



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection Alleged Quality of Care Issues and Privacy Violations Battle Creek VA Medical Center Battle Creek, Michigan

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Executive Summary

The VA Office of Inspector General, Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding quality of care issues and privacy violations at the Battle Creek VA Medical Center in Battle Creek, Michigan.

We substantiated that an employee had an allergic reaction, and that epinephrine was administered incorrectly. Managers requested a review of the care that was given, and appropriate actions were taken.

We could not substantiate or refute that acts of patient neglect occurred. However, we did find that the medical center's policy for reporting incidents was not followed or enforced. We substantiated that unit nurses had not been trained or determined to be competent on all defibrillator functions. We determined that not all unit staff were compliant with the medical center's basic life support training requirement. We could not substantiate or refute that unit nurses improperly interpret cardiac rhythms. Not all required staff had documentation of telemetry interpretation training. We could not substantiate or refute that the current number and levels of unit nurse staffing or the care delivery system was insufficient. We did find that NAs are required to administer gastric tube feedings, and this requirement is authorized by medical center policy.

We could not substantiate or refute that employees violated Health Insurance Portability and Accountability Act standards or the VA Rules of Behavior. Managers did not follow Veterans Health Administration (VHA) or medical center policy regarding actions to be taken when presented allegations of inappropriate access of electronic medical records. We did not substantiate that unit patients are left in wheelchairs for prolonged periods of time or that this resulted in increased rates of skin breakdown or falls. We substantiated that the unit's hospital acquired pressure ulcer incident rate exceeded the target in 4 of 6 months from June through November 2009, but we couldn't determine if this was the result of patients being left in wheelchairs for prolonged periods of time.

We recommended that: (1) all allegations of abuse or neglect are reported and investigated in compliance with medical center policy, (2) staff receive training and are deemed competent for all functions of the LIFEPAK® 12 defibrillator, (3) all clinically active staff achieve and maintain basic life support certification, (4) a review of the current telemetry training process is conducted and managers ensure competency of all staff required to interpret cardiac rhythms, and (5) complaints of computer security or privacy violations are documented and investigated in compliance with VHA and medical center policy. The Veterans Integrated Service Network and Medical Center Directors concurred with the findings and recommendations. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

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

SUBJECT: Healthcare Inspection – Alleged Quality of Care Issues and Privacy Violations, Battle Creek VA Medical Center, Battle Creek, Michigan

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) conducted an inspection to determine the validity of allegations regarding quality of care issues and privacy violations at the Battle Creek VA Medical Center (the medical center) in Battle Creek, Michigan.

Background

The medical center provides tertiary psychiatric, primary and secondary medical, extended, and long-term care for veterans in the Western and Lower Peninsula of Michigan. The primary service area has a population of approximately 939,500 veterans. The medical center has 199 operating beds and provides specialized services, including palliative care, substance abuse, Post-Traumatic Stress Disorder treatment, and 23-hour observation for medical and psychiatric conditions. The medical center is part of Veterans Integrated Service Network (VISN) 11.

A complainant contacted the OIG hotline with multiple allegations related to quality of care, patient neglect, staff competency, and privacy violations on Unit 82-1. The unit is uniquely distinguished because it is a medical unit which is situated in a psychiatric hospital. Further, it is accentuated by its 4-bed medical emergency room which has equipment that can be used to treat and stabilize critically ill patients. Unit 82-1 provides remote cardiac telemetry, detoxification, and acute, intermediate, and palliative care services.

The allegations are as follows:

- An employee was incorrectly diagnosed and overdosed with epinephrine¹ during treatment for an allergic reaction. The physician was questioned by other clinicians regarding the ordered dose, but the medication was still administered. As a result, the employee suffered a cardiac event and was hospitalized.
- Unit patients have been subjected to various acts of patient neglect by staff, such as:
 - Ignoring patient care needs and signs of distress.
 - Delays in starting cardiopulmonary resuscitation (CPR).
 - Belligerence and apathy when asked to provide patient care services.
- Unit nurses do not know how to use the defibrillator.
- Unit nurses do not properly interpret cardiac rhythms.
- Unit staffing methodology and care delivery system are not effective for the patient population. There are deficiencies in providing appropriate assessments and interventions. The number and levels of nursing staff are not sufficient to provide safe care. Nursing Assistants (NAs) are assigned tasks beyond their scope of practice, such as administering gastric tube feedings.
- There are breaches in Health Information Portability and Accountability Act (HIPAA) rules, and employees are not compliant with the VA Rules of Behavior. Unauthorized clinical staff access and research confidential patient and employee medical records.
- Unit patients are subjected to extended periods of time in wheelchairs increasing their risk of skin breakdown and falls.

