Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 09-02376-02

Combined Assessment Program Review of the Washington, DC, VA Medical Center Washington, DC

October 5, 2009

Washington, DC 20420

Why We Did This Review

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 June 1–5, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the Washington, DC, VA Medical Center (the medical center), Washington, DC. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 151 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 5.

Results of the Review

The CAP review covered eight operational activities. We made recommendations in six of the activities reviewed; two recommendations were repeat recommendations from the prior CAP review. For these activities, the medical center needed to:

- Ensure that all inter-facility transfer documentation complies with Veteran Health Administration (VHA) policy.
- Ensure that patients' health information is secured.
- Secure unused medications in accordance with VHA policy.
- Verify and document required training prior to granting provider privileges.
- Install call buttons in all locked behavioral health unit bathrooms.
- Ensure that designated employees receive training in the operation and use of the emergency eyewash equipment and that appropriate records are maintained.
- Lock all dirty utility room doors.
- Conduct and document environment of care (EOC) rounds at community based outpatient clinics (CBOCs).
- Install a ballistic window at the outpatient pharmacy's dispensing counter.
- Complete all peer reviews (PRs) within the required timeframes.
- Require that all clinical disclosure notes contain complete documentation of the incident and the

discussion with the patient or their representative and that staff appropriately identify and process institutional disclosures.

- Ensure that designated staff maintain current cardiopulmonary resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) certifications and that local policy defines a process to monitor compliance and actions to be taken when current certification is not maintained.
- Ensure that clinicians document patient and/or family receipt of discharge instructions and that documentation of instructions related to medications, diet, activity level, and recommendations for follow-up care is consistent in both discharge instructions and discharge summaries.
- Require requesting providers to document receipt of consultation responses.
- Verify contracted/agency registered nurses (RNs) primary source licensure prior to entry on duty or prior to renewal date of licensure and ensure that mandatory training is completed and clinical competence is demonstrated prior to the provision of patient care.
- Require nurses to consistently document pain medication effectiveness in the Bar Code Medication Administration system (BCMA).

The medical center complied with selected standards in the following two activities:

- Patient Satisfaction.
- Suicide Prevention Program.

This report was prepared under the direction of Nelson Miranda, Director, Washington, DC, Regional Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 17–23, 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

Profile

Organization. The medical center is a complexity Level 1A tertiary care facility located in Washington, DC, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at four CBOCs in Alexandria, VA; Greenbelt and Charlotte Hall, MD; and Washington, DC. The medical center is part of VISN 5 and serves a veteran population of about 607,600 throughout the District of Columbia, West Virginia, Virginia, and Maryland.

Programs. The medical center provides acute care, palliative care/hospice care, rehabilitative services, and long-term care services. It has 171 hospital beds and 120 community living center (CLC)[1] beds.

Affiliations and Research. The medical center is affiliated with four medical schools (Georgetown University, Howard University, Uniformed Services University of the Health Sciences, and the George Washington University) and provides training for 133 residents and for students and fellows. In fiscal year (FY) 2008, the medical center research program had 343 active projects and a budget of $2.8 million. Important areas of research included cardiology, infectious diseases, mental health, neurology, endocrinology, and genomics.

Resources. In FY 2008, medical care expenditures totaled $363.7 million. The FY 2009 medical care budget is approximately $384.1 million. FY 2008 staffing was 2,431 full-time employee equivalents (FTE), including 208 physician and 707 nursing FTE.

Workload. In FY 2008, the medical center treated 55,559 unique patients and provided 48,781 inpatient days in the hospital and 40,206 inpatient days in the CLC. The inpatient care workload totaled 6,508 hospital discharges and 213 CLC discharges. The average daily census, including CLC patients, was 243.2. Outpatient workload totaled 600,907 visits.

[1] A CLC (formerly called a nursing home care unit), provides compassionate, person-centered care in a safe and homelike environment to eligible veterans who require a nursing home level of care.

Objectives and Scope

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 eight activities:

- Contracted/Agency RNs.
- Coordination of Care.
- Emergency/Urgent Care Operations.
- EOC.
- Medication Management.
- Patient Satisfaction.
- QM.
- Suicide Prevention Program.

The review covered medical center operations for FY 2008 and FY 2009 through May 22, 2009, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the Washington, DC, VA Medical Center,* Report No. 06-00627-232,

September 29, 2006). We found that the medical center had not corrected all QM findings from our previous CAP review.

