Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-01081-135

Combined Assessment Program Review of the VA Central California Health Care System Fresno, California

April 22, 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 February 22–25, 2010, the OIG conducted a Combined Assessment Program (CAP) review of the VA Central California Health Care System (the system), Fresno, CA. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also presented fraud and integrity awareness training to 134 system employees. The system is part of Veterans Integrated Service Network (VISN) 21.

Results of the Review

The CAP review covered eight operational activities. We also followed up on two activities from the prior CAP review. We identified the following organizational strengths and reported accomplishments:

- Information Technology Award
- Best Employer Award Finalist

We made recommendations in six of the activities reviewed. For these activities, the system needed to:

- Ensure that corrective action plans to address problems identified in the medical record review performance improvement (PI) process are documented, implemented, and monitored.
- Require that designated employees maintain current life support certification and that appropriate actions are taken when life support training or certifications expire.
- Ensure that flash sterilization practices comply with VA policy.
- Implement interim measures to ensure appropriate air flow in Supply, Processing, and Distribution (SPD).
- Require the recording of the serial number, name(s) of operator(s), date and time of use, and patient identifier of the reusable medical equipment (RME) used for each patient procedure.
- Conduct a comprehensive risk assessment of the magnetic resonance imaging (MRI) area and implement additional safety measures as applicable.
- Require MRI personnel to follow up on positive responses on the screening questionnaire and document actions

taken to address any potentially dangerous conditions that are identified.

- Ensure that MRI personnel comply with the informed consent policy for all patients undergoing an MRI exam with contrast media.
- Ensure that Focused Professional Practice Evaluation (FPPE) timeframes are documented and results reported consistently and that individualized Ongoing Professional Practice Evaluation (OPPE) criteria for all physician staff are reviewed and documented consistently.
- Ensure compliance with Veterans Health Administration (VHA) policy for inter-facility transfers.
- Address the identified training deficiency for new Environmental Management Service (EMS) employees on the locked mental health (MH) unit.

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

- Medication Management
- Suicide Prevention Safety Plans

This report was prepared under the direction of Daisy Arugay, Director, Los Angeles Regional 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 17–24, 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 provides inpatient and outpatient health care services in Fresno, CA, and provides additional outpatient care at two community based outpatient clinics located in Atwater and Tulare, CA. The system is part of VISN 21 and serves a veteran population of approximately 103,000 throughout six counties in central California.

Programs. The system provides medical, surgical, and MH care services. It has 57 hospital beds and 60 community living center (CLC) beds.

Affiliations and Research. The system is affiliated with the University of California, San Francisco and provides training for 42 residents, as well as other disciplines, including nursing. In fiscal year (FY) 2009, the system research program had 15 projects and a budget of $167,000. Important areas of research included diabetes, osteoporosis, and cardiovascular disease.

Resources. In FY 2009, the system's medical care expenditures totaled $157 million. FY 2009 staffing was 926 full-time employee equivalents (FTE), including 78 physician and 195 nursing FTE.

Workload. In FY 2009, the system treated 25,342 unique patients and provided 16,306 inpatient days in the hospital. The inpatient care workload totaled 3,254 discharges, and the average daily census was 95. Outpatient workload totaled 297,350 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:

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

The review covered system operations for FY 2009 and FY 2010 through February 2010 and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on recommendations from our prior CAP review of the system (*Combined Assessment Program Review of the VA Central California Health Care System, Fresno, California,* Report No. 07-01605-186, August 13, 2007). We had identified improvement opportunities in the following activities (1) QM (action plans, adverse events disclosure process, and utilization management) and (2) business rules for veterans health information systems. During our follow-up review, we found sufficient evidence that program managers and staff had implemented appropriate actions to address the identified deficiencies in these areas. We consider these issues closed.

During this review, we also presented fraud and integrity awareness briefings to 134 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 activities in the "Review Activities Without Recommendations" section have no reportable findings.

Organizational Strengths

Information Technology Award

In July 2009, the system was recognized as one of only four VHA facilities to make the nation's Top 100 list in the "Most Wired Survey and Benchmarking Study" by the Hospitals and Health Networks magazine. The survey is conducted annually and focuses on how hospitals use information technology to address five key areas: (1) safety and quality, (2) customer service, (3) business processes, (4) workforce, and (5) public health and safety. The selection is based on a detailed scoring process, and only hospitals that have effectively deployed information technology are named to the list.

Best Employer Award Finalist

In 2008, the Best Companies Group recognized the system as one of the best companies to work for in central California. The system was one of the top five finalists in the category for large companies. The assessment included a comprehensive employer questionnaire and an employee survey. The selection was based on several areas: (a) effective communication, (b) recognition of employees, (c) community involvement, (d) effective teamwork, and (e) strong core values. High employee satisfaction and employee participation in the survey enabled the system to obtain this recognition.

Results

Review Activities With Recommendations

Quality Management

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 Director, Chief of Staff, and Chief of QM. We also

interviewed QM personnel and several service chiefs. We evaluated plans, policies, and other relevant documents.

