Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No.10-01233-136

Combined Assessment Program Review of the South Texas Veterans Health Care System San Antonio, Texas

April 26, 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.

To Report Suspected Wrongdoing in VA Programs and Operations:
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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 South Texas Veterans Health Care System (the system), San Antonio, TX. 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 783 system employees. The system is part of Veterans Integrated Service Network (VISN) 17.

Results of the Review

The CAP review covered eight operational activities. We identified the following organizational strengths and reported accomplishments:

- Performance Excellence Awards
- Physician Credentialing and Privileging (C&P) Process
- Kerrville Division New Patient Orientation

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

- Require that designated staff maintain current Advanced Cardiac Life Support (ACLS) certification, in accordance with local policy.
- Require that clinicians consistently document all required influenza vaccine elements.
- Require that Magnetic Resonance Imaging (MRI) personnel complete an MRI screening form for each patient and scan it into the medical record, as required by local policy.
- Require Supply, Processing, and Distribution (SPD) to maintain a clean environment.
- Require staff to wear appropriate personal protective equipment (PPE), in accordance with VA policy.
- Require SPD staff to clean reusable medical equipment (RME) according to the manufacturers' instructions.
- Require a written emergency action plan to be located adjacent to the ethylene oxide (EtO) sterilizer, in accordance with VA policy.

- Require the humidity range in the SPD sterile storage area to be maintained in accordance with VA policy.
- Require that staff identified as at risk for exposure to a harmful atmosphere receive annual respirator fit testing and training, as required by the Occupational Safety and Health Administration (OSHA).
- Require staff to consistently complete and document daily emergency cart checks, as required by local policy.

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

- Coordination of Care
- Physician C&P
- Suicide Prevention Safety Plans

This report was prepared under the direction of Linda DeLong, Director, Dallas 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 16–21, 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 a tertiary care system comprised of two divisions located in San Antonio and Kerrville, TX, and provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at 18 community based outpatient clinics in Corpus Christi, McAllen, Laredo, Victoria, Harlingen, Seguin, New Braunfels, Beeville, Del Rio, Uvalde, Kingsville, and San Antonio, TX. The system is part of VISN 17 and serves a veteran population of about 305,800 throughout 63 counties in Texas.

Programs. The system provides medical, surgical, psychiatric, geriatric, primary, and palliative care services. It has 232 acute hospital beds, 224 community living center (CLC) beds, 40 domiciliary beds, and 26 substance abuse residential rehabilitation treatment program beds.

Affiliations and Research. The system is affiliated with the University of Texas Health Science Center at San Antonio and supports 194 resident positions. In fiscal year (FY) 2009, the system's research program had 417 projects and a budget of $21 million. Important areas of research included diabetes, aging, neurodegeneration, kidney diseases, and human immunodeficiency virus/acquired immunodeficiency syndrome.

Resources. In FY 2009, medical care expenditures totaled $623 million. The FY 2010 medical care budget is $624 million. FY 2009 staffing was 3,436 full-time employee equivalents (FTE), including 224 physician and 1,076 nursing FTE.

Workload. In FY 2009, the system treated 92,352 unique patients and provided 76,366 inpatient days in the hospital and 70,266 inpatient days in the CLC unit. The inpatient care workload totaled 10,530 discharges, and the average daily census, including CLC patients, was 480. Outpatient workload totaled 1,058,553 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 C&P
- QM
- RME
- Suicide Prevention Safety Plans

The review covered system operations for FY 2009 and FY 2010 through January 25, 2010, and was done in accordance with OIG standard operating procedures (SOP) for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the system (*Combined Assessment Program Review of the South Texas Veterans Health Care System, San Antonio, Texas,* Report No. 07-01158-190, August 21, 2007). The system had corrected all findings related to health care from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 783 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

Performance Excellence Awards

The system received the VA's Robert W. Carey Performance Excellence Award at the achievement level in 2008 and at the excellence level in 2009. The system was recognized for strength in senior leadership and governance structure, accomplishment of organization objectives, performance improvement (PI), and its culture of honor and value for veterans. Advancement in the award category was achieved through attainment of higher levels of performance in key measures and by communicating and sharing information with employees, stakeholders, partners, and collaborators. Senior leaders established performance expectations through evaluation of Veterans Health Administration (VHA) priorities, stakeholder input, and budget resource considerations. Employees were engaged in improvement efforts and recognized for their high performance through well-deployed reward and recognition programs.