During this review, we also presented fraud and integrity awareness briefings for 151 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 "Review Activities Without Recommendations" section have no reportable findings.

Results

Review Activities With Recommendations

Emergency/Urgent Care Operations

The purpose of this review was to evaluate selected aspects of the emergency department (ED), such as clinical services, consultations, inter-facility transfers, staffing, and staff competencies.

We interviewed physicians, the ED program manager, and others. We reviewed policies and other pertinent documents, including competency files and credentialing and privileging folders. We reviewed the medical records of patients who received consults, were transferred to other medical facilities, or were admitted to inpatient units within the medical center.

Clinical services and consults were appropriate. The ED was staffed appropriately, and nurse competencies were completed annually. We found the following conditions that required management attention.

Inter-Facility Transfers. We reviewed the medical records of three patients transferred from the ED to other medical facilities for care. Transfer documentation did not comply with VHA policy,[2] which requires the use of VA Form 10-2649A, "Inter-Facility Transfer Form," and/or the appropriate electronic medical record template note.

[2] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.

Patient Privacy. We found workstations in the ED with unprotected computers screens displaying patient information. These screens were open to public view.

Medication Control. On a shelf in the medication room, we found unsecured medications that had been pulled from the automated drug dispensing machine but had not been used.

Training Documentation. We reviewed credentialing and privileging files for three ED physicians and found that all were privileged to perform endotracheal intubation. However, none of the files contained documentation to support the granting of this privilege, and we did not find documentation of certification in out-of-operating room airway management. Additionally, all three physicians had been granted moderate sedation privileges, but all three had expired ACLS certifications. ACLS certification is required prior to obtaining moderate sedation privileges.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that all inter-facility transfer documentation complies with VHA policy.

The VISN and Medical Center Directors concurred with the finding and recommendation. ED physicians and the transfer coordinator were re-educated. Compliance will be monitored through medical record reviews. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that patients' health information is secured.

The VISN and Medical Center Directors concurred with the finding and recommendation. Computer screens have been repositioned to eliminate public viewing of sensitive patient information. Continuous monitoring has been implemented. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that all unused medications be secured in accordance with VHA policy.

The VISN and System Directors concurred with the finding and recommendation. Unsecured medications were

removed, and staff were trained regarding the proper process for securing medications. Compliance is being monitored. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that providers are privileged to perform procedures only after verification and documentation of required training.

The VISN and Medical Center Directors concurred with the findings and recommendation. ED physicians with expired ACLS have been recertified. Out-of-operating room intubation certification documentation for ED physicians has been verified and placed in the physicians' files. Clarification of policy requirements has been provided to service chiefs. Monitoring will be conducted to ensure compliance. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Environment of Care

The purpose of this review was to determine whether the medical center maintained a clean, safe, and secure health care environment. Medical centers are required to provide a comprehensive EOC program that fully meets VHA, Occupational Safety and Health Administration, and external accreditation standards.

We inspected the CLC, the locked behavioral health unit, the dialysis unit, the medical intensive care unit, a surgical inpatient unit, a medical inpatient unit, primary care clinics, and the pharmacy. Overall, we found the areas we inspected to be clean and well maintained, and managers expressed satisfaction with the housekeeping staff assigned to their areas. However, we found the following conditions that required management attention.

Locked Behavioral Health Unit. The congregate bathrooms on the locked behavioral health unit do not have call buttons. Patients have no way to summon help in the case of a fall or other adverse event.

Emergency Eyewash. In the case of accidental chemical exposure to the eyes, a quick and effective response is essential to prevent lasting damage or loss of sight. VHA

policy[3] requires employees working in areas where emergency eyewashes are installed to be trained in the proper operation and effective use of the equipment. Also, appropriate records of inspection and maintenance of eyewash equipment are to be maintained. The eyewash station on the dialysis unit had not been inspected weekly, in accordance with VHA policy, and appropriate staff had not been trained.

Utility Rooms. Dirty utility rooms throughout the medical center need to be secured (locked) to prevent unauthorized access and to protect persons from possible exposure to cleaning products and hazardous waste. We found that utility rooms on several units were locked, but they were not consistently locked throughout the medical center.

