Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 09-03276-154

Combined Assessment Program Review of the Aleda E. Lutz VA Medical Center Saginaw, Michigan

May 18, 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 March 15–19, 2010, the OIG conducted a Combined Assessment Program (CAP) review of the Aleda E. Lutz VA Medical Center (the medical center), Saginaw, MI. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 315 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 11.

Results of the Review

The CAP review covered seven operational activities. We made recommendations in six of the activities reviewed. For these activities, the medical center needed to:

- Update medical center policy to include the actions to be taken when life support certification expires.
- Correct identified food safety, Occupational Safety and Health Administration (OSHA) bloodborne pathogens training, and environment of care (EOC) rounds concerns.
- Ensure that staff notate patient receipt of discharge instructions, in accordance with medical center policy.
- Complete inter-facility transfer documentation and implement processes to monitor and evaluate transfers.
- Ensure that clinicians consistently document all required influenza vaccination elements.
- Ensure that patients receive copies of their safety plans, as required by Veterans Health Administration (VHA) policy.
- Ensure that reusable medical equipment (RME) standard operating procedures (SOPs) are located in the areas where reprocessing occurs.
- Maintain humidity in the Supply, Processing, and Distribution (SPD) sterile storage area in accordance with VHA policy.
- Correct identified environmental deficiencies in the SPD decontamination and preparation areas.
- Require Material Safety Data Sheets (MSDS) to be available to employees in the ambulatory surgery reprocessing areas.

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

- Physician Credentialing and Privileging (C&P)

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 14–19 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 non-tertiary facility located in Saginaw, MI, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five community based outpatient clinics in Alpena, Clare, Gaylord, Oscoda, and Traverse City, MI. The medical center is part of VISN 11 and serves a veteran population of about 167,900 throughout 35 counties in Michigan.

Programs. The medical center provides primary and secondary medical services, ambulatory surgical services, and outpatient social work, psychology, and psychiatric services. Health care is provided in the areas of medicine, surgery, psychiatry, physical medicine, rehabilitation, dentistry, geriatrics, and extended care. The medical center has 33 hospital beds and 81 community living center (CLC) beds.

Affiliations. The medical center is affiliated with Michigan State University's College of Human Medicine and with Synergy Medical Education Alliance. Training is provided for five residents each month. The medical center also provides training for other disciplines, including nursing and occupational therapy.

Resources. In fiscal year (FY) 2009, medical care expenditures totaled $120.7 million. The FY 2010 medical care budget is $136.7 million. FY 2009 staffing was 823 full-time employee equivalents (FTE), including 40 physician and 272 nursing FTE.

Workload. In FY 2009, the medical center treated 27,459 unique patients and provided 3,321 inpatient days in the hospital and 19,669 inpatient days in the CLC. The inpatient care workload totaled 960 hospital discharges and 484 CLC discharges. The average daily census, including CLC patients, was 63. Outpatient workload totaled 247,788 visits.

Objectives and Scope

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following seven activities:

- Coordination of Care
- EOC
- Medication Management
- Physician C&P
- QM Program
- RME
- Suicide Prevention Safety Plans

The review covered medical center operations for FY 2009 and FY 2010 through March 15, 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 Aleda E. Lutz VA Medical Center, Saginaw, Michigan,* Report No. 07-01229-165, July 11, 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 315 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.

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 patient care and whether senior managers actively supported the program's activities. We interviewed the medical center's Director, the Acting Chief of Staff, the QM Chief, and key staff. We evaluated plans, policies, performance improvement (PI) data, and other relevant documents.

The QM program was generally effective in providing oversight of the medical center's quality of care, and senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. We identified one area that needed improvement.

Life Support Training. Medical center policy defines which staff are required to maintain current Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS) certifications. All staff required to maintain BLS and ACLS certifications were compliant with the policy. However, medical center policy did not specify actions to be taken when designated life support training is not maintained.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that medical center policy is updated to include the actions to be taken when life support certification expires.

