Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Iowa City Health Care System Iowa City, Iowa

Report No. 06-01602-219 **September 25, 2006**

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 is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- 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 19-23, 2006, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Iowa City Health Care System (the system). The purpose of the review was to evaluate selected operations, focusing on patient care administration, quality management, and administrative controls. During the review, we also provided fraud and integrity awareness training to 53 employees. The system is part of Veterans Integrated Service Network (VISN) 23.

Results of Review

The CAP review covered seven areas. The system complied with selected standards in the following two areas:

- Breast Cancer Management
- Diabetes and Atypical Antipsychotic Medications

We identified the following organizational strength:

- Volunteer drivers ensure patients receive care.

We made recommendations in five of the seven activities reviewed. For these activities, the system needed to:

- Improve re-privileging of clinicians and systematic reviews.
- Correct identified environmental deficiencies.
- Improve the VA Community Nursing Home Program's Oversight Committee membership and patient monitoring.
- Improve program oversight of patient transportation services.
- Address satisfaction areas that are below the target in the Survey of Healthcare Experiences of Patients.

This report was prepared under the direction of Ms. Verena Briley-Hudson, Director, and Ms. Wachita Haywood, Associate Director, Chicago Office of Healthcare Inspections.

VISN and Health Care System Director Comments

The VISN and Health Care System Directors agreed with the CAP review findings and provided acceptable improvement plans. (See Appendixes A and B, pages 12–18, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

System Profile

Organization. The VA Iowa City Health Care System (the system) provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five community based outpatient clinics located in Bettendorf, Dubuque, and Waterloo, Iowa; and Galesburg and Quincy, Illinois. The system is part of Veterans Integrated Service Network (VISN) 23 and serves a veteran population of about 184,000 in a primary service area that includes 32 counties in eastern Iowa and 16 counties in western Illinois.

Programs. The system provides medical, surgical, and mental health services and has 93 authorized hospital beds. The system is a national kidney transplant referral site and also has sharing agreements with the University of Iowa, their affiliated institution, to provide liver and simultaneous kidney-pancreas transplant services. Other sharing agreements for specialized physician/technical services include maxillofacial surgery, neuro/interventional radiology, urology, otolaryngology, neurology, cytotechnology, obstetrics, and gynecology. In addition, the system provides tissue typing services through sharing agreements with both the University of Iowa and the Iowa Donor Network and shares use of a system-owned Magnetic Resonance Imager purchased through a joint venture with Mercy Hospital, another community sharing partner.

Affiliations and Research. The system is affiliated with the University of Iowa Colleges of Medicine, Nursing, Pharmacy, and Dentistry and supports 9 medical resident positions in 28 training programs. In fiscal year (FY) 2005, their research program had 267 active research protocols, a budget of $8.7 million in VA funding, and $38 million in funding from other agencies, such as the National Institutes of Health. Important areas of research include the biology of inflammation, diabetic vascular disease, cancer, and immunology. They are a recipient of two 5-year Research Enhancement Award Programs (REAPs) and a Gulf War Special Initiative. The REAPs focus on the study of prostate cancer and vascular complications of diabetes; and the Gulf War initiative addresses infection with leishmaniasis, a blood-borne parasitic infection contracted by some Gulf War veterans. In addition to a successful medical research program, the system has developed an active Health Services Research and Development program.

Resources. In FY 2005, medical care expenditures totaled $165.2 million. The FY 2006 medical care budget is projected to be $164.5 million, a 0.4% decrease from FY 2005. FY 2005 staffing was 1,037 full-time equivalent (FTE) employees, including 81 physician and 279 nursing FTE.

Workload. In FY 2005, the system treated 40,335 unique patients, a 1.7 percent increase from FY 2004. The inpatient care workload totaled 3,426 discharges, and the average daily census was 55. The outpatient workload was 221,864 visits.

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 services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations focusing on patient care, quality management (QM), 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 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.

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

- Breast Cancer Management
- Diabetes and Atypical Antipsychotic Medications
- Environment of Care
- Patient Transportation Services
- Quality Management
- Survey of Healthcare Experiences of Patients (SHEP)
- VA Community Nursing Home (CNH) Program

The review covered system operations for FY 2005 and FY 2006 through June 16, 2006, and was done in accordance with OIG standard operating procedures for CAP reviews.

