Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 09-03271-84

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

February 16, 2010

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 October 19–23, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the VA Ann Arbor Healthcare System (the system), Ann Arbor, MI. 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 111 system employees. The system is part of Veterans Integrated Service Network (VISN) 11.

Results of the Review

The CAP review covered seven operational activities and one follow-up review area. We identified the following organizational strength and reported accomplishment:

- Wait Times Reduced Through Systems Redesign.

We made recommendations in six of the activities reviewed; two findings were repeat findings related to environment of care (EOC) and the QM program from our prior CAP review. We also made a recommendation in the follow-up review area. For these activities and the follow-up review area, the system needed to:

- Ensure that life support training is current for designated employees and that system policy is updated and reflects actions to be taken when life support training expires.
- Monitor the copy and paste functions in the electronic medical record.
- Correct identified infection control (IC), patient privacy, and environmental safety deficiencies.
- Ensure that all locked mental health (MH) unit staff receive environmental hazards training, as required by Veterans Health Administration (VHA) policy.
- Complete and document fire drills in accordance with Joint Commission (JC) standards.
- Ensure that magnetic resonance imaging (MRI) personnel complete comprehensive patient screenings and document follow-up of affirmative screening responses in the medical record.
- Provide MRI safety education for non-MRI employees who have access to the MRI area, in accordance with JC requirements.

- Ensure compliance with VHA policy regarding documentation of informed consents for high-risk patients who will have intravascular contrast during their MRI procedures.
- Ensure that providers consistently document medication and diet information in patient discharge instructions and discharge summaries.
- Ensure that staff document that the patient or caregiver has received a copy of the discharge instructions.
- Ensure that staff provide discharge education and document patient or caregiver understanding.
- Ensure that nurses document PRN (as needed) pain medication effectiveness within the timeframe specified by system policy.
- Ensure that the Ongoing Professional Practice Evaluation (OPPE) plan, provider files, and privileges are in compliance with VHA requirements.
- Ensure that MH patients who are on atypical antipsychotic medications receive laboratory follow-up that includes documentation of fasting status.

The system complied with selected standards in the following activity:

- Contracted/Agency Registered Nurses (RNs).

This report was prepared under the direction of Paula Chapman, Associate Director, Chicago Office of Healthcare Inspections.

Comments

The VISN and System Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 17–23, for 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 system is located in Ann Arbor, MI, and provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at three community based outpatient clinics (CBOCs) in Flint and Jackson, MI, and in Toledo, OH. The system is part of VISN 11 and serves a veteran population of about 160,000 throughout southeast Michigan and northwest Ohio.

Programs. The system provides medicine, surgery, psychiatry, physical medicine/rehabilitation, neurology, dentistry, geriatrics, and extended care services. It has 105 hospital beds and 60 community living center (CLC) beds.

Affiliations and Research. The system is affiliated with the University of Michigan's Medical School and with the University of Toledo's College of Medicine and provides training for 600 residents. It also provides training for nursing students and for trainees in 10 other associated health disciplines. In fiscal year (FY) 2009, the system research program had 435 projects and a budget of $10.8 million. Important areas of research included biomedicine, rehabilitation, health services, and cooperative studies.

Resources. The FY 2009 medical care budget was $259 million. FY 2009 staffing was 1,724 full-time employee equivalents (FTE), including 136 physician and 487 nursing FTE.

Workload. In FY 2009, the system treated 49,228 unique patients and provided 30,051 inpatient days in the hospital and 13,419 inpatient days in the CLC. The inpatient care workload totaled 5,172 discharges, and the average daily census, including CLC patients, was 119. Outpatient workload totaled 389,840 visits.

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 seven activities and follow-up review area:

- Contracted/Agency RNs.
- Coordination of Care.
- EOC.
- Follow-Up on Diabetes and Atypical Antipsychotic Medications.
- Medication Management.
- MRI Safety.
- Physician Credentialing and Privileging (C&P).
- QM Program.

The review covered system operations for FY 2009 and FY 2010 through October 16, 2009, 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 system (*Combined Assessment Program Review of the VA Ann Arbor Healthcare System, Ann Arbor, Michigan,* Report No. 06-00507-83, February 12, 2007). We identified three repeat findings from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 111 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. The activity in the "Review Activity Without Recommendations" section has no reportable findings.

Organizational Strength

Wait Times Reduced Through Systems Redesign

The Radiology Service identified a 6-month timeframe from the date MRI studies were ordered to completion. As a result of a systems redesign project effort, the system has improved patient flow in the MRI area, revised the MRI ordering system, and implemented the use of 30-minute appointment slots for MRI studies. At the time of our CAP review, the system was consistently completing MRI studies in 2 weeks or less from the date ordered.

Results

Review Activities With Recommendations

Quality Management Program

The purpose of this review was to evaluate whether the system's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the system's Acting Director,[1] the Chief of Staff, the QM Chief, and key staff. We evaluated policies, performance improvement (PI) data, and other relevant documents. We also followed up on recommendations from our prior CAP review.

