Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Martinsburg VA Medical Center Martinsburg, West Virginia

Report No. 07-01572-178

July 31, 2007

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.
- 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

The Department of Veterans Affairs, Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Martinsburg VA Medical Center (the medical center), Martinsburg, WV, during the week of May 7–11, 2007. The purpose of the review was to evaluate selected medical center operations, focusing on patient care administration and quality management (QM). During the review, the Office of Investigations provided five fraud and integrity awareness briefings to 485 employees.

Results of Review

This review focused on six areas. The medical center complied with standards in the following three areas:

- Business Rules for Veterans Health Information Systems.
- Surgical Care Improvement Project.
- Survey of Healthcare Experiences of Patients (SHEP).

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

- Complete and document background checks and licensure verification on clinicians in the community based outpatient clinics (CBOCs).
- Resolve environment of care (EOC) discrepancies.
- Improve QM oversight by standardizing committee minutes and tracking committee and Administrative Boards of Investigation (ABOI) action items, and strengthen the re-privileging process by defining, in writing, criteria for evaluation of provider professional practice.

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

Comments

The VISN and Acting Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 12–16 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

Facility Profile

Organization. The medical center provides medical, surgical, mental health, geriatric, and rehabilitation services and rehabilitative domiciliary care. Outpatient care is also provided at six CBOCs located in Cumberland and Hagerstown, MD; Harrisonburg and Stephens City, VA; and Franklin and Petersburg, WV. The medical center is part of Veterans Integrated Service Network (VISN) 5 and serves a veteran population of about 120,000 residing in 23 counties in western Maryland, south central Pennsylvania, northwestern Virginia, and West Virginia.

Programs. The medical center is a 69-bed primary and secondary care facility. Long-term care is provided in a 178-bed Nursing Home Care Unit and a 312-bed domiciliary. The domiciliary care programs include the Homeless Domiciliary Program, the Traumatic Brain Injury – Community Re-Entry Program, substance abuse treatment programs, and the Post-Traumatic Stress Disorder – Residential Rehabilitation Program.

Affiliations and Research. The medical center is affiliated with the George Washington University School of Medicine, the West Virginia School of Osteopathic Medicine, the West Virginia University School of Medicine, and the West Virginia University School of Dentistry. The medical center provides training opportunities to more than 300 students.

Resources. In fiscal year (FY) 2005, the medical center's medical care expenditures totaled $142 million. The FY 2006 medical care budget was approximately $162.9 million. FY 2005 staffing was 1,168.9 full-time employee equivalents (FTE), which included 64.9 physician FTE and 175.5 nursing FTE.

Workload. The medical center treated 31,394 unique patients in FY 2005 and 32,198 unique patients in FY 2006. There were 4,737 inpatient admissions in FY 2005 and 3,064 inpatient admissions in FY 2006. The annual outpatient workload totaled 327,229 visits in FY 2005 and 336,731 visits in FY 2006.

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 Information Systems	QM
CBOCs	Surgical Care Improvement Project
EOC	SHEP

The review covered medical center operations for FYs 2005, 2006, and 2007 through May 7, 2007, 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, Martinsburg, West Virginia,* Report No. 04-02974-90, February 25, 2005).

During the review, we presented five fraud and integrity awareness briefings for 485 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

Organizational Strength

The medical center pharmacy has implemented a wireless temperature monitoring system that monitors critical temperatures every 15 minutes in all refrigerators that store laboratory specimens and pharmaceuticals in the facility, eliminating human error and the cost of manual temperature documentation. Whenever temperature sensitive items are outside the prescribed parameters, the system e-mails and visually alerts a designated computer screen during business hours and pages the pharmacist on-call during off hours. The system requires that corrective action be taken in the event of a temperature incident. It can produce detailed reports on system equipment for any time period. This system helps ensure the quality of laboratory specimens and pharmaceuticals for veterans.

Opportunities for Improvement

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. The Veterans Health Administration (VHA) expanded ambulatory and primary care areas under Federal legislation passed in 1996, which included the creation of CBOCs throughout the United States. 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 them reasonable access to care and services.

The purpose of this review was to assess operations and delivery of health care services at CBOCs. CBOCs were designed to improve veterans' access to care by offering primary care in local communities while delivering the same standard of care as the parent facility. We visited two rural CBOCs in Franklin and Petersburg, WV. The Franklin CBOC is 150 miles from the medical center and served 198 veterans in FY 2006. The Petersburg CBOC is located 130 miles from the medical center and is physically part of Grant Memorial Hospital. It served 947 veterans in FY 2006.

