



Department of Veterans Affairs Office of Inspector General

Combined Assessment Program Review of the VA Ann Arbor Healthcare System Ann Arbor, Michigan

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.
- 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 July 17–21, 2006, the Office of Inspector General conducted a Combined Assessment Program (CAP) review of the VA Ann Arbor Healthcare 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 210 employees. The System is part of Veterans Integrated Service Network 11.

Results of Review

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

- VA Contract Community Nursing Home Program.
- Survey of Healthcare Experiences of Patients.

We identified the following organizational strengths:

- The Bed Utilization Team's daily meetings improved bed utilization.
- The Patient Advocate Liaison Program responds immediately to veterans' concerns.

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

- Improve the cardiac catheterization informed consent process.
- Provide cardiopulmonary resuscitation education for clinical staff.
- Improve documentation of patients' fasting status prior to specimen collections.
- Strengthen communication and documentation of suspicious or abnormal mammogram results.
- Correct identified environmental deficiencies.

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 System Directors' Comments

The VISN and System Directors agreed with the CAP review findings and provided acceptable improvement plans. (See Appendixes A and B, pages 13–18, 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 Ann Arbor Healthcare System (the System), located in Ann Arbor, Michigan, is a tertiary care referral center for veterans in the lower peninsula of Michigan and in northwestern Ohio. The System provides a broad range of inpatient and outpatient healthcare services and has three community based outpatient clinics (CBOCs) located in Flint and Jackson, Michigan, and Toledo, Ohio. The System is part of Veterans Integrated Service Network (VISN) 11 and serves a veteran population of more than 161,075 in a primary service area that includes 14 counties in southeastern Michigan and northwestern Ohio.



Programs. The System provides medical, surgical, mental health, geriatric, and rehabilitation services as well as advanced specialty care, which includes cardiology and cardiothoracic surgery, neurosurgery, comprehensive cancer care, and specialty imaging services. The System has 100 hospital beds, 38 nursing home beds, and operates several regional specialty referral and treatment programs. VISN 11 has Department of Defense (DoD) agreements with TRICARE¹ to provide specialty services to active duty personnel and a Memorandum of Agreement to provide medical and dental readiness services to DoD Reserve components. The System has training agreements with the Toledo, Ohio Air National Guard and the 323rd Combat Support Hospital, Southfield, MI. The System also has a sharing agreement with the University of Michigan Health System for endoscopy support and an agreement with a community cardiology practice group to provide nuclear medicine scan interpretations.

Affiliations and Research. The System is affiliated with the University of Michigan Schools of Medicine, Dentistry, and Nursing and supports 112 medical resident positions in 28 training programs. Other affiliations include nearly 40 other colleges and universities. More than 1,100 people receive training each year through the System's programs. In fiscal year (FY) 2005, their research program had 400 projects and a budget of \$10.6 million. Important areas of research include biomedical and clinical (pulmonary diseases, rheumatology, cardiology, and endocrinology), Health Services Center of Excellence, and rehabilitation (spinal cord injury).

¹ TRICARE is the health insurance program for military personnel and their families.

Resources. In FY 2005, medical care expenditures totaled approximately \$200 million. The FY 2006 medical care budget was \$200.1 million. FY 2005 staffing totaled 1,312 full-time equivalent (FTE) employees, including 117 physician and dentist FTE and 292 nursing FTE.

Workload. In FY 2005, the System treated 40,864 unique patients and provided 29,784 inpatient days of care in the hospital and 13,281 inpatient days of care in the Nursing Home Care Unit. The inpatient care workload totaled 4,891 discharges, and the average daily census, including nursing home patients, was 119. The outpatient workload was 277,769 visits.

Objectives and Scope of the CAP Review

Objectives. CAP reviews are one element of the Office of Inspector General's (OIG) 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	QM Program
Cardiac Catheterization Laboratory	Survey of Healthcare Experiences of
Services	Patients (SHEP)
Diabetes and Atypical Antipsychotic	VA Contract Community Nursing
Medications	Home (CNH) Program
Environment of Care	

The review covered facility operations for FY 2005 and FY 2006 through July 17, 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 210 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 5–10).

