Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 09-03040-114

Combined Assessment Program Review of the VA Eastern Colorado Health Care System Denver, Colorado

March 24, 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 January 25–29, 2010, the OIG conducted a Combined Assessment Program (CAP) review of the VA Eastern Colorado Health Care System (the system), Denver, CO. 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 225 system employees. The system is part of Veterans Integrated Service Network (VISN) 19.

Results of the Review

The CAP review covered eight operational activities and one follow-up review area from the previous CAP review. We identified the following organizational strengths and reported accomplishments:

- Virtual Intensive Care Unit (vICU)
- Polytrauma/Regional Amputee Program

We made recommendations in three of the activities reviewed and in the follow-up review area. For these activities and the follow-up review area, the system needed to ensure that:

- The Peer Review Committee (PRC) documents all required committee activities.
- Electronic medical records (EMRs) are continually monitored for appropriate use of the copy and paste functions.
- Device-specific standing operating procedures (SOPs) are posted in all areas where reusable medical equipment (RME) is reprocessed.
- Unique identifiers for endoscopes are recorded in the procedure log.
- Magnetic resonance imaging (MRI) personnel document their review of patient safety screening questionnaires.
- Contract Community Nursing Home (CNH) staff document the required monthly follow-up visits for all contract CNH patients in a timely manner.

The system complied with selected standards in the following five activities:

- Coordination of Care
- Environment of Care
- Medication Management
- Physician Credentialing and Privileging (C&P)
- Suicide Prevention Safety Plans

This report was prepared under the direction of Virginia L. Solana, Director, Denver Office of Healthcare Inspections.

Comments

The VISN and System Directors agreed with the CAP review findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 14–19, 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 system is a tertiary care facility located in Denver, CO, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at nine community based outpatient clinics in Alamosa, Aurora, Burlington, Colorado Springs, Lakewood, La Junta, Pueblo, Lamar, and Salida, CO. The system is part of VISN 19 and serves a veteran population of about 350,000 throughout the front range of Colorado and into Wyoming.

Programs. The system provides primary, tertiary, and long-term care in the areas of medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, geriatrics, and extended care. It has 128 hospital beds and 100 community living center (CLC) beds.

Affiliations and Research. The system is affiliated with the University of Colorado Denver's Schools of Medicine and Pharmacy and College of Nursing. It provides training for 120 residents in internal medicine and surgery and their subspecialties of psychiatry, neurology, physical medicine and rehabilitation, anesthesia, pathology, radiology, and dentistry. In fiscal year (FY) 2009, the system research program had approximately 362 projects and a budget of $18.7 million. Important areas of research included heart disease, diabetes, cancer, schizophrenia, suicide, and infectious and neurological diseases.

Resources. In FY 2009, medical care expenditures totaled $418.7 million. FY 2009 staffing was 2,084 full-time employee equivalents (FTE), including 207 physician and 498 nursing FTE.

Workload. In FY 2009, the system treated 61,000 unique patients and provided 43,061 inpatient days in the hospital and 20,289 inpatient days in the CLC unit. The inpatient care workload totaled 5,885 discharges, and the average daily census, including CLC patients, was 210. Outpatient workload totaled 644,026 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 eight activities and follow-up review area:

- Contract CNHs
- Coordination of Care
- Environment of Care
- Medication Management
- MRI Safety
- Physician C&P
- QM
- RME
- Suicide Prevention Safety Plans

The review covered system operations for FY 2009 and FY 2010 through November 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 Eastern Colorado Health Care System, Denver, Colorado,* Report

No. 06-02819-145, June 18, 2007). The system had corrected all but one finding related to health care from our prior CAP report. This finding is discussed in the section on contract CNHs.

During this review, we also presented fraud and integrity awareness briefings for 225 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.

Organizational Strengths

Virtual Intensive Care Unit

The system has implemented a vICU program. This program is a virtual rapid response team that coordinates and provides real time consultation and collaboration to registered nurse (RN) staff at rural facilities throughout VISN 19. The goals of the program are to improve the quality of care of critical services in rural sites, reduce fee basis costs for critical care services, reduce the frequency and costs of patient transfers, provide early physician intervention, increase collaboration among nursing and medical staff at VISN 19 hospitals, and increase patient satisfaction.