The QM program was generally effective in providing oversight of the system's quality of care. It was also evident that senior managers supported the program through participation in PI initiatives and provision of resources. However, we identified two areas that needed improvement.

Medical Record Review PI Process. VHA policy[1] and accreditation standards require that facilities have a systematic medical record quality review process. We noted that a comprehensive review process was in place. However, when problems were identified, actions to improve processes were not always taken. For example, Medicine Service had a 75, 83, and 67 percent rate of compliance with the use of unapproved abbreviations in July, August, and September 2009, respectively. During those same months, Surgical Service had a 77, 87, and 68 percent rate of compliance with the electronic and hard copy consent forms. The Medical Record Committee (MRC) sent this information to the services for action, but corrective action plans for improvement were not documented or implemented, and any actions taken were not monitored.

Resuscitation and Its Outcomes. VHA policy[2] requires that a policy is in place for Basic Life Support (BLS) and Advance Cardiac Life Support (ACLS) training. The system had a policy that identified/designated employees required to maintain BLS or ACLS training/certification. We found several employees who were not current with their BLS or ACLS training. For employees required to have current BLS training, 24 had expired certifications (2 had expired in 2007), and 3 had no documentation of training. For those required to maintain current ACLS certification, six had expired certifications, and two had no documentation of training. Although overall compliance for both BLS and ACLS training was noted at 95.6 and 95.8 percent, respectively, inadequate actions were taken when employees' certifications expired.

Recommendation 1 We recommended that the VISN Director ensure that the System Director requires that corrective action plans to

[1] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.
[2] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.

address problems identified in the medical record review PI process are documented, implemented, and monitored.

The VISN and System Directors agreed with the findings and recommendation. Problems identified in the medical record review process will be documented in MRC meeting minutes and monitored through the MRC until resolved. Trends and improvements will be reported quarterly to the appropriate committee. The target date for completion is April 30, 2010. 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 that designated employees maintain current certification and that appropriate actions are taken when life support training or certifications expire.

The VISN and System Directors agreed with the findings and recommendation. QM will track compliance of all staff required to maintain BLS and/or ACLS certification. Trends will be reported to the Quality Council at least quarterly. Local policy will be revised to better delineate clinical staff who are required to maintain certification and will include actions to be taken when certifications expire. The target date for completion is April 30, 2010. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

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 may transmit pathogens to patients and affect the functionality of the equipment. Facilities are responsible for minimizing patient risk and maintaining an environment that is safe. The system's SPD reprocessing area is required to meet VHA, Association for the Advancement of Medical Instrumentation, Occupational Safety and Health Administration (OSHA), and Joint Commission (JC) standards.

We inspected the SPD reprocessing area. We determined that the system had established appropriate guidelines and monitored compliance with those guidelines. However, we identified three areas that needed improvement.

Flash Sterilization. VA requires[3] full sterilization procedures to be used for all surgical instruments and recommends not to flash sterilize (a shorter sterilization process) certain items (suction tubes and power equipment). Flash sterilization is to be used during a surgical procedure only in case of emergency, such as a dropped sterilized instrument. We reviewed 12 months of operating room flash sterilization documentation. We found that 9 (82 percent) of the 11 surgical instruments in the log (including suction tubes, orthopedic screws, and power equipment) were inappropriately flash sterilized.

Additionally, VA requires the recording of pertinent information (reason for flash sterilization, signature of sterilizer operator, and pertinent dates) for items that were flash sterilized. We did not find complete documentation of required information for any of the items in the log.

Air Flow. VA requires[4] specific air flow and air exchanges in the decontamination (dirty) and sterile (clean) storage areas of SPD to minimize cross-contamination from dirty to clean areas. The decontamination areas are to be maintained under negative air pressure with six or more air exchanges per hour. The sterile storage areas are to be maintained under positive pressure with 10 or more air exchanges per hour. We reviewed documentation of testing conducted by an outside contractor. We determined that the system did not maintain the correct air pressures or meet the required number of air exchanges. System managers told us that they had submitted a project proposal to VISN 21 that would correct the air flow deficiencies. The project included the installation of a new heating, ventilation, and air conditioning (HVAC) system in SPD. It is unknown when this project will be completed.

RME Unique Identifier. VHA requires[5] that a system or log is in place to record the serial number (or other unique identifier) of the RME used for each patient procedure. The information should also include name(s) of operator(s), date and time of use, and patient identifier. For 3 (30 percent) of the 10 bronchoscopes in our sample, we did not find documented evidence of the required information.

[3] VA Handbook 7176; *Supply, Processing and Distribution (SPD) Operational Requirements*; August 16, 2002.
[4] VA Handbook 7176.
[5] VHA Directive 2009-031, *Improving Safety in the Use of Reusable Medical Equipment through Standardization of Organizational Structure and Reprocessing Requirements*, June 26, 2009.

Recommendation 3 We recommended that the VISN Director ensure that the System Director requires that flash sterilization practices are in compliance with VA policy.