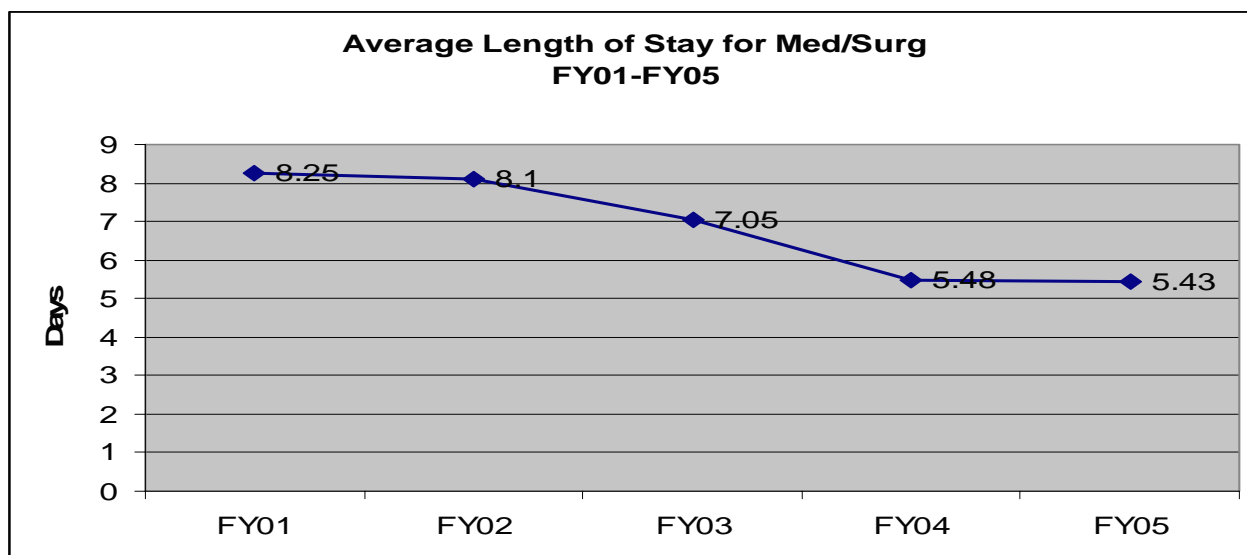
Results of Review

Organizational Strengths

Bed Utilization Team – Daily Meetings Improved Bed Utilization

The Bed Utilization Team was implemented in November 2002 by the Bed Utilization Committee. The team continues to meet daily, Monday–Friday at 9:00 a.m. Members include the Chief of Staff; Chiefs of Medicine, Surgery, Psychiatry, and Social Work; the Consult Attending for the Extended Care Center; the Admitting Supervisor; nurse managers; and utilization review clinical reviewers. Results include:

- Improved communication to all services.
- Assisted leadership in identifying factors that need improvement.
- Improved bed availability by avoiding patient diversions to outside facilities and increasing the ability to accept transfer patients from other facilities.
- Provided an opportunity to identify immediate interventions that could be implemented to avoid delays in patient discharges, contributing to reductions in lengths of stays.



Patient Advocate Liaison Program – Veterans' Concerns Are Addressed

The Patient Advocate Liaison (PAL) Program was established over 10 years ago for each area of the System and for the 3 CBOCs. The System utilizes more than 80 PAL

participants who are staff members with a broad knowledge base of the System, Federal regulations, and their immediate work area. The PAL Program assists veterans and visitors with addressing and resolving issues of concern at the point of origin and takes proactive measures to resolve barriers to good customer service. The PAL participants' interactions are communicated to the patient advocates for inclusion into the VA-wide database.