Environmental Rounds. Environmental rounds should be performed weekly by the EOC team. All on-campus and off-campus sites should be inspected at least semi-annually—all buildings, all floors, and all rooms and spaces.[4] We did not find documentation of CBOC EOC rounds for FY 2008.

Pharmacy. The outpatient pharmacy dispensing counter did not have a ballistic (bulletproof) window, as required by VA policy,[5] because management and staff wanted to provide a more customer-friendly design. Management took action to correct this safety violation while we were onsite.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires that call buttons are installed in all patient bathrooms on the locked behavioral health unit.

The VISN and Medical Center Directors concurred with our finding and recommendation. A review of the locked behavioral unit bathrooms was conducted, and a call system has been selected and ordered. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

[3] VHA Directive 2009-026, *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment,* May 13, 2009.
[4] Deputy Under Secretary for Health for Operations and Management, "Environmental Rounds," memorandum, March 5, 2007.
[5] VA Handbook 0730/1, *Security and Law Enforcement,* August 20, 2004.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires that designated employees receive training in the operation and use of the emergency eyewash equipment and that appropriate inspection and maintenance records are maintained.

The VISN and Medical Center Directors concurred with the findings and recommendation. The Safety Officer completed a risk assessment for the dialysis unit. Training on eyewash station procedures was conducted, and additional eyewash stations have been ordered. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires that all dirty utility room doors are locked.

The VISN and Medical Center Directors concurred with the finding and recommendation. An inspection of all dirty utility rooms has been conducted. All utility room doors now have locks applied, and staff have been educated on the requirement to lock doors. Continuous monitoring is being performed. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires that all EOC rounds of CBOCs are conducted and documented.

The VISN and Medical Center Directors concurred with the finding and recommendation. An EOC rounding schedule for CBOCs has been re-established. EOC rounds for CBOCs were completed and documented, and reports have been made to the EOC Committee. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 9 We recommended that the VISN Director ensure that the Medical Center Director requires that a ballistic window which meets VA regulations is installed at the outpatient pharmacy's dispensing counter.

The VISN and Medical Center Directors concurred with the findings and recommendation. A temporary window was installed immediately after the site visit. A ballistic window is expected to be delivered and installed in August. The

implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Quality Management

The purpose of this review was to evaluate whether the medical center's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the medical center's Director and Chief of Staff, and we interviewed QM personnel. We evaluated plans, policies, performance improvement data, and other relevant documents.

The medical center's QM program was generally effective, and senior managers supported the program through participation in and evaluation of performance improvement initiatives and through allocation of resources to the program. Meaningful data were analyzed, trended, and utilized to improve patient care. Appropriate review structures were in place for 11 out of the 14 program activities reviewed. However, we identified the following three areas that needed improvement.

PR. Once the need for a PR is determined, VHA policy[6] requires that initial reviews be completed within the 45 days and that final reviews be completed by the PR Committee within 120 days. Of the 41 PRs completed in the 1st quarter of FY 2009, 15 (37 percent) initial reviews were completed within the 45-day timeframe, and 30 (73 percent) final reviews were completed within the 120-day timeframe. This was a repeat finding from our prior CAP review. However, the medical center had improved since our previous review and had recently made additional changes to improve the process.

Adverse Event Disclosure. VHA regulations[7] require that clinicians disclose serious adverse events related to clinical care to patients or their personal representatives. The regulations define two types of disclosure.[8] We reviewed the medical records of nine patients who experienced serious adverse events and found that only three of the records had complete clinical disclosure notes. The other six records

[6] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.
[7] VHA Directive 2008-002, *Disclosure of Adverse Events to Patients*, January 18, 2008.
[8] Clinical disclosure is an informal process to discuss serious harmful events with patients and/or families. Discussions are documented in the medical record. Institutional disclosure is a formal process used in cases of serious injury, death, or potential legal liability. Institutional disclosure includes information about compensation and the procedures available to request it.

contained incomplete documentation of the clinical disclosures. In addition, we determined that one of the records reviewed met the criteria for an institutional disclosure. This was a repeat finding from our prior CAP review.

CPR Training. VHA and local policy define which medical center employees are required to maintain current ACLS and CPR certification.[9] We reviewed training files for respiratory technicians, intensive care and post-anesthesia care nurses, physicians who perform moderate sedation, and VA police officers. We found that 121 (75 percent) of the 161 employees had current certifications.