The VISN and System Directors agreed with the findings and recommendation. The system has implemented an administrative process that allows the OR clinical manager to expedite the purchase of surgical trays and equipment to reduce the need for flash sterilization. SPD staff will be trained, a log book will be used to track flash sterilization procedures, and the Associate Chief Nurse will be notified after each flash sterilization event. The OR clinical manager will monitor compliance and will report to the Hospital Epidemiology Committee quarterly. The target date for completion is April 30, 2010. 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 implements interim measures to ensure appropriate air flow in SPD until the proposed installation of a new HVAC system is completed.

The VISN and System Directors agreed with the findings and recommendation. The construction of a new HVAC system is planned to begin in July 2010. The air pressure deficiencies have been corrected, and a temporary air filtering process will be initiated as an interim measure. Until the new HVAC system is operational, the number of air exchanges per hour will be calculated, monitored, and reported to the EOC Board on a quarterly basis to determine the effectiveness of this interim plan. The target date for completion is December 30, 2010. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 5 We recommended that the VISN Director ensure that the System Director requires that the serial number, name(s) of operator(s), date and time of use, and patient identifier of the RME used for each patient procedure are recorded, as required.

The VISN and System Directors agreed with the finding and recommendation. A new charting template will be used during bronchoscopy procedures to ensure that physicians record all the required elements. Respiratory therapists will

record the scope number after each procedure. The target date for completion is April 30, 2010. 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. VA's MRI safety policy is detailed in an online resource guide that establishes requirements for safe MRI practices.[6]

We inspected the MRI area, examined patient and employee records, reviewed relevant policies, and interviewed key personnel. We noted that patients are directly observed during an MRI exam. Two-way communication is available between the patient and the MRI technologist, and patients have access to a push-button call system. The scanning room is clearly marked with a red light indicating that the magnet is "on" at all times. We noted recent improvements in several areas, including training and emergency preparedness.

Non-MRI personnel who have periodic access to the MRI area are required to complete a safety questionnaire, and any positive ("yes") response must be followed up to ensure safe access. Of the seven questionnaires reviewed, two had positive responses. While we were onsite, Imaging Service managers addressed these two questionnaires and agreed to monitor compliance with the screening requirements. Therefore, we did not make a recommendation for this finding. However, we identified the following areas that needed improvement.

Risk Assessment. Accreditation standards require facilities to identify safety and security risks associated with the MRI environment. Because of the limited space, the system had not fully complied with the four zone concept defined by the American College of Radiology's safe practice guidelines. We determined that Imaging Service needed to conduct a comprehensive risk assessment of the MRI area to identify and address safety vulnerabilities. Imaging Service managers agreed and told us that they will convene an

[6] VA "Radiology Online Guide," <http://vaww1.va.gov/Radiology/page.cfm?pg=167>, updated December 20, 2007, Secs. 4.1–4.3.

interdisciplinary team to analyze risk and implement strategies to supplement existing safety procedures.

Screening. VA requires[7] screening of patients using a standard screening questionnaire. Any positive ("yes") response on the questionnaire must be addressed before a patient is scanned. Of the 10 patient records reviewed, 3 (30 percent) contained positive responses. We did not find documented evidence that the positive responses were addressed.

Informed Consent. Local policy requires signed informed consent for high-risk patients undergoing an MRI scan with gadolinium (a contrast media that is used to enhance the image quality of the exam). We reviewed the medical record of one high-risk patient who had an MRI with contrast. We did not find the required signed consent for this patient.

For all other patients undergoing an MRI with contrast, signed informed consent is not required. However, the MRI technologist is expected to discuss and explain the procedure and risks associated with the use of contrast media. Of the seven records reviewed, we did not find documented evidence of this discussion. While we were onsite, Imaging Service managers revised the MRI screening form and agreed to monitor compliance.

Recommendation 6 We recommended that the VISN Director ensure that the System Director requires Imaging Service managers to conduct a comprehensive risk assessment of the MRI area and implement additional safety measures as applicable.

The VISN and System Directors agreed with the finding and recommendation. A comprehensive risk assessment of the MRI area by a multidisciplinary team is underway. Recommended safety measures from this assessment will be thoroughly analyzed and addressed. The target date for completion is April 30, 2010. 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 MRI personnel to follow up on positive responses on the screening questionnaire and

[7] VA "Radiology Online Guide."

document any actions taken to address potentially dangerous conditions that are identified.

The VISN and System Directors agreed with the finding and recommendation. Program managers modified the MRI screening form to include an area for comments by the MRI technologist on positive responses to screening questions. Random audits are being conducted each month to ensure that appropriate documentation is completed. Preliminary monitoring shows 100 percent compliance. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 8 We recommended that the VISN Director ensure that the System Director requires MRI personnel to comply with the informed consent policy for all patients undergoing an MRI exam with contrast media.

The VISN and System Directors agreed with the finding and recommendation. Informed consent is now being completed and documented for all high-risk patients receiving intravascular contrast during an MRI procedure. The MRI Safety Officer is conducting random audits to ensure documentation compliance, and audit results are being reported to the Safety Committee monthly. Verbal consent is being obtained and documented for patients receiving contrast who are not high risk. Preliminary monitoring shows 100 percent compliance. The corrective actions are acceptable, and we consider this recommendation closed.

