandum. Because this memorandum was not a supervisory reprimand and did not affect an adverse action against the employee, it did not constitute a disciplinary action as required by VA policy.

During April and May 2003, a second employee took seven cash advances totaling $713.25, including fees, while not in travel status. In July 2003, the MBO manager sent the employee a counseling memorandum. However, in January, February, and March 2004, the employee again used the card for nine cash advances totaling $1,675.05, including fees. In March 2004, the MBO manager, who was not the employee's supervisor, sent the employee another counseling memorandum and reduced the employee's cash advance limit to $1. Because the memoranda were not supervisory reprimands and did not affect adverse actions against the employee, they did not constitute disciplinary actions as required by VA policy.

Misuse of the Government travel charge card is a serious offense that justifies disciplinary action. Counseling memoranda that are issued by an official other than an

employee's supervisor and do not become part of an employee's Official Personnel File do not constitute disciplinary action.

Suggested Improvement Action(s) 1. We suggested that the VISN Director ensure that the System Director develops and implements policy for the use of Government travel charge cards that includes procedures for disciplinary actions if cardholders misuse them.

The VISN Director agreed with the finding and suggestion and reported that, by December 15, 2004, a local Government travel card policy will be developed that will detail guidance and procedures for disciplinary action for misuse of travel cards. The implementation plan is acceptable.

Pharmaceutical Cache Program – Control of Security Bands Needed To Be Improved

Condition Needing Improvement. Pharmacy Service staff needed to improve accountability of numbered security bands used to seal pharmaceutical cache storage containers. VA's Pharmaceutical Cache Program was established to provide emergency medical support to the general public in the event of a natural disaster, emergency, or terrorist attack. The cache is a stockpile of medications, treatment kits, intravenous solutions, and other medical supplies.

Pharmaceutical cache containers were sealed with serially numbered security bands. During monthly unannounced controlled substances inspections, inspectors verified the numbered security bands on the containers. Once every 3 months, inspectors required that the security bands be cut so that they could verify the contents of the containers. Although Pharmacy Service staff replaced the cut bands and recorded new serial numbers, they did not use the bands in sequential order and did not know the exact number of bands on hand. Therefore, an individual could gain access to the contents of a container without detection by cutting the band, replacing it, and recording the new band number. During our review, the Chief, Pharmacy Service took action to record the serial numbers of all security bands and to require that bands be used and recorded sequentially.

Suggested Improvement Action(s) 2. We suggested that the VISN Director ensure that the System Director takes action to improve security of the pharmaceutical cache by improving accountability of security bands.

The VISN Director agreed with the finding and suggestion and reported that, as of July 2004, a log of security bands for pharmaceutical cache stocks had been developed and that bands were being used in sequential order. The implementation plan is acceptable.

Appendix A

VISN 11 Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 2, 2004

From: Network Director, VISN 11 (10N11)

Subject: Combined Assessment Program Review of the VA Northern Indiana Healthcare System

To: Assistant Inspector General for Audit (52)

1. In response to the Draft Report of the Combined Assessment Program review for the VA Northern Indiana Healthcare System, attached please find comments, corrective actions plans, and completion dates for each recommendation and suggestion, as provided by the System Director.

2. I have reviewed and concur with the attached response.

(*original signed by*:)
Linda Belton

Attachment

Director Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendation and suggestions in the Office of Inspector General Report:

OIG Recommendation(s)

Recommended Improvement Action(s) 1. We recommend that the VISN Director ensure that the System Director requires that: (a) System policy is changed to ensure that contract physicians who are privileged to administer moderate sedation meet the same requirements for training and certification as System employees;

Concur **Target Completion Date:** November 1, 2004

Surgical Service will work with Education Service to ensure that all Licensed Independent Practitioners performing moderate sedation undergo moderate sedation training annually, and this competency will be documented in the Surgical Service files.

and (b) a formal process is established to capture and analyze adverse patient events related to moderate sedation.