Opportunities for Improvement

Cardiac Catheterization Laboratory Standards – Informed Consent Process Needed To Be Improved

Condition Needing Improvement. The purpose of this review was to determine if the System's cardiac catheterization laboratory practices were consistent with the American College of Cardiology (ACC) and the Society for Cardiac Angiography and Interventions Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards and with VHA policy. These standards define requirements for provider procedure volumes, laboratory procedure volumes, cardiac surgery resources, QM, the informed consent process, and cardiopulmonary resuscitation (CPR) training. The System needed to improve documentation of informed consents for cardiac catheterization procedures. VHA policy requires that informed consents include the names and professions of all participants in the procedure and any risks, benefits, and alternative treatments or procedures.

We reviewed the medical records of 10 patients who had undergone a cardiac catheterization procedure in FY 2005. Five informed consents lacked the name of an attending physician, and two additional informed consents had different providers than those listed on the cardiac catheterization procedure flow sheets. Seven informed consents lacked a cardiology fellow's name or included a cardiology fellow who did not participate in the procedure. Eight informed consents did not include procedure alternatives.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the System Director requires that staff complete informed consents for cardiac catheterization procedures that are consistent with VHA policy.

The VISN and System Directors agreed with the findings and recommendation and reported that they are implementing an electronic consent process and electronic consents will be available no later than November 13, 2006. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Quality Management Program – Cardiopulmonary Resuscitation Education Needed To Be Provided for Clinical Staff

Condition Needing Improvement. The QM program was generally effective, and senior managers actively participated in and supported performance improvement activities and initiatives. Processes were in place to ensure that performance improvement and patient safety were maintained. However, managers needed to ensure compliance with CPR training for clinical staff.

VHA policy requires that all clinically active staff have CPR education. Additionally, certain clinical staff who participate in critical care procedures or surgeries might require advanced cardiac life support (ACLS) certification. We reviewed seven credentialing folders and found that four clinicians had no current documentation of CPR training. Managers needed to ensure that clinicians have the appropriate education and certification for the privileges granted to them.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the System Director requires that (a) all clinically active staff have CPR education and (b) managers determine which staff should have ACLS certification.

The VISN and System Directors agreed with the findings and recommendations and reported that as of October 1, 2006, all clinically active staff will have current basic life support (BLS) certification before their clinical privileges are renewed. Currently, 55 percent are BLS certified. System managers established a tracking system for certifications in the credentialing software. A new policy defines which staff requires ACLS certification and establishes a process to ensure that BLS and ACLS certifications are up to date. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

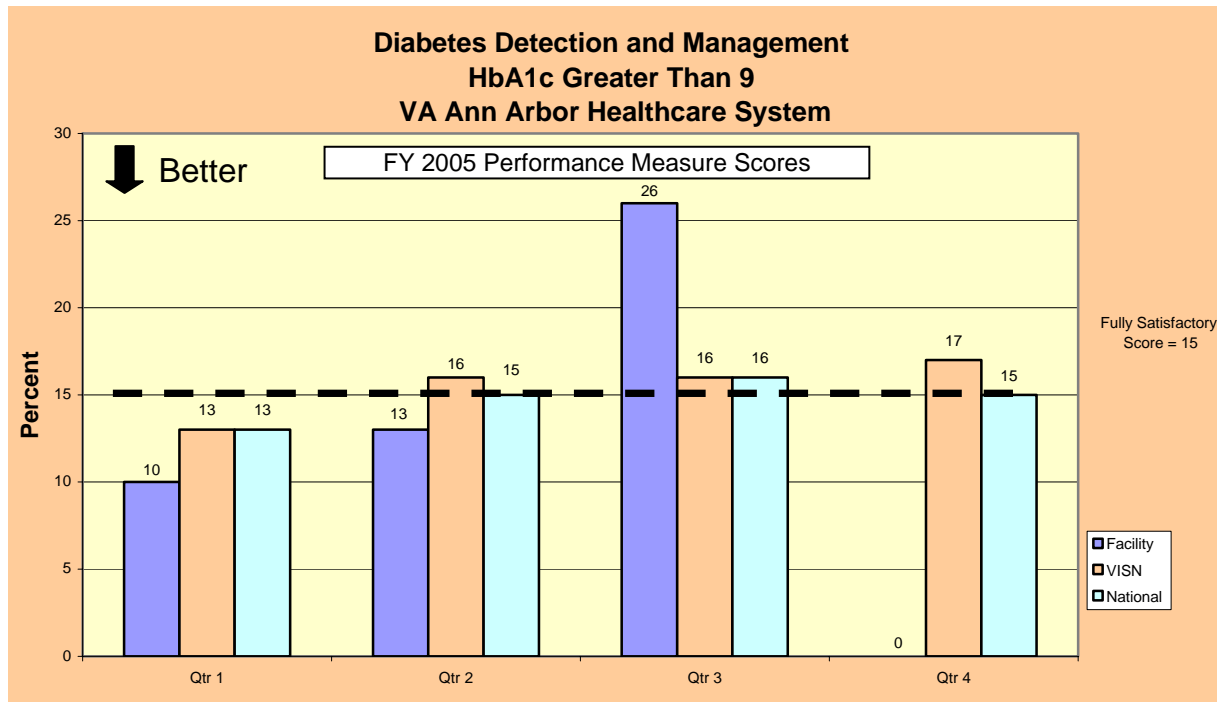
Diabetes and Atypical Antipsychotic Medications – Documentation of Fasting Status Needed To Be Improved

