Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-00049-169

Combined Assessment Program Review of the Chillicothe VA Medical Center Chillicothe, Ohio

June 10, 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 8–12, 2010, the OIG conducted a Combined Assessment Program (CAP) review of the Chillicothe VA Medical Center (the medical center), Chillicothe, OH. 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 304 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 10.

Results of the Review

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

- ArtSafe Program
- Patient Library

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

- Take measures to maintain the temperature and humidity in sterile storage areas at prescribed levels.
- Ensure that the television and table in the day room on the locked inpatient mental health (MH) unit are secured.
- Ensure that nursing management is consistently represented on environment of care (EOC) rounds.
- Ensure that hand hygiene monitoring data is reported to the Infection Control Committee (ICC) quarterly.
- Ensure that designated employees receive N95 respirator fit testing and that compliance is monitored.
- Ensure that locked inpatient MH unit employees and Multidisciplinary Safety Inspection Team (MSIT) members receive required annual training.
- Ensure that Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) comply with Veterans Health Administration (VHA) requirements.
- Ensure that designated employees maintain current Basic Life Support (BLS) training.

- Ensure that Medical Record Committee (MRC) functions adhere to VHA and local policy requirements.
- Require that staff complete inter-facility transfer documentation in accordance with VHA policy.

The medical center complied with selected standards in the following three activities:

- Magnetic Resonance Imaging (MRI) Safety
- Medication Management
- Suicide Prevention Safety Plans

This report was prepared under the direction of Carol Torczon, Associate Director, St. Petersburg 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 16–22 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 and long-term care facility located in Chillicothe, OH, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five community based outpatient clinics in Athens, Cambridge, Lancaster, Marietta, and Portsmouth, OH. The medical center is part of VISN 10, and serves a veteran population of about 34,900 throughout 18 counties in southeastern Ohio.

Programs. The medical center provides acute and chronic MH care, primary care, acute inpatient medical care, and long-term care. It has 135 hospital beds and 162 community living center (CLC) beds.

Affiliations. The medical center is affiliated with the Ohio State University College of Medicine, Ohio University's College of Osteopathic Medicine, and the University of Cincinnati College of Medicine. Training is provided for 264 residents and for students in other health care disciplines.

Resources. In fiscal year (FY) 2009, medical care expenditures totaled $179.9 million. The FY 2010 medical care budget is $154 million. FY 2009 staffing was 1,302 full-time employee equivalents (FTE), including 48 physician and 397 nursing FTE.

Workload. In FY 2009, the medical center treated 24,833 unique patients and provided 17,942 inpatient days in the hospital and 50,453 inpatient days in the CLC units. The inpatient care workload totaled 3,167 discharges, and the average daily census, including CLC patients, was 244. Outpatient workload totaled 285,402 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 Credentialing and Privileging (C&P)
- QM
- Reusable Medical Equipment (RME)
- Suicide Prevention Safety Plans

The review covered medical center operations for FY 2009 and FY 2010 through March 8, 2010, and was done in accordance with OIG standard operating procedures (SOPs) 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 Chillicothe VA Medical Center, Chillicothe, Ohio,* Report No. 06-03710-76, February 5, 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 to 304 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant

enough to be monitored by the OIG until corrective actions are implemented. Activities in the "Review Activities Without Recommendations" section have no findings requiring corrective action.

Organizational Strengths

ArtSafe Program

The ArtSafe program—a community program which began as a creative outlet for troubled adolescents then expanded to include long-term care residents—was brought to the medical center CLC through a local grant. Well-known local artists trained employees to assist CLC residents suffering from dementia with various forms of artistic expression.

The ArtSafe program has proven to have significant benefits for CLC residents. Several residents who generally did not communicate much were noted to be more engaged in communication and to have increased awareness of their surroundings. In addition, anxiety and confusion appeared to lessen for some residents while they were participating in the program.

Patient Library

Part of the cultural transformation in VA long-term care is to de-institutionalize the veteran's living environment. As a part of this process, the medical center refurbished the CLC patient library. The new library is an open, airy space designed to accommodate those with physical challenges yet maintain a comfortable, home-like environment. The library embraces information technology and has all types of multi-media resources available for CLC patients in a soothing but stimulating atmosphere.