Scope and Methodology

In response to the OHI's initial notification and inquiry to the medical center regarding these allegations, we were informed by medical center management that an Administrative Investigative Board (AIB) had been charged with investigating similar issues and had completed their work, and an external peer review had been conducted. We reviewed the results of the AIB and external peer review and conducted an onsite inspection February 8–10, 2010, to clarify issues that we considered unresolved. We reviewed medical center policies, committee minutes, quality management data and documentation, and other applicable medical center documents. We interviewed employees and managers with knowledge of or the responsibility for administrative controls related to these allegations.

¹ Used chiefly as a heart stimulant to constrict the blood vessels, and to relax the bronchi in asthma.

We conducted the inspection in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

Issue 1: Emergency Treatment of an Employee

We substantiated that an employee had an allergic reaction, and that epinephrine was administered incorrectly.

In March 2009, an employee was taken to the medical center's Special Needs Room, which is located on the Unit 82-1, for treatment due to an allergic reaction after a suspected insect bite. It was alleged that the employee was incorrectly diagnosed. The medical record does not indicate a diagnosis; however, it details the event and treatments rendered. The community Emergency Medical Service (EMS) was notified and arrived at the medical center to assist. According to documentation, a medical center physician gave verbal orders to EMS personnel for Solumedrol® 125 milligrams (mg), Benadryl® 50 mg, and of 1 mg of epinephrine to be administered intravenously (IV) for emergency treatment. The medical record shows that an order was placed for "EPI-Pen 0.3mg/0.3 milliliters injector, inject 0.3mg IVP for anaphylactic reaction."² According to a statement from the EMS personnel involved in the incident, they questioned the medical center physician regarding the dose of epinephrine, and the order was confirmed. EMS personnel stopped administering the medication once approximately 0.3 mg had been administered, citing their operating procedures.

We substantiated that epinephrine should not have been administered by IV. Managers investigated the event and requested an external peer review to evaluate the treatment provided. Given the medical center's review, we consider this issue closed.

Issue 2: Patient Neglect

We could not substantiate or refute that acts of patient neglect occurred.

Managers charged an AIB to review allegations of neglect of two unit patients. In May, patient A was found unresponsive. There was a delay in initiating CPR because of confusion among the staff regarding the patient's "Do Not Resuscitate" status. In June, it was alleged that the registered nurse (RN) assigned to care for patient B failed to assist the patient when he required airway suctioning.

We reviewed testimony, supporting documentation, and the AIB findings and recommendations. The Medical Center Director approved staff training, process

² Emergency treatment for epinephrine given in this type of emergency would typically be given intramuscularly not IV.

changes, and other appropriate action but determined that there was insufficient evidence to support neglect.

After the AIB's conclusion, additional allegations regarding unit patient care were forwarded to medical center management. The unit nurse manager (NM) received a written complaint from a staff nurse alleging that a respiratory therapist questioned the physician when he ordered an arterial blood gas test. The NM forwarded the letter to the respiratory therapy supervisor. The unit NM told us that the respiratory therapist's response to the provider who ordered the test was unacceptable. The respiratory therapy supervisor discussed the letter of complaint with the respiratory therapist, and the respiratory therapist refuted the details. The provider who ordered the arterial blood gas test was interviewed and did not find the respiratory therapist's questions or actions offensive or inattentive. Therefore, no further action was taken.

A second allegation concerned a patient who was sitting in a wheelchair attempting to stand unassisted. A NA observed the patient's actions but left the patient alone and informed the RN that the patient was going to fall. The RN submitted a complaint to the unit NM that the NA failed to appropriately assist the patient. The unit NM acknowledged receiving the written complaint but noted that it was "many weeks" after the incident. Therefore, the unit NM did not pursue fact finding or an investigation. We were informed that the unit NM made an inquiry regarding the allegation after being informed of our visit.

During the course of this inspection, we received letters that were presented to medical center management that outlined allegations of neglect. We were informed in interviews that the letters were often written a substantial period of time after the alleged incidents.