The QM program was generally effective in providing oversight of the system's quality of care, and senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. We identified two areas that needed improvement. One finding was a repeat finding from the prior CAP review.

Life Support Training. System policy defines which employees are required to maintain current Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS) certification. During our prior CAP review, we identified BLS training deficiencies. Of the 970 employees currently

[1] A permanent Director was appointed after our onsite review.

required to maintain BLS certification, we found that only 930 (96 percent) were in compliance. This is a repeat finding from our prior CAP review. All of the 173 employees identified to maintain ACLS certification were in compliance.

Additionally, we found that the system did not have a process in place to consistently review staff compliance with life support training requirements. Also, the system's policy did not specify actions to be taken when required training was not maintained, and the policy had expired.

Medical Records Reviews. VHA policy[2] requires that the system have a process for monitoring the copy and paste functions in the electronic medical record. We found that the system's policy defines the rules for copying and pasting text; however, the system does not have a process to monitor these functions.

Recommendation 1 We recommended that the VISN Director ensure that the System Director requires that designated employees maintain current life support training certification and that system policy is updated and reflects actions to be taken when life support training expires.

The VISN and System Directors concurred with the findings and recommendation. A centralized tracking process will be implemented to assure that compliance with certification is maintained. The system's policy will be updated and will include actions to be taken when life support training expires. 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 System Director requires monitoring of the copy and paste functions in the electronic medical record.

The VISN and System Directors concurred with the finding and recommendation. A monitoring tool is now in place, and the Medical Records Committee will audit a random sample of medical records monthly to ensure compliance. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

[2] VHA Handbook 1907.01, *Health Information Management and Health Records,* August 25, 2006.

Environment of Care

The purpose of this review was to determine whether the system maintained a safe and clean health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, National Center for Patient Safety, Occupational Safety and Health Administration, National Fire Protection Association, and JC standards.

We inspected the CLC, the Surgical Intensive Care Unit (SICU), the Progressive Care Unit (PCU), an inpatient medical unit, the Telemetry Unit, the locked MH unit, and the Hospital Based Intensive Outpatient Treatment Clinic. We also followed up on recommendations from our prior CAP review.

The system maintained a generally clean and safe environment. Managers and employees were responsive to environmental concerns identified during our inspection. We identified the following conditions that needed improvement. One finding was a repeat finding from the prior CAP review.

IC. Storage areas need to be maintained so that clean and dirty items are separated. We identified storage rooms in three patient care areas that did not have proper separation. Additionally, we observed inappropriate storage of items underneath sinks in three other patient care areas.

Patient Privacy. Federal law requires sensitive patient information to be secured from unauthorized access. We found documents with patients' names, social security numbers, dates of birth, and health information in an unsecured office in the CLC. Additionally, we observed sensitive information on two unsecured computers in the Urgent Care Treatment Room, one unsecured computer on the Telemetry Unit, and two unsecured computers on the SICU. Failure to appropriately protect sensitive patient information was identified during our prior CAP review.

Environmental Safety. System policy requires crash cart inspections to be conducted and documented at least every 24 hours. On the PCU, we noted that documentation of crash cart inspections was missing for 3 consecutive days. Medications must be monitored for expiration and secured from unauthorized access. We found expired medications in a supply room on the PCU and an unlocked medication cart in the CLC hallway. Cleaning products must be secured at all times. We noted unsecured cleaning products

underneath the sink in the CLC's recreation/occupational therapy area and in unlocked housekeeping closets in the CLC and on the SICU.

Environmental Hazards Training. VHA policy[3] requires that all staff who work on locked MH units receive training on the environmental hazards that represent a threat to suicidal patients. We reviewed 19 locked MH unit employees' training records and noted that 6 (32 percent) had not received this training.

Fire Drills. JC standards require fire drills to be completed and documented quarterly on each shift in each building designated for health care occupancy. System policy designates buildings 1 West, 1 East, and 28 (ground floor only) for health care occupancy. Also, all three of the system's CBOCs are designated for ambulatory health care occupancy. We reviewed fire drill reports for October 2008 through September 2009 and noted that quarterly drills were not completed, as required.

Recommendation 3 We recommended that the VISN Director ensure that the System Director requires identified IC, patient privacy, and environmental safety deficiencies to be corrected.

The VISN and System Directors concurred with the findings and recommendation. The EOC checklist was revised. Checklists will be completed weekly by staff and sent to QM. QM will review completed audit sheets and conduct random audits to assure compliance. 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 System Director requires that all locked MH unit staff receive environmental hazards training, as required by VHA policy.

The VISN and System Directors concurred with the finding and recommendation. All locked MH unit staff completed the required training. The unit manager will monitor and track education and will report quarterly to the EOC Committee. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

[3] Deputy Under Secretary for Health for Operations and Management, "Mental Health Environment of Care Checklist," memorandum, August 27, 2007.