The VISN and Medical Center Directors concurred with the finding and recommendation. Medical center policy has been updated to include the consequences for failing to maintain BLS and ACLS certification. 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, OSHA, National Fire Protection Association, and Joint Commission (JC) standards.

We conducted onsite inspections of two CLC units, the acute medicine unit, the intensive care unit, the emergency department, the specialty clinic area, and four primary care clinics. The medical center maintained a generally clean and safe environment. Managers were responsive to concerns identified during the inspection. We identified the following areas that needed improvement.

Food Safety. As a follow-up from our prior CAP review, we conducted an inspection of the Veterans Canteen Service's food service and storage areas. Deficiencies identified during the prior CAP review had been corrected. However, we identified potential food safety concerns due to improper monitoring and recording of refrigerator and freezer temperatures. We noted that a refrigerator was consistently documented to be colder than the acceptable temperature range. There was no evidence that this problem was addressed. We also noted that a refrigerated case was warmer than acceptable and that there was no temperature log for the case. Employees had not recognized the problem or initiated corrective action. Additionally, we noted that employees were documenting freezer temperatures on a refrigerator temperature log. Because the log noted an acceptable refrigerator temperature range, there was potential that employees would not recognize whether the freezer temperature was problematic.

OSHA Bloodborne Pathogens Training. Designated employees are required to complete initial and annual bloodborne pathogens training. We reviewed calendar year 2009 training records for 10 clinical staff and all housekeeping employees from two patient care areas. We found that all 10 clinical staff completed the training in 2009. However, only 19 (83 percent) of 23 housekeeping employees completed the training.

EOC Rounds. VHA policy[1] requires the Director or the Associate Director to lead weekly EOC rounds. Participants should include managers in nursing, building management, engineering, safety, patient safety, infection control, and information security. We reviewed weekly EOC rounds attendance rosters and noted that rounds did not include all required participants or, in their absence, a designee.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires the identified food safety, OSHA bloodborne pathogens training, and EOC rounds concerns to be corrected.

The VISN and Medical Center Directors concurred with the findings and recommendation. An improperly working thermometer was replaced, a temperature log was implemented for one refrigerated case, and the freezer log forms were replaced. Staff have been educated on temperature monitoring. All designated staff have completed the bloodborne training module, and monthly reports will be generated to ensure completion of mandatory training. All EOC rounds will include required participants or appropriate designees. The corrective actions are acceptable, and we consider this recommendation closed.

Coordination of Care

The purpose of this review was to evaluate whether inter-facility patient transfers and discharges were appropriately coordinated 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[2] 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 information. Also, we found that follow-up appointments occurred within the timeframes specified. However, we identified the following areas that needed improvement.

[1] Deputy Under Secretary for Health for Operations and Management, "Environmental Rounds," memorandum, March 5, 2007.
[2] VHA Handbook 1907.01, *Health Information Management and Heath Records,* August 25, 2006.

Discharge Instructions. Medical center policy requires that the medical record is documented when discharge instructions are given to the patient or designee. We reviewed the medical records of 10 discharged patients. For 9 (90 percent) of the 10 patients, we did not find documentation indicating that the patients or their designees received copies of discharge instructions.

Inter-Facility Patient Transfers. VHA policy[3] 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. Medical center policy requires the use of the VISN 11 inter-facility transfer template to document the required elements of the transfer process.

We reviewed transfer documentation for 10 patients transferred from the medical center to other facilities. We found that providers did not utilize the required template for 4 (40 percent) of the 10 patients. Additionally, we did not find evidence that patient transfers were monitored and evaluated as part of the QM program.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires staff to notate patient receipt of discharge instructions in accordance with medical center policy.

The VISN and Medical Center Directors concurred with the finding and recommendation. Medical center policy has been amended. Staff will be required to provide education and review discharge instructions with the patients or their caregivers. The corrective action is acceptable, and we consider this recommendation closed.

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. Medical center policy was amended to require use of the VA inter-facility transfer forms. Daily monitoring of inter-facility transfer documentation has

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

been initiated. Any fallouts are sent daily to service chiefs for follow-up and action. Monitoring and evaluation results will be reviewed at monthly Quality Executive Board meetings. The corrective actions are 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. We identified the following area that needed improvement.