Critical care RNs are available 24 hours a day, 7 days a week for consultation, collaboration, and support. The vICU RN contacts rural sites once each shift to discuss current clinical issues, patient status, and care needs. In addition, the vICU RN coordinates immediate remote video conferencing between specialists in Denver and the hospitalist at the rural site. The vICU RN also works with physicians and bed control to facilitate speedy transfers when necessary.

Polytrauma/ Regional Amputee Program

The newly opened Jewell Clinic is designed to provide state-of-the-art rehabilitative and prosthetic care through expansion of the Physical Medicine and Rehabilitation Service, the Prosthetic Treatment Center, and a health information call center. The clinic treats veterans with physical and cognitive impairments that cause activity and/or

social limitations in their daily lives. Guided by each veteran's goals and facilitated by a case manager, this interdisciplinary specialty care restores independence.

Outpatient programs include polytrauma, assistive technology, wheelchair, visual impairment service outpatient rehabilitation, and amputation. Outpatient services include drivers' training rehabilitation, therapeutic recreation, rehabilitation psychology, speech pathology and voice laboratory, and orthotic and prosthetic laboratory. The wheelchair and amputation programs, which supply specialty clinical services to rural areas, use telemedicine to improve veterans' access to care.

The wheelchair and amputation programs are accredited by the Commission on Accreditation of Rehabilitation Facilities, an independent organization that provides impartial, external reviews to assure conformance with national performance standards. The orthotic and prosthetic laboratory is accredited by the American Board for Certification in Orthotics and Prosthetics.

Results

Review Activities With Recommendations

Quality Management

The purposes of this review were to evaluate whether the system had a comprehensive QM program designed to monitor patient care quality and whether senior managers actively supported the program's activities. We evaluated policies, performance improvement (PI) data, and other relevant documents. We also interviewed appropriate senior managers and the QM Coordinator.

The QM program was generally effective, and senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. Appropriate review structures were in place for 10 of the 12 program activities reviewed. However, we identified the following conditions that needed improvement.

PRC. Veterans Health Administration (VHA) policy[1] requires the PRC to document feedback on non-punitive action implementation by supervisors of providers who receive

[1] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.

Level 2 and Level 3 peer reviews. PRC minutes did not include this required documentation.

Medical Record Review. VHA policy[2] requires that the system have a process for monitoring the copy and paste functions in the EMR. We found that the system's policy defines the rules for copying and pasting text; however, prior to December 2009, the system did not have a process to monitor these functions.

Recommendation 1 We recommended that the VISN Director ensure that the System Director requires the PRC to document all required committee activities.

The VISN and System Directors concurred with the finding and recommendation. A template was developed to document communication between individuals who receive either a Level 2 or Level 3 peer review and their supervisor. Once the PRC determines the case level, the supervisor will receive a copy of the PRC findings and a copy of the template. The supervisor will then complete the template, and this information will be documented in subsequent PRC meeting minutes. 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 the continual monitoring of EMRs for appropriate use of the copy and paste functions.

The VISN and System Directors concurred with the finding and recommendation. A monthly copy and paste monitor was started in FY 2010 and has been completed through February 2010. The Medical Records Committee currently discusses results, which will be reported to the PI Council and the Clinical Executive Board. The corrective actions are acceptable, and we consider this recommendation closed.

Reusable Medical Equipment

The purpose of this review was to evaluate whether the system had processes in place to ensure effective reprocessing of RME. Improper reprocessing of RME may transmit pathogens to patients and affect the functionality of the equipment. VHA facilities are responsible for minimizing patient risk and maintaining an environment that is safe. The system's Supply, Processing, and Distribution (SPD) and

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

satellite reprocessing areas are required to meet VHA, Association for the Advancement of Medical Instrumentation, Occupational Safety and Health Administration (OSHA), and Joint Commission (JC) standards.