Recommendation 5 We recommended that the VISN Director ensure that the System Director requires fire drills to be completed and documented in accordance with JC standards.

The VISN and System Directors concurred with the finding and recommendation. The Safety Office has developed a fire drill schedule, and a fire drill reports will be submitted to the EOC Committee quarterly. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Magnetic Resonance Imaging Safety

The purpose of this review was to evaluate whether the system maintained a safe environment and safe practices in the MRI area. Safe MRI procedures minimize risk to patients, visitors, and staff and are essential to quality patient care.

We inspected the MRI area, examined medical and training records, reviewed relevant policies, and interviewed key personnel. We determined that the system had adequate safety policies and had appropriately conducted a risk assessment of the environment, as required by the JC.

The system had appropriate signage and barriers to prevent unauthorized or accidental access to the MRI area. Patients in the magnet room were directly observed at all times. Two-way communication was available between the patient and the MRI technologist, and the patient had access to a push-button call system while in the scanner. We identified three areas that needed improvement.

Patient Screening. The JC recommends that trained personnel screen all non-emergent patients twice. This provides two separate opportunities for them to answer questions about any metal objects; any implanted devices, drug delivery patches, or tattoos; and any electrically, magnetically, or mechanically activated devices they may have.

We reviewed the screening processes for 10 patients who had MRI procedures in May 2009. At the system, the ordering provider completes seven pre-screening questions. For outpatients, another eight-question screening is completed by the employee who telephones the patient regarding his or her appointment. Lastly, when the patient

arrives for the MRI procedure, he or she is asked to complete a one-page screening questionnaire.

We determined that the screening process was limited and did not address the presence of drug delivery patches, tattoos, piercings, or other pertinent items that could be hazardous. Also, the system was not retaining the final screening forms or including them in the patients' medical records. Because of this, we were unable to determine whether affirmative responses on the screening questionnaires were investigated to determine any contraindications for an MRI procedure.

MRI Safety Education. As a risk reduction strategy, the JC recommends that protocols are implemented to allow maintenance and housekeeping personnel to enter the MRI suite only after proper safety education and when no patient is in the suite. The JC also recommends providing all medical and ancillary staff who may be expected to accompany patients to the MRI suite with annual safety education regarding the potential for accidents and adverse events in the MRI environment.

We reviewed the training records of six non-MRI employees who have occasional access to Zone III of the MRI suite. We determined that MRI safety education was not included as part of employees' initial orientation nor was it provided annually thereafter.

Informed Consent for High-Risk Patients. VHA policy[4] requires that the patient sign a consent form in the following instances:

- Intravascular injection of iodinated radiographic contrast agents in high-risk patients (for example, those with prior allergic reactions, renal failure, or other risk factors).
- Intravascular injection of gadolinium contrast agents in high-risk patients (for example, those with prior allergic reaction to gadolinium or at risk of nephrogenic systemic fibrosis).

We reviewed the medical records of 10 patients who had MRI procedures. One patient who was scheduled to have an intravascular contrast agent was identified as high risk,

[4] VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures,* August 14, 2009.

yet there was no documented informed consent prior to the patient's MRI procedure. Managers acknowledged that an informed consent process was currently lacking for high-risk patients who will have an intravascular contrast agent during their MRI procedures.

Recommendation 6 We recommended that the VISN Director ensure that the System Director requires MRI personnel to complete comprehensive patient screenings and document follow-up of affirmative screening responses in the medical record.

The VISN and System Directors concurred with the findings and recommendation. The system implemented a new MRI screening form, which will be part of the medical record. The MRI manager will audit the forms and report results monthly to the Medical Records Committee. 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 System Director requires that MRI safety education is provided for non-MRI employees who have access to the MRI area, in accordance with JC requirements.

The VISN and System Directors concurred with the finding and recommendation. All identified employees who have occasional access to the MRI area have been trained, and service supervisors will track education reports monthly. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 8 We recommended that the VISN Director ensure that the System Director requires compliance with VHA policy regarding documentation of informed consents for high-risk patients who will have intravascular contrast during their MRI procedures.

The VISN and System Directors concurred with the findings and recommendation. The system has transitioned to an electronic informed consent process for high-risk patients who will have intravascular contrast during their MRI procedures. The MRI manager will audit consent forms and report results monthly to the Medical Records Committee. 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 intra-facility transfers, discharges, and post-discharge MH care were coordinated appropriately over the continuum of care and met VHA and JC requirements. Coordinated transfers, discharges, and post-discharge MH care are essential to an integrated, ongoing care process and optimal patient outcomes.

We reviewed the documentation for 15 intra-facility transfers and determined that clinicians appropriately managed the transfers. We found transfer notes from sending to receiving units and documentation that nursing assessments were performed by the receiving units.

We reviewed the medical records of three patients who were discharged from the locked MH unit. We found documentation that patients received information about accessing emergency MH care, received follow-up contacts from system staff within 7 days after discharge, and were given MH clinic appointments within 2 weeks of discharge. We identified the following areas that needed improvement.

