Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 09-03275-147

Combined Assessment Program Review of the Michael E. DeBakey VA Medical Center Houston, Texas

May 13, 2010

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

During the week of January 25–29, 2010, the OIG conducted a Combined Assessment Program (CAP) review of the Michael E. DeBakey VA Medical Center (the medical center), Houston, 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 795 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 16.

Results of the Review

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

- Restraint Reduction Initiative

We made recommendations in seven of the activities reviewed. For these activities, the medical center needed to:

- Ensure that designated clinical staff comply with cardiopulmonary resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) education requirements.
- Require that physician credentialing and privileging (C&P) processes are in compliance with Veterans Health Administration (VHA) requirements for Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE).
- Ensure that the identified environment of care (EOC) rounds attendance, safety, environmental hazards training, infection control, and respirator fit testing and training concerns are corrected.
- Ensure that staff complete inter-facility patient transfer documentation and implement processes to monitor and evaluate patient transfers.
- Ensure that clinicians and providers adhere to medication ordering, dispensing, and administration requirements in accordance with medical center policy.
- Ensure that clinicians consistently document all required influenza vaccination elements.

- Ensure that employees who have access to the magnetic resonance imaging (MRI) area receive initial and annual MRI safety training.
- Ensure that personal protective equipment (PPE) is properly donned by anyone entering the reusable medical equipment (RME) decontamination area.
- Ensure that standard operating procedures (SOPs) are located in the Supply, Processing, and Distribution (SPD) decontamination area for all RME reprocessed.
- Ensure that annual competencies for the flash sterilizers are evaluated and documented.

The medical center complied with selected standards in the following activity:

- Suicide Prevention Safety Plans

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

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 17–22 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 medical center is a tertiary facility located in Houston, TX, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at four community based outpatient clinics in Lufkin, Beaumont, Galveston, and Conroe, TX. The medical center is part of VISN 16 and serves a veteran population of about 122,000 throughout 28 counties in Texas.

Programs. The medical center provides specialized diagnostic care, radiation therapy, surgery, and medical treatments. It also provides specialty care, including cardiovascular surgery, gastrointestinal endoscopy, nuclear medicine, and ophthalmology. The medical center is home to a post-traumatic stress disorder clinic, a network polytrauma center, a cardiac and general surgery program, and a liver transplant center. The medical center has one of the VA's six Parkinson's Disease Research, Education, and Clinical Centers and is a Cancer, Cardiovascular, and Neuroscience Center of Excellence. It has 426 hospital beds and 120 community living center (CLC) beds.

Affiliations and Research. The medical center is affiliated with Baylor College of Medicine and provides training for 251 residents. It also provides training for other disciplines, including radiology, nursing, dietetics, social work, physical therapy, and psychology. In fiscal year (FY) 2009, the medical center research program had 196 principal investigators, 144 funded projects, grants totaling $20 million, and an operating budget of $11 million. Important areas of research included stroke, epilepsy, and neuro-rehabilitation.

Resources. In FY 2009, medical care expenditures totaled $616 million. FY 2009 staffing was 3,331 full-time employee equivalents (FTE), including 321 physician and 721 nursing FTE.

Workload. In FY 2009, the medical center treated 113,157 unique patients and provided 155,165 inpatient days in the hospital and 42,008 inpatient days in the CLC units. The inpatient care workload totaled 13,412 discharges, and the average daily census, including CLC residents, was 425. Outpatient workload totaled 895,437 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
- EOC
- Medication Management
- MRI Safety
- Physician C&P
- QM Program
- RME
- Suicide Prevention Safety Plans

The review covered medical center operations for FY 2009 and FY 2010 through January 25, 2010, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the Michael E. DeBakey VA Medical Center, Houston, Texas,* Report No. 07-00604-148,

June 19, 2007). The medical center 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 795 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. The activity in the "Review Activity Without Recommendations" section has no reportable findings.

Organizational Strength

Restraint Reduction Initiative

The medical center embarked on a journey to move toward a restraint-free environment by developing a system-wide culture change. Nursing unit staff took ownership of the change and created champions to ensure the highest level of patient safety with minimal restraint use. While this initiative was done facility wide, it was particularly significant in the long-term care and intensive care units, which were among the highest users of restraints. Education was provided to the entire interdisciplinary team, focusing on assessment of need, alternatives to restraint use, and working as a team to change the perception that restraints prevent patient injuries and dislodgement of tubes. The interventions resulted in a 75 percent reduction in restraint use from 2007 to 2009.