Medical center policy requires that VA Form 10-2633, *Report of Special Incident Involving a Beneficiary*, be initiated without delay when a patient is involved in an incident that either has harmed or has the potential of causing harm. The Chief of Staff is responsible for reviewing the findings, and as indicated: (a) return to appropriate staff for further development of facts and clinical documentation, (b) recommend to the Medical Center Director further action to be taken, or (c) recommend no further action.

If staff observe a patient incident that harmed or had the potential to harm a patient it is their duty to report the incident that same day. Further, if managers receive written reports of patient neglect it is their responsibility to review the issue and determine if follow-up actions are needed.

Issue 3: Education

We substantiated that unit nurses had not been trained on all defibrillator functions.

Defibrillator Competency. The unit defibrillator is a LIFEPAK® 12 which has the ability to perform manual defibrillation and automated external defibrillation (AED). We found that a mandatory equipment review conducted during the spring of 2009 included AED function validation of the LIFEPAK 12. Per the equipment review documentation, 11 of the 19 RNs, 2 of the 5 Licensed Practical Nurses (LPNs), and 5 of the 10 NAs assigned to the unit were documented as competent for LIFEPAK 12 AED functionality. We inquired if nursing staff were required to demonstrate competency of the LIFEPAK 12 manual defibrillation feature. Managers reported that nurses do not receive training on the manual defibrillation functionality of the LIFEPAK 12. We determined that nursing staff do not have demonstrated competency on all functions of the LIFEPAK 12, creating a potential patient safety concern. Managers denied any unit incidents related to improper staff use of the LIFEPAK 12.

Basic Life Support Training. Medical center policy requires that all clinically active staff maintain evidence of Basic Life Support (BLS) training. This includes CPR and the use of public access AED. The medical center has also determined those clinical staff who are required to maintain Advanced Cardiac Life Support (ACLS) certification. ACLS includes CPR training, AED use, and manual defibrillation for lethal heart rhythms.

We reviewed the unit staff's competency folders. Managers reported that competencies are annually assessed and demonstrated. The following table shows the number and classification of nursing staff who have completed BLS with AED training.

Staff Classification	Number of FTEE	BLS with AED	Percent of Staff Compliant with BLS with AED Training Requirement
RNs	19	16	84
LPNs	5	5	100
NAs	10	8	80

Although ACLS is not a requirement for unit RNs, managers reported that nursing staff are encouraged to enhance their skills. Managers were considering making ACLS a requirement for all unit RNs.

We could not substantiate or refute that unit nurses improperly interpret cardiac rhythms.

Cardiac Rhythm Interpretation. Three unit RNs were current in ACLS which includes telemetry interpretation. Telemetry training is provided by medical staff and electronically using a Synquest® software program. Managers reported that the telemetry training dates for employees are entered into the VA Learning Management

System (LMS). LMS documentation shows that 9 (47 percent) of 19 RNs (including the NM) and 2 (40 percent) of 5 LPNs have current telemetry training. Managers informed us that LPNs are not responsible for cardiac interpretation at this time. We received LMS documentation for the American Heart Association Electrocardiography and Pharmacology course, and verified that 9 (47 percent) of 19 RNs completed this course in July 2009. Managers told us that this course is a mandatory training requirement and will be offered again in March 2010 for RNs who were unable to attend the first training date.

Managers were revising the Functional Statements for RNs to require ACLS certification. Managers have also approved the addition of one full-time employee (FTE) LPN to be dedicated to unit telemetry monitoring. Managers completed two internal reviews and documented a “near miss” related to monitors not being consistently observed; however, no incidents have been reported related to errors in cardiac rhythm interpretations.

Issue 4: Staffing

We could not substantiate or refute that the current number and levels of unit nurse staffing or the unit’s care delivery system was insufficient to provide safe care.

We reviewed the current unit staffing. The following table shows the authorized and filled FTE for the unit.

Current FTE Utilization		
Staff Classification	Number of Authorized FTE	Number of Filled FTE
NM	1	1
RNs	19	18
LPNs	5	5
NAs	11	10

Managers acknowledged that staffing has been a challenge, and active recruitment is ongoing. Managers also stated that they conducted staffing methodologies research and converted to “hours per patient day” to determine staffing needs based upon the unit’s patient complexity. Managers were also exploring the possibility of an intermittent nurse pool to fill voids during scheduled and unscheduled leave. Additionally, some NA positions were converted to RN positions to increase the unit staff capabilities. To address morale concerns related to involuntary overtime, compressed work schedules were being researched to determine impact on staffing.