We interviewed key individuals from the medical center and the CBOCs. We reviewed CBOC policies, performance documents, and provider credentialing and privileging (C&P) files. We also conducted an EOC inspection of the CBOCs. In order to determine if patients received the same standard of care, we compared the management of patients treated with warfarin[1] at the medical center and the CBOCs.

CBOC providers' C&P files and CBOC nurses' personnel folders contained evidence of appropriate documentation, except for one nurse license that was not verified. Background screenings, however, were not complete on five of the nine employees we reviewed. We found that the emergency management plans were current. Clinical staff were certified in Basic Life Support and educated in and knowledgeable about rendering emergency care. The CBOCs were clean and met The Joint Commission,[2] Health Insurance Portability and Accountability Act, and Life Safety requirements.

[1] Warfarin is used to prevent blood clots from forming or growing larger in your blood and blood vessels. Warfarin is in a class of medications called anticoagulants (blood thinners). It is prescribed for people with certain types of irregular heartbeat, people with prosthetic (replacement or mechanical) heart valves, and people who have suffered a heart attack. Warfarin is also used to treat or prevent venous thrombosis (swelling and blood clot in a vein) and pulmonary embolism (a blood clot in the lung). It works by decreasing the clotting ability of the blood.

[2] The Joint Commission was formerly the "Joint Commission on Accreditation of Healthcare Organizations," also known as JCAHO.

We determined that a pharmacist managed the warfarin clinic at the parent facility and that primary care providers managed patients on warfarin at the CBOCs. We found that patient education regarding warfarin use and side effects was one-on-one and individualized at both the parent facility and the CBOCs. Patients on warfarin received the same level of care at the CBOCs as patients at the parent facility.

Recommendation 1. We recommended that the VISN Director require that the Medical Director ensures that all nurses' licenses are verified and that Human Resources staff collect and maintain background investigations for CBOC clinicians.

The VISN and Medical Center Directors agreed with the findings and recommendation. The medical center has implemented a process to monitor nurse licensure verification and completion of background checks. The improvement actions are acceptable, and we will follow up on reported implementation actions to ensure that they have been completed.

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, and Joint Commission standards. To evaluate EOC, we inspected selected clinical and non-clinical areas for cleanliness, safety, infection control, and general maintenance. We randomly selected 10 medical records of patients admitted to the facility with a diagnosis of multi-drug resistant organism. We determined that this information was easily identified in the electronic medical record system,[3] which helped clinicians ensure that appropriate isolation precautions were in place. Overall, we found the medical center to be clean and well maintained. Medications were secured, and infection rates were regularly monitored. The following conditions required management attention.

Bulk Oxygen Utility Systems. The medical center needed to improve bulk oxygen operation and maintenance procedures and to amend local policy[4] to comply with VHA guidelines.[5] VA and Joint Commission have adopted the National Fire Protection Association (NFPA) standard, "NFPA 99: Standard for Healthcare Facilities," as the basis for the requirements of the design, installation, operation, and maintenance of oxygen utility systems at all VA facilities. Joint Commission standards require written Utility Systems Operational Plans, which must assure reliability, control risks, minimize failures, and require training of users and operators of oxygen distribution systems.

In September 2004, while onsite for the previous CAP, the OIG identified six deficiencies in the bulk oxygen operation and maintenance procedures, most of which

[3] VA's electronic medical records system is called VistA, which is the acronym for Veterans Health Information Systems and Technology Architecture.
[4] Medical Center Memorandum No.138-28, *Management of Essential Utility Support Systems,* November 2006.
[5] VHA Directive 2005-028, *Oxygen Distribution Systems*, June 24, 2005.

were addressed with the promulgation of the new local policy. The need for annual inspections by a qualified external expert to conduct and document NFPA 99 code compliant alarm-set point verification was not included in the policy. While monthly inspections by in-house experts have been accomplished, external expert inspections have not been conducted annually. Additionally, monitoring of bulk oxygen deliveries has been inconsistent. Qualified VHA technical staff must monitor tank refilling. Qualified individuals are staff trained to initiate a response to emergent conditions related to the oxygen distribution system. We reviewed documentation of 10 deliveries. Four of those 10 did not have the co-signature of a qualified VHA staff member, which would indicate that the delivery was properly monitored.