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 provider profiles.[8] We also reviewed meeting minutes during which discussions about the physicians took place.

We reviewed 10 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been appropriately obtained. However, we identified the following areas that needed improvement.

FPPE. VHA policy requires a time-limited FPPE review process to ensure the competence of newly hired physicians. For one of the three new providers, the FPPE did not have a

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

timeframe documented nor were the results reported to the Medical Staff Executive Board (MSEB). However, we noted improved compliance with the FPPE process for the two subsequent new providers who were hired.

OPPE. VHA policy also requires specific competency criteria for OPPE to be developed and approved by the MSEB for all privileged physicians. We did not find evidence of OPPE for teleradiologists, but during our review of the February 18, 2010, Professional Standards Board (PSB) meeting minutes, we noted efforts to develop and improve this process. Additionally, for the past 12 months, PSB and MSEB meeting minutes did not consistently reflect individualized discussion of each physician's competence to perform the privileges requested prior to reprivileging. However, we noted recent improvements in the documentation.

Recommendation 9 We recommended that the VISN Director ensure that the System Director requires that FPPE timeframes are documented and results are reported consistently to the MSEB and that individualized OPPE criteria for all physician staff are reviewed and documented consistently by the MSEB and PSB.

The VISN and System Directors agreed with the findings and recommendation. QM will take over FPPE and OPPE data collection, and clinical service chiefs will continue to evaluate that data. FPPE and OPPE forms have been reviewed to ensure that there is a place to document the respective 3-month and 6-month review periods. When FPPE or OPPE evaluation criteria is modified, that criteria will be presented to and approved by the MSEB through the PSB. Results of FPPE and OPPE evaluations will be tracked by QM and documented in PSB meeting minutes. The target date for completion is May 15, 2010. 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 discharges and inter-facility transfers were coordinated appropriately over the continuum of care and met VHA and JC requirements. Coordinated discharges and transfers are essential to an integrated, ongoing care process and optimal patient outcomes.

VHA policy[9] and JC standards require that providers include information regarding medication, diet, activity level, and follow-up appointments in written patient discharge instructions. We reviewed the medical records of 10 discharged patients and determined that clinicians had generally documented the required information. However, we identified improvement opportunities in the following area.

Inter-Facility Transfers. VHA policy[10] requires specific information (such as the reason for transfer, mode of transportation, and informed consent to transfer) to be recorded in the transfer documentation. VHA also requires inter-facility transfers to be monitored and evaluated as part of the QM program.

We reviewed documentation for 10 patients who transferred from the system's acute inpatient unit or emergency department to another facility. In 3 (30 percent) of the 10 records, we did not find documentation of all the required information. Missing information included acknowledgement of an advanced directive and informed consent to transfer. In addition, we did not find evidence that inter-facility transfers were monitored and evaluated as part of the system's QM program. Also, we determined that the local inter-facility transfer policy needed to be updated to ensure consistency with VHA policy.

Recommendation 10 We recommended that the VISN Director ensure that the System Director requires that the inter-facility transfer process complies with VHA policy.

The VISN and System Directors agreed with the findings and recommendation. The local policy will be updated, a transfer checklist has been implemented, and appropriate employees have been trained. Transfer coordinators will ensure clinicians' compliance with the required documentation. Also, inter-facility patient transfer processes are now being monitored as part of the system's QM program. Data will be collected monthly, and results will be presented to the Quality Council quarterly. The target date for completion is April 30, 2010. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

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

Environment of Care

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

We inspected all inpatient (medical-surgical, locked MH, and CLC) units, the gastrointestinal procedure area, specialty clinics, and the clinical laboratory. The system maintained a generally clean and safe environment. The infection control program monitored data and appropriately reported that data to relevant committees. Safety guidelines were generally met. However, we identified the following condition on the locked MH unit that needed improvement.

Training. VHA requires[11] that employees assigned to locked MH units receive initial and annual training on environmental hazards that represent a risk to suicidal patients. We did not find evidence of initial training for the new EMS employees on the unit.

Recommendation 11 We recommended that the VISN Director ensure that the System Director requires that new EMS employees on the locked MH unit receive initial training on environmental hazards that represent a risk to suicidal patients, as required.

The VISN and System Directors agreed with the finding and recommendation. EMS managers will provide the required initial training to new EMS employees assigned to work on the locked MH unit. Training will be provided annually thereafter and will be documented electronically. The target date for completion is April 30, 2010. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without 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.

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

The system had implemented a practice guideline governing the maintenance of chronic renal disease patients who receive erythropoiesis-stimulating agents.[12] We found that clinical staff had appropriately identified and addressed elevated hemoglobin levels in the 10 patients whose medical records we reviewed.

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. Also, although the pharmacy is closed from 6:00 p.m. to 6:00 a.m. daily, we found that the system had appropriately provided a qualified pharmacist to answer questions during those hours and had an adequate retrospective review process. We made no recommendations.

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. They must also include information about how patients can access professional help 24 hours a day, 7 days a week.[13]

A previous OIG review of suicide prevention programs in VHA facilities[14] found a 74 percent compliance rate with safety plan development. The issues identified in that review were that plans were not comprehensive (did not contain the above elements), were not developed timely, or were not developed at all. At the request of VHA, the OIG agreed to follow up on the prior findings.