Condition Needing Improvement. 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 patient's risk for the development of diabetes). The System needed to improve documentation of the fasting status of patients being screened for fasting blood glucose (FBG) specimens.

VHA clinical practice guidelines for screening patients who are at risk for the development of diabetes suggest that FBG is the preferred screening test and should be performed every 1–3 years. A normal FBG is less than or equal to 110 milligrams/deciliter (mg/dL). Patients with FBG values of 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 of 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 medications for at least 90 days in FY 2005. Of the 12 non-diabetic patients, 4 glucose serum values were greater than 110 mg/dL. There was no documentation to verify if these specimens had been collected while the patients were fasting. Clinicians have recognized this category of patients as high-risk for the development of diabetes. Further, they informed us that patients are educated to fast for laboratory metabolic profile testing. Clinicians expressed difficulty in assuring compliance with patients following fasting instructions. Of the 12 non-diabetic patients, 7 patients (58 percent) had HbA1c documented in the medical record. Clinicians informed us that they utilize glycosylated hemoglobin (HbA1c) as an indicator for glucose monitoring.



Note: The system had no patients meeting the criteria for Qtr 4.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the System Director requires that patients who have serum glucose tests ordered have their fasting status documented in their medical record.

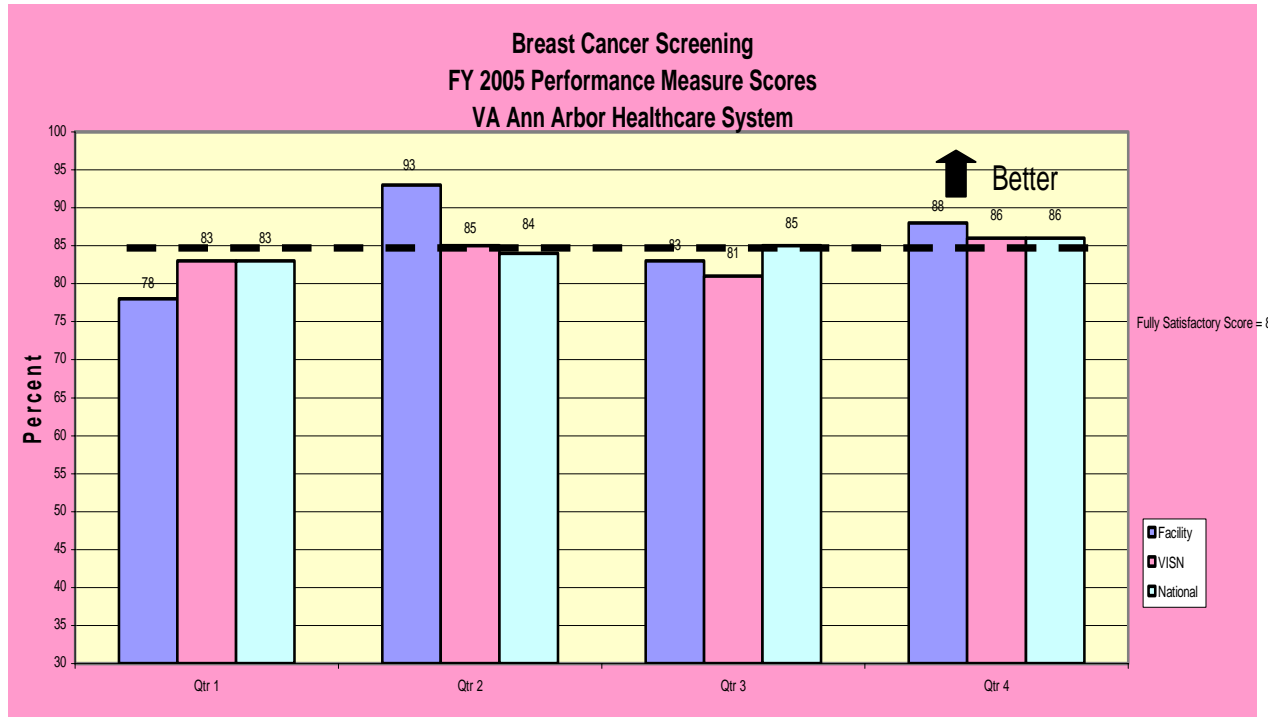
The VISN and System Directors agreed with the findings and recommendation and reported that on October 25, 2006, a FBG option has been added to the laboratory menu and the monitoring process has been revised. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Breast Cancer Management – Communication and Documentation of Abnormal Mammogram Results Needed Strengthening

Conditions Needing Improvement. The System refers all patients to community fee-basis facilities for mammography procedures. We reviewed the records of four patients who received mammography services at the University affiliate. Clinicians needed to document communication of abnormal mammography results in the medical record. Fee-basis facilities needed to send mammography results to the System within 30 days. There was documentation in the University affiliate hospital's web-based software (CareWeb) of patient communication; however, documentation was not available in the VA medical record. System providers have access to the affiliate's medical record software and are able to retrieve and review the abnormal results; however, VHA clinicians outside of the System have no access to these records.