Results

Review Activities With Recommendations

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 Supply, Processing, and Distribution (SPD) and satellite reprocessing areas are required to meet VHA, Association for the Advancement of Medical Instrumentation,

Occupational Safety and Health Administration (OSHA), and Joint Commission (JC) standards.

We inspected the SPD and gastrointestinal (GI) clinic areas. We determined that the medical center had established appropriate guidelines for reprocessing equipment and monitored compliance with those guidelines. For five pieces of RME, we reviewed the SOPs for reprocessing. In general, we found that SOPs were well developed and consistent with the manufacturers' instructions. Also, an employee was able to accurately demonstrate reprocessing procedures for two pieces of RME. We reviewed the competency folder and training records of the employee who demonstrated the reprocessing procedures and found that annual competencies and training were current and consistently documented.

VA requires[1] that only authorized personnel who are properly attired be allowed in the SPD area. We noted that access to the SPD supply and equipment storage area was not adequately controlled. While we were in the area, we observed non-SPD employees entering the sterile storage room without proper attire. While we were onsite, changes were made in procedure and signage, and access is now limited to SPD employees only. Any others requiring entry into the area now have to be accompanied by an SPD employee and don proper protective attire prior to entry. Therefore, we made no recommendation for this finding.

We found that SPD did not have an SOP or policy for cleaning and replacing brushes used to clean instruments prior to sterilization. An SOP was written and implemented, and SPD staff were educated on the new procedure while we were onsite; therefore, we made no recommendation for this finding.

We noted that an eyewash station in the SPD decontamination area did not have an adequate drainage system. We observed that when the water was turned on at the eyewash station, puddles formed on the floor, and water was tracked to other areas. While we were onsite, a pipe was attached and routed to a floor drain. We also noted that the GI clinic decontamination room did not have an eyewash station available for immediate use, as required by OSHA standards. A portable station was installed while we were

[1] VA Handbook 7176, *Supply, Processing and Distribution (SPD) Operational Requirements*, August 16, 2002.

onsite. Therefore, we made no recommendation for this finding. However, we identified the following area that needed improvement.

Temperature and Humidity Controls. VA requires[2] temperature to be maintained between 65 and 72 degrees and humidity to be maintained at 35 to 45 percent in all areas where sterile items are kept. Sterility of equipment kept in storage areas cannot be assured if temperature and humidity are not maintained at prescribed levels. We found that temperature and humidity were not adequately controlled in the SPD and GI clinic sterile storage areas. We were told that there were no humidity controls and that due to the ages of the building and the air conditioning unit as well as the physical location of SPD, temperatures have been difficult to control.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that measures be taken to maintain temperature and humidity in sterile storage areas at prescribed levels.

The VISN and Medical Center Directors concurred with the finding and recommendation. Measures have been taken to closely control and monitor temperature and humidity in the sterile storage areas. Plans to relocate SPD are in place. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Environment of Care

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

We inspected the urgent care (UC) unit, the special care/telemetry unit, the locked inpatient MH unit, the acute medicine unit, seven primary care clinics, three CLC units, the home based primary care program office, and Radiology Service. We found that the medical center was generally clean; however, we identified the following areas that needed improvement.

[2] VA Handbook 7176.

Environmental Safety on the Locked Inpatient MH Unit. VHA requires[3] that furnishings in patient care areas of the locked inpatient MH unit be physically heavy or secured to the floor to prevent them from being moved, overturned, thrown, or used as weapons. We noted that a large flat screen television in the day room was on top of a lightweight table and was not secured.

Environmental Rounds. VHA policy[4] requires that EOC rounds include participation by managers in nursing, building management, engineering, and safety; patient safety representatives; infection control representatives; and others, as required. We found that nursing management was not represented on EOC rounds 21 percent of the time during FY 2009.

Infection Control.

Hand Hygiene Program. VHA policy[5] requires the medical center to have a hospital-wide hand hygiene program that includes monitoring of adherence to required hand hygiene practices. Local policy requires that information about soap product usage be reported to the ICC quarterly. We reviewed data and ICC minutes for hand hygiene monitors for the last 4 quarters prior to our visit. We found that monitoring results were not reported to the ICC on a quarterly basis.