We inspected reprocessing areas in gastrointestinal endoscopy, anesthesia, pulmonary, SPD, and the operating room. We determined that the system had established appropriate guidelines and monitored compliance with those guidelines. However, we identified the following areas that needed improvement.

SOPs. VHA requires[3] device-specific SOPs for the set up and reprocessing of RME to be posted in any area where these devices are reprocessed. We requested the SOPs for 12 pieces of RME. While SOPs had been developed for all pieces of RME selected, we found two locations where SOPs were not posted in the reprocessing areas. The system took immediate action to post the SOPs while we were onsite.

RME Unique Identifier. VHA requires[4] that a log is in place to record the serial number (or other unique identifier) of the RME used, operator(s), date and time, and patient identifier for each patient procedure. We found that the anesthesia procedure log did not contain the endoscope identifier for any of the procedures completed.

Recommendation 3 We recommended that the VISN Director ensure that the System Director requires that device-specific SOPs are posted in all areas where RME is reprocessed.

The VISN and System Directors concurred with the finding and recommendation. Actions were taken to post SOPs in all RME reprocessing areas, and compliance will be monitored. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 4 We recommended that the VISN Director ensure that the System Director requires that the serial number or other

[3] VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.

[4] VHA Directive 2009-031, *Improving Safety in the Use of Reusable Medical Equipment through Standardization of Organizational Structure and Reprocessing Requirements*, June 26, 2009.

unique identifier of the endoscope used for each patient procedure is recorded in the procedure log.

The VISN and System Directors concurred with the finding and recommendation. The unique identifier of the endoscope used for each patient procedure is now being recorded in all logs, and compliance will be monitored. The corrective actions are acceptable, and we consider this recommendation closed.

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 are directly observed at all times. Two-way communication is available between the patient and the MRI technologist, and the patient has access to a push-button call system while in the scanner. Additionally, mock fire and emergency response drills have been conducted in the MRI area.

We reviewed the medical records of 11 patients who received an MRI. Eight of these patients had an MRI with contrast media. The one high-risk patient in this review signed an informed consent document prior to his procedure, in accordance with local policy. We identified one area that needed improvement.

Screening. Local policy requires that MRI personnel screen patients who have access to the MRI area. The MRI technician must review the patient's safety screening questionnaire, consult with the radiologist when necessary, and document the screening in the medical record. Required documentation was absent in all patient medical records examined.

Recommendation 5 We recommended that the VISN Director ensure that the System Director requires MRI personnel to document their review of patient safety screening questionnaires, as required by local policy.

The VISN and System Directors concurred with the finding and recommendation. MRI safety screening questionnaires will be reviewed and signed by appropriate personnel and then scanned into the patients' medical records. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Contract Community Nursing Homes

The prior CAP review finding regarding contract CNH oversight was not corrected. VHA policy[5] requires a social worker or RN to visit each VA patient in a CNH at least every 30 days unless otherwise indicated by the patient's treatment plan. These follow-up visits are necessary to ensure that treatment goals are being met and that the patient care provided is appropriate.

We reviewed a sample of 10 medical records, and 4 (40 percent) of the 10 records lacked documentation of monthly visits. The CNH Coordinator told us that all the visits were conducted each month; however, staff had not documented the visits in the Computerized Patient Record System. While we were onsite, staff completed documentation of CNH visits.

Recommendation 6 We recommended that the VISN Director ensure that the System Director requires CNH program staff to document the required monthly follow-up visits for all contract CNH patients in a timely manner.

The VISN and System Directors concurred with the finding and recommendation. The system's policy will be revised to require documentation of CNH visits within 72 business hours. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Coordination of Care

The purpose of this review was to evaluate whether inter-facility transfers and discharges were coordinated appropriately over the continuum of care and met VHA and

[5] VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.

JC requirements. Coordinated transfers and discharges are essential to an integrated, ongoing care process and optimal patient outcomes.

VHA policy[6] requires that the system have a policy that ensures the safe, appropriate, and timely transfer of patients and that transfers are monitored and evaluated as part of the QM program. We determined that the system had an appropriate transfer policy and that acceptable monitoring was in place.