Discharge Instructions. VHA policy[5] requires that providers include information regarding medications, diet, and activity level in patient discharge instructions. We reviewed medical record documentation for 15 discharges and found that in 7 (47 percent) of the medical records, provider discharge instructions were inconsistent with the discharge summaries regarding medications and diet. Five medical records had inconsistencies related to discharge medications, and two had inconsistencies related to diet. Additionally, in 3 (20 percent) of the 15 records, there was no documentation that the patients or caregivers were provided copies of the discharge instructions.

Discharge Education. JC standards require that education is provided regarding treatment and services required after discharge and that written instructions are provided in a manner that the patient or caregiver can understand. Of the 15 medical records reviewed, we found that 3 (20 percent) did not include documentation of patient or caregiver understanding of the discharge instructions.

Recommendation 9 We recommended that the VISN Director ensure that the System Director requires that providers consistently

[5] VHA Handbook 1907.01.

document medication and diet information in patient discharge instructions and discharge summaries.

The VISN and System Directors concurred with the findings and recommendation. Providers and nursing staff have been educated on the requirement to document medication and diet information. QM will conduct audits and report results monthly to the Nurse Executive Board. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 10 We recommended that the VISN Director ensure that the System Director requires that staff document that the patient or caregiver has received a copy of the discharge instructions.

The VISN and System Directors concurred with the finding and recommendation. Providers and nursing staff have been educated on the requirement to document that the patient or caregiver has received a copy of the discharge instructions. QM will conduct audits and report results monthly to the Nurse Executive Board. 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 System Director requires staff to provide discharge education and document patient or caregiver understanding.

The VISN and System Directors concurred with the finding and recommendation. An interdisciplinary team has been convened to educate providers and nursing staff on the requirements to provide discharge education and to document patient and/or caregiver understanding. QM will conduct audits and report results monthly to the Nurse Executive Board. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Medication Management

The purpose of this review was to evaluate whether the system had developed effective and safe medication management practices. We reviewed selected medication management processes in the inpatient medical, surgical, locked MH, and intensive care units and in the CLC.

We found that the system had a designated Bar Code Medication Administration Program coordinator who had

appropriately identified and addressed problems. We reviewed two CLC patients' medical records to determine whether pharmacy staff had conducted monthly medication reviews. We found that these reviews were completed, as required. We identified one area that needed improvement.

Pain Medication Effectiveness Documentation. System policy requires that nurses document the effectiveness of PRN pain medications within 4 hours after administration. We reviewed the medical records of 24 patients who received a total of 100 doses of PRN pain medications. Nurses documented 73 (73 percent) of the 100 doses within the designated timeframe.

Recommendation 12 We recommended that the VISN Director ensure that the System Director requires that nurses document PRN pain medication effectiveness within the timeframe specified by system policy.

The VISN and System Directors concurred with the finding and recommendation. Staff have been educated regarding documentation of PRN pain medication effectiveness. Audits began in November 2009, and monitoring will continue to assure compliance. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Physician Credentialing and Privileging

The purpose of this review was to determine whether the system maintained consistent processes for physician C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and provider profiles.[6] We also reviewed meeting minutes during which the physicians' privileges were discussed and recommendations were made.

We reviewed 10 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. Focused Professional Practice Evaluations were appropriately implemented for the two physicians hired within the past 12 months. We identified one area that needed improvement.

OPPE. VHA regulations require a thorough written plan with specific competency criteria for OPPE for all privileged physicians. The system's written plan did not include

[6] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

service-specific competency criteria. OPPE data for the eight physicians who had been reprivileged during the past 12 months were sufficient to meet current requirements; however, the evaluation time periods were not clearly designated on all OPPE forms. Also, Clinical Executive Board meeting minutes did not reflect detailed discussion of any physician's privileges or performance data prior to reprivileging.

Recommendation 13 We recommended that the VISN Director ensure that the System Director requires that the OPPE plan, provider files, and privileges are in compliance with VHA requirements.

The VISN and System Directors concurred with the findings and recommendation. The written policy for OPPE will be revised as necessary to include service-specific competency criteria, and Clinical Executive Board meeting minutes will reflect detailed discussion of provider data. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Follow-Up on Diabetes and Atypical Antipsychotic Medications

As a follow-up to a recommendation from our prior CAP review, we reassessed the system's diabetes screening, monitoring, and treatment of MH patients receiving atypical antipsychotic medications (medications that cause fewer neurological side effects but increase the patient's risk for the development of diabetes). During our prior CAP review, we identified that the system needed to improve documentation of the fasting status for patients who received fasting blood glucose (FBG) laboratory testing.

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

Non-Diabetic Patients. We reviewed medical record documentation for a sample of 10 non-diabetic patients who were on one or more atypical antipsychotic medications for at least 90 days during FY 2009. Of these patients, 5 (50 percent) had glucose serum values that were greater

than 110 mg/dL. There was no documentation to show that the providers had ordered the tests as fasting. Additionally, there was no documentation in the progress notes or in the laboratory reports to show or verify whether these specimens were collected while the patients were fasting.