CLC Influenza Vaccinations. VHA policy[4] requires that several items be documented for each influenza vaccine 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. According to the medical records, the vaccination was medically contraindicated for one patient, and two patients refused the vaccination. For the remaining seven patients who received the vaccination, the manufacturer and the Vaccine Information Statement edition date were omitted in the medical record documentation. Additionally, in one of the seven records, the lot number was omitted.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires that clinicians consistently document all required influenza vaccine elements.

The VISN and Medical Center Directors concurred with the findings and recommendation. Required elements have been added to documentation templates. The corrective action is acceptable, and we consider this recommendation closed.

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.

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

Safety plans must also include information about how patients can access professional help 24 hours a day, 7 days a week.[5]

A previous OIG review of suicide prevention programs in VHA facilities[6] 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 identified the following area that needed improvement.

Safety Plan Receipt. VHA requires that clinicians ensure that high-risk patients receive copies of their safety plans. We reviewed the medical records of 10 high-risk patients and found that 4 (40 percent) records did not include safety plan receipt affirmation.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires that patients receive copies of their safety plans, as required by VHA policy.

The VISN and Medical Center Directors concurred with the finding and recommendation. The mental health clinic safety plan note template was revised to include safety plan discussion and provision. The Suicide Prevention Coordinator will monitor all high-risk patient records to ensure completion of safety plans. 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[7] 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

[5] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
[6] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009;* Report No. 09-00326-223; September 22, 2009.
[7] The process of cleaning, disinfecting, and/or sterilizing RME.

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

We inspected the SPD area and ambulatory surgery reprocessing areas. We determined that the medical center had established appropriate guidelines and monitored compliance. Annual employee competencies and training were current and consistently documented. However, we identified the following areas that needed improvement.

SOPs. VHA requires[8] that device-specific SOPs for the setup and reprocessing of RME are posted in any area where these devices are reprocessed. We reviewed six pieces of RME to determine whether reprocessing was being conducted in accordance with the medical center's SOPs and manufacturers' guidelines. Reprocessing was being conducted in accordance with SOPs and guidelines. However, during our inspection of the SPD decontamination area, we found that the dental tray and cassette SOP was not present for staff reference.

Environment. VA requires[9] humidity in SPD sterile storage areas to be maintained between 35 and 75 percent. We inspected the SPD sterile storage area and noted that the humidity was at 29 percent. Humidity is monitored electronically every 15 minutes. We reviewed humidity log readings for February 17–March 17, 2010, and found documentation that 2,638 (97 percent) of 2,724 readings were not in the required range.

We observed penetrated ceiling tiles in the SPD decontamination and preparation areas. Additionally, a rusted vent was located above the sink in the SPD decontamination area.

Safety. VHA policy also requires MSDS to be accessible in designated work areas where employees are using chemicals, such as decontamination areas. We found that MSDS were not kept in the ambulatory surgery reprocessing areas.

[8] VHA Directive 2009–004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.
[9] VA Handbook 7176, *Supply, Processing, and Distribution (SPD) Operational Requirements,* August 16, 2002.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires that RME SOPs are located in the areas where reprocessing occurs.

The VISN and Medical Center Directors concurred with the finding and recommendation. RME SOPs were relocated to the reprocessing areas. The corrective action is acceptable, and we consider this recommendation closed.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires that humidity in the SPD sterile storage area is maintained in accordance with VHA policy.

The VISN and Medical Center Directors concurred with the findings and recommendation. A non-recurring maintenance project has been approved to redesign the SPD heating, ventilation, and air conditioning system. The planned completion date is September 2011. In the interim, staff will monitor SPD humidity levels and utilize portable humidifiers. 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 the identified environmental deficiencies in the SPD decontamination and preparation areas to be corrected.

The VISN and Medical Center Directors concurred with the findings and recommendation. Penetrated ceiling tiles and rusted vents have been replaced. 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 MSDS to be available to employees in the ambulatory surgery reprocessing areas.