VHA requires specific information (such as the reason for transfer and services required) to be recorded in the transfer documentation. We reviewed documentation for 10 patients who transferred from the system's acute inpatient unit, emergency department, or urgent care clinic to another facility. We determined that clinicians consistently documented the required information for the patient transfers reviewed.

VHA policy[7] and JC standards require that providers include information regarding medications, diet, activity level, and follow-up appointments in written patient discharge instructions. We reviewed the medical records of 16 discharged patients and determined that clinicians had generally documented the required elements. Also, we found that follow-up appointments occurred within the timeframes specified. We made no recommendations.

Environment of Care

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

We inspected the inpatient mental health units, medical and surgical inpatient units, medical and surgical intensive care units, the CLC unit, ambulatory surgery, the infusion clinic, outpatient specialty clinics and primary care units, occupational and physical therapy, the hemodialysis unit, the gastrointestinal endoscopy laboratory, the pulmonary laboratory, cardiology, nuclear imaging, and the outpatient mental health units. The system maintained a generally

[6] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.
[7] VHA Handbook 1907.01.

clean and safe environment. The infection control program monitored data and appropriately reported that data to relevant committees. Safety guidelines were generally met, and risk assessments were in compliance with VHA standards. We made no recommendations.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had developed effective and safe medication management practices. We reviewed selected medication management processes for outpatients and CLC residents.

The system had implemented a practice guideline governing the maintenance of chronic renal disease patients who received erythropoiesis-stimulating agents (ESAs).[8] We found that clinical staff had appropriately identified and addressed elevated hemoglobin levels in five (83 percent) of six patients whose medical records we reviewed. Additionally, clinical reminders are being added to screens to track and monitor elevated hemoglobin levels.

In general, influenza vaccinations were documented adequately for CLC residents, and clinical staff followed the established protocol when a delay in receipt of vaccines was experienced. We made no recommendations.

Physician Credentialing and Privileging

The purpose of this review was to determine whether VHA facilities have consistent processes for physician C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and physician profiles.[9] We also reviewed meeting minutes during which discussions about the physicians took place.

We reviewed 17 C&P files and profiles and found that licenses were current and that primary source verification had been obtained. Focused Professional Practice Evaluation was appropriately implemented for newly hired physicians. Service-specific criteria for Ongoing Professional Practice Evaluation had been developed and approved. We found sufficient performance data to meet current requirements. Meeting minutes consistently documented thorough discussions of the physicians' privileges and performance data prior to recommending renewal of or initial requested privileges. We made no recommendations.

[8] Drugs that stimulate the bone marrow to make red blood cells and are commonly used to treat anemia.
[9] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

Suicide Prevention Safety Plans

The purpose of this review was to determine whether clinicians had developed safety plans that provided strategies to mitigate or avert suicidal crises for patients assessed to be at high risk for suicide. Safety plans should have patient and/or family input, be behavior oriented, and identify warning signs preceding crisis and internal coping strategies. They should also identify when patients should seek non-professional support, such as from family and friends, and when patients need to seek professional help. Safety plans must also include information about how patients can access professional help 24 hours a day, 7 days a week.[10]