N95 Respirator Fit Testing. Centers for Disease Control and Prevention guidelines recommend that all health care personnel entering rooms of patients with confirmed, suspected, or probable H1N1 influenza should wear, at a minimum, a fit tested disposable N95 respirator.[6] In addition, OSHA regulations require designated staff to be medically cleared, fit tested, and trained for respirator use as part of a complete respiratory protection program. We requested documentation of N95 fit testing during the past 12 months for 26 employees from the bronchoscopy area, Radiology Service, the acute medicine unit, and the UC unit. We found

[3] VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist," January 4, 2010.
[4] Deputy Under Secretary for Health for Operations and Management, "Environmental Rounds," memorandum, March 5, 2007.
[5] VHA Directive 2005-002, *Required Hand Hygiene Practices*, January 13, 2005.
[6] A disposable particulate respirator that has the ability to filter out 95 percent of particles greater than 0.3 microns in diameter.

that 11 (42 percent) of the 26 selected employees had not received the required annual N95 fit testing.

Training. VHA policy[7] requires employees of locked inpatient MH units and members of the MSIT to complete annual training on environmental hazards that represent a threat to suicidal patients. We reviewed training records and found that 7 (33 percent) of the 21 selected employees, including members of the MSIT, had not completed the required training.

Recommendation 2 We recommended that the VISN Director require that the Medical Center Director ensures that the television and table in the day room on the locked inpatient MH unit be secured, as required.

The VISN and Medical Center Directors concurred with the finding and recommendation. The television and table have been secured. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that nursing management is consistently represented on EOC rounds, as required.

The VISN and Medical Center Directors concurred with the finding and recommendation. New attendance tracking methods have been implemented to ensure attendance by appropriate representatives or their designees. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that hand hygiene monitoring data is reported to the ICC quarterly.

The VISN and Medical Center Directors concurred with the finding and recommendation. A more comprehensive approach to hand hygiene monitoring and reporting has been implemented. The corrective actions are acceptable, and we consider this recommendation closed.

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

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires that designated employees receive N95 respirator fit testing and that compliance is monitored.

The VISN and Medical Center Directors concurred with the finding and recommendation. Staff who require fit testing have been identified. Plans are in place to address the backlog of fittings and to ensure future compliance. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires that locked inpatient MH unit employees and MSIT members receive required annual training.

The VISN and Medical Center Directors concurred with the finding and recommendation. All required employees have completed the training for FY 2010. New employees and members of the MSIT will receive training upon orientation and/or assignment to the team. The annual training requirement will also be added to their educational plans. The corrective actions are acceptable, and we consider this recommendation closed.

Physician Credentialing and Privileging

The purpose of this review was to determine whether the medical center had consistent processes for physician C&P. We reviewed C&P files and provider profiles[8] for 10 physicians for selected elements required by VHA.[9] We also reviewed meeting minutes during which discussions about the physicians took place.

We found that licenses were current and that primary source verification[10] had been obtained. We also found that the clinical privileges for each physician were appropriate for the provider, service, and medical center. However, we identified the following areas that needed improvement.

[8] Provider profiles contain practitioner-specific data utilized to assist service chiefs and medical staff leadership in the privileging and reprivileging processes.
[9] VHA Handbook 1100.9, *Credentialing and Privileging*, November 14, 2008.
[10] Primary source verification is documentation from the original source of a specific credential that verifies the accuracy of a qualification reported by an individual health care practitioner.

FPPE. VHA policy[11] requires a review process to ensure the competence of newly hired physicians and currently privileged physicians requesting new privileges. We reviewed files for six physicians hired and three physicians who added new privileges within the last 12 months. We found that seven of the nine physicians did not have an FPPE completed to support the privileges granted.

OPPE. VHA policy also requires a thorough written plan with specific competency criteria for OPPE for all privileged physicians. Local policies and bylaws contained service-specific criteria to be included in OPPEs. However, we found that two of the four physicians reprivileged in the last 12 months did not have an OPPE.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires that FPPE and OPPE comply with VHA requirements.

The VISN and Medical Center Directors concurred with the findings and recommendation. The local policy on professional practice evaluations has been updated and includes a process to track FPPE and OPPE. The Chief of Staff has informed all physicians of the policy and process. The Chief of Staff's office will monitor adherence and report compliance to the Leadership Council quarterly. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Quality Management

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, and QM personnel. We evaluated policies, performance improvement (PI) data, and other relevant documents.

The medical center's QM program was generally effective, and senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. Appropriate review structures were in place for most program activities

[11] VHA Handbook 1100.9.

reviewed; however, we identified the following areas that needed improvement.