The VISN and Medical Center Directors concurred with the finding and recommendation. MSDS books were placed in the ambulatory surgery reprocessing areas. The corrective action is acceptable, and we consider this recommendation closed.

Review Activity Without Recommendations

Physician Credentialing and Privileging

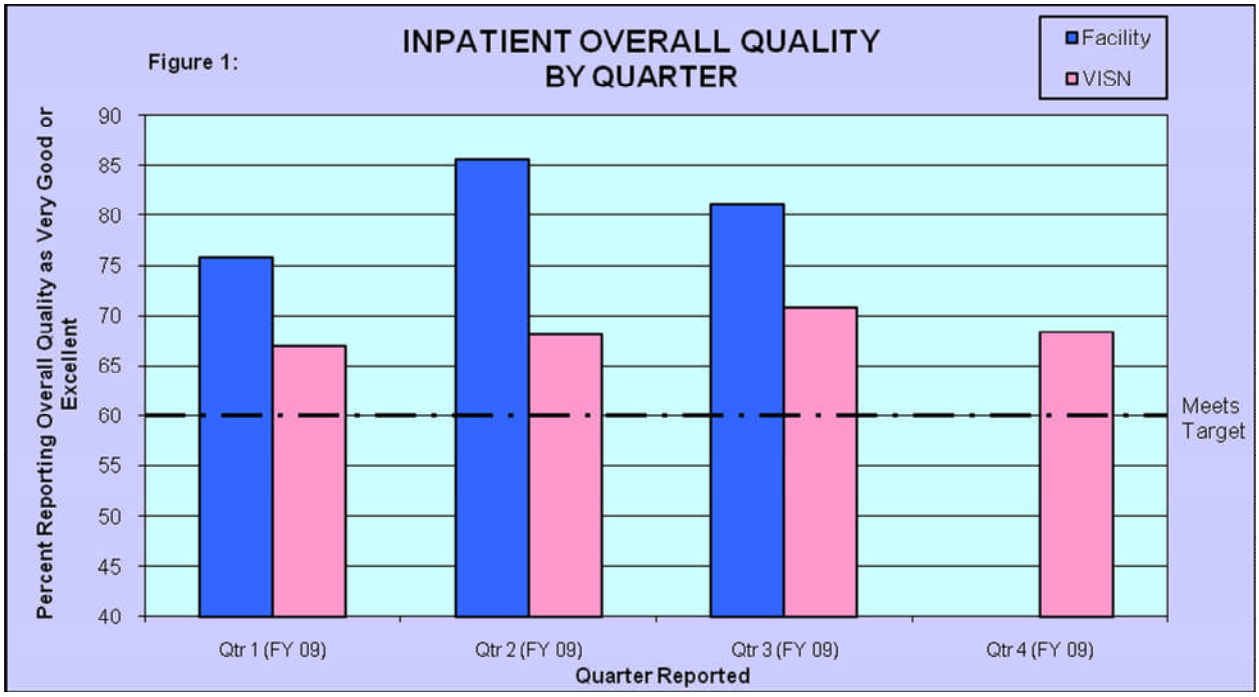
The purpose of this review was to determine whether VHA facilities have consistent processes for physician C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and physician profiles.[10] We also reviewed meeting minutes during which discussions about the physicians took place.