During this review, we also presented 3 fraud and integrity awareness briefings for 53 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report we make recommendations for improvement that pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities needing improvement are discussed in the Opportunities for Improvement section (pages 4-9).

Results of Review

Organizational Strength

Volunteer Drivers Ensure Patients Receive Care

The extensive use of volunteer drivers enables a significant number of patients with no other means of transportation to keep their appointments. The system has over 200 volunteer drivers enrolled in the Disabled American Veterans' Transportation Network. During 2005, volunteer drivers donated 42,371 hours and drove over 985,000 miles, transporting over 16,600 patients to and from their appointments. Statistics for January through March 2006 show that the demand for these services is increasing. During this 3-month period, volunteer drivers donated 11,304 hours, logged over 258,200 miles, and transported over 4,300 patients.

Opportunities for Improvement

Quality Management Program – Re-Privileging of Clinicians and Systematic Reviews Required Improvement

Condition Needing Improvement. The QM program was generally effective, and senior managers actively participated in and supported QM activities and initiatives. However, several aspects of the QM program had not been systematically reviewed during the previous year; this included the re-privileging process, which was identified as problematic during the previous CAP review. The following aspects required management attention.

Re-Privileging of Clinicians. A review of six credentialing and privileging (C&P) folders of clinicians who had been re-privileged within the previous 12 months revealed that clinician-specific performance improvement (PI) information was not considered prior to the granting of renewed clinical privileges. VHA policy requires that the re-privileging process includes an appraisal of professional performance, judgment, and clinical/technical competence and skills based in part on clinician-specific PI activities.

Cardiopulmonary Resuscitation (CPR) Education and Advanced Cardiac Life Support (ACLS) Certification. Further review of these six C&P folders showed that four clinicians had no current documentation of CPR education, and two others, an anesthesiologist and a surgeon, had no current documentation of ACLS certification. VHA policy requires that all clinically active staff have had CPR education and that certain clinical staff who participate in critical care procedures or surgeries have current ACLS certification. Managers needed to ensure that clinicians have the appropriate education or certification based on their privileges.

Medical Records Reviews. VHA and the Joint Commission on Accreditation of Healthcare Organizations require that medical records are reviewed on an ongoing basis at the point of care. During the most recent 12-month period, managers conducted medical records reviews for only the 6 months prior to this CAP review. Without ongoing analysis of documentation in patients' medical records, it was difficult for managers to evaluate the completeness or effectiveness of the care provided or to make recommendations for improvement.

Peer Reviews. Managers were not timely in establishing the system's peer review policy, peer review committee, and regular committee examination of peer reviews. According to VHA policy, a system-developed peer review policy was required by March 2005, and a peer review committee was to be established and meet quarterly. Their peer review policy was not effective until August 2005; the first Peer Review Committee meeting was in September 2005, resulting in only one committee meeting in FY 2005. The committee first considered peer reviews beginning with the 1st quarter of FY 2006 in January 2006.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the System Director requires that: (a) clinician-specific PI data are appropriately considered during the re-privileging process and documentation of this data review is maintained, (b) all clinically active staff have had CPR education and that those staff who participate in critical care procedures or surgeries have current ACLS certification, (c) medical records reviews are regularly conducted at the point of care, and (d) peer reviews are submitted for committee review quarterly as required by VHA policy.

Environment of Care – Environmental Deficiencies Needed To Be Corrected

Condition Needing Improvement. VA policy requires that the system be clean, sanitary, and maintained to optimize infection control and patient safety. We inspected a sample of occupied and made-ready patient rooms and their restrooms (private and communal). We found that the system was generally clean and effectively maintained. The following concerns required management attention.

Emergency Call System Cords. Emergency call system cords were of a rope-like material and were observed in patient restrooms near sink, commode, and shower areas. Many of these cords appeared soiled, and the surfaces could not be easily cleaned due to the fabric consistency of the cords. Some of the cords were not long enough to be accessible from the floor.

Security of Cleaning Products, Electrical Boxes and System Panels, and Sharp Items. Multiple spray bottles of a disinfectant product were stored in the unlocked biohazardous waste storage room on three inpatient units. In one of these storage rooms, there was an unlocked electrical box and a system panel with the key in it. There were unlocked

treatment carts in patient rooms in the Intensive Care Unit. These carts contained needles and other sterile supplies.