NA Duties. It was alleged that NAs perform unit tasks that are beyond their skill set, such as administering gastric tube feedings. We reviewed the position description that is

unique for NAs assigned to this unit and found that the administration of tube feedings is listed as a responsibility. Additionally, medical center policy states that NAs are responsible for this task.

Issue 5: Privacy Violations

We could not substantiate or refute that employees violated HIPAA standards or the VA Rules of Behavior policy.

VA policy³ requires that employees report suspected or identified information security incidents (security and privacy) to the Information Security Officer (ISO), Privacy Officer (PO), and their immediate supervisors. Unauthorized access or misuse of VA systems or resources is strictly prohibited. According to medical center policy, a person who observes or discovers an actual or suspected security violation should complete a Report of Contact and forward it to the ISO. Information security incidents are events, whether suspected or proven, deliberate or inadvertent, that threaten the integrity, availability, or confidentiality of information systems. Medical center policy requires that the ISO monitor, document, investigate, and evaluate security incidents to ascertain trends and to recommend appropriate corrective actions. The ISO determines whether the incident is a true information security incident and whether or not it is reportable. If the incident is deemed a privacy violation, the PO leads an investigation of the incident with guidance from and collaboration with the ISO.

Automated Information System security incidents to be reported and tracked include unauthorized access, use, disclosure, or other misuse of data and issues affecting confidentiality, integrity, and availability of data. Individuals who have access to sensitive information are responsible for accessing the minimum necessary data for which they have authorized privileges and may access the information only on a need-to-know basis in the performance of official VA duties. VHA⁴ and medical center policy requires that all complaints regarding an individual's privacy are to be documented by the facility PO in the Privacy Violation Tracking System (PVTs) software program. The PO maintains a spreadsheet to document privacy violations. We reviewed the spreadsheet to determine whether the alleged unauthorized access was documented. There was no unauthorized access incidents listed on the spreadsheet. The ISO reported that he had informally investigated a privacy violation complaint. This informal investigation was not logged into the PVTs, contrary to medical center policy. We were unable to determine the extent to which the allegation was investigated.

We were informed that the ISO, PO, and the medical center's Chief Information Officer work collaboratively regarding information security matters. We noted that only substantiated breaches are reported in their meetings.

³ VA Handbook 6500, *Department of Veterans Affairs (VA) National Rules of Behavior*, September 18, 2007.

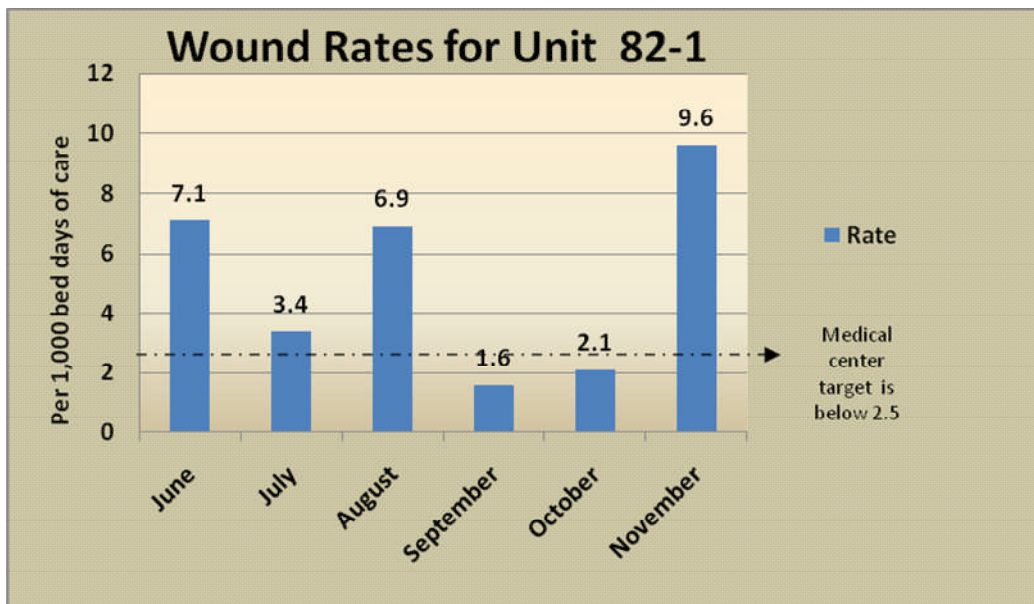
⁴ VHA Handbook 1605.3, *Privacy Compliance Assurance Program and Privacy Compliance Monitoring*, April 13, 2009.