Concur **Target Completion Date:** October 1, 2004

NIHCS reviewed our current process of obtaining information on adverse patient events related to moderate sedation. Currently, the nurses in the involved areas send an e-mail with the information to a PI Nurse for further analysis. Our review of the process also indicated that the only type of event typically reported is administration of reversal agents. We did query other VAs in an attempt to identify a better process. We found from those that responded that our process is not that unusual, in that other VAs also obtain this information via methods such as e-mail, phone calls and faxes.

Nursing and Performance Improvement have developed a form which we believe is preferable to the current e-mail system of reporting. While the e-mail method was open-ended, the new form has check boxes which cue the nurse to indicate other types of reactions, rather than just reversals. We believe this will encourage more timely and complete reporting.

Action Plan:

1) Change from e-mail reporting mechanism to the new Moderate Sedation Outcomes fax form. Target date: implementation by October 1, 2004.

2) Complete focused review of 10% of records involving moderate sedation procedures to validate that adverse events are being captured. Target: review each quarter of FY 2005, with joint review of effectiveness of fax form by Nursing PI and Performance Improvement RN.

Recommended Improvement Action(s) 2. We recommend that the VISN Director ensure that the System Director requires that: (a) sharp instruments and hazardous cleaning products be secured;

Concur **Target Completion Date:** September 1, 2004

Policies regarding storage of cleaning products and storage of sharp instruments was discussed with 4E nursing staff on July 9, 2004.

Policies regarding storage of cleaning products will be shared with 172-1E and all nursing staff by 9-30-2004. Nursing staff will also share policies and remind staff that all soiled utility rooms should be locked to further secure sharp instruments.

Environmental Management Department (EMD) has reinforced to staff, through staff meetings and training classes, the importance of securing housekeeping closets and keeping cleaning products away for patients and visitors. EMD supervisors will be participating in environmental rounds to observe and ensure that products are not left out in the open.

(b) patient medication and nourishment refrigerator temperatures be monitored and maintained within an acceptable temperature range;

Concur **Target Completion Date:** September 30, 2004

Nursing will complete a focused review regarding the monitoring of medication refrigerators temperatures by 9-30-04 with a subsequent review completed by end of first quarter 2005. The need and frequency of subsequent reviews will be determined by the results of the initial reviews.

Nutrition & Food Service will reinforce their Standard Operating Procedure regarding nourishment refrigerators through staff meetings and supervisors with quarterly review for compliance.

Refrigerator temperature will continue to be monitored and documented during Environment of Care rounds.

(c) pillows and furniture in patient care areas be regularly inspected and replaced if damaged;

Concur **Target Completion Date:** September 1, 2004

EMD housekeepers and supervisors will routinely check furniture and bedding during cleaning activities. Broken or worn furniture/bedding will be work-ordered for repair. If damaged or worn beyond repair, replacement will occur. Staff will be reminded that torn or ripped furniture/bedding could lead to infection control problems and should be eliminated.

In addition, nursing staff will conduct a review of pillow and furniture surfaces and take appropriate action by September 30, 2004 so that items may be replaced.

Nursing staff will be re-educated regarding the need to assist EMD with continuous monitoring for damaged surfaces by 9-30-04.

and (d) doors to restricted access areas be secured.

Concur **Target Completion Date:** October 1, 2004

The door is keyed for engineering access to the rooftop mechanical room. A workorder was issued to adjust door hardware, making deadbolting easier. Engineering staff reminded to secure roof access doors, to and from work area.

Recommended Improvement Action(s) 3. We recommend that the VISN Director ensure that the System Director takes action to: (a) fully implement GIP;

Concur **Target Completion Date:** February 1, 2005

Since the review, NIHCS has continued to expand its implementation of GIP and is using barcoding and scanning procedures for all areas with functioning inventories, which now also encompasses dental, laboratory and radiology supplies at both campuses. Active inventory management is in place for the clinical areas identified and items continue to be added as identified. The engineering GIP inventories are being built. Approximately 250 items have been identified and loaded into the system and barcode labels are in the process of being affixed. Full implementation of the engineering inventories will occur concurrent to the filling of vacancies currently being recruited specific to the GIP program.