Additionally, we found that the medical center did not have a process in place to consistently review staff compliance with currency of required certifications. Also, local policy did not define actions that would be taken if an individual failed to maintain current certification.

Recommendation 10 We recommended that the VISN Director ensure that the Medical Center Director requires that all PRs are completed within the required timeframes.

The VISN and Medical Center Directors concurred with the findings and recommendation. The medical center has implement changes regarding the deadline for initial PR completion. Changes have also been made to PR Committee processes. Audits for compliance are being conducted and reported to the PR Committee monthly. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 11 We recommended that the VISN Director ensure that the Medical Center Director requires that all clinical disclosure notes contain complete documentation of the incident and the discussion that occurs with the patient or their representative and that staff appropriately identify and process institutional disclosures.

The VISN and Medical Center Directors concurred with the findings and recommendation. Medical staff were re-educated regarding documentation standards, and Risk Management is monitoring clinical disclosure and providing

[9] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.

immediate feedback for non-compliance. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 12 We recommended that the VISN Director ensure that the Medical Center Director requires that designated staff maintain current CPR and ACLS certification and that local policy defines a process to monitor compliance with certification and actions to be taken when current certification is not maintained.

The VISN and Medical Center Directors concurred with the findings and recommendation. The medical center took immediate action to ensure that designated staff were certified. The local policy has been revised to include a process for managing and maintaining certifications. Monitoring will be conducted. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Coordination of Care

The purpose of this review was to evaluate whether inpatient consultations, intra-facility (ward-to-ward) transfers, and discharges were coordinated appropriately over the continuum of care and met VHA and Joint Commission requirements. Coordinated consultations, transfers, and discharges are essential to an integrated, ongoing care process resulting in optimal patient outcomes.

We reviewed the medical records of 14 inpatients who were transferred within the medical center. In general, we found that intra-facility transfers were appropriately documented and were in compliance with local policy. However, we identified the following areas that needed improvement.

Discharges. We reviewed the medical records of 21 discharged patients and found that none contained all the required documentation specified by local policy. We found a lack of consistency between patient discharge instructions and patient discharge summaries. Fifteen (71 percent) lacked consistency regarding medication instructions, 16 (76 percent) lacked consistency regarding diet orders, and 9 (43 percent) lacked consistency regarding follow-up instructions. Also, we found no mention of activity level in the discharge summaries. In addition, we determined that 7 (33 percent) of the 21 records did not contain

documentation that the patient and/or family received a copy of the discharge instructions.

Consultations. We reviewed the medical records of 17 inpatients who had consults ordered and performed internally. Five (29 percent) records did not contain documentation that the provider who requested the consult had received/reviewed the response from the consulted provider.

Recommendation 13 We recommended that the VISN Director ensure that the Medical Center Director requires that clinicians document in the medical record patient and/or family receipt of discharge instructions and that documentation of instructions related to medications, diet, activity level, and recommendations for follow-up care is consistent in both discharge instructions and discharge summaries.

The VISN and Medical Center Directors concurred with the findings and recommendation. Process and documentation practices have been addressed. Continuous monitoring of medical records has been implemented to assess compliance. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 14 We recommended that the VISN Director ensure that the Medical Center Director requires that the requesting provider document receipt of the response to a consultation.

The VISN and Medical Center Directors concurred with the finding and recommendation. Medical staff have been educated, and the consult policy has been revised. Continuous monitoring of medical records has been implemented to assess compliance. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Contracted/Agency Registered Nurses

The purpose of this review was to evaluate whether RNs working at the medical center through contracts or temporary agencies met the same entry requirements as RNs hired as part of VHA facility staff. We examined 10 files of contracted/agency RNs who worked at the medical center within the past year. We reviewed documents for several required components, including background investigations,

licensure, training, and competencies. We identified three areas that needed improvement.

Licensure. According to local policy, nurses are required to have proof of current licensure prior to entry on duty and to maintain that licensure. We did not find evidence that primary source verification was completed for any of the 10 contracted/agency RNs prior to their entry on duty or prior to the renewal date of their licensure.

Training. VA and VHA require several training courses for staff as well as contracted/agency RNs.[10] We did not find evidence that all mandatory training was completed. For example, we found documentation of the required VHA information security training and VHA privacy training for only 1 (10 percent) of 10 contracted/agency RNs. However, these RNs had access to VHA computer systems, which include patient information.