Physician Credentialing and Privileging Process

The system achieved a best practice physician profile system for Ongoing Professional Practice Evaluation (OPPE) through continuous cycles of improvement over the past 2 years. Policies were developed, and bylaws were revised to meet Joint Commission (JC) standards. Service chiefs and staff responsible for conducting privileging reviews were educated on core competencies and ongoing review processes. In the first cycle, physician profile core indicators were built and included basic elements, such as trends in adverse events, overall workload activity, complaints and compliments, and morbidity and mortality. The second cycle of improvement significantly strengthened the profile at the service level and included indicators with target rates under each of the competencies. Group indicators were added to reflect performance in clinical guidelines.

Active engagement of all physician service chiefs in this process and in the Professional Standards Board (PSB)

enabled problem solving for difficult privilege decisions, such as low and zero volume providers or leave of absence. Through these strong practices, the PSB has worked through many difficult privileging decisions over the past 2 years. This has resulted in changes to privilege status for multiple providers. In addition, the process has significantly improved the standard for privileging and has ensured that providers are competent to perform the privileges granted.

Kerrville Division New Patient Orientation

In 2007, a new patient customer service initiative was developed utilizing an interdisciplinary approach to obtain pertinent information from service leaders. This information was identified as being most beneficial to veterans accessing health care. As a result of this initiative, veterans are issued a folder with helpful telephone numbers and detailed information on services provided. An interactive orientation is scheduled monthly and includes a VA audiovisual presentation, speakers from different disciplines, and a Texas Veterans Commission representative. Veterans provide feedback regarding orientation effectiveness, which is reported to senior leaders for PI. This has resulted in improved customer service scores in timeliness of care for new patients.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was 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 interviewed the system's Director, Chief of Staff, and QM Chief. We evaluated plans, policies, PI data, and other relevant documents.

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. However, we identified one area that needed improvement.

Life Support Training. VHA policy[1] requires the system to monitor Basic Life Support (BLS) and ACLS training and to

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

ensure timely renewal of all certifications. Additionally, the system has a local policy addressing the requirements for BLS and ACLS certification. The system complied with policy requirements for BLS training. For ACLS certification, managers had identified 282 employees required to have this certification; however, 23 (8 percent) employees did not have current certificates.

Recommendation 1 We recommended that the VISN Director ensure that the System Director requires that designated staff maintain current ACLS certification, in accordance with local policy.

The VISN and System Directors concurred with the finding and recommendation. The recent revision to the local policy, which added ACLS as a requirement for additional employees, was rescinded on February 25, 2010. The system is now in compliance with the current local policy. ACLS training will be tracked in the Learning Management System (LMS), and each service chief will ensure that staff members mandated to complete ACLS certification are entered into LMS. The corrective action is acceptable, and we consider this recommendation closed.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had 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 receive erythropoiesis-stimulating agents.[2] We found that clinical staff had appropriately identified and addressed elevated hemoglobin levels in 9 (90 percent) of the 10 CLC residents whose medical records we reviewed.

Influenza vaccinations were offered and administered to CLC residents, and documentation was adequate for most required elements. However, we identified the following area that needed improvement.

[2] Erythropoiesis-stimulating agents are drugs that stimulate the bone marrow to make red blood cells. They are used to treat anemia.

CLC Influenza Vaccinations. For each dose of influenza vaccine, VHA policy[3] requires the following items to be documented:

- Date of administration
- Lot number
- Manufacturer
- Route
- Site
- Provider name and title
- Edition and date of the Vaccine Information Statement (VIS) from the Centers for Disease Control and Prevention

We reviewed the medical records of 10 CLC residents and found that the records did not contain documentation of the VIS edition.

Recommendation 2 We recommended that the VISN Director ensure that the System Director requires that clinicians consistently document all required influenza vaccine elements.