We were also informed that training regarding privacy issues had occurred on the unit. LMS documentation shows that as of February 11, 2010, 97 percent of unit staff completed VA Privacy Awareness training. Additionally, the ISO informed us that an additional unit training session was conducted on February 10.

Issue 6: Practices Contributing to Skin Breakdown and Falls

We did not substantiate that unit patients are left in wheelchairs for prolonged periods of time resulting in higher incidences of skin breakdown and falls. We substantiated that the unit's hospital acquired pressure ulcer incident rate exceeded the target in 4 of 6 months from June through November 2009, but we couldn't determine if this was the result of patients being left in wheelchairs for prolonged periods of time.

Unit Skin Monitoring. The medical center's Skin Committee collects data on the number of hospital acquired pressure ulcers on each patient care unit. The following table depicts the rate per 1,000 bed days of care for hospital acquired pressure ulcers for the period of June–November 2009.



The medical center's hospital acquired pressure ulcer incidence rate was higher than the target in 4 of 6 months. We reviewed the Skin Committee minutes that document discussions of root causes, trends, and actions to address hospital acquired pressure ulcers. We did not find discussions that committee members attributed pressure ulcer incidence to prolonged time in wheelchairs. Daily skin assessments have been implemented at the committee's recommendation, and we were informed that there has been improvement in this unit's patient skin assessment. We were informed that the wound care nurse specialist generally conducts unit rounds on Fridays. However, due to time constraints related to collateral duties, her availability to educate and support unit staff and patients is limited.

Falls. We did not find an increase in patient falls for this unit. Fall data is trended quarterly and includes study of the day of the week, length of stay, time of day, and location of each fall. Managers initiated fall huddles, comprised of a team of staff, to investigate the reasons for patient falls and solicit feedback regarding the environment and ways to prevent future falls.

Conclusions

We substantiated that an employee had an allergic reaction, and that epinephrine was administered incorrectly. Managers requested a review of the care that was given, and appropriate actions were taken.

We could not substantiate or refute that acts of patient neglect occurred. However, we did find that the medical center's policy for reporting incidents was not followed or enforced by staff and managers. We substantiated that unit nurses had not been trained or determined to be competent on all defibrillator functions. Additionally, we determined that not all unit staff were compliant with the medical center's BLS training requirement. We could not substantiate or refute that unit nurses improperly interpret cardiac rhythms. Not all required staff had documentation of telemetry interpretation training.

We could not substantiate or refute that the current number and levels of unit nurse staffing or the care delivery system was insufficient to provide safe care. Managers have been actively recruiting and have converted some NA positions to RN positions. We did find that NAs are required to administer gastric tube feedings, and this requirement is authorized by medical center policy.

We could not substantiate or refute that employees violated HIPAA standards or the VA Rules of Behavior. Managers did not follow VHA or medical center policy regarding actions to be taken when presented allegations of inappropriate access of electronic medical records. We did not substantiate that unit patients are left in wheelchairs for prolonged periods of time or that this resulted in increased rates of skin breakdown or falls. We substantiated that the unit's hospital acquired pressure ulcer incident rate exceeded the target in 4 of 6 months from June through November 2009, but we couldn't determine if this was the result of patients being left in wheelchairs for prolonged periods of time.

Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires that allegations of abuse or neglect are reported and investigated in compliance with medical center policy.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that staff receive training and are deemed competent for all functions of the LIFEPAK 12 defibrillator.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that all clinically active staff achieve and maintain BLS certification.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires a review of the current telemetry training process and ensures competency of all staff required to interpret cardiac rhythms.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that complaints of computer security or privacy violations are documented and investigated in compliance with VHA and medical center policy.

Comments

The VISN and Medical Center Directors concurred with the findings and recommendations. (See Appendixes A and B, pages 11–15, for the Directors' comments). The implementation plans are acceptable, and 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

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: May 5, 2010

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

Subject: Healthcare Inspection – Alleged Quality of Care Issues and Privacy Violations, Battle Creek VA Medical Center, Battle Creek, Michigan

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

Director, Management Review Service (10B5)

Per your request, attached is the response to the draft report from Battle Creek.