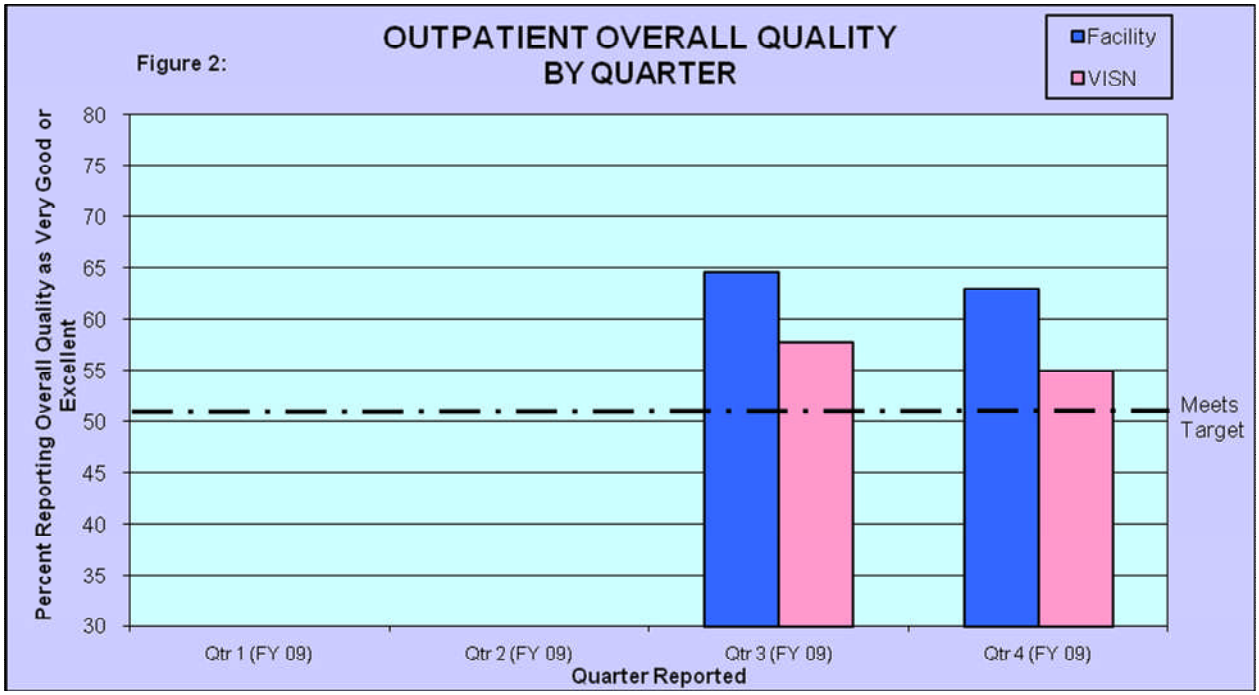
We reviewed 10 C&P files and profiles and found that licenses were current and that primary source verification had been obtained. Focused Professional Practice Evaluation was appropriately implemented for newly hired physicians. Service-specific criteria for Ongoing Professional Practice Evaluation had been developed and approved. We found sufficient performance data to meet current requirements. Meeting minutes consistently documented thorough discussions of the physicians' privileges and performance data prior to recommending renewal of or initial requested privileges. We made no recommendations.

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.[11] 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.[12] The target scores are noted on the graphs.