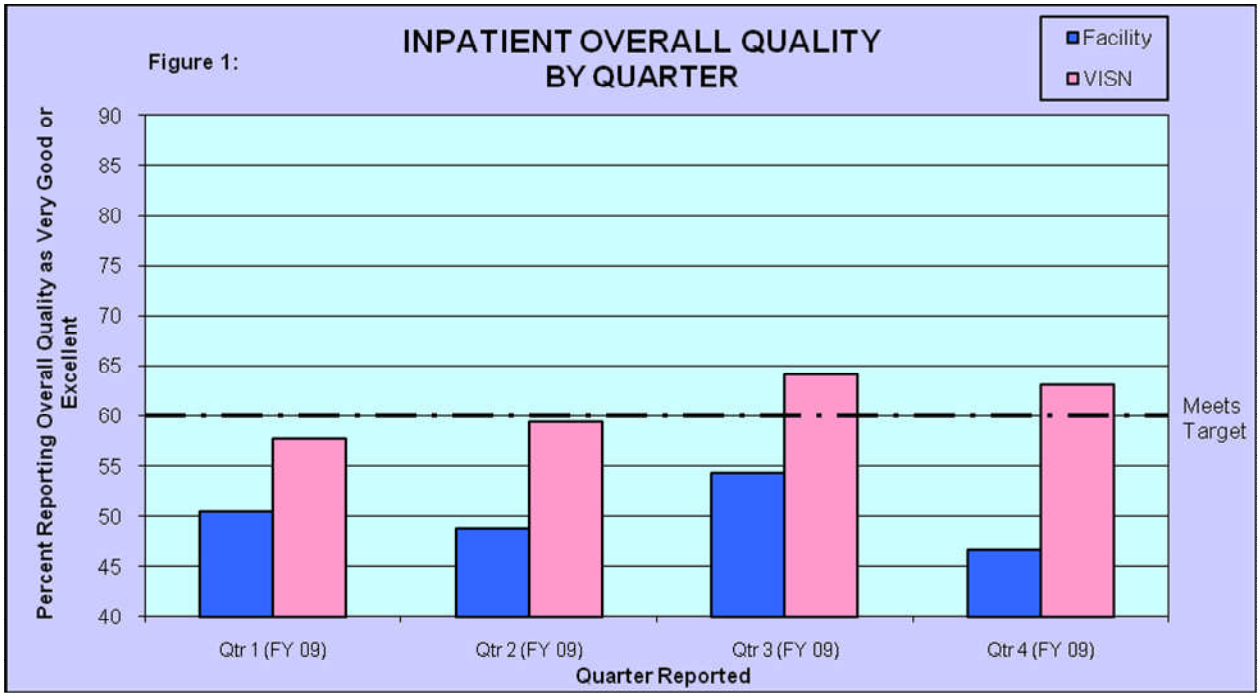
A previous OIG review of suicide prevention programs in VHA facilities[11] found a 74 percent compliance rate with safety plan development. The safety plan issues identified in that review were that plans were not comprehensive (did not contain the above elements), were not developed in a timely manner, or were not developed at all. At the request of VHA, the OIG agreed to follow up on the prior findings.

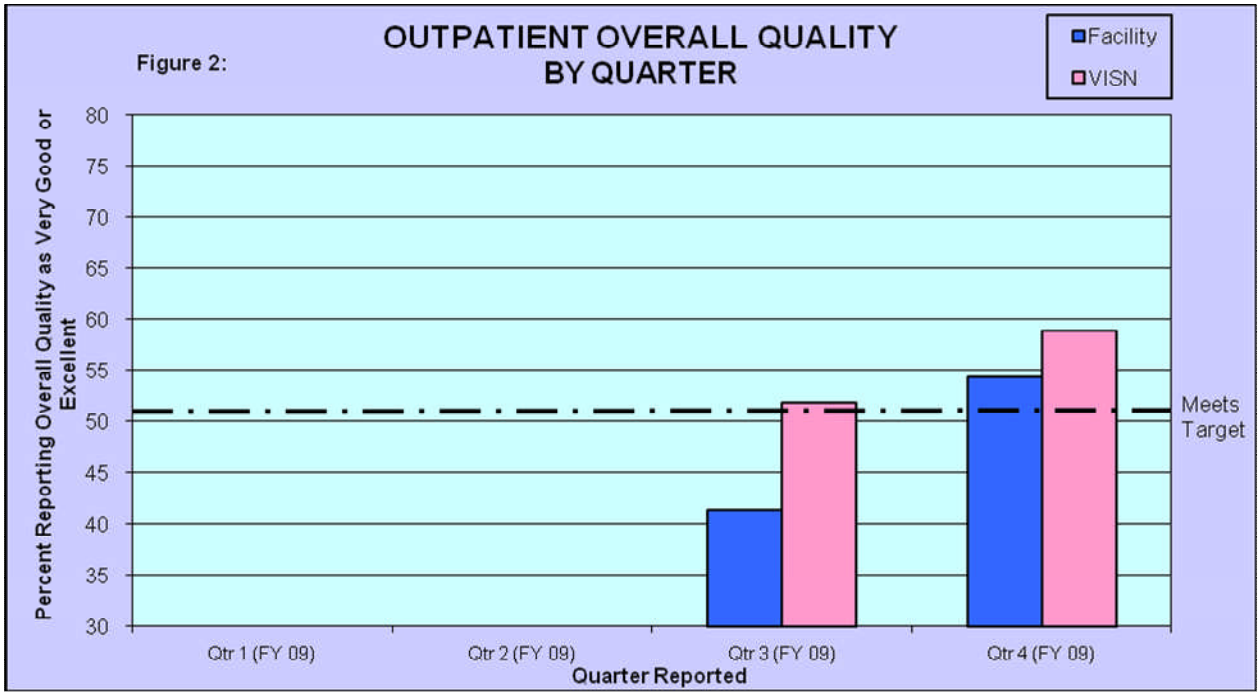
We reviewed the medical records of 10 patients assessed to be at high risk for suicide and found that clinicians had developed timely safety plans that included all required elements. We also found evidence to support that the patients and/or their families participated in the development of the plans. We made no recommendations.