VHA mammography standards require normal findings to be documented in the medical record within 30 days of the procedure. Suspicious or abnormal results must be communicated to the ordering provider within 3 working days. Communication can be by telephone contact between the mammography procedure site and the ordering provider and must be documented in the patient's medical record. Timely results need to be available and accessible to guide patient care and treatment. We assessed the documentation of timely communication in a review of four patients who were diagnosed with breast cancer and had abnormal mammography results during FYs 2004 and 2005. We found that timely documentation and mammography results were not available in VA medical records; however, timely interventions were implemented through the System's affiliate.

The VHA breast cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. The medical center achieved the fully satisfactory level in 2 of 4 quarters in FY 2005, as shown in the subsequent chart.



Recommended Improvement Action 4. We recommended that the VISN Director ensure that the System Director takes action to (a) document the notification of suspicious or abnormal mammography results in the medical record and (b) ensure that mammography results completed by fee-basis agreements are entered into the medical record within 30 days.

The VISN and System Directors agreed with the findings and recommendations and reported that patient notification is timely, patient notification is documented in the medical record through use of clinical reminders, and mammography results are entered into the medical records timely. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Environment of Care – Environmental Deficiencies Needed To Be Corrected

Conditions 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. Employees were responsive to concerns identified during the inspection. The following concerns required management attention and were immediately followed up on or corrected during our review.

Refrigerator Temperature Monitoring. Several medication and nourishment refrigerator temperatures were outside the acceptable ranges for the month of July with no documented immediate corrective actions. The refrigerators must be maintained within the acceptable temperature range to ensure the integrity of medications and nourishments.

Emergency Call System Cords. On patient unit 5W, emergency call system cords near the commodes in patient restrooms were too short. The cords need to be accessible from the floor in case of a fall.