Clinicians have recognized this category of patients as high risk for the development of diabetes and informed us that patients are educated to fast for laboratory metabolic profile testing. Clinicians reported that they utilize glycosylated hemoglobin (HbA1c) as an indicator for glucose monitoring. We reviewed medical record documentation for an additional sample of 10 non-diabetic patients and found that 5 (50 percent) had HbA1c results documented in their medical records, 3 (30 percent) did not have HbA1c documented in their medical records, and 2 (20 percent) did not have provider orders for either HbA1c or FBG laboratory testing.

Recommendation 14 We recommended that the VISN Director ensure that the System Director requires that MH patients who are on atypical antipsychotic medications receive laboratory follow-up that includes documentation of fasting status.

The VISN and System Directors concurred with the findings and recommendation. The glucose laboratory order for MH patients who are on atypical antipsychotic medications has been changed to a fasting glucose laboratory order. The system will regularly measure its performance to assure effective screening, and results will be reported at the Pharmacy and Therapeutics Committee, to the MH Service, and to providers. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activity Without Recommendations

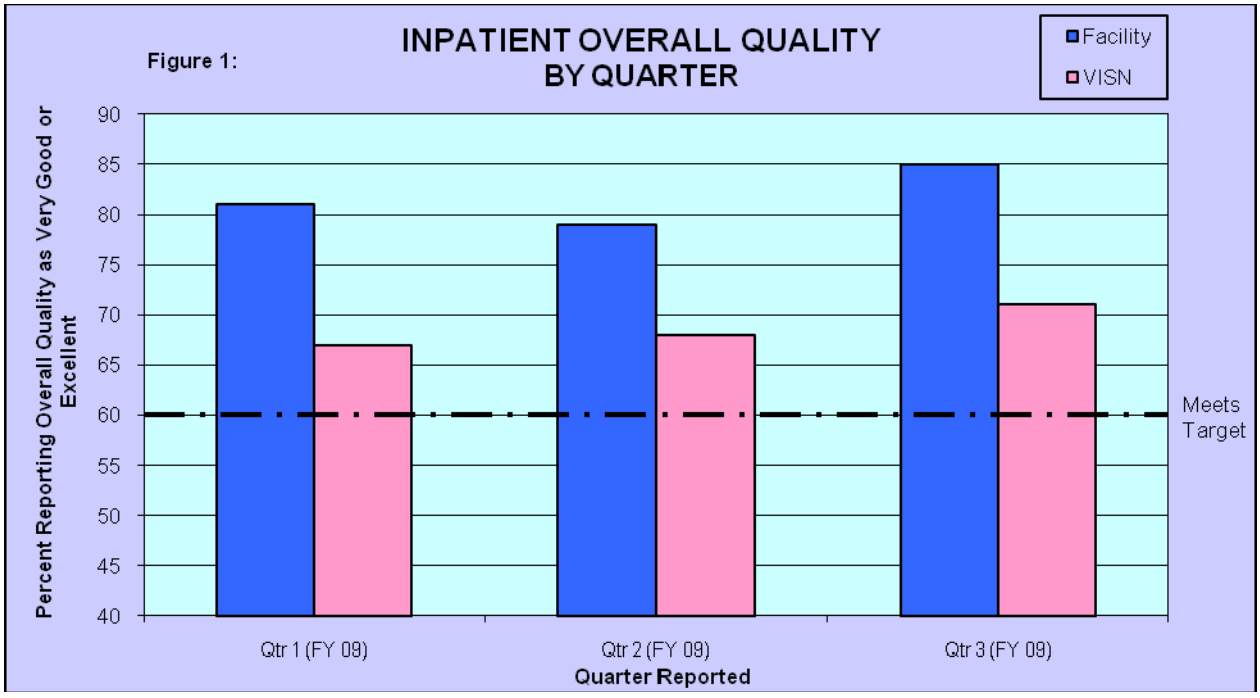
Contracted/Agency Registered Nurses

The purpose of this review was to evaluate whether RNs working at the system through contracts or temporary agencies met the same entry requirements as RNs hired as part of system staff. We reviewed documents for several required components for 10 contracted/agency RNs. We found that managers had verified current licensure, BLS certification, completed competencies, required information security and privacy training, and completion of background checks. We made no recommendations.