Life Support Training. Local policy identifies specific employees who require BLS training. We found that 235 (34 percent) of 692 required employees did not have current BLS training.

MRC. Local policy requires medical record reviews to be done monthly and results to be reported to the MRC quarterly. Local policy also requires that the MRC meet monthly. MRC meeting minutes are to reflect actions and recommendations and are to be sent to the MEC for approval. We found that the MRC did not meet monthly, that medical record reviews were not consistently completed, and that results of medical record reviews were not reported quarterly. Local policy also requires the MRC to monitor usage of the copy and paste functions in the electronic medical record for appropriateness. We found that the MRC did not follow up on identified deficiencies in the use of the copy and paste functions.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires that designated employees maintain current BLS training.

The VISN and Medical Center Directors concurred with the finding and recommendation. Time requirements for training have been clarified, courses have been added to accommodate staff, and staff will receive advanced notice when training is due. Additionally, compliance will be reflected in staff and management performance evaluations. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 9 We recommended that the VISN Director ensure that the Medical Center Director requires that MRC functions adhere to VHA and local policy requirements.

The VISN and Medical Center Directors concurred with the findings and recommendation. The MRC is now meeting monthly, and minutes, including actions and recommendations, are being submitted to the MEC quarterly. Copy and paste function usage is being monitored and reported to the MRC and MEC. 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[12] and JC standards require that providers include information regarding medications, diet, activity level, and follow-up appointments in written patient discharge instructions. We reviewed the medical records of 10 discharged patients and determined that clinicians had generally documented the required elements.

VHA requires that medical centers have a policy that ensures the safe, appropriate, and timely transfer of patients and that inter-facility transfers are monitored and evaluated as part of the QM program. We determined that the medical center had an appropriate transfer policy and appropriately monitored inter-facility transfers. However, we identified the following area that needed improvement.

Advanced Directives and Informed Consent. VHA[13] requires specific information (such as the reason for transfer, advanced directive information, and informed consent to transfer) to be recorded in the transfer documentation. We reviewed the medical records of 10 patients transferred from the medical center to another facility. We found that all 10 records contained information regarding the date, time, location, and reason for transfer; the level of services required; and patient condition at the time of transfer. However, we found that providers did not document all required information for 3 (30 percent) of the 10 patients. For three patients, the status of advanced directives was not documented, and for one patient, there was also no informed consent documentation.

Recommendation 10 We recommended that the VISN Director ensure that the Medical Center Director requires staff to complete

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

inter-facility transfer documentation in accordance with VHA policy.

The VISN and Medical Center Directors concurred with the findings and recommendation. A template with required transfer documentation criteria has been developed and implemented. Compliance with transfer documentation requirements was 100 percent in February 2010, and compliance will continue to be monitored to ensure sustained improvement. Additionally, a new procedure has been implemented to ensure that all required elements are completed prior to transfer. The corrective actions are acceptable, and we consider this recommendation closed.

Review Activities Without Recommendations

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 a risk assessment of the environment, as required by The JC.

The medical center had appropriate signage and barriers to prevent unauthorized or accidental access to the MRI area. Patients in the magnet room are directly observed at all times. Two-way communication is available between the patient and the MRI technologist, and the patient has access to a push-button call system while in the scanner.

We reviewed the medical records of 10 patients who received an MRI. In all cases, patients received appropriate screening. None of the five patients who had an MRI with contrast media were determined to be high risk; therefore, signed informed consent was not required prior to their procedures.

We reviewed the training records of six Radiology Service personnel and six support personnel who had access to the MRI area and found that all had completed appropriate MRI

safety training by the time of our visit. We made no recommendations.

Medication Management

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

The medical center had implemented a practice guideline governing the maintenance of chronic renal disease patients who receive erythropoiesis-stimulating agents.[14] We found that clinical staff had appropriately identified and addressed elevated hemoglobin levels in the 10 patients whose medical records we reviewed. In general, influenza vaccinations were documented adequately for CLC residents, and clinical staff followed the established protocol if vaccines were refused by the patient.

We also found that although the pharmacy is not open 24 hours a day, the medical center had provided a qualified pharmacist to answer questions while the pharmacy was closed and had an adequate retrospective review process. We made no recommendations.