Patient Safety Issues. Temperature control dials in patient showers in the locked mental health unit could be used as a wrap-around point for patients intending to harm themselves. Because of the patient population, it is critical that the unit provides a safe environment to minimize risk.

Patient food trays were observed in an open cart and on top of a cart and a table in the dining room in the Extended Care Center. The trays were accessible to patients for some time after the breakfast meal. Trays need to be secured to ensure patients do not have access to leftover food and to prevent attraction of pests.

We noted several bedside stands in patient rooms that were damaged on the corners and edges of drawers. Managers should consider replacement of this furniture.

Patient Privacy. A clipboard with patients' names and the last four of their social security numbers was accessible to the public at the Nuclear Medicine reception desk. Patients and visitors in an outpatient clinic hallway could view a computer monitor in the oncology treatment room. A triage room in Urgent Care was configured so that staff may screen two patients simultaneously. The room had a cubicle; however, because the cubicle did not fully separate the room, auditory privacy could not be maintained. Managers need to ensure that patient privacy is maintained by safeguarding sensitive information on clipboards and computer monitors and assuring that intake areas provide reasonable accommodation for privacy during conversations.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the System Director requires that: (a) employees initiate corrective actions when a medication or nourishment refrigerator is not in the acceptable temperature range, (b) emergency call system cords are accessible from the floor, (c) managers perform a risk assessment of the temperature control dials in the patient showers in the locked mental health unit, (d) patient food trays are secured after meals, (e) damaged furniture in patient rooms is replaced, and (f) patient privacy is maintained through the protection of sensitive information and by assuring auditory privacy.

The VISN and System Directors agreed with the findings and recommendations and reported that a new process was implemented on October 25, 2006, to ensure that refrigerator temperature logs are maintained on a daily basis and that staff initiate

electronic work orders when required. All emergency call system cords are now reachable from the floor and a monitor was implemented to ensure they remain in good condition. A risk assessment was conducted and action taken to modify the shower control handles. Daily spot checks and weekly environment of care rounds are now used to identify and correct any problems with patient tray storage. Ten bedside stands were identified for replacement and will be purchased in FY 2007 when funds become available. The sign-in form was immediately changed during the CAP review, and sound proof partition options are being evaluated to ensure auditory privacy. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Other Activities Reviewed

VA Contract Community Nursing Home Program – Program Complied with VHA Policy

The purpose of the review was to assess the System's compliance with VHA policy regarding the selection, placement, and monitoring of patients in contract CNHs and the inclusion of patients and their families in this process. The System's CNH Program Oversight Committee provides oversight of all CNH activities. The CNH Inspection Team, comprised of a registered nurse (RN), social worker, safety manager, and dietitian, has completed annual reviews of each CNH facility and made recommendations to the contracting officer based on the team's findings. We reviewed the medical records of 10 VA patients who were placed in CNH facilities on System contracts. All patients received monthly visits from VA staff, with the RN and social worker alternating months. We visited patients at two of the CNH facilities and found that the patients were satisfied with their care and were able to discuss any concerns with VA staff members during their visits or by telephone.

Survey of Healthcare Experiences of Patients – Action Plan was Implemented

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. Performance Measure 21 of the VHA Executive Career Field 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 targets for the performance period October 2005–June 2006. The System's results are shown in the subsequent table:

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

The following graphs show the System's SHEP results for inpatients and outpatients:

Inpatient SHEP Results										
	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition	Overall Quality
National	81.31	78.63	89.95	68.02	65.80	75.85	83.41	74.49	70.03	**
VISN	83.8+	79.6+	90.10	68.10	66.40	76.20	83.60	74.40	68.90	**
Medical Center	90.4+	84.5+	94.6+	76.2+	76.4+	85.4+	88.7+	82.1+	79.2+	**

Outpatient SHEP Results											
	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	Specialist Care	Visit Coordination
National	80.7	78.1	94.8	72.6	83.3	75.8	81.5	65.5	81.7	80.8	84.7
VISN	81.8	78.1	94.8	69.7	80.8	74.3	82.1	68.7	80.1	80.3	82.9
Outpatient Clinics	77	73.3	91.1	68	80.8	70.8	83.5	68.4	78.5	77	82