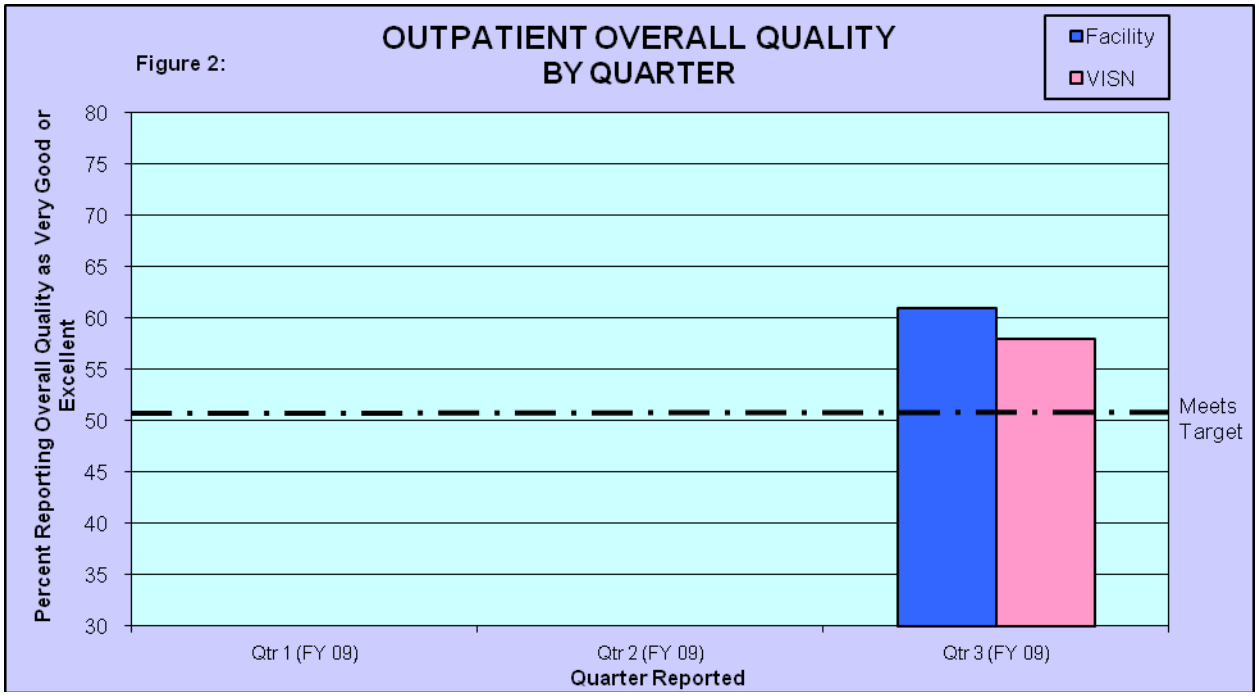
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 below shows the system's and VISN's overall inpatient satisfaction scores for quarters 1, 2, and 3 of FY 2009. Figure 2 on the next page shows the system's and VISN's overall outpatient satisfaction scores for quarter 3 of FY 2009.[7] The target scores are noted on the graphs.

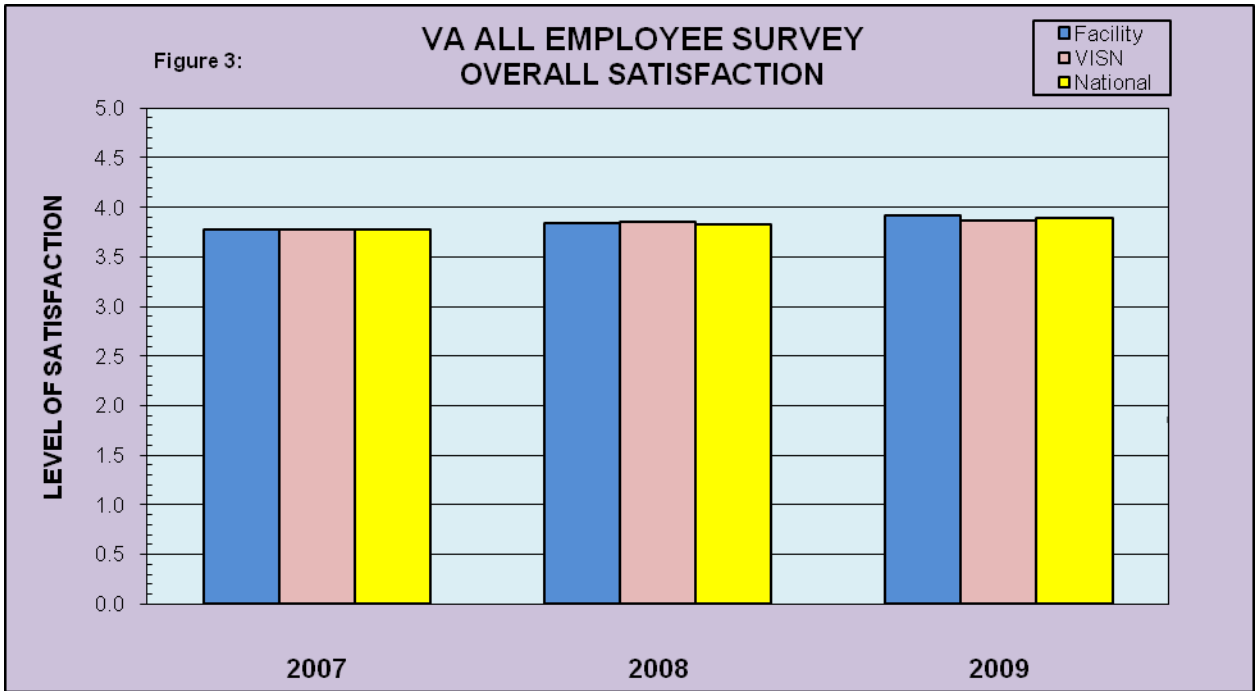
Figure 1:



[7] Due to technical difficulties with VHA's outpatient survey data, outpatient satisfaction scores for quarters 1 and 2 of FY 2009 are not included for comparison.



