



# **Department of Veterans Affairs Office of Inspector General**

---

## **Combined Assessment Program Review of the Dayton VA Medical Center Dayton, Ohio**

## **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.

**To Report Suspected Wrongdoing in VA Programs and Operations  
Call the OIG Hotline – (800) 488-8244**

## Contents

	Page
<b>Executive Summary</b> .....	i
<b>Introduction</b> .....	1
Medical Center Profile .....	1
Objectives and Scope of the Combined Assessment Program Review .....	2
<b>Results of Review</b> .....	3
Opportunities for Improvement .....	3
Business Rules for Veterans Health Information Systems .....	3
Community Based Outpatient Clinics .....	4
Environment of Care .....	5
Quality Management Program .....	6
Other Observations .....	7
Cardiac Catheterization Laboratory Standards .....	7
Survey of Healthcare Experiences of Patients .....	8
 <b>Appendixes</b>	
A. VISN Director Comments .....	10
B. Medical Center Director Comments .....	11
C. OIG Contact and Staff Acknowledgments .....	16
D. Report Distribution .....	17

## **Executive Summary**

### **Introduction**

The Department of Veterans Affairs, Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Dayton VA Medical Center (the medical center), Dayton, OH, during the week of February 26–March 2, 2007. The purpose of the review was to evaluate selected system operations, focusing on patient care administration and quality management (QM). During the review, the Office of Investigations provided three fraud and integrity awareness briefings to 120 employees.

### **Results of Review**

This review focused on six areas. The system complied with standards in the following areas:

- Cardiac Catheterization Laboratory Standards.
- Survey of Healthcare Experiences of Patients (SHEP).

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

- Revise business rules for veterans health information systems.
- Resolve environment of care (EOC) discrepancies.
- Establish a site-specific emergency policy for each community based outpatient clinic (CBOC).
- Complete root cause analyses within 45 days and improve QM oversight of the Morbidity and Mortality (M&M) Committee by tracking and trending committee meeting minutes and actions.

This report was prepared under the direction of Randall Snow, JD, Associate Director, and Carol Torczon, RN, MSN, ACNP, Health Systems Specialist, Washington, DC, Office of Healthcare Inspections.

## Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 10–16 for the full text of the Directors’ comments.) We consider Recommendations 1 and 3 closed and will follow up on the other planned actions until they are completed.

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

## Introduction

### Medical Center Profile

**Organization.** The medical center is a tertiary care facility that provides a full continuum of care encompassing a broad range of inpatient and outpatient health care services, including nursing home, domiciliary, and home and community health programs. Outpatient care is also provided at four CBOCs located in Springfield, Middletown, and Lima, OH, and in Richmond, IN. The medical center is part of Veterans Integrated Service Network (VISN) 10 and serves a veteran population of about 159,353 in a primary service area that includes 16 counties in Ohio and Indiana.

**Programs.** The medical center provides comprehensive health care through medical, surgical, mental health, geriatric, neurology, oncology, dentistry, hospice, and physical and rehabilitation services. The medical center has 500 hospital beds (265 nursing home beds, 120 acute care beds, and 115 domiciliary beds) and has sharing agreements with Wright-Patterson Air Force Base Medical Center and 11 community hospitals. The medical center is a national referral center for hyperbaric oxygen therapy and staffs a national call center for VA/Department of Defense transition of care issues.

**Affiliations and Research.** The medical center has active affiliations with the Wright State University Boonshoft School of Medicine and the Wright State University School of Professional Psychology. Over 275 university residents, interns, and students are trained at the medical center each year. There are also nursing student affiliations with Wright State University, the University of Cincinnati, Miami University, Kettering College of Medical Arts, Sinclair Community College, Indiana University, Indiana Wesleyan University, and Miami Valley University Career Technology Center, as well as affiliations with some 50 other academic programs involving dentistry, pharmacy, social work, and psychology. Through sharing agreements, there are collaborations in the areas of radiation therapy, professional radiology services, sleep laboratory, electron microscopy, and cardiac catheterization laboratory. The medical center participates in the Dayton Area Graduate Medical Education Consortium and has funded research and development programs.

**Resources.** In fiscal year (FY) 2006, medical care expenditures totaled \$205.4 million. The FY 2007 medical care budget is \$174 million. FY 2006 staffing totaled 1,575.6 full-time equivalent employees (FTE), including 78.5 physician and 490.3 nursing FTE.