The System's inpatient SHEP scores significantly exceeded the target score of 76 percent in all aspects of Performance Measure 21. However, outpatient SHEP scores were lower than the target score of 77 percent in the following four aspects: (1) Continuity of Care, (2) Education & Information, (3) Overall Coordination, and (4) Pharmacy Pickup. SHEP results were discussed monthly at the Patient Satisfaction Sub-Committee meetings and reported to the Customer Satisfaction Oversight Committee. SHEP results were communicated to employees through service meetings, and patients and employees can view the SHEP results in the System's atrium. Committee members are developing a patient survey tool to use in the CBOCs that will provide more specific information regarding customer satisfaction in ambulatory care areas. Committee members have also developed a customer service reference card for employees.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: November 2, 2006

From: Network Director, VISN 11 (10N11)

Subject: **Combined Assessment Program Review of the VA Ann Arbor Healthcare System, Ann Arbor, Michigan**

To: Director, Chicago Office of Healthcare Inspections (54CH)

1. Per your request, attached is the report from VA Ann Arbor Healthcare System. If you have any questions, please contact Jim Rice, VISN 11 QMO at (734) 222-4314.



Linda W. Belton

Attachments (2)

Healthcare System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: October 31, 2006

From: Director, VA Ann Arbor Healthcare System (506/00)

Subject: **Combined Assessment Program Review of the VA Ann Arbor Healthcare System, Ann Arbor, Michigan**

To: Director, Veterans Integrated Service Network 11 (10N11)

We appreciate the opportunity to review the draft report of the Healthcare Inspection at our facility.

The attached comments are being submitted for your review. If additional information is needed, please contact Bonnie M. Johnson, Staff Assistant to the Director, at (734) 761-7910.

(original signed by:)

LOU ANN ATKINS

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

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

OIG Recommendation(s)

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the System Director requires that staff complete informed consents for cardiac catheterization procedures that are consistent with VHA policy.

Concur **Target Completion Date:** November 13, 2006.

We recognized the deficiencies in our informed consent documents and have been transitioning to the IMed Consent (Electronic Consent document available in CPRS). We have customized the screens to reflect our procedures, and are scheduled to go live with electronic consents no later than 11/13/06. This process will ensure documents are accurate and complete for every patient (see consent). **Recommend closure.**

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the System Director requires that: (a) all clinically active staff have CPR education and (b) managers determine which staff should have ACLS certification.

Concur **Target Completion Date:** Initiated October 1, 2006.
Ongoing

a. As of October 1, 2006, all applicants holding a clinically active staff appointment will be required to have BLS certification before their clinical privileges are renewed. Currently, 55% of our clinically active staff are BLS certified.

Per VA Ann Arbor Healthcare System policy 11-38, dated 8/21/06, all clinically active staff will have current BLS certification. Clinically Active Staff has been defined as all full-time, part-time, and intermittent providers. A tracking system has been established in the credentialing software to track certification. Providers will be notified by letter 6 months prior to expiration of their certification. Services will receive a physician listing,

alert their staff, retrieve a copy of the certification, and forward the copy to the Medical Staff Office.

b. Managers determined which staff are required to have ACLS certification. The same process will be followed as that for BLS certification (see policy).

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the System Director requires that patients who have serum glucose tests ordered have their fasting status documented in their medical record.

Concur **Target Completion Date:** October 25, 2006

A new laboratory menu option, Fasting Blood Glucose (FBS), was instituted on 10/25/2006. Additionally, we have revised the monitoring process, incorporating the new option.

Process

Providers have been instructed to:

- a. Select the FBS option.
- b. During the clinic visit, educate the patient about the rationale and procedure for the test, and document this education in the patient's record.
- c. Share the test results with the patient during a follow-up clinic visit and document in the medical record that the patient followed the prescribed procedure. **Recommend closure.**

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the System Director takes action to (a) document the notification of suspicious or abnormal mammography results in the medical record and (b) ensure that mammography results completed by fee-basis agreements are entered into the medical record within 30 days.