Environment of Care Rounds. Semi-annual EOC rounds by the EOC team with membership that includes Environmental Management, Infection Control, the Associate Director, Safety, and others were conducted in the medical center in compliance with Joint Commission and local EOC policy. However, EOC rounds of the six CBOCs were not conducted semi-annually, and team representation was inconsistent.

Utility Rooms. Unlocked dirty utility rooms on patient care units could be accessed by unauthorized individuals, while clean utility rooms were locked. The dirty utility rooms, marked with hazardous waste signs, contained sharp items (used needles), cleaning products, and other items that have the potential to cause injury.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires annual inspections of all oxygen distribution systems by a qualified external expert, semi-annual CBOC inspections by the EOC team, and installation of locks on dirty utility room doors.

The VISN and Medical Center Directors agreed with the findings and recommendation. The medical center has arranged for annual external expert inspections of oxygen distribution systems, incorporated CBOC inspections with EOC inspections, and directed the installation of key pad locks on dirty utility rooms. The improvement actions are acceptable, and we will follow up on reported implementation actions to ensure that they have been completed.

Quality Management

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.

Follow-Up on Corrective Actions. It was difficult to determine the effectiveness of performance improvements because committee minutes did not clearly document all actions and did not evaluate corrective actions for effectiveness. The medical center

adopted a standardized reporting format in April 2006; however, there was still a lack of consistency and standardization of reporting among the program components reviewed. Not all reports identified action items and assigned responsibility and timeframes for completion and re-evaluation. For example, committee meeting minutes identified the need to establish a committee to further investigate a problem and identified the committee members; however, there was no timeframe set for initiating the committee meetings or for the committee to report back on their findings and recommendations.

Administrative Boards of Investigation. It was difficult to determine if recommendations from ABOIs were completed. Upon completion of an ABOI, the recommendations are submitted to the Quality Council for concurrence. Approved actions are then initiated. We reviewed 10 ABOIs completed during FY 2006 and the 1st quarter of FY 2007. Six of these 10 directed action by Human Resources staff, yet there was no documentation indicating if these actions were completed and whether the proposed action had the intended effect.

Evaluation of Provider Professional Practice. The Joint Commission requires health care organizations to have a clearly defined process in place that facilitates the evaluation of each provider's professional practice. The data collected for this evaluation are defined by individual departments in the medical center and approved by the Executive Committee of the Medical Staff. During orientation, new providers at the medical center receive a check sheet with quality indicators that will be used in the evaluation of their professional practice during the re-privileging process. There are no written guidelines that define what criteria each service will collect and how it impacts the re-privileging process.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires standardization of committee minutes with identification of action items and persons assigned responsibility for tracking timeframes for completion and evaluation; documentation of completion of ABOI recommendations; and implementation of written provider evaluation standards by individual departments with approval of the Executive Committee of the Medical Staff.

The VISN and Medical Center Directors agreed with the findings and recommendation. The medical center issued a revised standardized committee minute format for immediate implementation by all services, developed a tracking system for all ABOI recommendations, and directed development of written provider evaluation standards for the re-privileging process. The improvement actions are acceptable, and we will follow up on reported implementation actions to ensure that they have been completed.

Other Observations

Business Rules for Veterans Health Information Systems

The health record, as defined in 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 addenda to the original notes, or as new notes—all reflecting accurately the time and date recorded.

A communication (software informational patch[6] 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 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. The 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. We found that all of the business rules provided to the OIG inspector were in compliance with VHA Handbook 1907.1. We made no recommendations.

Surgical Care Improvement Project

The purpose of the review was to determine if clinical managers implemented strategies to prevent or reduce the incidence of surgical infections for patients having major surgical procedures. Surgical infections present significant patient safety risks and contribute to increased post-operative complications, mortality rates, and health care costs.

We reviewed the medical records of 30 patients who had surgery performed during the 1st quarter of FY 2007. The review included medical records for each of the following surgical categories (1) colorectal and (2) orthopedic (knee or hip replacement).

[6] A patch is a piece of code added to computer software in order to fix a problem.