Clinical Competence. According to local policy, contracted/agency RNs are expected to present documented evidence of current clinical competence before providing patient care. We did not find competency documentation for any of the 10 contracted/agency RNs.

Recommendation 15 We recommended that the VISN Director ensure that the Medical Center Director requires that nursing managers verify and document contracted/agency RNs' primary source licensure prior to entry on duty or prior to renewal date of licensure and that mandatory training is completed and clinical competencies are demonstrated prior to the provision of patient care.

The VISN and Medical Center Directors concurred with the findings and recommendation. As of spring 2009, the medical center no longer uses contracted/agency RNs. In the event that the use contracted/agency RNs is reinstated, the medical center will apply all requirements. The corrective action is acceptable, and we consider this recommendation closed.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had adequate medication management practices. A safe medication management system includes medication ordering, administering, and monitoring. We reviewed

[10] VHA Directive 2007-026, *Mandatory and Required Training for VHA Employees*, September 17, 2007.

selected medication management processes on an inpatient surgical unit, a medical and oncology unit, and a psychiatric unit.

We found adequate management of medications brought into the facility, appropriate patient identification prior to medication administration, and consistent monthly medication reviews by pharmacists. We found that reconciliation of controlled substances discrepancies at the unit level was adequate. However, we identified one area that needed improvement.

Pain Medication Effectiveness. Program managers informed us that nurses are expected to document effectiveness of PRN (as needed) pain medication in BCMA. We reviewed the medical records 14 patients who received a total of 52 doses of PRN pain medication. We found that only 16 (31 percent) of the 52 doses were documented in BCMA, as required by local policy.

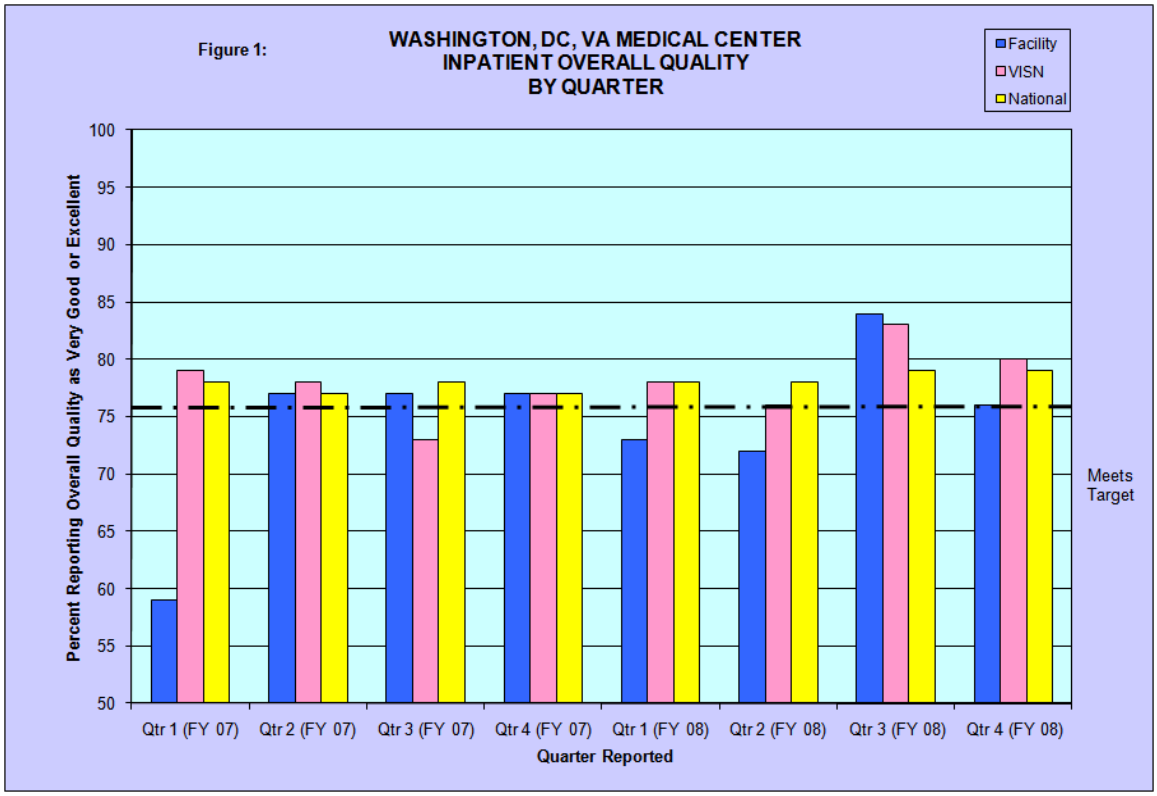
Recommendation 16 We recommended that the VISN Director ensure that the Medical Center Director requires that nurses consistently document pain medication effectiveness in BCMA.