**Workload.** In FY 2006, the medical center treated 33,149 unique patients. The medical center provided 22,832 inpatient days of care in the hospital and 62,625 inpatient days of care in the Nursing Home Care Unit. The inpatient care workload totaled 4,282 discharges. The average daily census was 62 for acute care, 65 for the domiciliary, and 172 for the nursing home. The outpatient workload was 319,773 visits.

## Objectives and Scope of the Combined Assessment Program 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 administration and QM.
- 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 and QM. 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.

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

Business Rules for Veterans Health Information Systems	CBOCs EOC
Cardiac Catheterization Laboratory Standards	QM Program SHEP

The review covered facility operations for FYs 2005 and 2006 and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the VA Medical Center, Dayton, Ohio*, Report No. 04-01822-45, December 7, 2004).

During the review, we presented three fraud and integrity awareness briefings for 120 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. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the section titled “Other Observations” have no reportable conditions.

## Results of Review

### Opportunities for Improvement

#### Business Rules for Veterans Health Information Systems

The health record, as defined in Veterans Health Administration (VHA) Handbook 1907.01, *Health Information Management and Health Records*, issued August 25, 2006, includes the electronic medical record and the paper record, combined, and is also known as the legal health record. It includes items such as physician orders, chart notes, examinations, and test reports. Once notes are signed, they must be kept in unaltered form. New information, corrections, or different interpretations may be added as further entries to the record, as an addendum to the original note, or as a new note—all reflecting accurately the time and date recorded.

A communication (software informational patch<sup>1</sup> USR\*1\*26) was sent from the VHA Office of Information (OI) on October 20, 2004, to all medical centers, providing guidance on a number of issues relating to the editing of electronically signed documents in the electronic medical records<sup>2</sup> system. The OI cautioned that, “the practice of editing a document that was signed by the author might have a patient safety implication and should not be allowed.” On June 7, 2006, VHA issued a memorandum to all VISN Directors instructing all VA medical centers to comply with the informational patch sent in October 2004.

Business rules define what functions certain groups or individuals are allowed to perform in the medical record. OI has recommended institution of a VHA-wide software change that limits the ability to edit a signed medical record document to the medical center’s Privacy Officer. We reviewed VHA and medical center information and technology policies and interviewed Information Resource Management Service staff. The medical center had eight rules that allowed editing of a signed note by users other than the author. Two additional rules needed to be changed to limit retraction, amendment, or deletion of notes to the Privacy Officer or the Chief, Health Information Management Service. Medical center staff took action to edit and remove these business rules while we were onsite.

**Recommendation 1.** We recommended that the VISN Director ensure that the Medical Center Director requires compliance with VHA Handbook 1907.1, *Health Information Management and Health Records*, and the October 2004 OI guidance.

---

<sup>1</sup> A patch is a piece of code added to computer software in order to fix a problem.

<sup>2</sup> VA’s electronic medical records system is called VistA, which is the acronym for Veterans Health Information Systems and Technology Architecture.

Based on the actions taken while we were onsite, we consider this recommendation closed.

## Community Based Outpatient Clinics

A CBOC is a VA-operated, VA-funded, or VA-reimbursed health care facility or site geographically distinct or separate from a parent medical facility. VHA expanded ambulatory and primary care areas under Federal legislation passed in 1996, including the creation of CBOCs throughout the United States. The enactment of this legislation requires that VA maintain its capacity to provide for the specialized treatment and rehabilitation needs of disabled veterans (including those with spinal cord dysfunction, blindness, amputations, and mental illness) within distinct programs or facilities that are dedicated to the specialized needs of those veterans in a manner that affords those veterans reasonable access to care and services. We reviewed compliance with VHA regulations regarding selected standards of operation, services, patient safety, credentialing and privileging, and provision of emergency care.

We visited the CBOC located in Richmond, IN, where we interviewed primary care service line employees and reviewed documents related to the CBOC's services, specifically the management of patients taking warfarin (an anticoagulant medication). We also reviewed credentialing and privileging files and background investigations. We evaluated the clinic's EOC and interviewed 10 veterans.

CBOC clinicians were properly credentialed, privileged, and licensed and managed patients taking warfarin according to current VHA clinical practice guidelines. Human Resources Services completed background investigations on all CBOC employees. The CBOC was clean and safe.