Results

Review Activities With Recommendations

Quality Management Program

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

The QM program was generally effective in providing oversight of the medical center's quality of care**.** It was also evident that senior managers supported the program through

participation in performance improvement initiatives and through allocation of resources to the program. Appropriate review structures were in place for 11 of the 12 program activities reviewed. We identified one area that needed improvement.

Resuscitation and Its Outcomes. VHA policy[1] requires that the medical center have a policy governing CPR and ACLS training for designated clinical staff as well as a mechanism in place to ensure staff compliance with CPR and ACLS education requirements. The medical center's policy was comprehensive, but we found that 133 (25 percent) of 532 designated staff did not have current ACLS certification and that 73 (3.5 percent) of 2,059 designated staff were not in compliance with CPR education requirements.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires designated clinical staff to comply with CPR and ACLS education requirements.

The VISN and Medical Center Directors concurred with the findings and recommendation. The medical center's CPR policy is being revised to clearly define which staff are required to complete ACLS training. Mechanisms to ensure staff compliance have been established. Monthly monitoring will be conducted, and results will be reported to senior leadership. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Physician Credentialing and Privileging

The purpose of this review was to determine whether the medical center maintained consistent processes for physician C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and provider profiles.[2] We also reviewed meeting minutes during which the physicians' privileges were discussed and during which recommendations were made.

We reviewed 13 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. We identified two areas that needed improvement.

[1] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.
[2] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

FPPE. VHA policy requires an FPPE review process to be established to ensure the competence of newly hired physicians. Results of FPPE must be documented in provider profiles and reported to the Clinical Executive Board (CEB) for consideration in making recommendations for privileges. During the review, we found that dates were missing from approval signatures on FPPE forms. We noted that the medical staff bylaws discuss an FPPE process; however, five of the six newly hired physicians' folders did not have criteria developed to determine the type of monitoring needed for the initial evaluation period. Additionally, two of the six FPPEs were not documented in the physicians' profiles, and another two were not reported to the CEB.

OPPE. VHA policy requires a thorough written plan with specific competency criteria for OPPE for all privileged physicians. The written plan for OPPE was incomplete because several services had not developed service-specific competency criteria. Also, OPPE data for four of the seven physicians who had been reprivileged during the past 12 months was not documented in the providers' profiles.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that physician C&P processes are in compliance with VHA requirements for FPPE and OPPE.

The VISN and Medical Center Directors concurred with the findings and recommendation. Service-specific criteria for FPPE and OPPE have been developed and approved by the CEB. In February 2010, the Credentialing and Clinical Privileging Subcommittee initiated a mechanism for monthly review and tracking of FPPE and OPPE. Subcommittee reports will be presented to the CEB. The corrective actions are acceptable, and we consider this recommendation closed.

Environment of Care

The purpose of this review was to determine whether the medical center maintained a clean and safe health care environment. VHA facilities are required to provide a comprehensive EOC program that fully meets VHA, National Center for Patient Safety, Occupational Safety and Health Administration (OSHA), National Fire Protection Association (NFPA), and Joint Commission (JC) standards.

We conducted onsite inspections of the locked acute mental health (MH) unit, the emergency department (ED), the surgical intensive care unit, the post-anesthesia care unit, the telemetry unit, the spinal cord injury unit, two general medicine units, an oncology medical and surgical unit, three CLC units, the neurology and rehabilitation unit, the hemodialysis unit, and the primary care outpatient clinic area. The medical center maintained a generally clean and safe environment. Medical center managers conducted quarterly MH EOC assessments for the locked acute MH unit and were pursuing corrective actions. We identified the following areas that needed improvement.

EOC Rounds. VHA[3] requires the Director or the Associate Director to lead weekly EOC rounds. Participants should also include managers in nursing, building management, engineering, safety, patient safety, infection control, and information security. The medical center did not maintain attendance records of weekly EOC rounds. Consequently, we were unable to validate whether the required participants or appropriate designees attended the rounds.

Safety. NFPA standards require fire drills to be conducted quarterly on each shift in buildings that are designated for health care occupancy. The medical center could not provide documentation that fire drills were conducted as required. For three selected inpatient units, we reviewed fire drill documentation for the previous 5 quarters. The medical center was only able to provide fire drill participation documentation for 28 (62 percent) of 45 required fire drills.