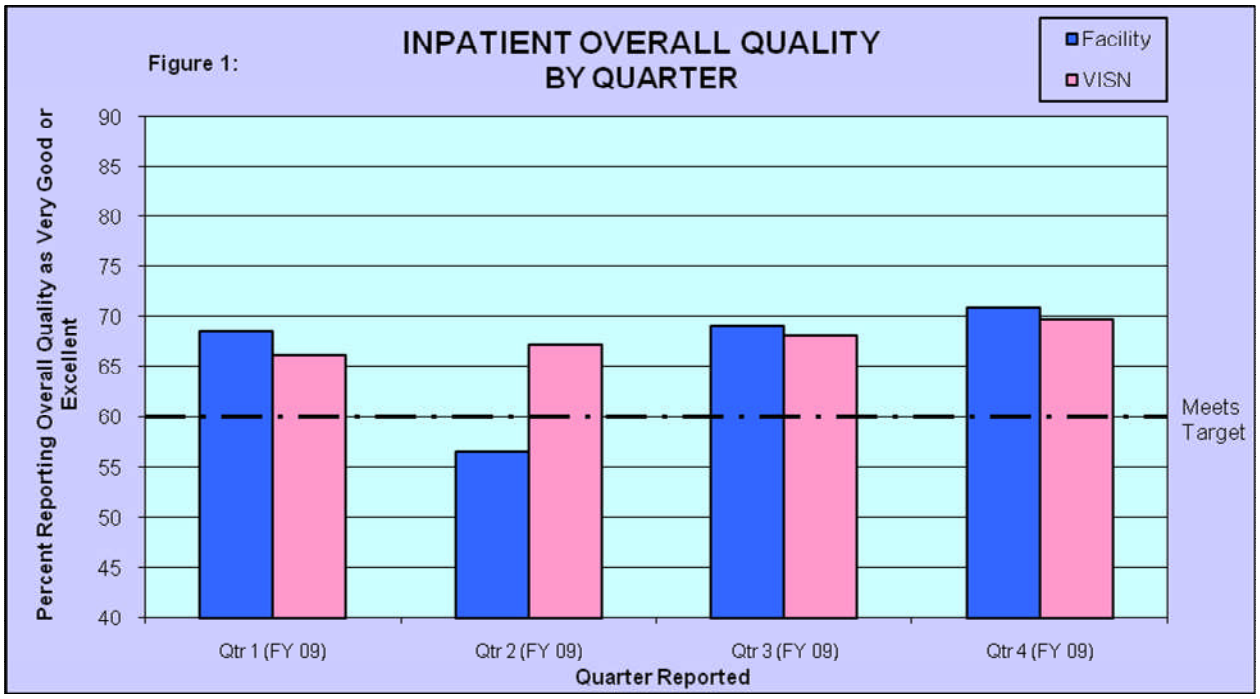
We reviewed the medical records of 10 patients assessed to be at high risk for suicide and found that clinicians had developed timely safety plans that included all required elements. We also found evidence to support that the

[12] Drugs that stimulate the bone marrow to make red blood cells; used to treat anemia.
[13] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
[14] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009;* Report No. 09-00326-223; September 22, 2009.

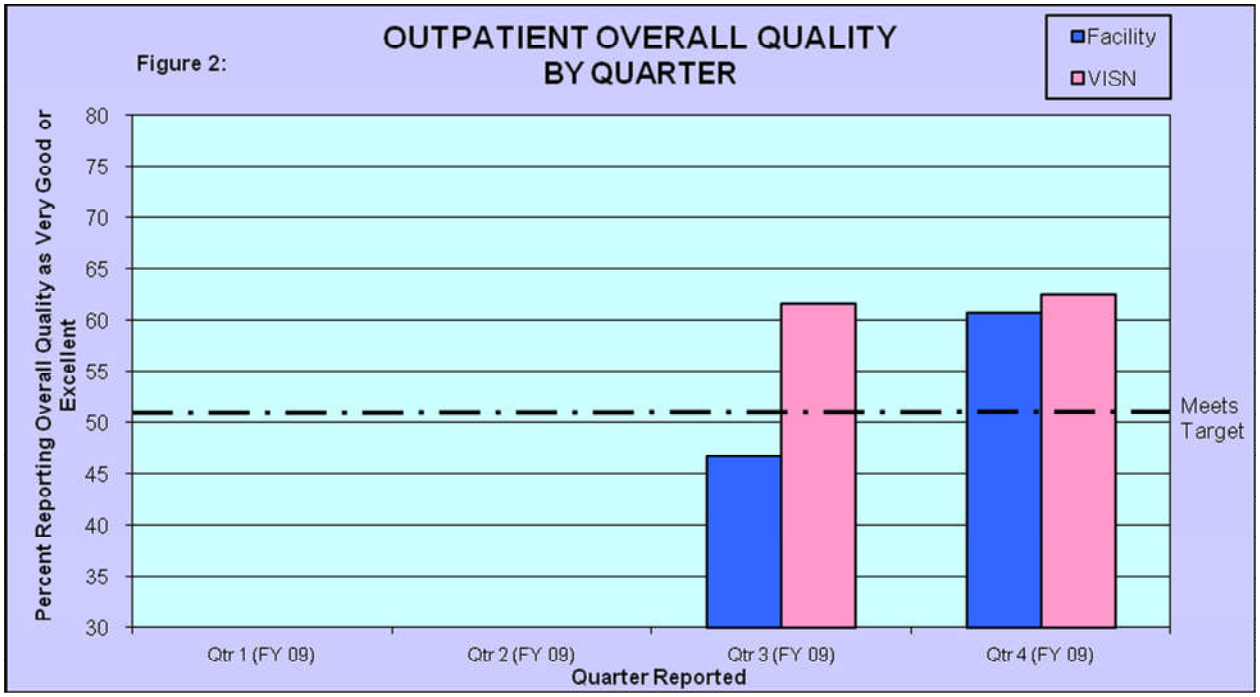
patients and/or their families participated in the development of the plans. We made no recommendations.