VHA Satisfaction Surveys

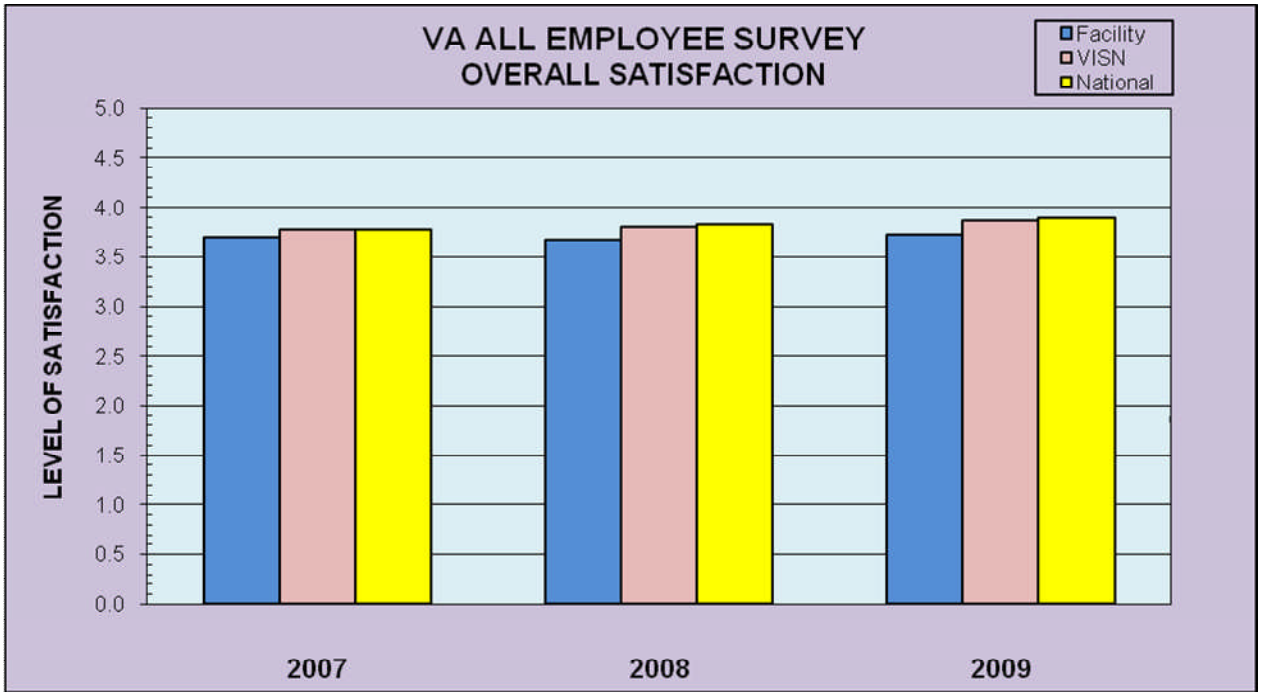
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 on the next page shows the system's and VISN's overall inpatient satisfaction scores for quarters 1–4 of FY 2009. Figure 2 on the next page shows the system's and VISN's overall outpatient satisfaction scores for quarters 3 and 4 of FY 2009.[12] The target scores are noted on the graphs.