Environmental Hazards Training. VHA[4] requires that all staff assigned to locked acute MH units receive training in environmental hazard identification at orientation and annually thereafter. Housekeeping staff assigned to the unit did not receive training during orientation or annually. While we were onsite, housekeeping staff assigned to the locked acute MH unit received the required training.

Infection Control. Medical center policy requires that staff cleanse and disinfect blood sugar monitors (glucometers) after every use. The medical center defines further infection control practices to be used when providing care to patients

[3] Deputy Under Secretary for Health for Operations and Management, "Environmental Rounds," memorandum, March 5, 2007.
[4] Deputy Under Secretary for Health for Operations and Management, "Mental Health Environment of Care Checklist," memorandum, August 27, 2007.

on contact isolation. We interviewed one registered nurse (RN) from each of three separate units. Two of the three RNs indicated that they did not cleanse and disinfect glucometers between patients. We observed an RN performing glucometer testing and noted that the glucometer was not cleaned or disinfected between patient uses. One of the patients being tested was on contact isolation precautions, and the RN did not follow medical center policy.

Because exposure to blood and potentially contaminated items can be anticipated during dialysis, the Centers for Disease Control and Prevention requires gloves to be worn whenever caring for a dialysis patient or touching the patient's equipment. Staff on the hemodialysis unit did not wear gloves while touching the external surfaces of hemodialysis machines that were in use.

Staff did not routinely inspect patient care items for damaged surfaces and request repair or remove items from service as needed. We observed cracked arm rests on two reclining chairs and one wheelchair on a CLC unit and on three wheelchairs on the neurology and rehabilitation unit.

Respirator Fit Testing and Training. OSHA requires that staff identified to wear an N95 respirator undergo initial and annual fit testing and training. We reviewed N95 respirator fit testing and training documentation and noted that 6 (30 percent) of 20 selected direct care staff at risk for exposure did not receive the required N95 respirator fit testing and training.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires the identified EOC rounds attendance, safety, environmental hazards training, infection control, and respirator fit testing and training concerns to be corrected.

The VISN and Medical Center Directors concurred with the findings and recommendation. Attendance records for EOC rounds will be maintained. Fire drill participation will be documented and monitored. A process has been established to ensure that housekeeping staff receive environmental hazards training. Staff were educated on glucometer cleaning and disinfection and on infection control practices for patients in isolation. Additionally, a competency for glucometer cleaning was developed. Staff implemented the practice of wearing gloves when touching external

hemodialysis machine surfaces. A process has been developed to routinely inspect and obtain repair of damaged patient care equipment surfaces. A tracking process has been developed to ensure consistent annual respirator fit testing and training. The improvement 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 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[5] 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 18 discharged patients and determined that clinicians had generally documented the required elements. Also, we found that follow-up appointments occurred within the specified timeframes.

VHA policy[6] requires that medical centers have a policy that ensures the safe, appropriate, and timely transfer of patients. We determined that the medical center had an appropriate transfer policy. However, we identified the following area that needed improvement.

Inter-Facility Transfers. VHA policy 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 patient transfers to be monitored and evaluated as part of the QM program.

We reviewed transfer documentation for 10 patients transferred from the medical center's ED to another facility. We found that for 8 (80 percent) of the 10 patients, providers did not document all of the required information. Additionally, we did not find evidence that patient transfers were monitored and evaluated as part of the QM program.

[5] VHA Handbook 1907.01, *Health Information Management and Heath Records,* August 25, 2006.
[6] VHA Directive 2007-015, *Inter-Facility Transfer Policy,* May 7, 2007.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires staff to complete inter-facility patient transfer documentation and implement processes to monitor and evaluate transfers.

The VISN and Medical Center Directors concurred with the findings and recommendation. The medical center's policy has been revised. An electronic inter-facility documentation template has been initiated, and appropriate staff will be educated. Inter-facility transfers will be monitored, and results will be reported to the appropriate committees. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Medication Management

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

In November 2007, the U.S. Food and Drug Administration issued a safety alert stating that for chronic renal disease (CRD) patients, erythropoiesis-stimulating agents (ESAs)[7] should be used to maintain hemoglobin levels between 10 and 12 grams per deciliter (g/dL). Hemoglobin levels greater than 12g/dL increase the risk of serious conditions and death. We reviewed the medical records of 10 outpatients with CRD who had hemoglobin levels greater than 12g/dL and found that clinical staff had appropriately identified and addressed elevated hemoglobin levels. We identified the following two areas that needed improvement.