Security of Patient Health Information. As the OIG team was leaving the facility one evening at 5 p.m., we noted that a volunteer workroom door was open and unattended. A large stack of documents on a table in the room included patient names, addresses, and specific clinic appointment times. There were no employees or volunteers in the immediate area at the time.

Canteen Eyewash. We followed up on a recommendation from the previous CAP that eyewash equipment be installed in the canteen food preparation area. A permanent eyewash station was observed in this area. The Chief, Facilities Management Service (FMS), stated that FMS employees are required to test eyewash stations quarterly, and employees in the area where the eyewash is located are required to test them weekly. The Chief, Canteen Service, was not aware of the unit ever being tested or that Canteen Service employees should test the station weekly and maintain testing documentation.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the System Director requires that: (a) emergency call system cords are replaced with cords that can be easily cleaned and the cords are accessible from the floor; (b) cleaning products, electrical boxes and system panels, and sharp items are secured at all times; (c) patient health information is protected from unauthorized access; and (d) Canteen Service employees are trained on operating the eyewash station, unit testing is conducted weekly, and testing documentation is maintained.

VA Community Nursing Home Program – Oversight Committee Membership and Patient Monitoring Required Improvement

Condition Needing Improvement. VHA policy provides guidelines for the VA CNH Program, to include oversight and monitoring of patients who have been placed in CNHs by VA facilities. The system's Community Nursing Home/Adult Day Health Care Committee provides oversight of all CNH activities. VHA policy also requires that this oversight committee report to the chief clinical officer (Chief of Staff, Associate Director for Patient Care Services, or the equivalent) and includes multidisciplinary management-level representatives from social work, nursing, QM, acquisitions, and medical staff. The oversight committee did not include a representative from the medical staff and did not regularly report their CNH oversight activities to clinical leadership, such as the Clinical Executive Board (CEB).

We reviewed the medical records of 10 VA patients who were placed in CNH facilities. Nine of the 10 patients did not receive VA staff visits and/or monthly monitoring as required by VHA policy. A registered nurse (RN) had not visited CNH patients since December 2004. VHA policy requires that an RN participate in regular visits of CNH-placed patients and monitor the care of these patients.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the System Director requires that (a) a medical staff representative be appointed to the Community Nursing Home/Adult Day Health Care Committee and this committee regularly report to the system's CEB and (b) managers ensure that an RN visits CNH-placed patients and monitors their care in accordance with VHA policy.

Patient Transportation Services – Program Oversight Needed Improvement

Condition Needing Improvement. We reviewed the system's patient transportation service program as a follow-up to deficiencies identified during the previous CAP review in 2003. We determined that additional program oversight was required in the following areas.

Driving Record Reviews. We found documentation that employee motor vehicle operator (MVO) and volunteer driver licenses were annually verified and proof of insurance was documented for volunteer drivers. MVOs and volunteer drivers were receiving health examinations as required by VA policy. However, we found no evidence that supervisors completed an annual review of MVOs' and volunteer drivers' driving records. Review of driving records is important to determine any history of moving violations, accidents, or other violations that may impact a driver's suitability to transport patients.

Safe Driving Training. VA policy requires that facilities are to present at least one formal safe driving program annually. MVOs and volunteer drivers should also receive safe driving training prior to beginning their job of transporting patients. Voluntary Service managers maintained records of initial and annual driver training provided to volunteer drivers. Employee MVOs report that they have taken safe driving training; however, we were unable to find documentation of this annual training in their employee training records.

Security Practices. We observed a patient sitting in a shuttle vehicle that was parked in the system's ambulance entrance garage. The vehicle keys were in the ignition while the MVO was attending to other duties and was not in the immediate area. Managers needed to enforce that the shuttle vehicle be properly secured when the MVO must leave the area.

System Transportation Policy. The system policy, "Inter-Facility Transfer and Transport Services," dated March 27, 2006, was reviewed. The policy states that a form VAOP 378, "Doctor's Orders for Patient Transport" must be completed by the physician for patients who will be transported on the shuttle. However, managers reported that this documentation requirement has not been enforced and may not be necessary. Managers needed to determine if a physician's order for transport on the shuttle was still a requirement, modify the policy as appropriate, and enforce the policy. The policy also

needed to further detail requirements of the shuttle driver, to include the need to secure patient care equipment (such as wheelchairs, walkers, and oxygen bottles) during transports and properly secure vehicles when the MVOs are not in the immediate area.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the System Director requires that: (a) supervisors of MVOs and volunteer drivers complete annual driving record reviews, (b) MVOs complete safe driving training and the training is documented in the employees' official training records, (c) patient safety is maintained by properly securing the patient shuttle when not in use, and (d) system policy is amended to reflect any documentation requirements for patients riding the shuttle and the policy is strengthened by detailing responsibilities of the shuttle driver.