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: May 5, 2010

From: Director, Battle Creek VA Medical Center (515/00)

Subject: **Healthcare Inspection – Alleged Quality of Care Issues and Privacy Violations, Battle Creek VA Medical Center, Battle Creek, Michigan**

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

I have participated in a conference call with the Healthcare Inspection Team and reviewed the draft report. I concur with the findings and recommendations and have implemented action plans to address the identified opportunities for improvement. The Healthcare Inspection Team was thorough and professional throughout the review process and I appreciate their feedback to the positive changes at the medical center which they affirmed are resonating among staff. Thank you.



SUZANNE M. KLINKER

Director's 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's report:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires that allegations of abuse or neglect are reported and investigated in compliance with medical center policy.

Concur

Target Completion Date: May 30, 2010

The VISN and Medical Center Directors concurred with the findings and recommendation. All medical center staff will be re-educated to the reporting requirements for allegations of patient abuse or neglect as well as the investigatory processes for these allegations as outlined in medical center policy. Compliance with completion of the training will be tracked in LMS. The Medical Center Director addressed reporting requirements and the investigatory process for allegations of patient abuse or neglect with all service chiefs at the Director's Staff Meeting held on April 10, 2010. The Medical Center Director also covered this same information at the medical center's town hall meeting on April 22, 2010. The town hall meeting is a communication venue with all employees.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that staff receive training and are deemed competent for all functions of the LIFEPAK 12 defibrillator.

Concur

Target Completion Date: June 30, 2010

The VISN and Medical Center Directors concurred with the findings and recommendation. Seventeen of the 20 acute medicine unit nursing personnel received simulated training with regard to the manual defibrillation and automated external defibrillation functions of the LIFEPAK 12 defibrillator during April 2010. This training was provided by nursing educators from a complexity level 1b sister VA facility in VISN 11. The Acute Medicine NM and a Nursing Education Specialist from the Battle Creek VA Medical Center will be trained and competency verified by nursing educators in the same sister facility so that these individuals can in turn train nursing staff members in the Battle Creek VA Medical Center. All nursing personnel on the acute medicine unit will

receive training on the manual defibrillation and AED functions of the LIFEPAK 12 defibrillator. Verification of these competencies will then occur annually during the mandatory equipment review and competency verification process. Compliance rate will be reported to the office of the Associate Director for Patient Care Services and documented in multiple facility-wide committees.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that all clinically active staff achieve and maintain BLS certification.

Concur

Target Completion Date: Completed

The VISN and Medical Center Directors concurred with the findings and recommendation. The medical center has established a tracking mechanism that assures BLS certification is achieved and maintained by all clinically active staff. The office of the Associate Director for Patient Care Services will coordinate the overall compliance and tracking. This compliance rate will be reported to facility leadership on a monthly basis.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires a review of the current telemetry training process and ensures competency of all staff required to interpret cardiac rhythms.

Concur

Target Completion Date: June 30, 2010

The VISN and Medical Center Directors concurred with the findings and recommendation. All but three RNs on the Acute Medicine Unit have received hands-on simulated telemetry training since July 2009. Two of the RNs who have not had the telemetry training on station are currently ACLS certified. These two RNs will be enrolled in the next telemetry class offered by our complexity level 1b sister VA facility in VISN 11. Accordingly, one RN was recently hired, is on orientation, and will be enrolled in the same telemetry course. Compliance with the mandatory training requirement will be documented, reviewed, and real time action will assure compliance. Maintenance will be assured by establishing a practice of providing the simulated telemetry training on a bi-annual sequence. As new nursing staff join the acute unit, an individualized plan will assure timely compliance. Compliance rate will be reported to the office of the Associate Director for Patient Care Services and documented in multiple facility-wide committees.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that complaints of computer security or privacy violations are documented and investigated in compliance with VHA and medical center policy.

Concur

Target Completion Date: Completed

The VISN and Medical Center Directors concurred with the findings and recommendation. All future suspected or identified information security incidents (security and privacy) will be investigated by the Facility Information Security Officer (FISO) and PO. Effective immediately, the FISO will evaluate all security incidents to determine if trends are occurring and recommend correction actions where appropriate. All complaints regarding an individual's privacy are now documented in the PPTS software program.

OIG Contact and Staff Acknowledgments

OIG Contact	Verena Briley-Hudson, MN, RN, Director Chicago Office of Healthcare Inspections (708) 202-2672
Acknowledgments	Jennifer Reed, RN-BC, Project Leader Judy Brown, Program Support Assistant Paula Chapman, CTRS Kathy Gudgell, JD, RN

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