Medication Ordering, Dispensing, and Administration. Medical center policy requires a Pharmacy Service review of medication orders. If a licensed independent practitioner (LIP) excludes Pharmacy Service's review when ordering a medication, the LIP is responsible for dispensing and administration.

During our inspection, we noted that renal providers manage ESA therapy for outpatients who receive dialysis at the medical center. Renal providers write medication orders for ESAs in the Computerized Patient Record System (CPRS) utilizing the nursing text order feature, which bypasses the decision support software and a patient-specific pharmacy

[7] Drugs that stimulate the bone marrow to make red blood cells; used to treat anemia.

review. Nurses provide Pharmacy Service with a list of patient names and dosage amounts that are filled as a ward stock order by the pharmacy. Nurses then administer the ESAs to outpatients on the hemodialysis unit. This practice is not consistent with medical center policy.

CLC Residents' Influenza Vaccinations. VHA policy[8] requires several items to be documented for each influenza vaccination given, including the route, site, and date of administration. We reviewed the medical records of 10 CLC residents to determine whether the influenza vaccination had been administered. One patient refused the influenza vaccination. Documentation of the manufacturer and the Vaccine Information Statement edition date was omitted in all nine of the remaining patient records, and the lot number was omitted in two of the nine records.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires that clinicians and providers adhere to medication ordering, dispensing, and administration requirements in accordance with medical center policy.

The VISN and Medical Center Directors concurred with the findings and recommendation. Effective February 9, 2010, ESA prescriptions written by LIPs will be sent to the pharmacy for order review and entry into the outpatient medication profile. Medications will be dispensed to the hemodialysis unit on a weekly basis. Medication administration will be documented on the dialysis flow sheet and in the controlled medication/treatment record. These documents will be scanned into patients' electronic medical records. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires that clinicians consistently document all required influenza vaccination elements.

The VISN and Medical Center Directors concurred with the findings and recommendation. Changes were made to the CPRS influenza documentation template, and the revised template was distributed to all nursing staff. Staff received training on the template changes and on VHA's influenza

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

immunization policy. The corrective actions are acceptable, and we consider this recommendation closed.

Magnetic Resonance Imaging Safety

The purpose of this review was to evaluate whether the medical center 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 medical center had adequate safety policies and had appropriately conducted an environmental risk assessment, as required by The JC.

The medical center had appropriate signage and barriers to prevent unauthorized or accidental access to MRI areas. Patients in the magnet rooms were directly observed at all times. Two-way communication was available between the patients and the MRI technologists, and the patients had access to push-button call systems while inside of the scanners.

We reviewed the medical records of 11 patients who received an MRI. In all cases, patients received appropriate screenings. One patient who had an MRI with contrast media and was assessed to be at high risk had a signed informed consent prior to the study. We identified one area that needed improvement.

MRI Safety Training. The JC provides risk reduction strategies and recommendations regarding the provision of MRI safety training for non-MRI personnel. We reviewed the training records of six non-MRI staff, such as police officers and housekeepers, who have occasional access to the MRI areas. We determined that the medical center had not yet incorporated MRI safety training in new employee orientation and in annual training for these staff. Staff with occasional access to the MRI area must be knowledgeable of the unique safety precautions and need for screening prior to entering the area.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires that staff who have access to the MRI area receive initial and annual MRI safety training.

The VISN and Medical Center Directors concurred with the finding and recommendation. Staff who have access to the MRI area have received MRI safety training, and a process has been established to ensure that appropriate staff receive initial and annual training. The corrective actions are acceptable, and we consider this recommendation closed.

Reusable Medical Equipment

The purpose of this review was to evaluate whether the medical center 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 medical center's SPD and satellite reprocessing areas are required to meet VHA, Association for the Advancement of Medical Instrumentation, OSHA, and JC standards.

We inspected the SPD area, cardiology decontamination area, and operating room (OR). We determined that the medical center had established appropriate guidelines and monitored compliance; however, we identified the following areas that needed improvement.

Infection Control. VA policy[9] requires that PPE (approved head and hair coverings, face shields, gloves, gowns, and shoe covers) is donned before entering the decontamination area. We found that SPD staff did not consistently wear gloves, face shields, and approved hair coverings. Also, we observed a contract repairman who was not wearing appropriate shoe coverings.