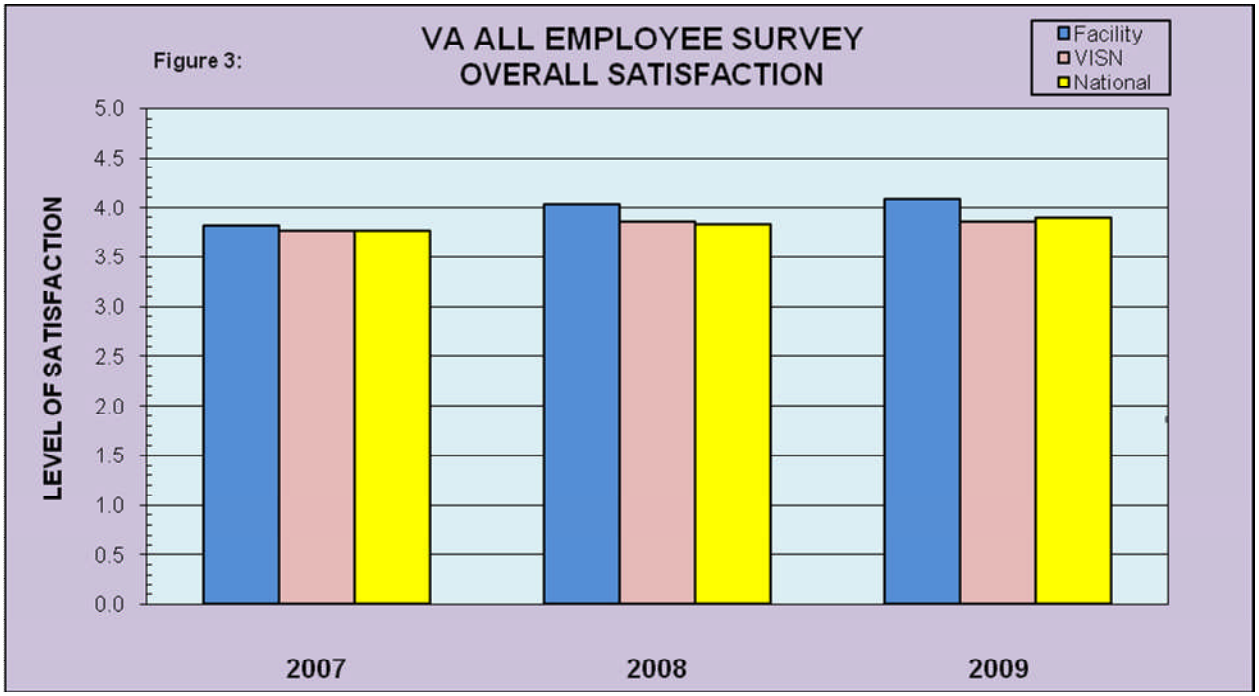
[10] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[11] Data for the medical center's inpatient satisfaction score for quarter 4 of FY 2009 was not available.
[12] Due to technical difficulties with VHA's outpatient survey data, outpatient satisfaction scores for quarters 1 and 2 of FY 2009 are not included for comparison.





Employees are surveyed annually. Figure 3 on the next page shows the 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.

Figure 3:


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 28, 2010

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

Subject: **Combined Assessment Program Review of the Aleda E. Lutz VA Medical Center, Saginaw, Michigan**

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

Director, Management Review Service (10B5)

Per your request, attached is the response to the CAP review draft report from Saginaw.

If you have any questions please contact Jim Rice, VISN 11 QMO, at (734) 222-4314.

Michael S. Finegan

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 26, 2010

From: Director, Aleda E. Lutz VA Medical Center (655/00)

Subject: **Combined Assessment Program Review of the Aleda E. Lutz VA Medical Center, Saginaw, Michigan**

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

1. We appreciate the opportunity to review the draft report of the CAP review completed March 15–19, 2010, for the Aleda E. Lutz VA Medical Center in Saginaw, Michigan.

2. Attached are comments regarding actions taken to complete identified items and those that are currently in process to improve and resolve non-compliance in areas cited. Many of the cited areas were resolved during the time of the audit.

3. It should be noted that the IG Team Leader and Team that conducted the audit did it in a very professional and collegial manner that lent the site visit to be a truly productive one for the VA.

4. If you have any questions regarding the content of this report, please contact me at (989) 497-2500, extension 13000.

DENISE M. DEITZEN

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 that medical center policy is updated to include the actions to be taken when life support certification expires.

Concur **Target Completion Date: Completed**

Facility Response: Medical Center Memorandum 11-5, "Code Blue Emergency Response" was updated to include the consequences of failing to maintain the required ACLS and BLS certification. An amendment to policy was made on March 25, 2010, stating, "Failure to maintain current certification in either ACLS or BLS may be grounds for disciplinary action and/or suspension of privileges/scopes of practice or reassignment. Service chiefs and supervisors are responsible for initiating appropriate actions." Monthly reports are pulled, and fallouts are communicated to the service chief for appropriate action and shared with the senior leadership and the Leadership/Performance Improvement Board entitled "Quality Executive Board."

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires the identified food safety, OSHA bloodborne pathogens training, and EOC round concerns to be corrected.