The following area needed management attention:

Community Based Outpatient Clinic Specific Emergency Care Plan. VHA Handbook 1006.1<sup>3</sup> requires each CBOC to have a local policy or standard operating procedure defining how medical emergencies are handled, including mental health emergencies. Even though the Richmond CBOC had a crash cart (equipment and drugs to respond to a medical emergency) onsite, two primary care physicians certified in Advanced Cardiac Life Support, and nurses who were all certified in Basic Life Support, the CBOC did not have a local policy for handling medical or mental health emergencies.

**Recommendation 2.** We recommended that the VISN Director ensure that the Medical Center Director requires that each CBOC have an Emergency Care Plan policy relevant to the specific needs and resources of each CBOC.

We will follow up until all planned actions are completed.

---

<sup>3</sup> VHA Handbook 1006.1, *Planning and Activating Community-Based Outpatient Clinics*, issued May 19, 2004.

## Environment of Care

The purpose of the evaluation was to determine whether the facility established a comprehensive EOC program that met selected VHA, Occupational Safety and Health Administration (OSHA), and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards. To evaluate EOC, we inspected selected clinical and non-clinical areas for cleanliness, safety, infection control, and general maintenance. Overall, we found the facility to be clean and well-maintained, and issues identified during our 2004 assessment to be resolved or in the process of resolution. Managers provided excellent documentation of EOC rounds. The following conditions required management attention.

Interim Life Safety Measures. Certain areas of the medical center were undergoing renovation and construction, which requires the implementation and monitoring of Interim Life Safety Measures (ILSM). The construction zone in the Primary Care Clinic was not adequately sealed off from patient care areas, and dust/debris mats were not in place to prevent the spread of construction debris into patient areas. ILSM were not in place for pneumatic tube system construction on the Intensive Care Unit (ICU). Construction of the tube system opened into the ICU clean utility room where clean supplies were kept. Staff took steps to correct these deficiencies while we were onsite.

Bulk Oxygen. VHA Directive 2005-028, *Oxygen Distribution Systems*, requires documented signatures of both the person delivering the oxygen shipment and the medical center representative receiving the shipment. Compliance with the directive was inconsistent. Seven of 29 delivery documents were not signed by both representatives. However, since the current supervisor of the Sterile Processing Department assumed his position, all bulk oxygen delivery documents have complied with the directive.

Community Based Outpatient Clinic Environment of Care Inspections. Semi-annual Safety Committee inspections of CBOCs are required by medical center and JCAHO policy. Representatives from Infection Control must participate in the inspections. Infection Control representatives did not participate in the semi-annual inspections during FYs 2005 and 2006.

Dirty Utility Room Security. According to JCAHO and OSHA standards, dirty utility rooms must be locked to prevent mishandling of hazardous materials and waste. Medical center reports showed that a patient had entered a dirty utility room, removed a “sharps container,” and attempted to open it. We found that the rooms had hazardous waste posters displayed, stating that only authorized personnel could enter, but no locks were in place in the majority of the rooms.

Cardboard Boxes. Corrugated cardboard boxes were found on the floor in dirty utility rooms. JCAHO standards require removal or elevation of the boxes off the floor to prevent insect infestations.

Medication Refrigerators. The inpatient pharmacy and several patient care units used temperature discs to automatically calibrate the temperature in the medication refrigerators. While the discs were replaced weekly, the daily temperatures were not recorded, and data was not evaluated to verify proper temperature control.

**Recommendation 3.** We recommended that the VISN Director ensure that the Medical Director requires that: (a) ILSM are implemented and monitored; (b) staff comply with VHA Directive 2005-028, *Oxygen Distribution Systems*; (c) Infection Control participates in the semi-annual inspection of CBOCs; (d) locks are installed on dirty utility rooms; (e) cardboard boxes are removed from the floors; and (f) medication refrigerator temperatures are recorded, monitored, and analyzed daily.

Based on the comments and action plans provided, we consider this recommendation closed.

## Quality Management Program

To evaluate QM activities, we interviewed the medical center Director, Chief of Staff, and QM personnel, and we evaluated plans, policies, and other relevant documents. We found that the QM Program generally provided appropriate comprehensive oversight of patient care. However, the following areas needed improvement.