SOPs. VHA requires[10] SOPs reflecting current manufacturers' instructions to be available in each area where reprocessing occurs for each type of RME used. During our inspection of the SPD decontamination area, we found that bronchoscope and colonoscope SOPs were not present. Additionally, SOPs for dental and orthopedic instruments were not available.

Competency and Training. VHA requires[11] that all employees involved in the use and reprocessing of RME have documented training on the set-up, use, reprocessing,

[9] VA Handbook 7176, *Supply, Processing, and Distribution (SPD) Operational Requirements,* August 16, 2002.
[10] VHA Directive 2009-031, *Improving Safety in the Use of Reusable Medical Equipment through Standardization of Organizational Structure and Reprocessing Requirements*, June 26, 2009.
[11] VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.

and maintenance of the specific equipment leading to initial competency and validation of that competency annually. We reviewed the competency folders for 10 OR RNs and found no documentation indicating competency for the flash sterilizers.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires that PPE is properly donned by anyone entering the RME decontamination area.

The VISN and Medical Center Directors concurred with the findings and recommendation. Staff have been re-educated on the requirements for PPE in the decontamination area. Ongoing monitoring will be conducted. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 9 We recommended that the VISN Director ensure that the Medical Center Director requires that SOPs are located in the SPD decontamination area for all RME reprocessed.

The VISN and Medical Center Directors concurred with the findings and recommendation. SOPs for all pieces of RME being processed have been placed in the reprocessing area and are being maintained on an ongoing basis. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 10 We recommended that the VISN Director ensure that the Medical Center Director requires that annual competencies for flash sterilizers are evaluated and documented.

The VISN and Medical Center Directors concurred with the finding and recommendation. A flash sterilization competency was developed for OR RNs, initial verifications have been completed, and competencies will be reviewed annually. The corrective actions are acceptable, and we consider this recommendation closed.

Review Activity Without 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]

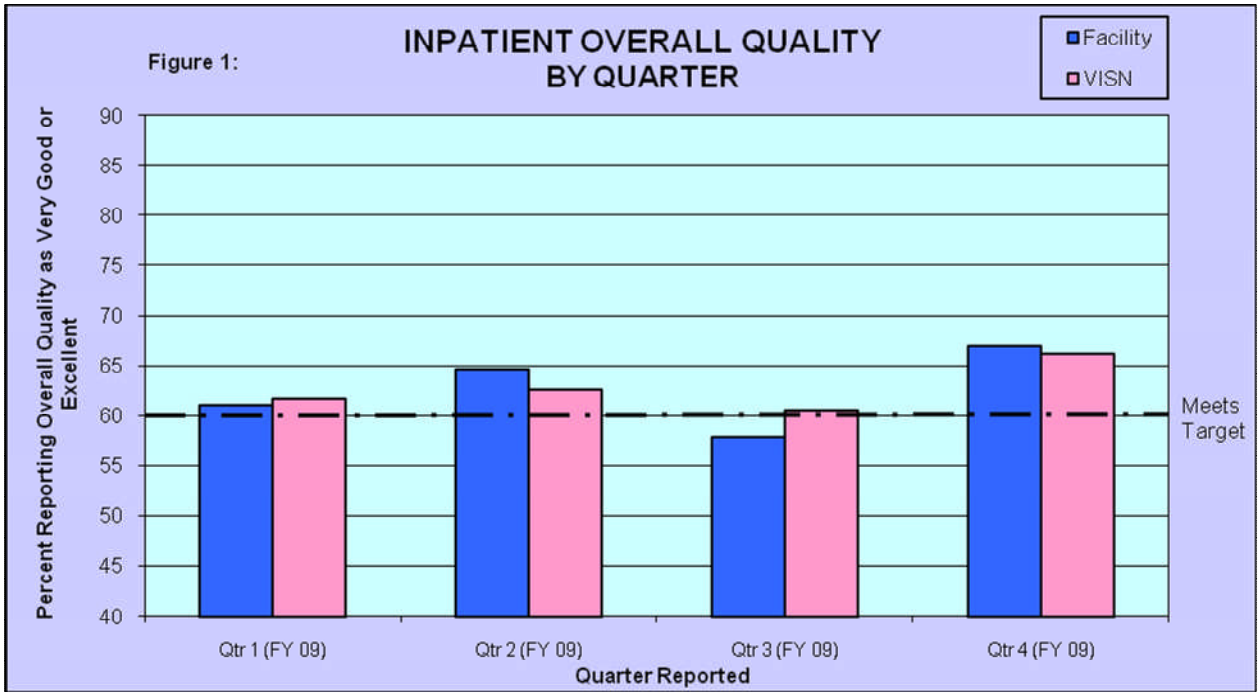
A previous OIG review of suicide prevention programs in VHA facilities[13] found a 74 percent compliance rate with safety plan development. The safety plan issues identified in that review were that plans were not comprehensive (did not contain the above elements), were not developed timely, or were not developed at all. At the request of VHA, the OIG agreed to follow up on the prior findings.