Concur **Target Completion Date: Completed**

Facility Response: Food Safety: 1-Improperly working thermometer was replaced, and staff were educated on steps to complete when temperatures are found to be out of range. 2-Temperature log was implemented on day of the finding for the refrigerator. 3-Correct form replaced for monitoring the freezer temperatures, and staff educated on steps to take if found to be out of range. **OSHA Training:** All designated staff have completed the bloodborne training module as of March 17, 2010. Department Automated Data Processing Application Coordinator is now pulling monthly reports to ensure all designated employees have completed mandatory training. **EOC Rounds:** All EOC rounds will include required participants. If required staff are not present to start rounds, the Safety Manager will call for an appropriate designee prior to starting.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires staff to notate patient receipt of discharge instructions in accordance with medical center policy.

Concur **Target Completion Date: May 13, 2010**

Facility Response: Medical Center Memorandum 122-6, "Discharge Planning" will be amended to reflect practice: "Staff will provide education and review discharge instructions with patient/caregiver."

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: Completed**

Facility Response: Medical Center Memorandum 136-55, "Inter-Facility Transfers and Referrals" was amended on March 18, 2010, to include "The VISN 11 VA Medical Center Inter-facility Transfer Form, VA forms 10-2649A and 10-2649B are to be used when transferring a patient to a VA or non-VA facility, and will be accompanied by a discharge summary, and any other pertinent information." Due to our medical center identifying issues with compliance prior to survey, daily monitoring and evaluation of compliance was established on January 14, 2010. All fallouts are sent daily to the appropriate service chief for follow-up and action. Education was given to the providers, nurses, and Patient Administration staff on March 23, 2010. Monitoring and evaluation results are reviewed by the Leadership/Performance Improvement Board entitled "Quality Executive Board" monthly as of April 13, 2010.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that clinicians consistently document all required influenza vaccine elements.

Concur **Target Completion Date: Completed**

Facility Response: The required missing elements of "vaccine manufacturer and CDC and Prevention VIS edition date" were added to the Nursing/Influenza Immunization Inpatient and Nursing/Influenza Outpatient Clinical Reminders on March 16, 2010.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that patients receive copies of their safety plans, as required by VHA policy.

Concur **Target Completion Date: Completed**

Facility Response: The MHC Safety Plan Note was updated on March 17, 2010, to include, "The plan was discussed with the patient and a copy of the note was given to the patient." The SPC monitors all high-risk patient records to ensure completion of safety plans. Data is reported to Prevention and Management of Disruptive Behavior Committee, Leadership Mental Health Committee, and at staff meetings.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that RME SOPs are located in the areas where reprocessing occurs.

Concur **Target Completion Date: Completed**

Facility Response: RME SOPs were relocated to the areas where reprocessing occurs while the surveyor was in the room on the day of the finding.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires that humidity in the SPD sterile storage area is maintained in accordance with VHA policy.

Concur **Target Completion Date: September 2011**

Facility Response: Non-recurring Maintenance Project Number: 655-10-104 titled "Basement Building #1 HVAC System" has been submitted. The Scope of Work includes total redesign of the SPD HVAC System and replacement of existing ceiling. Design phase is to be completed by March 1, 2011. Construction is to be completed in September 2011. In the interim, the facility will continue to monitor the humidity levels in the storage area and utilize portable humidifiers to increase the humidity level.

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director requires the identified environmental deficiencies in the SPD decontamination and preparation areas to be corrected.

Concur **Target Completion Date: Completed**

Facility Response: Penetrated ceiling tiles have been corrected, and the rusted vents have been replaced in the SPD decontamination and preparation areas.

Recommendation 10. We recommended that the VISN Director ensure that the Medical Center Director requires MSDS to be available to employees in the ambulatory surgery reprocessing areas.

Concur **Target Completion Date: Completed**

Facility Response: MSDS books were placed in the decontamination and clean rooms of the ambulatory surgery reprocessing areas on March 18, 2010.

OIG Contact and Staff Acknowledgments

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Report Distribution

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U.S. House of Representatives: Dave Camp, Pete Hoekstra, Dale Kildee, Candice Miller, Bart Stupak

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