Root Cause Analysis Process. VHA Handbook 1050.1, *VHA National Patient Safety Improvement Handbook*, requires completion of a root cause analysis (RCA) within 45 days. We reviewed seven individual RCAs, four of which had not been completed within the 45-day time frame. Without timely identification, reporting, and analysis of significant patient outcomes and events, managers could not be assured of a comprehensive and efficient patient safety process.

Morbidity and Mortality Reviews. The M&M process needs to be improved to ensure effective communication, identification of trends, and follow-up on issues raised during the reviews that would lead to process improvement. The purpose of the M&M review is for clinicians to discuss the care provided to individual patients who experienced complications and to identify actions that lead to process improvement. We reviewed 6 months of M&M Committee meeting minutes. It was difficult to determine the effectiveness of performance improvements because the minutes did not document identification of actions or trends that would lead to performance improvement.

**Recommendation 4.** We recommended that the VISN Director ensure that the Medical Center Director ensures (a) compliance with the 45-day completion standard for RCAs and (b) QM analysis of M&M Committee meeting minutes to identify process improvements, to document actions, and to follow-up to ensure completion of performance improvement initiatives.

Management's action plan was acceptable; we will follow up until all planned actions are completed.

## **Other Observations**

### **Cardiac Catheterization Laboratory Standards**

Coronary artery disease is the leading cause of death in America. The American Heart Association estimated that 1.2 million Americans had a new or recurrent heart attack in 2006. Cardiac catheterization is a specialty procedure used to diagnose defects in the heart chambers, valves, and blood vessels and provide treatment for certain heart problems. There are two types of catheterization procedures—diagnostic and therapeutic. The diagnostic procedure uses radiographic equipment to record images of the heart, which may identify a blockage that requires therapeutic intervention. The therapeutic procedure is a combination of specialized procedures designed to open blockages of coronary blood vessels.

The American College of Cardiology (ACC) has developed standards, which include benchmarks for the clinical experience of physicians who direct cardiac catheterization laboratories, physicians who perform cardiac catheterizations, and the volume of cases that a laboratory must perform. According to the ACC, there is a direct correlation between low-volume laboratories, low-volume physicians, and increased complication rates. The minimum number of interventional cases per year is 75 for a physician and 400 for a laboratory. A low-volume physician (less than 75 interventional cases per year) should only work in a high-volume laboratory (greater than 600 interventional cases per year).

Due to the advancements in cardiac catheterizations, the risks of the procedure are low; however, complications such as death, stroke, heart attack, and emergency bypass surgery do occur.

The medical center has one cardiac catheterization laboratory, one cardiologist that performs diagnostic and interventional cardiac catheterizations, and one cardiology fellow in training. The laboratory performed 468 coronary diagnostic cases and 142 interventional procedures in FY 2005, exceeding the minimal number of interventional procedures recommended for an individual physician. The laboratory had an active quality assurance program, which identified only two complications that were appropriately managed by laboratory staff.

The laboratory was using IMED (a computer-based informed consent program) to complete the required patient consents. IMED eliminates common problems in the consent process, such as listing all practitioners performing care during the procedure and identifying the major risks associated with cardiac catheterization.

## Survey of Healthcare Experiences of Patients

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 its patients using a standardized instrument modeled from the 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 SHEP. To meet Measure 21 of the VHA Executive Career Field Performance Plan for FY 2006, the medical center needed to achieve patient satisfaction scores of "very good" or "excellent" in 77 percent of outpatients and 76 percent of inpatients surveyed. The following graphs show the medical center's SHEP results for inpatients and outpatients.

**Dayton VAMC Inpatient SHEP Results  
Q3 and Q4 FY 2006**

	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition	Overall Quality
<b>National</b>	81.35	78.90	89.90	67.92	65.97	75.95	83.43	74.66	70.11	**
<b>VISN</b>	82.9+	79.70	89.70	66.2-	64.90	76.00	82.40	73.60	68.50	**
<b>Medical Center</b>	82.00	79.30	89.90	64.7-	63.50	73.70	81.40	70.4-	67.40	**