Concur **Target Completion Date:** October 4, 2006

- a. Patients are notified of abnormal/suspicious results in accordance with VHA Handbook Mammography Standards 1104.1. Patients are notified in a timely manner, patient notification is documented in the record through the use of clinical reminders to annotate phone or letter notification, and results are documented in the medical record upon receipt. Radiology/Ambulatory Care "Breast Management" meetings were held in August and September

and are ongoing, to discuss and implement recent changes, track timeliness of obtaining results, notification of patients, and developments for the mammography process. A Primary Care in-service was held on 10/4/06 regarding mammogram consults, updates, and clinical review reminders.

b. Effective August 2006, all fee-basis mammogram results are entered into the electronic medical record system (CPRS) within 30 days. A review of August and September reports confirms that diagnostic reports have been entered into CPRS within 30 days. **Recommend closure.**

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the System Director requires that: (a) employees initiate corrective actions when a medication or nourishment refrigerator is not in the acceptable temperature range, (b) emergency call system cords are accessible from the floor, (c) managers perform a risk assessment of the temperature control dials in the patient showers in the locked mental health unit, (d) patient food trays are secured after meals, (e) damaged furniture in patient rooms is replaced, and (f) patient privacy is maintained through the protection of sensitive information and by assuring auditory privacy.

Concur **Target Completion Date:** October 26, 2006 (a-b-c-d) January 2007 (e-f)

a. Completed: A new process is now in place. Medication refrigerator temperature logs are maintained on a daily basis by the pharmacy staff. When the temperature falls below an acceptable range, an electronic work order is generated by pharmacy staff and the charge nurse is notified to ensure the repair is made promptly. This process was implemented on 10/25/06, and will be an ongoing PI monitor.

The nutrition refrigerator log is maintained by housekeeping staff; the charge nurse checks the log daily to ensure the proper temperature. This process was implemented on 10/25/06, and will be an ongoing PI monitor. **Recommend closure.**

b. Completed: All emergency call system cords near commodes in patient restrooms were surveyed and repaired; they are now reachable from the floor. To ensure facility-wide call system cords are maintained in acceptable fashion, a monthly PI monitor was implemented in 10/25/06. **Recommend closure.**

c. Completed: A risk assessment was conducted of the locked mental health unit's shower temperature controls. The existing holes in the shower control handles were filled with epoxy, resulting in a hard smooth finish

with no residual hole. Until such time that acceptable newer model handles are found, this is the only remedy available. **Recommend closure.**

d. Completed: Food service carts were evaluated and determined to be of sufficient size to accommodate the number of trays required on any given day. Daily spot checks for possible violations are being conducted. This review item has also been added to the weekly multidisciplinary environment of care checklist. Any deficiencies are reported back to the unit manager for corrective action. This process was implemented 10/26/06. **Recommend closure.**

e. Ongoing: A facility-wide survey of bedside stands revealed 10 which could be considered in need of replacement because of rough edges. The stands have been placed on a priority purchase list, and will be ordered when FY-07 funding is received.

f. Nuclear Medicine: The sign-in form was changed the day of the inspection; patients currently sign in with their last names only. Additionally, there is a cover on the clipboard to ensure privacy; the clipboard is now under the control of the receptionist. **Recommend closure.**

Outpatient clinic: A staff architect and the Interior Designer evaluated the clinic rooms. In order to achieve auditory privacy, new floor to ceiling barriers will be installed. Staff are in the process of determining whether building a sound insulated drywall partition to the ceiling, or purchasing prefab sound barrier partitions to the ceiling would be the most economical. As soon as that determination is made, new partitions will be constructed and/or purchased and installed.

OIG Contact and Staff Acknowledgments

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

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Veterans Integrated Service Network (10N11)
Director, VA Ann Arbor Healthcare System (506/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction and Veterans Affairs
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction and Veterans Affairs
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
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