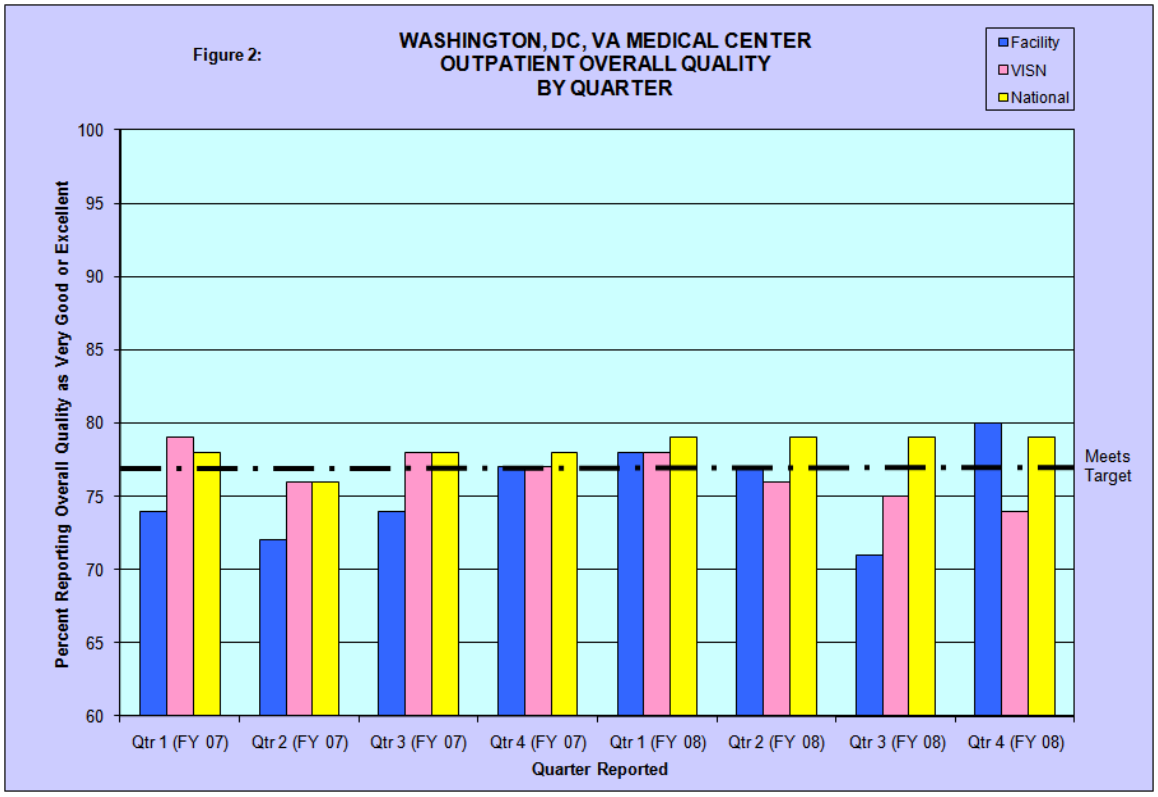
The VISN and Medical Center Directors concurred with the finding and recommendation. The medical center conducted a review of current practices and technological limitations. Continuous monitoring is being conducted, and feedback is being provided to supervisors and staff. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Patient Satisfaction The purpose of this review was to assess the extent that VHA medical centers use quarterly survey results of patients' health care experiences with the VHA system to improve patient care, treatment, and services. The Performance Analysis Center for Excellence of the Office of Quality and Performance within VHA is the analytical, methodological, and reporting staff for the Survey of Healthcare Experiences of Patients (SHEP). VHA set performance measure goals for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients. Medical centers are expected to address areas that fall below target scores.