VHA Satisfaction Surveys

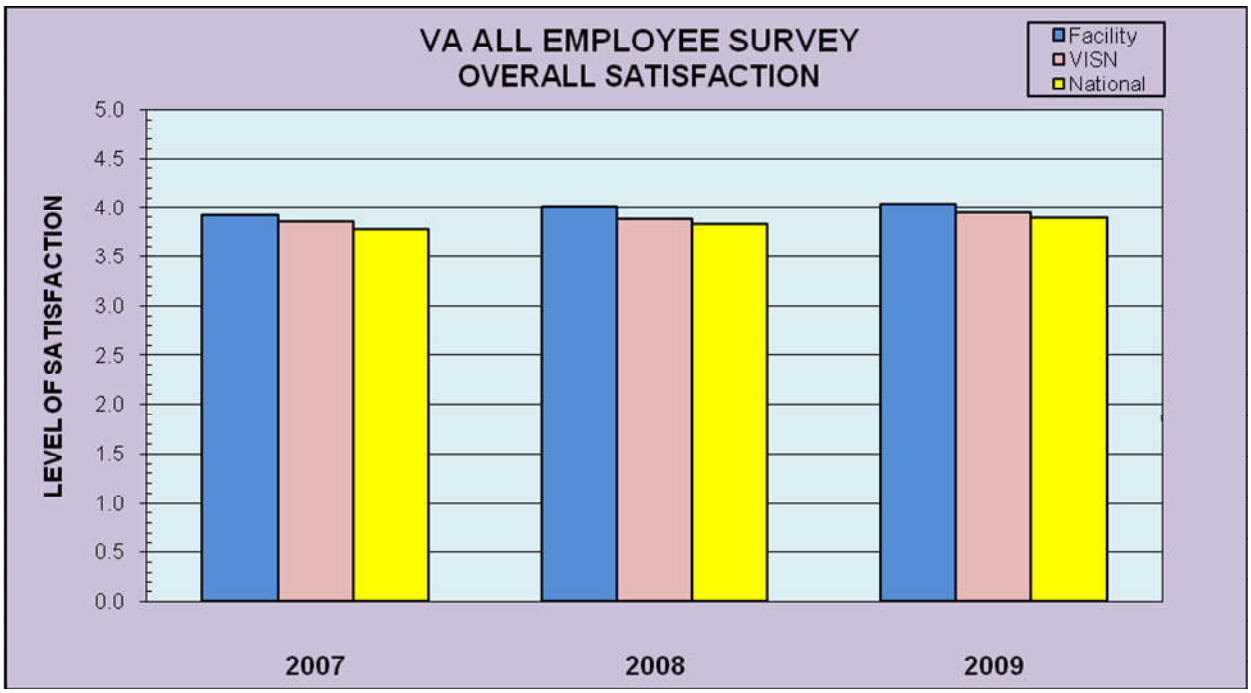
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 below shows the system's and VISN's overall inpatient satisfaction scores for FY 2009. Figure 2 on the next page shows the system's and VISN's overall outpatient satisfaction scores for quarters 3 and 4 of FY 2009.[15] The target scores are noted on the graphs.



[15] 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: April 5, 2010

From: Director, VA Sierra Pacific Network (10N21)

Subject: **Combined Assessment Program Review of VA Central California Health Care System, Fresno, California**

To: Director, Los Angeles Region, Office of Healthcare Inspections (54LA)

1. Thank you for the opportunity to review the draft report on the Combined Assessment Program Review of the VA Central California Health Care System that was conducted during the week of February 22–25, 2010. I concur with the recommendations and the staff at the Central California facility have completed two of the eleven recommendations and the remaining ones will be addressed as described in the attached plan.

2. If you have any questions regarding the responses and actions outlined in the plan, please contact Terry V. Sanders, VISN 21 Associate Quality Management Officer, at (707) 562-8370.