\* Less than 30 respondents

+ Significantly better than national average

- Significantly worse than national average

**Dayton VAMC Outpatient SHEP Results  
Q4 FY 2006**

	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	Specialist Care	Visit Coordination
<b>National</b>	81.10	77.90	94.7	72.8	83.1	75.6	81.9	65.9	81.4	80.7	84.4
<b>VISN</b>	84.3 +	75.00	95.6	71.1	82	75.9	89 +	70.9	81.7	83.1	84.3
<b>Outpatient Clinics - Overall</b>	78.30	70.00	92.5	64.6	76.4	72	88.3	61.5	74.9	79.9	83.8
Dayton Outpatient Clinic	73.9	72.4	90.9	61.1	73.3	70	*	55.5	71.4	79.3	82
Middletown Outpatient Clinic	91.6 +	75.2	92.7	89.6 +	94 +	89.7 +	*	85.6 +	90.6 +	91.9 +	90.1
Lima Community Based Outpatient Clinic	89.6 +	55.5 -	97.3	75.6	88	74.5	87.8	81.7	84.7	79.2	90.9 +
Richmond CBOC	91.6 +	71	97	71	83.7	80.2	87.3	*	85.7	93.3 +	88.5
Springfield CBOC	91 +	60.7	98.3	61	73.2	69.5	75.3	71.5	78.4	70.7	83.5

\* Less than 30 respondents

+ Significantly better than national average

- Significantly worse than national average

The medical center scored above the 76 percent threshold in 4 of the 10 areas for inpatient SHEP. The medical center was below the threshold of 76 percent for education

and information, emotional support, family involvement, preferences, and transition factors.

The medical center scored above the 77 percent threshold in 5 of the 11 standards for outpatient SHEP. The medical center was below the threshold of 77 percent in overall outpatient clinic scores for continuity of care, education and information, emotional support, overall coordination, pharmacy pick-up, and preferences. Four of the five outpatient clinics scored significantly better than the national average in at least one area, and none were significantly worse than the national average in any area.

Specific measures taken by the medical center to address areas of concern include:

- Physicians were hired as permanent staff for CBOCs to ensure continuity of care.
- Clinic staff were given “quick card” coordinator duties. Quick cards are patient surveys done on a daily basis.
- The primary care areas have pamphlets and posters visible to patients with information on common medical problems.
- An “exit nurse” position was established for exit interviews of patients following primary care visits.
- Two pharmacists are now assigned to the primary care clinics for better coordination and processing of patient medications.

## VISN Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** March 23, 2007

**From:** Network Director, VA Healthcare System of Ohio,  
VISN 10 (10N10)

**Subject:** **Combined Assessment Program Review of the Dayton  
VA Medical Center, Dayton, Ohio**

**To:** Assistant Inspector General for Healthcare, Office of  
Inspector General

Please find attached the comments from the Medical  
Center Director, VA Medical Center Dayton, Ohio, on  
pages 11–15.

*(original signed by:)*

JACK G. HETRICK, FACHE

## Medical Center Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** March 23, 2007

**From:** Medical Center Director, Veterans Affairs Medical Center  
Dayton, Ohio (552/008Q)

**Subject:** **Combined Assessment Program Review of the Dayton  
VA Medical Center, Dayton, Ohio**

**To:** Network Director, VA Healthcare System of Ohio,  
VISN 10 (10N10)

Please find attached our comments regarding the CAP  
review of the Dayton VA Medical Center on pages 12–15.

*(original signed by:)*

GUY B. RICHARDSON, MHSA, FACHE

## **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**

**Recommendation 1.** We recommend that the VISN Director ensure that the Medical Center Director requires compliance with VHA Handbook 1907.1, *Health Information Management and Health Records*, and the October 2004 OI guidance.

Concur

**Target Completion Date:** Completed

- On March 13, 2007, the Clinical Application Coordinator, a member of the Medical Records Review Committee, made the recommendation that any creation, editing, or removal of TIU business rules will be a standing agenda item for Medical Records Review Committee. The recommendation was approved by the committee, and starting in April 2007, business rule discussion will be a standing agenda item.

- A permanent change to the business rules will need the approval of the Medical Records Review Committee.

- The Clinical Coordinators reserve the right to assist patient care situations with business rules that will be presented at the next Medical Records Review Committee.

- Requests for changes in business rules by clinical services will be brought to the Medical Records Review Committee prior to implementation. The Service will provide all justification and implications for change.

**Recommendation 2.** We recommend that the VISN Director ensure that the Medical Center Director requires that each CBOC have an Emergency Care Plan policy relevant to the specific needs and resources of each CBOC.