The VISN and System Directors concurred with the finding and recommendation. On January 27, 2010, requests to include mandatory VIS edition date fields on template notes were submitted to the Medical Records Committee Rapid Response Team (RRT). The requests were approved by the RRT, and the additions to the templates were completed on January 29, 2010. The corrective action is 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

[3] VHA Directive 2009-058, *Seasonal Influenza Vaccine Policy for2009–2010*, November 12, 2009.

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 rooms 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.

Local policy requires that personnel who have access to the MRI area receive appropriate MRI safety training. We reviewed the training records of 12 personnel and found that all had completed required safety training. We identified the following area that needed improvement.

Screening. Local policy requires an MRI screening form to be completed for each patient and scanned into the medical record. We reviewed the medical records of 10 patients who received an MRI prior to our visit and found that 3 (30 percent) records did not contain the MRI screening form. Additionally, we were unable to locate paper copies of the screening forms for these three patients.

Recommendation 3 We recommended that the VISN Director ensure that the System Director requires that MRI personnel complete an MRI screening form for each patient and scan it into the medical record, as required by local policy.

The VISN and System Directors concurred with the finding and recommendation. A process was instituted to monitor MRI screening form completion and scanning of the form into the medical record. Results will be reported to the Quality Executive Board monthly. 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 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 SPD and satellite reprocessing areas are required

to meet VHA, Association for the Advancement of Medical Instrumentation, OSHA, and JC standards.

We inspected SPD, gastroenterology, anesthesiology, interventional radiology, and the hemodialysis unit. We determined that the system had established appropriate guidelines and monitored compliance with those guidelines. Also, the system had a process in place to track RME should a sterilization failure occur.

For 12 pieces of RME, we reviewed the SOPs for reprocessing. In general, we found that SOPs were current and consistent with the manufacturers' instructions. We reviewed the competency folders and training records of employees who we had asked to demonstrate and/or verbalize cleaning procedures. We found that annual competencies and training were current and consistently documented. However, we identified the following areas that needed improvement.

Infection Control. VA policy[4] requires the system to maintain a clean environment in SPD. We found multiple holes in the ceiling around sprinkler heads in SPD, outside the EtO area, and in temporary plastic sheeting (temporary construction wall). Additionally, we identified a stained, dirty wall in SPD.

Decontamination Area. VA policy[5] requires appropriate PPE to be utilized. Strict control of the decontamination area is critical to attaining and maintaining a high degree of confidence in the RME cleaning process. We found that staff did not don appropriate PPE prior to entering the decontamination area and did not wear PPE at all times while in the decontamination area.

Cleaning. VHA policy[6] requires that staff clean RME according to manufacturers' instructions. We observed that staff did not follow proper sequence when cleaning RME.

EtO Sterilization. VA policy[7] requires a written emergency action plan to be posted adjacent to the EtO sterilizer. We

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

found that the emergency action plan was not adjacent to the EtO sterilizer and was difficult to retrieve.

SPD Sterile Storage Area. VA policy[8] requires sterile items to be stored in carefully controlled conditions that are protective of extreme temperature and humidity. Humidity must be maintained between 35–75 percent. We found that humidity was not maintained in the appropriate range.

Recommendation 4 We recommended that the VISN Director ensure that the System Director requires SPD to maintain a clean environment.

The VISN and System Directors concurred with the findings and recommendation. The system repaired the ceilings and reinforced the temporary wall prior to our exit. A work order has been submitted for painting. The estimated completion date is April 16, 2010. The implementation plan is acceptable, and we will follow up on the planned action until it is completed.

Recommendation 5 We recommended that the VISN Director ensure that the System Director requires that staff wear appropriate PPE, in accordance with VA policy.

The VISN and System Directors concurred with the findings and recommendation. All SPD employees received training on the proper use of PPE on March 12, 2010. The corrective action is acceptable, and we consider this recommendation closed.

Recommendation 6 We recommended that the VISN Director ensure that the System Director requires SPD staff to clean RME according to the manufacturers' instructions.