We reviewed the inpatient and outpatient survey results for each quarter, beginning with the 1st quarter of FY 2007 and ending with the 4th quarter of FY 2008. Figures 1 and 2 below and on the next page show the medical center's SHEP performance measure results for inpatients and outpatients, respectively.





The medical center's inpatient results met or exceeded the target in 5 of the 8 quarters reviewed. The medical center's outpatient results met or exceeded the target in 4 of the 8 quarters reviewed. The medical center's Director shared SHEP data with staff, service chiefs, and patients. All data were analyzed, and actions were taken when appropriate. We made no recommendations.

Suicide Prevention Program

The purpose of this review was to determine whether VHA health care facilities had implemented a suicide prevention program that was in compliance with VHA regulations. We assessed whether senior managers had appointed Suicide Prevention Coordinators (SPCs) at facilities and very large CBOCs,[11] and we evaluated whether SPCs fulfilled all required functions. Also, we verified whether medical records of patients determined to be at high risk for suicide contained Category II Patient Record Flags (PRFs),[12] documented safety plans that addressed suicidality, and documented collaboration between mental health providers and SPCs.

[11] Very large CBOCs are defined as clinics with more than 10,000 unique patients enrolled.
[12] A Category II PRF is an alert mechanism that is displayed prominently in medical records.

We interviewed the SPC, and we reviewed pertinent policies and the medical records of 7 medical center patients and 3 CBOC patients determined to be at risk for suicide. We found that senior managers had appropriately appointed the SPC and that the SPC fulfilled the required functions. We also found that documentation was complete in all 10 medical records reviewed. We made no recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 20, 2009

From: VISN Director

Subject: **Combined Assessment Program Review of the Washington, DC, VA Medical Center, Washington, DC**

To: Director, Washington, DC, Healthcare Inspections Division (54DC)

Director, Management Review Service (10B5)

1. I have reviewed the comments provided by the Medical Center Director, DC VA Medical Center, and I concur with the responses and proposed action plans to the 16 recommendations outlined in the report.

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

3. If further information is required, please contact Ruthanne Burris, MBA, RN, Director of Quality Management, DC VA Medical Center, at (202) 745-8564.

(original signed by:)
SANFORD M. GARFUNKEL, FACHE

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 12, 2009

From: Medical Center Director

Subject: **Combined Assessment Program Review of the Washington, DC, VA Medical Center, Washington, DC**

To: Sanford Garfunkel, Network Director, VISN 5

See attached for medical center response to OIG recommendations.

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 ensure that the Medical Center Director requires that all inter-facility transfer documentation complies with VHA policy.

Concur

Re-education of ED physicians and transfer coordinator was conducted in June, 2009. Medical record reviews for compliance will be conducted for a three month period.

Target completion date: September 1, 2009

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that patients' health information is secured.

Concur

Computer screens have been repositioned to eliminate public viewing of sensitive patient information. Continuous monitoring per daily rounding has been implemented to achieve 100% compliance.

Target completion date: August 30, 2009

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that all unused medications be secured in accordance with VHA policy.

Concur

Unsecured medications were immediately removed at the time of discovery and staff re-educated regarding proper policy and process. Continuous monitoring is occurring on a daily basis to achieve 100% compliance.

Target completion date: September 1, 2009

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that providers are privileged to

perform procedures only after verification and documentation of required training.

Concur

Re-certification of ED physicians was completed in June 2009 for expired ACLS. Out of OR Intubation certification documentation has been verified and placed in physician files. Clarification of requirements per policy was provided to Service Chiefs in June 2009. Monitoring of providers in critical care and ED will be conducted to ensure compliance.

Target completion date: September 1, 2009

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that call buttons are installed in all patient bathrooms on the locked behavioral health unit.

Concur

Review of the locked behavioral health unit bathrooms was completed and call system has been selected and ordered.

Target completion date: October 1, 2009

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that designated employees receive training in the operation and use of the emergency eyewash equipment and that appropriate inspection and maintenance records are maintained.

Concur

Risk assessment was completed by Safety Officer in June 2009 for the dialysis unit. Amendment to current eyewash inspection and maintenance requirements was completed across the medical center in July 2009. Training on eyewash stations have occurred at the department level in July and August, 2009. Additional eyewash stations have been ordered and being implemented in August, 2009.