Employees are surveyed annually. Figure 3 below shows the system's overall employee scores for 2007, 2008, and 2009. Since no target scores have been designated for employee satisfaction, VISN, and national scores are included for comparison.



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: **January 25, 2010**

From: Director, Veterans In Partnership Network (10N11)

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

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

Director, Management Review Service (10B5)

1. Attached please find VA Ann Arbor Healthcare System's response to the draft report of the Combined Assessment Program Review.

2. If you have any questions, please contact James Rice, Quality Management Officer, at 734-222-4314.

MICHAEL S. FINEGAN

Attachment

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: **January 25, 2010**

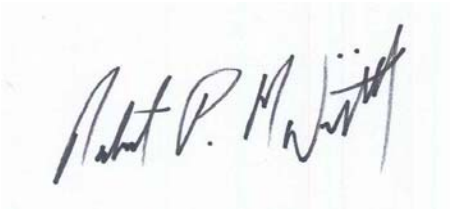
From: Director, VA Ann Arbor Healthcare System (506/11P)

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

To: Director, Veterans In Partnership Network (10N11)

1. I appreciate the opportunity to review and respond to the draft report on the CAP review of our facility and, on behalf of the VA Ann Arbor Healthcare System, concur with the recommendations that have been made. The attached comments are submitted for your review.

2. If additional information is needed, please contact Winifred Verse-Barry, Chief of Quality Management, at (734) 845-5527.



ROBERT P. McDIVITT, FACHE

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 System Director requires that designated employees maintain current life support training certification and that system policy is updated and reflects actions to be taken when life support training expires.

Concur: **Target completion date: March 1, 2010**

During the OIG CAP visit in October 2009, 96% of staff were compliant with their BLS certification; this was an increase from 54% found in 2006. 100% of indentified staff were compliant with ACLS certification. A centralized tracking process will be implemented to assure compliance with certification is maintained. The current policy will be updated to reflect the tracking system and actions to be taken when life support training expires. QM will audit and report to CEB monthly.

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires monitoring of the copy and paste functions in the electronic medical record.

Concur: **Completed**

A monitoring tool is now in place. Copy and paste function will be monitored monthly by the Medical Records Committee. A random sample of inpatient and outpatient medical records will be audited monthly by the Medical Records Committee and reported quarterly to CEB. **Recommend closure**.

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires identified IC, patient privacy, and environmental safety deficiencies to be corrected.

Concur: **Target completion Date: April 1, 2010**

A memorandum was sent to services outlining the responsibilities of area managers to assure compliance with EOC standards. EOC checklist was revised and implemented to assure crash carts are checked, medication and patient information is secured and other EOC issues are in compliance. EOC checklists will be completed weekly by area staff and

sent to QM. QM will review audit sheets completed by areas and conduct random audits to assure compliance. Privacy screens are in place on computers to protect patient sensitive information. Housekeeping closets will be kept locked. Cabinets under sinks will be locked to prevent inappropriate storage. A work order for the lock installation was submitted on January 15, 2010. Interim measures have been taken to eliminate inappropriate storage until the locks arrive and are installed. Reports are sent monthly to the EOC Committee.

Recommendation 4. We recommended that the VISN Director ensure that the System Director requires that all locked MH unit staff receive environmental hazards training, as required by VHA policy.

Concur: **Completed**

All MH staff completed the training. Tracking of education will be monitored by the unit manager and reported quarterly to the EOC Committee. New employees working on the locked MH unit will receive unit specific education. **Recommend closure.**

Recommendation 5. We recommended that the VISN Director ensure that the System Director requires fire drills to be completed and documented in accordance with JC standards.

Concur: **Completed**

The completion rate for fire drills for FY 2010 1st quarter was 100%. The Safety Office developed a fire drill schedule to assist in assuring the required number of drills and areas to be drilled are completed when due. At least 50% of the fire drills will be unannounced per JC standards. A standing fire drill report will be submitted to the EOC Committee quarterly to monitor compliance. **Recommend closure.**

Recommendation 6. We recommended that the VISN Director ensure that the System Director requires MRI personnel to complete comprehensive patient screenings and document follow-up of affirmative screening responses in the medical record.