The VISN and System Directors concurred with the finding and recommendation. The piece of RME that was not cleaned in proper sequence was tested to ensure that all microorganisms were removed prior to proceeding with reprocessing/sterilization. The piece of RME was then cleaned thoroughly. The staff member was retrained to follow SOPs exactly as written. The corrective actions are acceptable, and we consider this recommendation closed.

[8] VA Handbook 7176.

Recommendation 7 We recommended that the VISN Director ensure that the System Director requires a written emergency action plan to be located adjacent to the EtO sterilizer, in accordance with VA policy.

The VISN and System Directors concurred with the finding and recommendation. The written emergency action plan for EtO leaks/spills was immediately placed adjacent to the EtO sterilizer. The corrective action is acceptable, and we consider this recommendation closed.

Recommendation 8 We recommended that the VISN Director ensure that the System Director requires the humidity range in the SPD sterile storage area to be maintained in accordance with VA policy.

The VISN and System Directors concurred with the finding and recommendation. On March 10, 2010, the system developed an SOP that requires SPD staff to submit a work order regarding temperature and humidity concerns. This requirement has been posted on the temperature and humidity log to ensure compliance. The corrective actions are acceptable, and we consider this recommendation closed.

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 EOC program that fully meets VHA, National Center for Patient Safety, OSHA, National Fire Protection Association, and JC standards.

We conducted onsite inspections of the spinal cord injury unit; the hemodialysis unit; the locked mental health (MH) unit; the emergency department; the bone marrow transplant unit; the urgent care clinic; outpatient clinic areas; and inpatient medical, surgical, intensive care, and CLC units. The system maintained a generally clean and safe environment. Staff and nurse managers expressed satisfaction with the responsiveness of the housekeeping staff on their units. System managers conducted quarterly MH EOC assessments of the locked MH unit, identified opportunities for improvement, and implemented corrective action plans. We identified the following conditions that needed improvement.

Respirator Fit Testing. OSHA requires that staff identified as at risk for exposure to a harmful atmosphere, such as tuberculosis, receive annual respirator fit testing and training. We found that 17 (63 percent) of 27 selected staff at risk for exposure did not receive the required annual respirator fit testing and training.

Emergency Cart Checks. Local policy requires designated staff to complete and document emergency cart checks each day. We reviewed documentation for daily emergency cart checks in 17 clinical areas and found that staff did not consistently complete the checks in 8 (47 percent) areas.

Recommendation 9 We recommended that the VISN Director ensure that the System Director requires that staff identified as at risk for exposure to a harmful atmosphere receive annual respirator fit testing and training, as required by OSHA.

The VISN and System Directors concurred with the finding and recommendation. Service chiefs and nurse managers will identify employees who need to be trained. Employees will complete the required LMS training by April 30, 2010, and will be fit tested no later than July 30, 2010. 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 staff to consistently complete and document daily emergency cart checks, as required by local policy.

The VISN and System Directors concurred with the finding and recommendation. The local policy has been revised. The nurse manager or designee will annotate daily crash cart checklists and will monitor completion of daily crash cart checks. This information will be tracked monthly on the Nursing Service dashboard. Weekly and monthly audits will be conducted. 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 JC requirements. Coordinated transfers and discharges are

essential to an integrated, ongoing care process and optimal patient outcomes.

VHA policy[9] requires that systems 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 also 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[10] 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 10 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.

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

We reviewed 10 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 OPPE had been developed and approved. We found sufficient performance data to meet current requirements. Meeting minutes consistently documented thorough discussions of the

[9] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.
[10] VHA Handbook 1907.01, *Health Information Management and Heath Records*, August 25, 2006.
[11] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

physicians' privileges and performance data prior to recommending renewal of or initial requested privileges. 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. Safety plans must also include information about how patients can access professional help 24 hours a day, 7 days a week.[12]