Concur

**Target Completion Date:** June 1, 2007

Each CBOC is developing an Emergency Care Plan Policy relevant to the specific needs and resources of their location. The CBOC plans will

incorporate the process for handling medical and mental health emergencies.

**Recommendation 3.** We recommend that the VISN Director ensure that the Medical Director requires that: (a) ILSM are implemented and monitored; (b) staff comply with VHA Directive 2005-028, *Oxygen Distribution Systems*; (c) Infection Control participates in the semi-annual inspection of CBOCs; (d) locks are installed on dirty utility rooms; (e) cardboard boxes are removed from the floors; and (f) medication refrigerator temperatures are recorded, monitored, and analyzed daily.

3a)

Concur **Target Completion Date:** Completed

Existing ILSM requires Safety to conduct weekly inspections of construction sites. Since this was identified, they will increase the frequency of inspections to ensure contractor compliance.

3b)

Concur **Target Completion Date:** Completed

To assure compliance with VHA Directive 2005-028, a standing operating procedure for bulk oxygen delivery has been added to the local Dayton SPD handbook, which addresses bulk oxygen fill procedures, necessary paper work and documentation, and quality assurance monitoring.

3c)

Concur **Target Completion Date:** Completed

Infection Control staff are now participating in the semi-annual safety inspections for the CBOC's. The next scheduled safety inspection of all CBOC's will occur in August 2007.

3d)

Concur **Target Completion Date:** June 1, 2007

The locks for the dirty utility rooms were ordered on March 6, 2007. The locks will be installed once received.

3e)

Concur

**Target Completion Date:** Completed

The boxes on the floors in dirty utility rooms have been removed. This will be monitored on a regular basis through the Environment of Care rounds.

3f)

Concur

**Target Completion Date:** Completed

Medication refrigerator temperatures will be recorded, monitored, and analyzed daily. In areas that are not open on weekends and holidays, the recordings will be reviewed the next business day. When temperatures are within expected limits, the assigned staff member will initial the temperature log to document the analysis. If the temperature is or has not been within the expected limits, Engineering Service will be contacted to correct the malfunction, and Pharmacy Service will examine the medications to determine if they need to be discarded. Temperature logs are maintained for 2 years. Spot checks of the temperature logs will be done on the Environment of Care rounds to assure compliance.

**Recommendation 4.** We recommend that the VISN Director ensure that the Medical Center Director ensures (a) compliance with the 45-day completion standard for RCAs and (b) QM analysis of M&M Committee meeting minutes to identify process improvements, document actions, and follow-up to ensure completion of performance improvement initiatives.

4a)

Concur

**Target Completion Date:** Completed

For each RCA convened:

- A pre-briefing will be held with appropriate medical center leaders to discuss team membership and establish the completion date.
- The closing briefing will be scheduled upon initiation to assure compliance with the 45-day standard.
- Team meetings will be scheduled during the orientation briefing for each RCA Team.

4b)

Concur

Target Completion Date: June 1, 2007

The M&M minutes will identify process improvements, document action, and follow-up. The minutes will be forwarded to Quality Management Service for analysis and incorporation into the Medical Center Performance Improvement Oversight function.

## OIG Contact and Staff Acknowledgments

---

OIG Contact	Randall Snow, JD, Associate Director Regional Office of Healthcare Inspections Washington, DC 202 565-8305
Acknowledgments	Gail Bozzelli Donna Giroux Richard Horansky Gavin McClaren Carol Torczon

---

## Report Distribution

### **VA Distribution**

Office of the Secretary  
Veterans Health Administration  
Assistant Secretaries  
General Counsel  
Director, Veterans Integrated Service Network 10 (10N10)  
Director, Dayton VA Medical Center (552/00)

### **Non-VA Distribution**

House Committee on Veterans' Affairs  
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and  
Related Agencies  
House Committee on Oversight and Government Reform  
Senate Committee on Veterans' Affairs  
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and  
Related Agencies  
Senate Committee on Homeland Security and Governmental Affairs  
National Veterans Service Organizations  
Government Accountability Office  
Office of Management and Budget  
U.S. Senate: Evan Bayh, Sherrod Brown, Richard G. Lugar, George V. Voinovich  
U.S. House of Representatives: John A. Boehner, Brad Ellsworth, David Hobson, Jim  
Jordan, Mike Pence, Michael Turner

This report is available at <http://www.va.gov/oig/publications/reports-list.asp>.