Survey of Healthcare Experiences of Patients – Satisfaction Areas Below Target Needed To Be Addressed

Condition Needing Improvement. Veteran patient satisfaction surveying is designed to promote health care quality assessment and improvement strategies that address patients' needs and concerns, as defined by patients. In 1995, VHA began surveying patients using a standardized instrument modeled from Picker Institute, a non-profit health care surveying group. The Performance Analysis Center for Excellence of the Office of Quality & Performance is the analytical, methodological, and reporting staff for the SHEP. Measure 21 of the VHA Executive Career Field (ECF) Performance Plan for FY 2006 states that in FY 2006 the percent of patients reporting overall satisfaction as Very Good or Excellent will meet or exceed the following targets:

	Meets Target	Exceeds Target
Ambulatory Care	77%	80%
Inpatients (Discharged 10/2004–6/2005)	76%	79%

Following are the graphs showing the system's SHEP results for inpatients and outpatients:

Dates of Survey Reporting period: Quarter 3, Quarter 4, FY 2005

VA Iowa City Health Care System

INPATIENT SHEP RESULTS

Facility Name	Access	Coordination of Care	Courtesy	Education & Information	Emotional Suppor	Family Involvement	Physical Comfort	Preferences	Transition
National	80.73	78.27	89.40	67.36	65.08	75.37	83.35	73.98	69.52
VISN	85.9+	81.2+	90.5+	68.60	66.40	76.20	86.5+	76.2+	71.4+
Medical Center	88.4+	83.1+	92+	70.6+	69.2+	75.30	87.6+	77.9+	72.9+

Dates of survey reporting period: Quarter 1, FY 2006

VA Iowa City Health Care System

OUTPATIENT SHEP RESULTS

	Access	ontinuity of Care	Courtesy	Education & nformation	Emotional Support	Overall Coordination	harmacy Mailed	harmacy Pick-up	Preferences	pecialist Care	isit Coordination
National	**81.5**	**78**	**95.3**	**73.1**	**83.7**	**76.2**	**82.6**	**66.5**	**82.2**	**80.7**	**85.2**
VISN	**85.5 +**	**77**	**97 +**	**74.2**	**85.2**	**78.2**	**85.5**	**72**	**83.3**	**82.7**	**87.9 +**
Outpatient Clinics-Overall	**81.5**	**85.4**	**95.5**	**76.4**	**83.5**	**80.1**	**86.2**	**74.5**	**83.6**	**85.4**	**85.5**

The system has not met the standards of ECF Performance Measure 21: Patient Satisfaction. Although the scores for the system were above the national averages in all nine inpatient areas measured, scores in the following four areas were less than the target: (1) Education & Information, (2) Emotional Support, (3) Family Involvement, and (4) Transition. Outpatient scores were lower than the target in the following two areas: (1) Education & Information and (2) Pharmacy Pick-Up.

Scores have been shared with employees and are available electronically. At the time of this review, there was no coordinated effort to analyze and review these data, no committee existed to develop improvement plans, and no actions had been taken.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the System Director requires that an action plan be developed and implemented to address satisfaction areas that are below the target.

Other Activities Reviewed

Breast Cancer Management – Processes Were Timely and Appropriate

The VHA breast cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. The system exceeded the fully satisfactory level for 3 of the 4 quarters in FY 2005. Timely diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. The system provides mammography to its patients by utilizing fee-basis providers.

The system provided a list of five patients. Of those five, one patient qualified for the population identified for the focused review. We assessed the timeliness and communication of the abnormal mammogram results. The patient received timely mammography services through a fee-basis provider. The system received timely notification of the patient's results and implemented an interdisciplinary treatment plan.

Diabetes and Atypical Antipsychotic Medications – Patients Were Appropriately Screened and Managed

The purpose of this review was to determine the effectiveness of diabetes screening, monitoring, and treatment of mental health patients receiving atypical antipsychotic medications (medications that cause fewer neurological side effects but increase the risk for the development of diabetes).