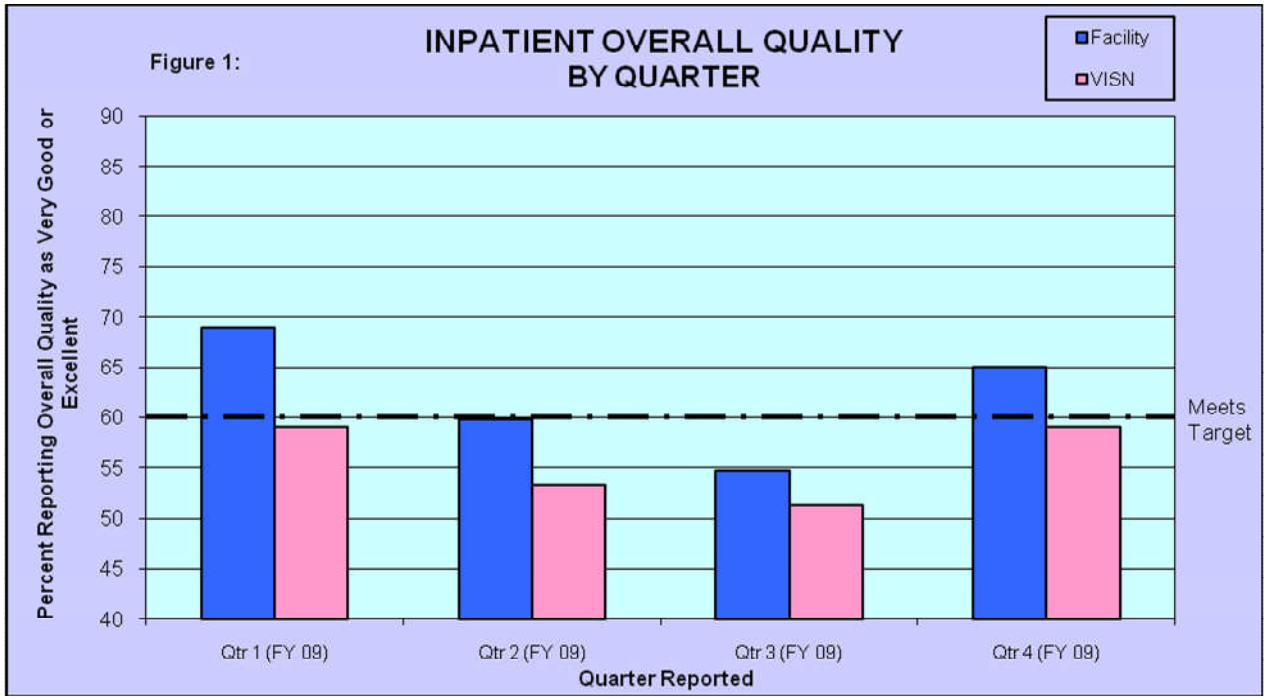
We reviewed the medical records of 10 patients assessed to be at high risk for suicide and found that clinicians had developed timely safety plans that included all required elements. We also found evidence to support that the patients and/or their families participated in the development of the plans.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