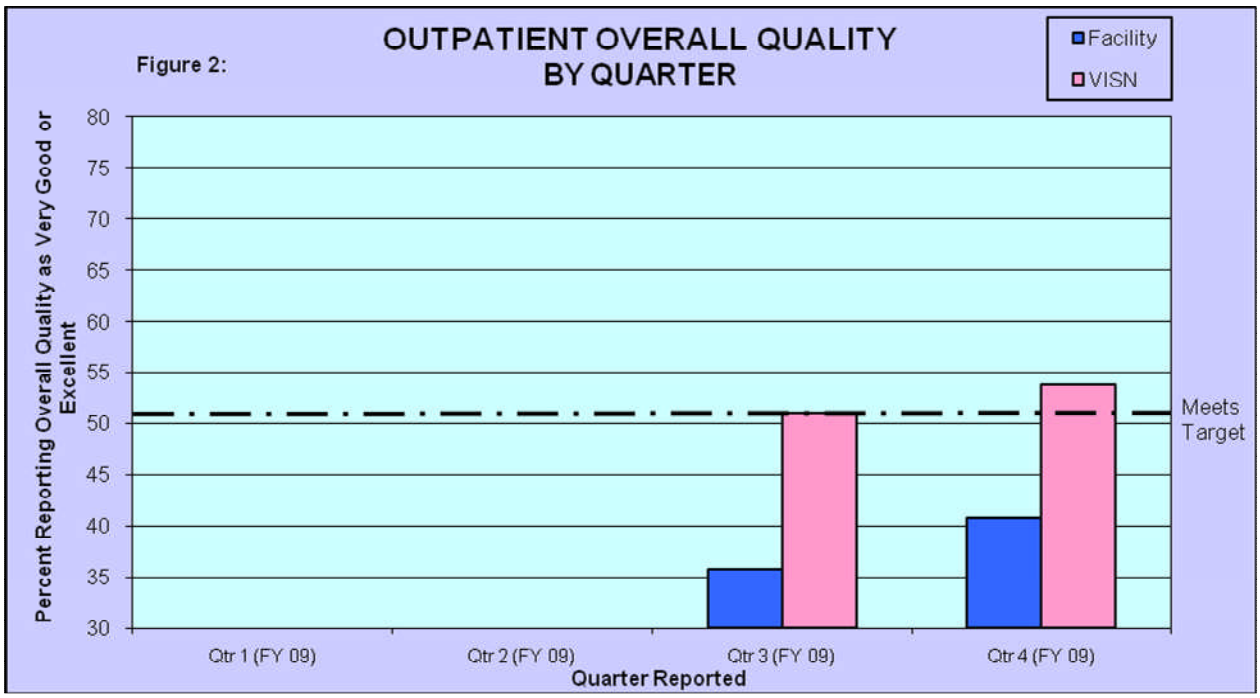
We reviewed the medical records of 10 patients assessed to be at high risk for suicide and found that clinicians had developed timely safety plans that included all required elements. We also found evidence to support that the patients and their families participated in the development of the plans.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