(*original signed by:)*
Sheila M. Cullen

Attachments

cc: Director, Management Review Service (VHA CO 10B5 Staff)

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 5, 2010

From: Director, VA Central California Health Care System (570)

Subject: **Combined Assessment Program Review of VA Central California Health Care System, Fresno, California**

To: Director, VISN 21

1. We appreciate the opportunity to provide input on the VA OIG-Combined Assessment Program (CAP) review of our healthcare system which took place February 22–25, 2010.

2. We would like to express our thanks to the OIG-CAP review team which visited our facility. We found the team members very helpful throughout our preparatory activities as well as during the survey itself.

3. We appreciate the important feedback we received from the review and we will use that information to further strengthen our administrative and clinical operations.

Sincerely,

(*original signed by:)*
Alan S. Perry, FACHE

Director, VA Central California Health Care System

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:

Recommendation 1. We recommended that the VISN Director ensure that the System Director requires that corrective action plans to address problems identified in the medical record review PI process are documented, implemented, and monitored.

Concur

Target date of completion: April 30, 2010

Planned Action: The problems identified through the medical record review process will be discussed and documented at the Medical Record Committee (MRC) meetings. The identified problems will be sent to the service chiefs with an "Action required" notification letter from the MRC requesting an action plan response within two weeks of the notification letter.

The identified problems and the proposed action plan will be monitored and documented in the MRC minutes until the resolution of the problem.

The medical record reviews will continue to be done on a monthly basis, however, the MRC will dedicate one meeting every quarter to go over the medical record reviews, action plans received, and trend and document improvements to the identified problems as well as make recommendations to the service chiefs as needed. Trends and improvements will be reported on a quarterly basis to the Medical Staff Executive Council.

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires that designated employees maintain current certification and that appropriate actions are taken when life support training or certifications expire.

Concur

Target date of completion: April 30, 2010.

Planned Action: A process was implemented by which the Quality Management Service will track on an organizational level the compliance of all staff that are expected to maintain either BLS and/or ACLS

certification. This will be done by obtaining compliance reports from each service, collating the data, and sending out compliance reports on a monthly basis to all Clinical Service Chiefs. Trends will be reported to the Quality Council through the Code Blue/Rapid Response Committee on at least quarterly.

The Life Support policy is being revised to better delineate which clinical staff are required to have BLS and/or ACLS certification. The policy will include the possibility of suspension should an employee (who is required to have such certification) allow it to lapse.

At the time of this report, most staff holds current BLS and/or ACLS certification as required. We anticipate that the remaining three staff members who need current BLS certification will have obtained that within the next four weeks; that the remaining one staff member who needs current ACLS certification will have obtained that within the next week.

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires that flash sterilization practices are in compliance with VA policy.

Concur

Target date of completion: April 30, 2010

Planned Action: An administrative process was defined and initiated to allow the OR Clinical Manager to procure/purchase duplicate surgical trays quickly if inventory seems inadequate. Extra screws and other orthopedic equipment were purchased to decrease the potential need for flash sterilization. A nurse from the OR was made available to mentor SPD staff and help them learn the proper way to replenish orthopedic trays.

A new log book with an easy-to-use check list was created to improve documentation for tracking flash procedures. The log book will be monitored daily and the Associate Chief Nurse will be notified on a real-time basis after an episode of flash sterilization has occurred. All staff reviewed the flash sterilization competency document.

Overall compliance to flash policy will be monitored by the OR Clinical Manager. This information will be reported to the Hospital Epidemiology Committee on a quarterly basis.

Recommendation 4. We recommended that the VISN Director ensure that the System Director implements interim measures to ensure appropriate air flow in SPD until the proposed installation of a new HVAC system is completed.

Concur

Target date of completion: December 31, 2010

Planned Action: A contract to design the new HVAC System is being initiated at this time. New ductwork must be engineered and installed along with new heating and cooling coils, humidification equipment, etc. Construction of the new HVAC is planned to begin in July 2010 with completion by December 31, 2010. Air pressure relationships between the clean and dirty side have been corrected. A temporary HEPA air filtering process will be initiated in the interim. The spot assessment of the number of air exchanges per hour will be calculated and monitored on a quarterly basis and reported to the Environment of Care Board to determine the effectiveness of this interim plan.

Recommendation 5. We recommended that the VISN Director ensure that the System Director requires that the serial number, name(s) of operator(s), date and time of use, and patient identifier of the RME used for each patient procedure are recorded, as required.

Concur

Target date of completion: April 30, 2010

Planned Action: A new charting template for use during bronchoscopies is being created to ensure that all these elements are documented in the medical record by the physician.

Concurrently, there is a templated note that the respiratory therapist enters after a procedure that includes the scope number. The respiratory therapy staff was re-inserviced on this process.

The Chief, Respiratory Therapy will check the bronchoscopy log book against the respiratory therapy note to verify documentation and provide an additional check and balance. The same process is in place in our gastroenterology department.

Recommendation 6. We recommended that the VISN Director ensure that the System Director requires Imaging Service managers to conduct a comprehensive risk assessment of the MRI area and implement additional safety measures as applicable.