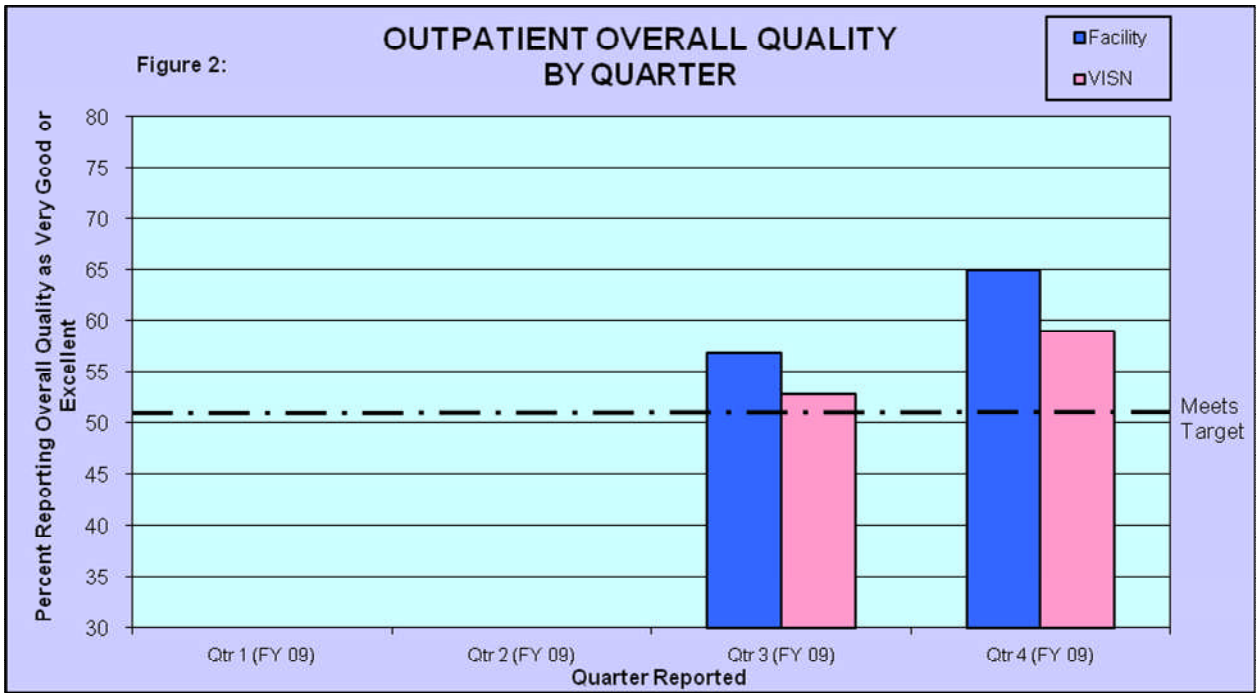
VHA Satisfaction Surveys

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.[13] The target scores are noted on the graphs.

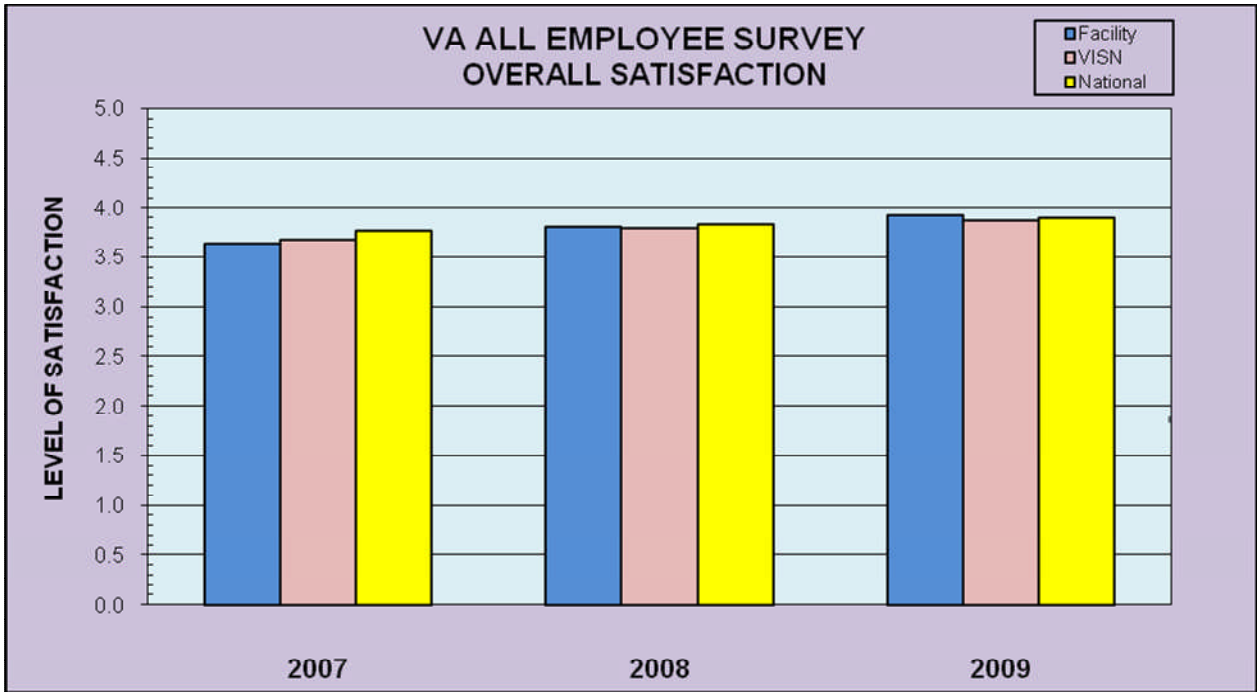
[12] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.