Concur **Completed**

We implemented a new MRI Screening form using ACR guidelines. This form is part of the patient's medical record. The MRI Manager will audit forms bi-weekly and report to Medical Records Committee monthly. **Recommend closure.**

Recommendation 7. We recommended that the VISN Director ensure that the System Director requires that MRI safety education is provided for

non-MRI employees who have access to the MRI area, in accordance with JC requirements.

Concur: **Completed**

All identified employees who have occasional access to Zone III are trained. In the future, the education will be broadened to include all employees who may have access to MRI areas. Education reports will be tracked monthly by service supervisors. Reports will be sent quarterly to Employee Education. **Recommend closure**.

Recommendation 8. We recommended that the VISN Director ensure that the System Director requires compliance with VHA policy regarding documentation of informed consents for high-risk patients who will have intravascular contrast during their MRI procedures.

Concur: **Completed**

We have transitioned to IMed Consent for high-risk patients who received intravascular contrast during the MRI procedure. The MRI manager will audit consent forms for documentation weekly and report to Medical Records Committee monthly. **Recommend closure.**

Recommendation 9. We recommended that the VISN Director ensure that the System Director requires that providers consistently document medication and diet information in patient discharge instructions and discharge summaries.

Concur: **Target completion date: February 19, 2010**

An Interdisciplinary team was convened to educate providers and nursing staff on requirements to document medication and diet information. Education was provided to providers and nursing staff on requirements to document medication and diet information. QM will audit and report to Nurse Executive Board monthly.

Recommendation 10. We recommended that the VISN Director ensure that the System Director requires that staff document that the patient or caregiver has received a copy of the discharge instructions.

Concur: **Target completion date: February 19, 2010**

An Interdisciplinary team was convened to educate providers and nursing staff on the requirements to document that the patient or caregiver received a copy of the discharge instructions. QM will audit and report to Nurse Executive Board monthly.

Recommendation 11. We recommended that the VISN Director ensure that the System Director requires staff to provide discharge education and document patient or caregiver understanding.

Concur: Target completion date: February 19, 2010

An Interdisciplinary team was convened to educate providers and nursing staff on requirements to provide discharge education and to document patient and/or caregiver understanding. QM will audit and report to Nurse Executive Board monthly.

Recommendation 12. We recommended that the VISN Director ensure that the System Director requires that nurses document PRN pain medication effectiveness within the timeframe specified by system policy.

Concur: Target completion date: October 23, 2009

Staff education regarding documentation of PRN effectiveness was completed in October through poster presentations, development of visual cue cards, inservices and staff meetings. Audits of PRN effectiveness began November 2009 and monitoring will continue to assure compliance. QM will audit and report to Nurse Executive Board monthly. **Recommend closure.**

Recommendation 13. We recommended that the VISN Director ensure that the System Director requires that the OPPE plan, provider files, and privileges are in compliance with VHA requirements.

Concur Target completion date: March 1, 2010

The written policy for OPPE will be reviewed and revised as necessary to include service specific competency criteria. Forms will be reviewed at time of submission to the board for completeness, including evaluation times. CEB minutes will reflect the broader detailed discussion of provider data, i.e., review of provider profile and other documents.

Recommendation 14. We recommended that the VISN Director ensure that the System Director requires that MH patients who are on atypical antipsychotic medications receive laboratory follow-up that includes documentation of fasting status.

Concur: Target completion date: April 17, 2010

VA Ann Arbor Healthcare System (VAAAHS) agrees with the need to provide effective diabetes screening for patients who receive atypical antipsychotic medications. Revisions to the atypical antipsychotics order dialogue include changing the glucose laboratory order to a fasting glucose laboratory order. The reminder dialogue displays the fasting

glucose laboratory values. If these values are not available or not current, the dialogue contains an option to enter new laboratory orders. The fasting glucose quick order was added to the laboratory menu so that providers can order outside of the reminder dialogue. We have added a new basic panel that includes fasting glucose. Depending on the clinical circumstances, VAAAHS providers screen for diabetes using three approaches: fasting glucose, hemoglobin A1C (A1C) and random glucose level ≤ 110 mg/dl (i.e. a normal random glucose essentially excludes diabetes and qualifies as an effective screening test). The use of A1C and random glucose testing for this purpose is supported by our local endocrinology specialists, widespread clinical practice and clinical practice guidelines including a recent position statement from the American Diabetes Association (Diabetes Care 33[Supp 1]:S62-S69, 2010). As of 12/8/09, there were 1513 active prescriptions for atypical antipsychotics involving 1400 patients (several patients receive more than one agent, most of these are prescriptions are longstanding). Diabetes screening was done for 86% of prescriptions within one year of the date the prescription was last issued and for 94% of prescriptions within a 3-year window. This greatly exceeds published reports (e.g., Am J Psychiatry 166(3):345-53, 2009) and compares favorably with most clinical performance measure targets. We plan to regularly measure our performance to assure that we continue to provide effective screening. Results will be reported at the P&T Committee, MH service and provider levels.

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