[10] Barbara Stanley and Gregory K. Brown, *Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version,* August 20, 2008.
[11] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009,* Report No. 09-00326-223, September 22, 2009.
[12] 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 on the next page 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.


VA ALL EMPLOYEE SURVEY
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VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 5, 2010

From: Director, Rocky Mountain Network (10N19)

Subject: **Combined Assessment Program Review of the VA Eastern Colorado Health Care System, Denver, Colorado**

To: Director, Denver Office of Healthcare Inspections (54DV)

Thru: Director, Management Review Service (10B5)

1. We are submitting written comments in response to the Combined Assessment Program Review completed January 25–29, 2010, at the VA Eastern Colorado Health Care system (ECHCS) at Denver, Colorado.

2. In reviewing the draft report, the facility has addressed all identified deficiencies and has a plan to resolve all non-compliant areas cited in the report. Network 19 concurs with the report.

3. If you have any questions regarding this response, please contact Ms. Marilyn Lynn at (303) 393-4644.

(original signed by:)
Glen Grippen

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 5, 2010

From: Director, VA Eastern Colorado Health Care System (554/00)

Subject: **Combined Assessment Program Review of the VA Eastern Colorado Health Care System, Denver, Colorado**

To: Director, Rocky Mountain Network (10N19)

1. We are submitting written comments in response to the Combined Assessment Program Review completed January 25–29, 2010, at the VA Eastern Colorado Health Care system (ECHCS) at Denver, Colorado.

2. In reviewing the draft report, the facility has addressed all identified deficiencies and has a plan to resolve all non-compliant areas cited in the report. ECHCS concurs with the report.

3. If you have any questions regarding this response, please contact Ms. Marilyn Lynn at (303) 393-4644.

(original signed by:)
Lynette A. Roff

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 the PRC to document all required committee activities.

Concur

Facility's Response: ECHCS is in compliance with all components of VHA Directive 2008-004, except for in Level 2 and Level 3 peer reviews, a process was not in place whereby communication between the supervisor and the individual receiving the Level 2 or Level 3 peer review was documented in writing back to the Peer Review Board (PRB). This deficiency was discussed in the November 20, 2009, PRB meeting and a process to get into compliance was initiated. A template was presented at the January 8, 2010, PRB meeting and the board concurred on the process. The template will now be used consistently in ECHCS to get into compliance with this component of the Directive. (There have been no cases where this can be used as of this date.) When the Peer Review Board (PRB) makes the determination that a case is either a Level 2 or 3, the supervisor receives a copy of the PRB findings and a copy of the template. The supervisor completes the template and returns it to the Risk Manager within 14 days of receipt of the notification. This information is then shared at the subsequent PRB, documented in the minutes and the case is closed.

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires the continual monitoring of EMRs for appropriate use of the copy and paste functions.

Concur

Facility's Response: A monthly copy and paste monitor started in FY 2010 and has been completed through February 2010. In quarter 1, only outpatient records were monitored. Starting January, a monthly review of ten outpatient and ten inpatient records has occurred. This methodology of review was taken from the VHA HIM Practice Brief titled, "Monitoring Copy and Paste." This information is being discussed at the Medical Records Committee for corrective action. The copy and paste will also be monitored by the Coding Unit starting March 2010. The Coding

Unit will track whenever a copy and paste instance occurs while reviewing patient records and notify the Chief, HIMS. Starting Q3, FY 2010 this monitor will be reported up to the Performance Improvement Council, one of the ECHCS QM oversight committees, and the Clinical Executive Board (CEB).

Target Completion Date: Completed February, 2010.