[13] 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
OVERALL SATISFACTION
Facility
VISN
National
LEVEL OF SATISFACTION
5.0
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0
2007
2008
2009

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 23, 2010

From: Acting Director, VA Heart of Texas Health Care Network (10N17)

Subject: **Combined Assessment Program Review of the South Texas Veterans Health Care System, San Antonio, Texas**

To: Director, Dallas Office of Healthcare Inspections (54DA)

Director, Management Review Service (10B5)

1. I have reviewed the comments provided by the Medical Center Director, South Texas Veterans Health Care System and concur with the responses and proposed action plans to the recommendations outlined in the report.

2. We appreciate the professionalism and consultative manner demonstrated by your team during the review process.

(original signed by:)

JOSEPH M. DALPIAZ

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 18, 2010

From: Director, South Texas Veterans Health Care System (671/00)

Subject: **Combined Assessment Program Review of the South Texas Veterans Health Care System, San Antonio, Texas**

To: Director, VA Heart of Texas Health Care Network (10N17)

1. I concur with all of the findings and recommendations in the draft report. The South Texas Veterans Health Care System has completed and is proceeding with the completion of the following attached action plan.

2. Our appreciation is extended to the entire OIG-CAP Team led by Marilyn Walls. Every member of the team was consultative and professional and provided excellent feedback to our staff.

3. If you have any questions, please contact Donna Gladstone, Chief of Quality Management at 210-617-5300, extension 16167.

(original signed by:)

Marie L. Weldon, 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 staff maintain current ACLS certification, in accordance with local policy.

Concur: **Target Completion Date:** September 30, 2010

The recent revision of the *Basic Life Support (BCLS) and Advanced Cardiac Life Support (ACLS) Training for VA Employees* policy, which added ACLS as a requirement for physicians, advance practice nurses, physician assistants, and nurses practicing in designated special care areas, was rescinded by the Clinical Executive Board (CEB) February 25, 2010. The system is in compliance with the current facility policy. In order to ensure that ACLS certification is maintained in accordance with facility policy, all ACLS training will be tracked in the Learning Management System (LMS) by Education Service. At the March 10, 2010 meeting of the CEB, the methodology for tracking ACLS certification was defined. Each Service Chief will ensure staff members mandated to complete ACLS certification are entered into LMS by the LMS Administrator as a curriculum assignment on the individual's Learning Plan so that the employee and their supervisor will receive 90, 60, and 30 day reminders prior to their expiration dates. Recommend closure.

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires that clinicians consistently document all required influenza vaccine elements.

Concur: **Target Completion Date:** Completed

On Wednesday, January 27, 2010, requests were submitted to the Medical Records Committee Rapid Response Team (RRT) to modify the note titles *Immunization Note, Flu Shot Group Note, and Employee Health Nurse Flu Shot Note* to include a mandatory field requiring the CDC VIS edition date be entered on each of these notes. The requests were approved by the RRT on that date and the additions to these templates were made on Friday, January 29, 2010. Recommend closure.

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires that MRI personnel complete an MRI screening form for each patient and scan it into the medical record, as required by local policy.

Concur: **Target Completion Date:** Completed

Prior to the OIG CAP visit on January 25, 2010, a monitoring process was instituted to audit completion of the MRI screening form and scanning of the form into the medical record. An audit form was created and the Chief Technologist audits 70 charts per month. Audit results will be reported to the Quality Executive Board monthly. Recommend closure.

Recommendation 4. We recommended that the VISN Director ensure that the System Director requires SPD to maintain a clean environment.

Concur: **Target Completion Date:** April 16, 2010

The issues identified were as follows: Repairs to the ceiling (completed prior to OIG exit); reinforcement of temporary wall (completed prior to OIG exit); painting of Case Card assembly area, work order submitted with an estimated completion date of April 16, 2010.

Recommendation 5. We recommended that the VISN Director ensure that the System Director requires that staff wear appropriate PPE, in accordance with VA policy.