Target completion date: September 1, 2009

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that all dirty utility room doors are locked.

Concur

Inspection of all utility rooms was conducted in June 2009. All doors have locks applied, and staff has been educated on requirement to maintain a locked environment. Continuous monitoring is performed during daily rounding, with immediate follow up for non-compliance.

Target completion date: July 1, 2009–Completed

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires that all EOC rounds of CBOCs are conducted and documented.

Concur

EOC rounding schedule has been re-established and completed for all CBOCS since June 2009, with subsequent documentation reported to CBOCS and to EOC committee in July and August 2009.

Target completion date: July 31, 2009–Completed

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director requires that a ballistic window which meets VA regulations is installed at the outpatient pharmacy's dispensing counter.

Concur

A temporary window was installed immediately after survey. Ballistic window will be delivered and installed in August, 2009.

Target completion date: September 1, 2009

Recommendation 10. We recommended that the VISN Director ensure that the Medical Center Director requires that all PRs are completed within the required timeframes.

Concur

Changes have been implemented July 1, 2009, regarding the deadline for initial peer review completion and in the composition and frequency of meeting for the Peer Review Committee. Audits for compliance are being conducted and reported to the Peer Review Committee monthly to ensure compliance with completion threshold.

Target completion date: August 30, 2009

Recommendation 11. We recommended that the VISN Director ensure that the Medical Center Director requires that all clinical disclosure notes contain complete documentation of the incident and the discussion that

occurs with the patient or their representative and that staff appropriately identify and process institutional disclosures.

Concur

Re-education of medical staff occurred in June, 2009 regarding documentation expectations through service line meetings, Chief of Staff, and MEC in June and July, 2009. Monitoring of clinical disclosures is occurring through Risk Management on quality of documentation, with immediate feedback to providers for non-compliance.

Target completion date: September 30, 2009

Recommendation 12. We recommended that the VISN Director ensure that the Medical Center Director requires that designated staff maintain current CPR and ACLS certification and that local policy defines a process to monitor compliance with certification and actions to be taken when current certification is not maintained.

Concur

Immediate steps were taken for mandatory certification of staff in June 2009 following this inspection, with 100% remediation. Policy and process for management and maintenance of certification has been revised to include tracking in LMS, which offers an automatic notification feature for direct supervisors regarding compliance. Monitoring occurs at the service line or program level for all eligible staff.

Target completion date: October 1, 2009

Recommendation 13. We recommend that the VISN Director ensure that the Medical Center Director requires that clinicians document in the medical record patient and/or family receipt of discharge instructions and that documentation of instructions related to medications, diet, activity level, and recommendations for follow-up care is consistent in both discharge instructions and discharge summaries.

Concur

Follow-up with stakeholder groups immediately followed inspection to address process and documentation practices. Continuous monitoring of medical records has been implemented to assess compliance at the service level, with immediate feedback to providers for non-compliance

Recommendation 14. We recommended that the VISN Director ensure that the Medical Center Director requires that the requesting provider document receipt of the response to a consultation.

Concur

Education of medical staff occurred in June 2009. Policy for consults was revised in July 2009. Continuous monitoring of medical records has been implemented to assess compliance at the service level, with immediate feedback to providers for non-compliance.

Target completion date: October 1, 2009.

Recommendation 15. We recommended that the VISN Director ensure that the Medical Center Director requires that nursing managers verify and document contracted/agency RNs' primary source licensure prior to entry on duty or prior to renewal date of licensure and that mandatory training is completed and clinical competencies are demonstrated prior to the provision of patient care.

Concur

Decision to no longer use contract or agency nurses was implemented in Spring 2009 at DCVAMC prior to the inspection. That decision has been maintained, but in the event DCVAMC does determine to re-instate contract or agency nursing, all requirements for hiring, licensure and education validation, and training/competency will be applied.

Target completion date: June 5, 2009–Completed

Recommendation 16. We recommend that the VISN Director ensures that the Medical Center Director requires that nurses consistently document pain medication effectiveness in BCMA.

Concur

Review was conducted in June 2009 following inspection to determine current practice and technology limitations. Continuous monitoring is occurring through BCMA reports and medical record audits, with continuous feedback to supervisors and staff.

Target completion date: July 1, 2009–Completed

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