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires that device-specific SOPs are posted in all areas where RME is reprocessed.

Concur

Facility's Response: Device-specific SOPs have been developed for all devices and are available in all required areas. However, they were not directly visible in two areas: (1) the manual cleaning area in anesthesia for the trans-esophageal echo (TEE) and the peri-aortic probes and (2) in the decontamination area in SPD for dental instruments. SOPs were developed and approved for anesthesia devices in July 2009. On-going tracers confirmed that SOPs were posted in the reprocessing area. In December 2009, the manual cleaning process was relocated and a vapor control system for soaking the ultrasound probes was installed. The SOP was revised to reflect these changes and was approved in January 2010. The revised SOP was not posted in the manual cleaning area at the time of the survey. The SOP for cleaning non-powered surgical instruments, to include dental instruments, was developed and approved in December 2009. The SOP for powered dental instruments was developed in January 2010. Actions were immediately taken to post the SOPs in these areas during the IG CAP survey. The presence of these SOPs was verified by direct observational rounds on February 24, 2010. Monitoring for compliance with postings of SOPs in all reprocessing areas is accomplished through annual reviews, through tracers in each reprocessing area a minimum of twice a year, and through periodic unannounced spot checks during Executive Leadership rounds.

Target Completion Date: Completed February 24, 2010.

Recommendation 4. We recommended that the VISN Director ensure that the System Director requires that the serial number or other unique identifier of the endoscope used for each patient procedure is recorded in the procedure log.

Concur

Facility's Response: Anesthesia had developed device-specific procedure logs for each of their two endoscopes labeled with the name of the device. However, the specific procedure log for the anesthesia TEE (SN 038JOG) and the peri-aortic (SN 036D1H) probe did not include the serial number of each probe. This was immediately corrected while the IG CAP survey team was on site. Procedure logs for February 2010 were reviewed on March 1, 2010, and were found to be 100 percent compliant. The unique identifier of the endoscope used for each patient procedure is recorded on all logs. Compliance is monitored through tracers to anesthesia and all other areas a minimum of twice a year.

Target Completion Date: Completed March 1, 2010.

Recommendation 5. We recommended that the VISN Director ensure that the System Director requires MRI personnel to document their review of patient safety screening questionnaires, as required by local policy.

Concur

Facility's Response: Corrective adjustments were made immediately upon discovery of the deficiency. Per local policy (115-4), a Magnetic Resonance Imaging (MRI) Safety Screening Questionnaire is completed and reviewed with each patient, relative, or provider depending on the patient's condition. As with patients, any hospital staff that has Zone IV access also completes the MRI Safety Questionnaire and it is reviewed by a Level II MRI Technologist or the MRI Safety Officer. The radiologist is consulted for any possible contraindication. The MRI Safety Screening Questionnaire is signed by the patient (or legal representative) and by Level II personnel. The questionnaire is then scanned immediately into the patient's medical record.

Recommendation 6. We recommended that the VISN Director ensure that the System Director requires CNH program staff to document the required monthly follow-up visits for all contract CNH patients in a timely manner.

Concur

Facility's Response: The Chief, Social Work Service, is monitoring the timeliness and entry of all documentation of required monthly follow-up visits for all contract Community Nursing Home (CNH) patients. The CNH staff is tracking completion of monthly visits and documentation dates and submitting a report to the Chief by the fifth business day of each month. The report includes every veteran in the program. This was initiated in February 2010. The Chief (or designee) will complete a random audit of documentation (10 percent for each program) to verify completion of visits, appropriate level of documentation based on documented treatment plan,

and timely note entry per policy. The report audit will be submitted to the ECHCS Executive Leadership Team (ELT) by the tenth business day of each month starting February 2010. The ECHCS policy (136-15) will be revised to modify the timeframe for entry of progress notes following community visits to within 72 business hours of the visit.

Target Completion Date: April 30, 2010.

OIG Contact and Staff Acknowledgments

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Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Michael F. Bennet, Mark Udall
U.S. House of Representatives: Mike Coffman, Diana DeGette, Ed Perlmutter, Jared Polis

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