Concur: **Target Completion Date:** Completed

This recommendation was made for one SPD employee that requires a certain size shoe covers. These shoe covers were on back order from the company and he had to wear standard shoe covers over his shoes. The requirement to put on all PPE prior to entrance into the decontamination area was addressed with this employee. The shoe covers were received from the company on 26 Jan 2010 and there have been no additional backorders on this item. Additionally, all other SPD employees were retrained on proper wear of PPE on March 12, 2010. Review of 7176 policy related to PPE was included in this training. Recommend closure.

Recommendation 6. We recommended that the VISN Director ensure that the System Director requires SPD staff to clean RME according to the manufacturers' instructions.

Concur: **Target Completion Date:** Completed

All RME cleaning demonstrations were completed according to manufacturer's instructions/STVHCS SOP's except for one endoscope by

one employee. During the aforementioned demonstration, the employee inverted two steps (the employee brushed the suction port (opening) prior to brushing the suction channel as written on the SOP instructions). As a part of the SPD Quality Assurance program, a "Channel Chek™" test was completed on the endoscope channels to ensure all bioburden was removed and the endoscope passed prior to proceeding with reprocessing/Sterilization. The endoscope was cleaned thoroughly per result of this test; however, this employee was retrained to follow the SOP exactly as written. Recommend closure.

Recommendation 7. We recommended that the VISN Director ensure that the System Director requires a written emergency action plan to be located adjacent to the EtO sterilizer, in accordance with VA policy.

Concur: **Target Completion Date:** Completed

The written Emergency Action Plan for EtO leaks/spills was obscured by the temporary construction wall built the day prior to the inspection. The plan was relocated immediately to a more visible location and an additional plan was placed on the EtO Sterilizer panels. Recommend closure.

Recommendation 8. We recommended that the VISN Director ensure that the System Director requires the humidity range in the SPD sterile storage area to be maintained in accordance with VA policy.

Concur: **Target Completion Date:** Completed

An SOP was created March 10, 2010, that requires SPD Staff to call energy systems, submit a work order, and annotate the work order number under the comments section of the temperature and humidity log. This requirement has been posted on the Temperature and Humidity logs and highlighted to ensure compliance. Recommend closure.

Recommendation 9. We recommended that the VISN Director ensure that the System Director requires that staff identified as at risk for exposure to a harmful atmosphere receive annual respirator fit testing and training, as required by OSHA.

Concur: **Target Completion Date:** July 30, 2010

The following actions will occur:

1. Service Chiefs and Nurse Managers to identify employees at risk for TB exposure who will need to be trained to wear a N95 Respirator no later than March 31, 2010.

2. Employees identified to wear N95 will complete OSHA N95 Respirator Medical Evaluation Questionnaire and must be medically cleared by Occupational Health Clinic by April 16, 2010.
3. Employees cleared by Occupational Health Clinic will have TB and Respirator Etiquette course entered into their LMS learning plan by the Service LMS administrator and will complete the required LMS training by April 30, 2010.
4. All identified employees, following completion of steps 2 and 3, will be fit tested no later than July 30, 2010.
5. Ongoing compliance will be assured through curriculum assignment on individuals' Learning Plans so that employees and their supervisors receive 90, 60, and 30 day reminders prior to their expiration dates.

Recommendation 10. We recommended that the VISN Director ensure that the System Director requires staff to consistently complete and document daily emergency cart checks, as required by local policy.

Concur **Target Completion Date:** Completed

1. Policy Number 11-08-13 has been revised to designate the nurse manager or her designee only to annotate the daily crash (crisis) cart checklists. The Sterile Processing Department will conduct a monthly check to ensure that all crash (crisis) carts are fully stocked and that supplies remain in-date and will annotate this on a separate form.
2. The completeness of these daily crash (crisis) cart checks will be monitored daily by the nurse manager and/or her/his designee and this information will be tracked monthly on the Nursing Service dashboard
3. Weekly audits of the daily crash (crisis) cart checks will be conducted during the Chief Nurse rounds.
4. Monthly audits of the crash (crisis) cart checks will be conducted during both Environment of Care rounds and by Quality Management during Tracers. Recommend closure.

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