VHA Satisfaction Surveys

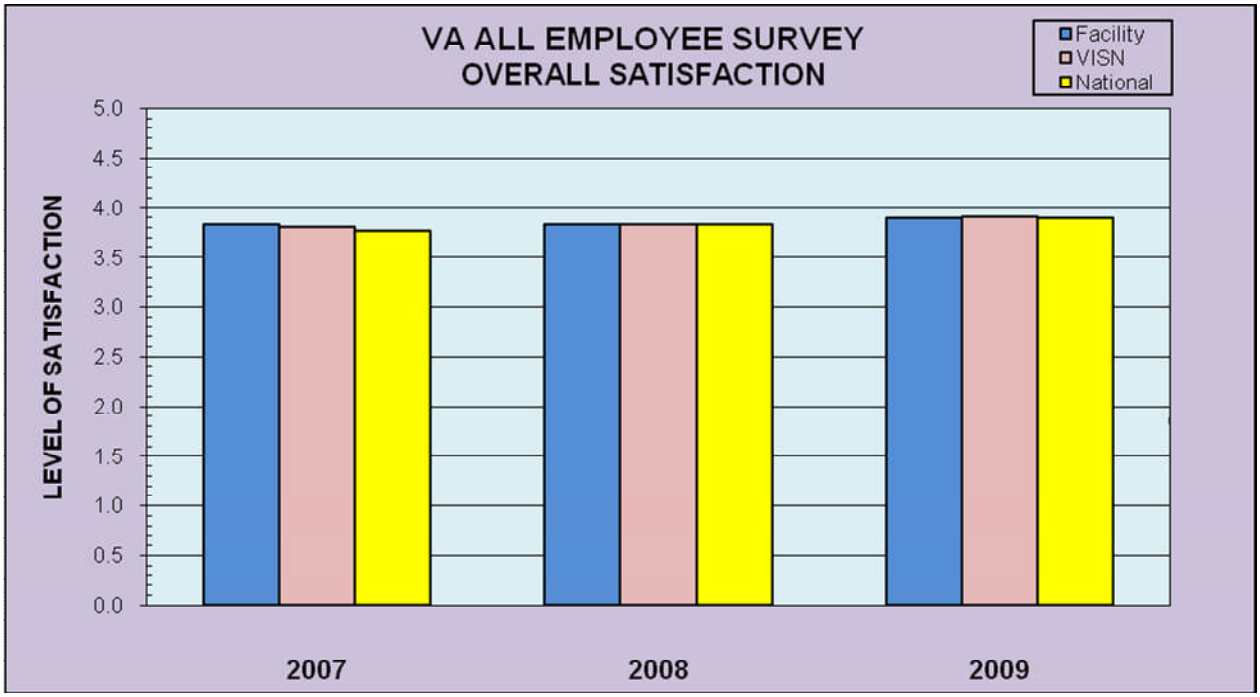
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 on the next page shows the medical center's and VISN's overall inpatient satisfaction scores for quarters 1–4 of FY 2009. Figure 2 on the next page shows the medical center's and VISN's overall outpatient satisfaction scores for quarters 3 and 4 of FY 2009.[14] 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] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009;* Report No. 09-00326-223; September 22, 2009.
[14] 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 medical center'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: April 21, 2010

From: Director, South Central VA Health Care Network (10N16)

Subject: **Combined Assessment Program Review of the Michael E. DeBakey VA Medical Center, Houston, Texas**

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

Director, Management Review Service (10B5)

1. Enclosed is the response to the report. I concur with the recommendations and the responses.

2. If you have any questions regarding the report, please contact Mary Jones, HSS, at 601-206-6974.

George H. Gray, Jr.

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: **April 16, 2010**

From: Director, Michael E. DeBakey VA Medical Center (580/00)

Subject: **Combined Assessment Program Review of the Michael E. DeBakey VA Medical Center, Houston, Texas**

To: Director, South Central VA Health Care Network (10N16)

I have reviewed the report and concur with the recommendations. Action plans have been implemented to comply with the recommendations.

Adam Walmus

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires designated clinical staff to comply with CPR and ACLS education requirements.

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

Facility Response: The CPR Policy is being revised to more clearly define which staff is required to complete ACLS training by specific job function. Mechanisms to ensure staff compliance with CPR and ACLS, including employee counseling, have been established. Employee counseling has been instituted for those employees who are not current with CPR. Monthly monitoring will be conducted with reporting to senior leadership.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that physician C&P processes are in compliance with VHA requirements for FPPE and OPPE.

Concur **Target Completion Date: Completed**

Facility Response: Service-specific criteria for FPPE and OPPE have been developed and approved by the CEB. A mechanism for monthly review and tracking of the FPPEs and OPPEs by the Credentialing and Clinical Privileging Subcommittee was initiated in February 2010. Reports of subcommittee will be presented to the CEB.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires the identified EOC rounds attendance, safety, environmental hazards training, infection control, and respirator fit testing and training concerns to be corrected.