(b) improve the accuracy of GIP and PIP by ensuring that transactions are correctly recorded into these systems;

Concur **Target Completion Date:** October 1, 2004

NIHCS has instituted numerous process changes and increased accountability in order to maintain an accurate accounting of inventory. By example, SPD has established a position at each campus that is responsible for entering receipts and posting stock and all respective SPD staff are accountable to report all transactions to these individuals for posting. Inclusively, all issues are conducted using GIP scanning and up-loading procedures and the auto-generation of picking tickets.

PIP has been fully implemented. We will review procedures to ensure inventory accuracies.

(c) reduce inventory levels to a 30-day supply;

Concur **Target Completion Date:** October 1, 2004

Staff are actively reviewing inventory items for adjustment in stocking level and for potential for removal where no longer in use. This work should be completed by October 1, 2004.

It is anticipated, however, that it will not be possible to reduce the inventory level of all items to a 30 day level. Although items are purchased in the smallest case sizes available, there are a significant number of the items mandated to be stocked that will not be utilized within 30 days due to the relative low usage of the respective item.

and (d) conduct annual physical inventories of dental, laboratory, and radiology medical supplies.

Concur **Target Completion Date:** Completed

NIHCS concurs that recurring inventories of all formal GIP inventories should be conducted at least annually. Procedures are currently in place to accomplish these recurring inventories.

Recommended Improvement Action(s) 4. We recommend that the VISN Director ensure that the System Director requires that: (a) recommendations from HFMEA™ and RCA reviews are implemented timely and corrective actions are monitored for effectiveness;

Concur **Target Completion Date:** Completed

Delinquent RCA and HFMEA action items are now reviewed monthly with Senior Leadership at Joint Conference Council. In addition, Senior Leaders are sent a summary log of all outstanding action items (both delinquent and pending) monthly. The communication of "pending, not yet delinquent" items gives senior leaders time to reinforce the expectation of timely implementation in order to prevent future delinquent items. Effectiveness will be measured by decrease in number of delinquent items through review of logs with senior leaders.

and (b) System managers analyze and use patient assault data to develop and implement strategies to reduce such incidents and improve patient employee, and visitor safety.

Concur **Target Completion Date:** October 1, 2004

The current practice of providing data logs to Prevention and Management of Disruptive Behavior Committee has not resulted in action plans, merely review of data.

NIHCS will conduct a quarterly aggregate RCA review of assault data for FY 2005. The Patient Safety Report will continue to display data on events including patient-to-staff and patient-to-patient assaults which will indicate effectiveness of RCA action items related to these aggregates.

OIG Suggestion(s)

Suggested Improvement Action(s) 1. We suggest that the VISN Director ensure that the System Director develops and implements policy for the use of Government travel charge cards that includes procedures for disciplinary action if cardholders misuse their cards.

Concur **Target Completion Date:** December 15, 2004

A local Government Travel Card policy will be developed and implemented to ensure the card holders understand their responsibilities. The policy will also detail appropriate guidance and procedures for disciplinary action for misuse of travel cards.

Suggested Improvement Action(s) 2. We suggest that the VISN Director ensure that the VAMC Director takes action to improve security of the pharmaceutical cache by improving accountability of security bands.

Concur **Target Completion Date:** July 2004

A log of all security bands for the pharmaceutical cache is now maintained at each campus. At the time of the July 2004 narcotic inspection the bands were replaced and are now being used in sequential order.

Appendix B

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
3c	Reducing supply inventories would free up funds for other uses.	$48,000

Appendix C

OIG Contact and Staff Acknowledgments

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Appendix D

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