VHA clinical practice guidelines for the management of diabetes suggest that: (1) a diabetic patient's hemoglobin A1c, which reflects the average blood glucose level over a period of time, be maintained at less than 9 percent to avoid symptoms of hyperglycemia; (2) blood pressure should be less than or equal to 140/90 millimeters of mercury; and (3) cholesterol should be less than 120 milligrams per deciliter (mg/dL).

VHA clinical practice guidelines for screening patients who are at risk for the development of diabetes suggest that fasting blood glucose (FBG) is the preferred screening test and should be performed every 1–3 years. A normal FBG is less than or equal to 110 mg/dL. Patients with FBG values more than 110 mg/dL but less than 126 mg/dL should be counseled about prevention strategies (calorie-restricted diets, weight control, and exercise). A FBG value more than or equal to 126 mg/dL on at least two occasions is diagnostic for diabetes.

We reviewed a sample of 13 patients who were on one or more atypical antipsychotic medication for at least 90 days. One of the 13 patients had diabetes. The review showed that the system met or exceeded VHA clinical practice guidelines for diabetes management with the care of this patient. The system appropriately screened 75 percent of the 12 non-diabetic patients in accordance with the VHA clinical practice guidelines.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 27, 2006

From: Director, VISN 23

Subject: **Combined Assessment Program Review of the VA Iowa City Health Care System, Iowa City, IA**

To: Director, Chief of Regional Office of Healthcare Inspections

Attached please find our response to the Iowa City CAP report. Please let us know if you need further information.

(original signed by:)
ROBERT A. PETZEL, M.D.

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

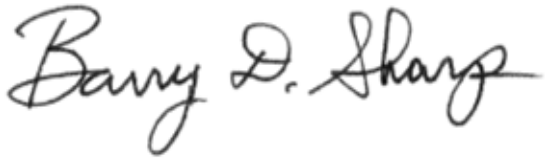
Date: July 27, 2006

From: Director, VA Iowa City Health Care System

Subject: **Combined Assessment Program Review of the VA Iowa City Health Care System, Iowa City, IA**

To: Director, VA Midwest Health Care Network (10N23)

The purpose of this memorandum is to forward our comments to the Combined Assessment Program review conducted at this facility on June 19-23, 2006. If you have any questions please contact me directly at 319-339-7100.



BARRY D. SHARP, CGFM

System Director's Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the System Director requires that:

(a) clinician-specific PI data are appropriately considered during the re-privileging process, and documentation of this data review is maintained;

Concur **Target Completion Date:** 8/31/06

Clinical Leadership will ensure that an appraisal of professional performance, judgment, and clinical/technical competence and skills based on specific PI activities is completed. Templates for services are to be developed. Data for the template will be collected monthly and reviewed for follow up by service chief. Documentation of this data will be maintained and reviewed during the re-privileging process.

(b) all clinically active staff have had CPR education, and that those staff who participate in critical care procedures or surgeries have current ACLS certification;

Concur **Target Completion Date:** 8/31/06

Clinical Leadership will implement procedures to provide mandatory CPR education to all clinically active staff. Staff who participate in critical care procedures or surgeries will be mandated to participate in annual ACLS certification, and this information will be maintained and reviewed during the re-privileging process.

(c) medical records reviews are regularly conducted at the point of care;

Concur **Target Completion Date:** Implemented

Medical record reviews are occurring on an ongoing basis at the point of care. Managers are responsible for ensuring that this occurs and that all data is provided to the Medical Records Committee and the PI/QI Manager. Appropriate analysis will occur after the documentation is collected.

and (d) peer reviews are submitted for committee review quarterly as required by VHA policy.

Concur **Target Completion Date:** Implemented

A process has been implemented to have all peer reviews submitted for committee review on a quarterly basis as required by VHA policy.

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the System Director requires that:

(a) emergency call system cords are replaced with cords that can be easily cleaned, and the cords are accessible from the floor;

Concur **Target Completion Date:** 11/15/06

Samples of nurse call cords have been received and are being tested. The call cords will be purchased as soon as a decision is made on what type to use.