Suicide Prevention Safety Plans

The purpose of this review was to determine whether clinicians had developed safety plans that provided strategies to mitigate or avert suicidal crises for patients assessed to be at high risk for suicide. Safety plans should have patient and/or family input, be behaviorally 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.[15]

A previous OIG review of suicide prevention programs in VHA facilities[16] 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

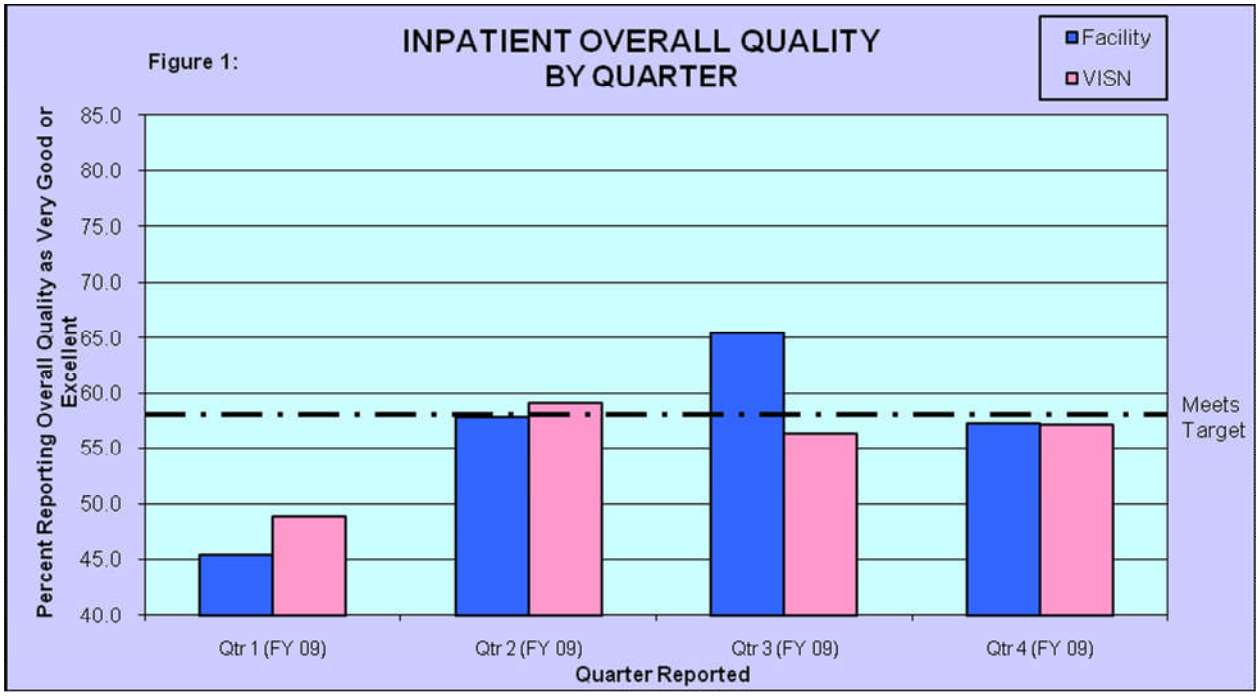
[14] Drugs that stimulate the bone marrow to make red blood cells; used to treat anemia.
[15] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
[16] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation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

were not developed at all. At the request of VHA, the OIG agreed to follow up on the prior findings.