Healthcare inspectors evaluated the following VHA performance measure (PM) indicators:

- Timely administration of prophylactic antibiotics to achieve therapeutic serum and tissue antimicrobial drug levels throughout the operation. Clinicians should administer antibiotics within 1–2 hours prior to the first surgical incision. The time of administration depends on the antibiotics given.
- Timely discontinuation of prophylactic antibiotics to reduce risk of the development of antimicrobial resistant organisms. Clinicians should discontinue antibiotics within 24–48 hours after surgery. The time depends on the surgical procedure performed.
- Controlled core body temperature for colorectal surgery, which should be maintained at greater than or equal to 36 degrees Centigrade or 96.8 degrees Fahrenheit immediately post-operative. Decreased core body temperature is associated with impaired wound healing.

VHA set target PM scores for each of the above indicators. To receive fully satisfactory ratings, a facility must achieve the following scores, as summarized in the table below.

Performance Measure	Target Score
Timely antibiotic administration	90 percent
Timely antibiotic discontinuation	87 percent
Controlled body temperature – colorectal surgery	70 percent

The table below demonstrates that the medical center appropriately administered and discontinued antibiotics or documented clinical reasons why this did not occur. In addition, post-operative body temperature was controlled for patients who had colorectal surgery performed.

Antibiotic given timely	Antibiotic stopped timely	Body temperature control (colorectal surgery)
96 percent (26/27)	100 percent (27/27)	100 percent (7/7)

Additionally, healthcare inspectors determined whether clinical managers developed and implemented action plans for PM scores falling below VHA established targets. For PMs that fell below VHA targets, managers had developed and implemented acceptable improvement strategies and are monitoring the efficacy of the improvement strategies. We made no recommendations.

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 must 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.

Martinsburg 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
National	81.35	78.90	89.90	67.92	65.97	75.95	83.43	74.66	70.11	**
VISN	79-	77.1-	86.9-	66.1-	62.2-	75.70	79.5-	71.3-	69.30	**
Medical Center	84.4+	83.9+	88.60	71.9+	70.3+	80.4+	84.60	78.7+	74.3+	**

* Less than 30 respondents
\+ Significantly better than national average
\- Significantly worse than national average
** No data available

Martinsburg Outpatient SHEP Results
Q1 FY 2007

	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	Specialist Care	Visit Coordination
National	81.00	77.80	94.9	72.7	83.5	75.7	82	65.3	82	81.1	84.8
VISN	81.90	75.80	95.6	72.7	84	76.2	78.8	58.8	82.9	80.5	87.7
Martinsburg Outpatient Clinic - Overall	88.3 +	79.50	96.4	75.9	87.4	80.6	83	78.2	89.4 +	86.7	90.3 +
-Martinsburg Outpatient Clinic	86.3	85.4	95.9	74	86.2	80	*	79.2	90.8 +	*	90.2
-Cumberland Outpatient Clinic	88.2	79.3	96.6	83.9	93.4 +	84.9 +	78.5	*	89.5 +	*	92.4 +
-Hagerstown Outpatient Clinic	89.9 +	73.3	96.6	76.4	87.8	78.5	83.8	*	87.3	77.4	84.3
-Stephens City Outpatient Clinic	93 +	72.8	98.4 +	74.4	85.8	82.9	81.7	*	87.2	79.3	93.7 +
-Franklin CBOC	*	*	*	*	*	*	*	*	*	*	*
-Petersburg CBOC	92 +	77.5	96.9	84.7 +	90.6 +	82.9	84.3	*	88.9 +	*	94 +
-Harrisonburg CBOC	93.7 +	55.2 -	96.7	75.8	87.5	78.3	79.5	*	85.2	83.8	90.8 +

* Less than 30 respondents
\+ Significantly better than national average
\- Significantly worse than national average

The medical center scored above the 76 percent threshold in 6 of the 10 areas for inpatient SHEP. The medical center was below the threshold of 76 percent for Education and Information, Emotional Support, and Transition factors. The scores were

significantly above the national average in 7 of the 10 areas, including the 3 areas where the scores were below 76 percent.

Overall, the medical center scored above the 77 percent threshold in 10 of the 11 standards for outpatient SHEP. The medical center was below the threshold of 77 percent in overall outpatient clinic scores for Education and Information. Three of the 11 overall clinic scores were significantly better than the national average. All six of the outpatient clinics that had reported data this quarter scored significantly better than the national average in at least one area, and only one was significantly worse than the national average in any area.

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

- Realignment of the Patient Advocate to report directly to the medical center Director.
- Daily rounds made on inpatients by the Patient Advocate, with results discussed in morning report.
- Medical center Director focuses on the top three complaints identified by the Patient Advocate from rounds and local survey results as opportunities for improvement.
- Specific service line improvements made in wait times for prescriptions to be filled and availability of pharmacy staff for telephone calls.