Concur **Target Completion Date: Noted in each subsection below**

Facility Response:

EOC Rounds – A process has been established to maintain attendance records for the EOC rounds. **Completed**

Safety – A process has been established to track documentation of staff participation in fire drills with timely submission of the documentation to the Safety Office. Fire drill participation will be monitored through the Patient Safety and Environment of Care Board. **Completed**

Environmental Hazards Training – Effective February 1, 2010, a process has been established to ensure orientation and annual environmental hazard training of housekeeping staff on an ongoing basis. **Completed**

Infection Control – Staff was re-inserviced during the OIG review on cleansing and disinfection of glucometers after each use and appropriate infection control practices for patients in isolation. Additionally, a competency for cleaning of glucometers was developed and completed for all nursing staff in patient care areas by February 12, 2010. **Completed**

Infection Control – Staff in hemodialysis implemented the practice of wearing gloves when touching external surfaces of the hemodialysis machines when in use as part of the department's SOP. **Completed**

Infection Control – A process for routine inspection and obtaining repair of damaged surfaces of patient care equipment, wheelchairs, and geri chairs, has been developed. All appropriate staff have been educated on this process through broadcast messages and other venues. **Completed**

Infection Control – A process has been put in place to identify staff who need to have respirator fit testing. Currently training is being done for all previously identified staff. A tracking process has been developed to ensure consistent annual fit testing and training. **April 30, 2010**

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires staff to complete inter-facility patient transfer documentation and implement processes to monitor and evaluate transfers.

Concur **Target Completion Date: May 15, 2010**

Facility Response: The Inter-facility Transfer Policy has been revised to clearly outline the requirements for inter-facility transfers. Use of the electronic inter-facility documentation template has been initiated, and all appropriate staff will be educated on the process. Inter-facility transfers will be monitored and reported to the Utilization Management Committee and subsequently to the CEB as part of the facility's QM program.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that clinicians and providers adhere to medication ordering, dispensing, and administration requirements in accordance with medical center policy.

Concur **Target Completion Date: Completed**

Facility Response: Effective February 9, 2010, a Licensed Independent Practioner writes a prescription for ESAs for hemodialysis patients seen in the outpatient dialysis clinic. The prescription is sent to pharmacy where the order is reviewed and entered into the outpatient medication profile. The medication is then dispensed to the hemodialysis unit on a weekly basis. VA Form 10-2638, Controlled Substance Administration Record, is used to sign out and document use of the ESAs in the hemodialysis unit. These records are utilized for retrospective drug accountability review. Upon giving the medication, the medication is documented in the dialysis flow sheet and in the controlled medication/treatment record. These documents are scanned into the patient's electronic medical record. If the medication dose is adjusted, a new prescription is written.

A clinical pharmacist attends the monthly hemodialysis multidisciplinary meeting to review patients receiving hemodialysis. A multidisciplinary hemodialysis treatment progress note is documented in the patient's electronic medical record.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that clinicians consistently document all required influenza vaccination elements.

Concur **Target Completion Date: Completed**

Facility Response: Changes were immediately made to the influenza CPRS documentation template to include the manufacturer and the CDC Vaccine Information Sheet. The revised template was distributed to all nursing staff, and all staff were inserviced on the changes in the template and the VHA Influenza Immunization Policy 2009-2010.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that staff who have access to the MRI area receive initial and annual MRI safety training.

Concur **Target Completion Date: Completed**

Facility Response: Staff who have access to the MRI areas have received initial MRI safety training, and a process has been established to ensure initial and annual training.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires that PPE is properly donned by anyone entering the RME decontamination area.

Concur **Target Completion Date: Completed**

Facility Response: Staff has been re-inserviced on the requirements for PPE in the decontamination area. Ongoing monitoring is being conducted.

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director requires that SOPs are located in the SPD decontamination area for all RME reprocessed.

Concur **Target Completion Date: Completed**

Facility Response: SOPs for all RMEs being processed were immediately placed in the reprocessing area and are being maintained in the area on an ongoing basis.

Recommendation 10. We recommended that the VISN Director ensure that the Medical Center Director requires that annual competencies for flash sterilizers are evaluated and documented.

Concur **Target Completion Date: Completed**

Facility Response: A flash sterilization competency was developed for the OR nurses, and initial competency verification has been completed for all of the OR nurses. This will be done on an annual basis.

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