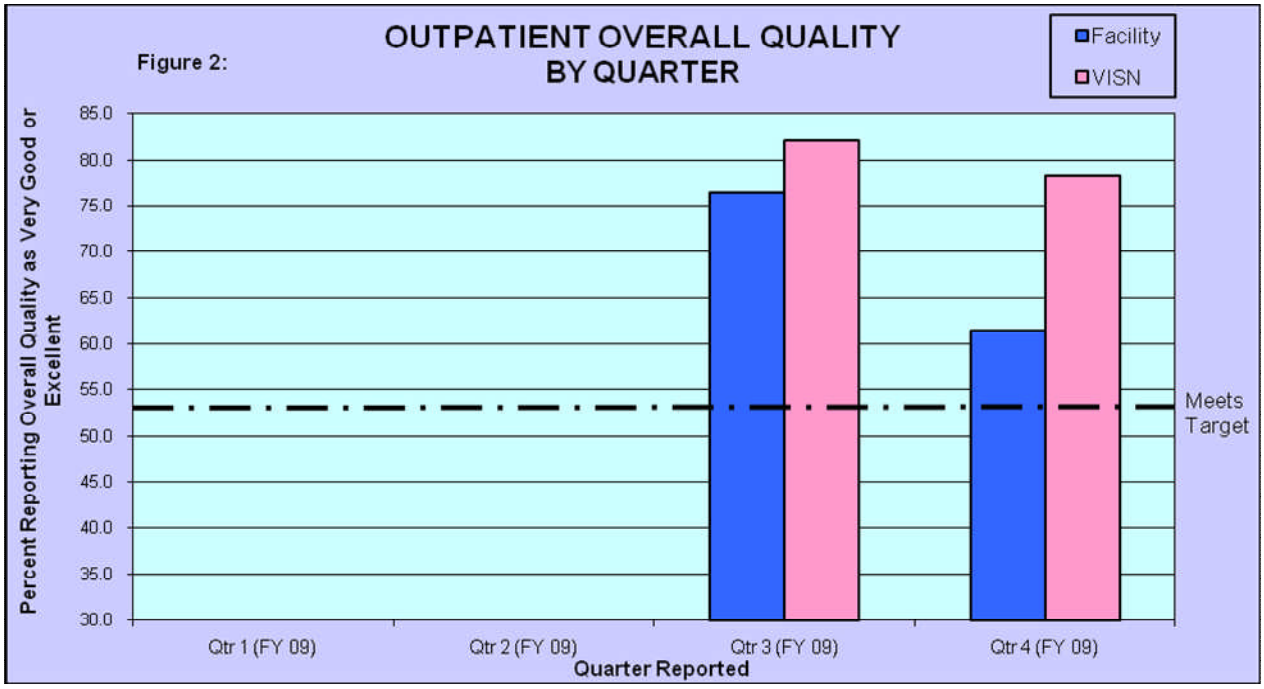
We reviewed the medical records of 10 patients assessed to be at high risk for suicide and found that clinicians had developed timely safety plans for 9 (90 percent) of the 10 patients and that the plans included all required elements. We also found evidence to support that patients participated in the development of the plans. Documentation showed that Suicide Prevention Program social workers provided excellent case management for high-risk patients. We made no recommendations.

VHA Satisfaction Surveys

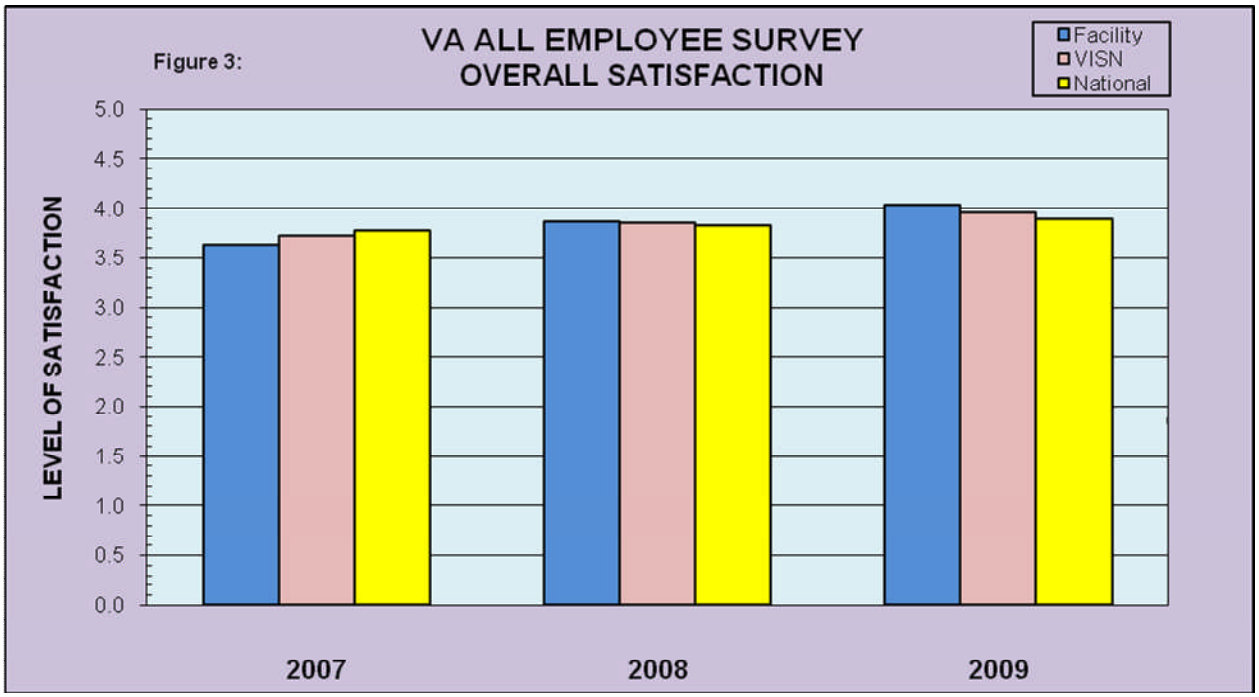
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 below shows the medical center's and VISN's overall inpatient satisfaction scores for quarters 1–4 of FY 2009. Figure 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.[17] The target scores are noted on the graphs.