Because of actions the medical center had already taken, we made no recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 1, 2007

From: Network Director, (10N5)

Subject: **Combined Assessment Program Review Martinsburg, West Virginia**

To: Assistant Inspector General for Healthcare, Office of Inspector General (OHI)

1. I concur with the actions taken by the Acting Medical Center Director as outlined in the comments and implementation plan to improve processes at the Martinsburg VA Medical Center.

2. We appreciate the opportunity for this review as a continuing process to improve the care to our veterans.

3. If you have any questions regarding this report, please contact Pedro Garcia, Acting Medical Center Director at 304-263-0811, extension 4000.

(original signed by:)

SANFORD M. GARFUNKEL, FACHE

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 1, 2007

From: Acting Director,
Martinsburg Veterans Affairs Medical Center

Subject: **Combined Assessment Program Review Martinsburg, West Virginia**

To: Director, Veterans Integrated Service Network 5 (10N5)

1. We have reviewed the draft report of the Inspector General Combined Assessment Program Review conducted May 7–10, 2007, at Martinsburg VA Medical Center. We concur with the findings and recommendations.

2. Attached please find the action plans for the three (3) recommendations from the Office of the Inspector General Combined Assessment Program Review.

3. We appreciate the professionalism demonstrated by the OIG Team during this review process and opportunity to review the report.

(original signed by:)

PEDRO E. GARCIA, MHSA

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 recommended that the VISN Director require that the Medical Center Director ensures that all nurses' licenses are verified and that Human Resources staff collect and maintain background investigations for CBOC clinicians.

Concur. **Target Completion Date: June 30, 2007**

Nursing Service has developed a tracking log for all original source nursing license verification, which now includes contracted nursing staff in the CBOCs.

Human Resource Service has developed a tracking log for all background investigations submitted, including contracted staff in the CBOCs. If the background investigation has not been returned within 30 days, the CBOC Coordinator will contact the CBOC Contractor by telephone that action is required and the status documented. If the investigation has not been returned within the next 30 days, the CBOC Contractor will be contacted by telephone to inform them that failure to comply will result in termination of the contract for default. This requirement will also be added to the CBOC contracts as they come up for renewal.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires annual inspections of all oxygen distribution systems by a qualified external expert, semi-annual CBOC inspections by the EOC team, and installation of locks on dirty utility room doors.

Concur. **Target Completion Date: June 25, 2007**

The bulk oxygen system will be inspected by a qualified external expert by June 18, 2007. This annual external expert inspection will be incorporated into the contract. The local policy will be amended by June 18, 2007.

Semi-annual CBOC (including contract sites) have been added to the EOC schedule. This schedule will be monitored by the Safety Officer and reported to the EOC Committee.

Secure (lock) all dirty utility room doors in the medical center and in the CBOCs. FMS will install locks or keypads on all dirty utility room doors (where needed) by June 29, 2007. Chief, FMS, to report status to EOC Committee until completed.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires standardization of committee minutes, with identification of action items and persons assigned responsibility for tracking timeframes for completion and evaluation; documentation of completion of ABOI recommendations; and implementation of written provider evaluation standards by individual departments with approval of the Executive Committee of the Medical Staff.

Concur. A revised standardized committee minute format has been adopted for immediate implementation by all services and committee chairs. This will be monitored for compliance by the Executive Committee of the Medical Staff and Quality Council for 3 months (May 21, 2007, to August 20, 2007). If compliance is determined to be at 100%, then annual monitoring will occur. If compliance is less than 100%, the appropriate chair will be contacted, offered assistance, and minutes monitored monthly until in 100% compliance. Once 100% compliance is achieved, minutes will be monitored quarterly for 2 quarters, then annually.

The Risk Manager has developed a tracking system for all Administrative Boards of Investigation recommendations. If the actions on the recommendations have not been returned within 30 days, follow-up telephone contact will be made,

status documented, and referral made to the medical center Director for further actions.

The four Clinical Service Chiefs are developing written provider evaluation standards for the re-privileging process, which will be submitted to the Executive Committee of the Medical Staff for approval by July 23, 2007.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Randall Snow, J.D., Associate Director Office of Healthcare Inspections, Washington, D.C.
Acknowledgments	Gail Bozzelli Donna Giroux Sarah Lake Carol Torczon

Appendix D

Report Distribution

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