(b) cleaning products, electrical boxes and system panels, and sharp items are secured at all times;

Concur **Target Completion Date:** Implemented

Cleaning products are to be secured by Housekeeping staff, and this has been communicated at Housekeeping staff meetings. The electrical panels are checked on routine rounds to determine if they are locked. Nursing staff has been reminded to ensure that all sharp items are to be secured at all times.

(c) patient information is protected from unauthorized access;

Concur **Target Completion Date:** Implemented

The Chief of the service was verbally informed of the specific incident cited in the report. The Information Security Officer participates in weekly environmental rounds to ensure the proper security of protected health information. Any incidents of noncompliance are reported to the supervisor of the area, and they are asked to reinforce to his/her staff their responsibility to ensure the security of all confidential patient information.

and (d) Canteen Service employees are trained on operating the eyewash station, unit testing is conducted weekly, and testing documentation is maintained.

Concur **Target Completion Date:** 8/15/06

The facility Industrial Hygienist has provided the Chief, Canteen Service, with information on eyewash training, which will be provided to the Canteen staff by August 15, 2006. Procedures will be developed to ensure training for new staff as turnover occurs.

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the System Director requires that:

(a) a medical staff representative be appointed to the Community Nursing Home/Adult Day Health Care Committee, and that this committee regularly report to the system's CEB

Concur **Target Completion Date:** 9/30/06

A medical staff representative will be appointed to the Community Nursing Home/Adult Day Health Care Oversight Committee. The Committee has already made its first report to the Clinical Executive Board, and is also scheduled to report annually to the Clinical Executive Board.

and (b) managers ensure that a RN visits CNH-placed patients and monitors their care in accordance with VHA policy.

Concur **Target Completion Date:** 9/30/06

The Extended Care Site Manager, who is supervisor of the Community Nursing Home Coordinator, has requested an additional 0.5 FTEE Community Health Nurse position in order to implement visits by a Registered Nurse to the nursing homes on a rotational basis with the Community Nursing Home social worker. We will fill this position with either existing or new FTEE.

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the System Director requires that:

(a) supervisors of MVOs and volunteer drivers complete annual driving record reviews;

Concur **Target Completion Date:** 9/30/06

The Supervisor of the MVOs has implemented a process to ensure that their driving records (i.e., license, insurance, and driving record) are reviewed on an annual basis. The Voluntary Program Manager is working with the Police Service to assist in annual reviews of volunteers' driving records. Review of driving records will include any history of violations, accidents, or other violations that may impact a driver's suitability to transport patients.

(b) MVOs complete safe driving training, and the training is documented in the employees' official training records;

Concur **Target Completion Date:** Implemented

The MVOs have viewed the safe driving video, and this has been documented in TEMPO records.

(c) patient safety is maintained by properly securing the patient shuttle when not in use;

Concur **Target Completion Date:** 9/30/06

The supervisor of the MVOs verbally discussed this issue with the shuttle drivers, and this has been documented. Medical Center Memorandum 59, Inter-Facility Transfer and Transport Services, is currently in the process of revision to include detailed requirements of the shuttle drivers to secure patient care equipment during transports and properly securing the vehicles when the shuttle drivers are not in the immediate area.

and (d) system policy is amended to reflect any documentation requirements for patients riding the shuttle, and the policy is strengthened by detailing responsibilities of the shuttle driver.

Concur **Target Completion Date:** 9/30/06

Medical Center Memorandum 59, Inter-Facility Transfer and Transport Services, is in the process of being reviewed by appropriate staff to determine the need for a physician's order for transport on the shuttle. The policy will be revised once a determination has been made.

Recommended Improvement Action 5. We recommend that the VISN Director ensure that the System Director requires that an action plan be developed and implemented to address areas that are below the target range.

Concur **Target Completion Date:** 9/30/06

The Customer Service Committee will be responsible for collecting, analyzing, and reporting information from SHEP data. Once leadership responsibility has been defined, the committee will ensure regular and recurring review of the SHEP data and the development of appropriate action plans. In addition, the Customer Service Committee membership will be reviewed and updated.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Verena Briley-Hudson Director, Chicago Office of Healthcare Inspections (708) 202-2672
Acknowledgments	Paula Chapman Joseph Duffy Wachita Haywood Jennifer Reed Leslie Rogers

Appendix D

Report Distribution

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This report will be available in the near future on the OIG's Web site at http://www.va.gov/oig/52/reports/mainlist.htm. This report will remain on the OIG Web site for at least 2 fiscal years after it is issued.