Concur

Target date of completion: April 30, 2010

Planned Action: A comprehensive risk assessment of the MRI area is underway. The multidisciplinary team is composed of representatives

from pharmacy, facilities, imaging, nursing, medicine, police, and the Chief of Staff. Representatives have met as a group and are currently working solo or in small groups to analyze risk in various scenarios. Once completed, the risk assessment will provide a comprehensive picture of the nature and likelihood of MRI risks and means of mitigating or eliminating these risks. Recommended safety measures will be thoroughly analyzed and addressed.

Recommendation 7. We recommended that the VISN Director ensure that the System Director requires MRI personnel to follow up on positive responses on the screening questionnaire and document actions taken to address any potentially dangerous conditions that are identified.

Concur

Target date of completion: March 30, 2010

Planned Action: The MRI Screening form has been modified and includes an area for comments by the MRI Technologist on positive responses to screening questions. Positive responses are being addressed by the MRI Technologist using ACR guidelines prior to performing the MRI exam in consultation with the MRI Medical Director when necessary. A random audit of medical records is conducted each month to ensure appropriate documentation is completed. Preliminary monitoring shows 100% compliance. The results of this audit will be reported monthly at the Imaging Performance meeting and to the Safety Committee by the MRI Safety Officer until the improvement has been sustained.

Recommendation 8. We recommended that the VISN Director ensure that the System Director requires MRI personnel to comply with the informed consent policy for all patients undergoing an MRI exam with contrast media.

Concur

Target date of completion: March 30, 2010

Planned Action: Informed consent is now completed and documented for all high-risk patients receiving intravascular contrast during an MRI procedure. The MRI Safety Officer conducts a random audit of charts to review consent forms for appropriate documentation and results are reported to the Safety Committee monthly. Verbal consent is now obtained and documented for non-high-risk patients receiving contrast. Preliminary monitoring shows 100% compliance. The results of this audit will be reported monthly at the Imaging Performance meeting and to the Safety Committee by the MRI Safety Officer until the improvement has been sustained.

Recommendation 9. We recommended that the VISN Director ensure that the System Director requires that FPPE timeframes are documented and results are reported consistently to the MSEB and that individualized OPPE criteria for all physician staff are reviewed and documented consistently by the MSEB and PSB.

Concur

Target date of completion: May 15, 2010

Planned Action: All Focused Professional Practice Evaluations (FPPEs) and Ongoing Professional Practice Evaluations (OPPEs) are currently being completed by each clinical Service Chief or their designee. Data for these evaluations will be collected on a bi-annual basis. By July 1, 2010, the bulk of the data collection work will be transitioned to a registered nurse working within Quality Management Service. Final responsibility for evaluation of data will remain with each Service Chief, with subsequent sign-off by the Chief of Staff.

FPPE data will be tracked by the Quality Management Service on a specific tracking form, with updates provided routinely to the Professional Standards Board (PSB). The period for initial FPPE will generally be three months, although low-volume providers may be under review (and placed on the tracking form) indefinitely until adequate patient care volume is such that an effective FPPE can take place or comparable data can be obtained by another facility in which that physician has an affiliation.

OPPE data will be collected consistently on a bi-annual basis. Both FPPE and OPPE forms have been reviewed to ensure that there is a place to document the 3-month and 6-month review periods, respectively.

When FPPE or OPPE evaluation criteria is modified, that criteria will be presented to and approved by the MSEB through its PSB.

Results of both FPPE and OPPE evaluations are to be tracked by Quality Management Service and documented in the PSB minutes on a routine basis.

Recommendation 10. We recommended that the VISN Director ensure that the System Director requires that the inter-facility transfer process complies with VHA policy.

Concur

Target date of completion: April 30, 2010

Planned Action: VHA Directive 2007-15 “Inter-facility Transfer Policy” was reviewed and the local inter-facility transfer policy is being updated.

The facility transfer coordinators now ensure that medical staff complete the inter-facility transfer form and the inter-facility consent form and send them with the patient upon transfer. Also, prior to transfer it is determined whether the patient has an Advanced Directive on file. If so, a copy of that document is sent to the receiving facility. The Administrative Officers of the Day, as well as appropriate medical and nursing staff have been educated regarding this process. A new check-list has been implemented to ensure compliance.

Performance improvement data regarding compliance with expected transfer processes is now being monitored as part of the Quality Management Program. Data is being collected monthly and will be presented to the Quality Council on a quarterly basis.

Recommendation 11. We recommended that the VISN Director ensure that the System Director requires that new EMS employees on the locked MH unit receive initial training on environmental hazards that represent a risk to suicidal patients, as required.

Concur

Target date of completion: April 30, 2010

Planned Action: New EMS employees assigned to work in the MH unit will receive initial employment training and annual training thereafter. Training resources will include HCSM 116A-07-003 Safety Procedures on the Inpatient Psychiatry Unit, HCSM 11Q-08-005 Patient Safety Program, and/or the national Power Point regarding safety on inpatient psychiatric units. EMS leadership will provide the in-service training. Training will be documented and records will be maintained in the employee competency files as well as recorded in the Learning Management System. Competencies will be developed and used as a means of verifying employee knowledge.

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