[17] Due to technical difficulties with VHA's outpatient survey data, outpatient satisfaction scores for quarters 1 and 2 of FY 2009 are not included for comparison.



Employees are surveyed annually. Figure 3 below shows the 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.



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 10, 2010

From: Director, Veterans Integrated Service Network 10 (10N10)

Subject: **Combined Assessment Program Review of the Chillicothe VA Medical Center, Chillicothe, Ohio**

To: Associate Director, St Petersburg Healthcare Inspections (54SP)

Director, Management Review Service (10B5)

1. I concur with the comments and action plans submitted by the Medical Center Director at Chillicothe, Ohio, in response to the OIG CAP review conducted in March 2010. The staff found the review educational and appreciated the professionalism of the OIG Team.

2. If you have questions regarding the response, please contact Jeffrey T. Gering, FACHE, Medical Center Director, at (740) 773-1141, extension 7002.

(original signed by:)

JACK G. HETRICK

Director, Veterans Integrated Service Network

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 10, 2010

From: Director, Chillicothe VA Medical Center (538/00)

Subject: **Combined Assessment Program Review of the Chillicothe VA Medical Center, Chillicothe, Ohio**

To: Director, Veterans Integrated Service Network 10 (10N10)

1. Attached is the response from the VA Medical Center, Chillicothe, Ohio, to the OIG CAP Review in March 2010. We found the review educational and helpful in preparation for our upcoming Joint Commission Survey. We also appreciated the professionalism of the review team.

2. If you have any questions about the response imbedded in the report above, please feel free to contact me.

(original signed by:)

JEFFREY T. GERING, FACHE

Medical Center Director

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 measures be taken to maintain temperature and humidity in sterile storage areas at prescribed levels.

Concur

SPD in Building 24 and 27 has several sterile storage areas and these are served from the main building HVAC system in both buildings. These systems can result in the temperature being too high and the humidity being too low. To correct low humidity situations, which occasionally occur, the currently inactive direct steam humidifiers will be reactivated by June 30, 2010. Facility Management Service is now providing closer management of the controls to ensure both temperature and humidity levels are within the established thresholds. The automated Checkpoint Monitoring System is now in place to do daily monitoring of both temperature and humidity. The long-term solution to the temperature and humidity problems in SPD in building 24 will be addressed by a Minor construction project planned for FY 2012. This project will relocate SPD in new space adjacent to Building 31.

Recommendation 2. We recommended that the VISN Director require that the Medical Center Director ensures that the television and table in the day room on the locked inpatient MH unit be secured, as required.

Concur

The large flat screen television in the dayroom has been secured to the table and the table has been secured to the floor. This recommendation has been completed.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that nursing management is consistently represented on EOC rounds, as required.

Concur

New attendance tracking has been implemented to ensure consistent attendance by EOC rounds team. Steps have also been taken to ensure that the EOC rounds attendance roster indicates when a substitute is filling in for another team member. This recommendation has been completed.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that hand hygiene monitoring data is reported to the ICC quarterly.

Concur

Effective April 27, 2010, the Chillicothe VA Medical Center implemented a more comprehensive approach to hand hygiene monitoring and reporting. A team consisting of 42 staff at the Chillicothe facility and in the Community Based Outpatient Clinics (CBOC) now conducts hand hygiene monitoring on a monthly basis utilizing a standardized form. The results are submitted to the Infection Control Nurse by the 15th day of the month for the previous month, i.e., May data to be reviewed at the June Infection Control Committee meeting. The Infection Control Nurse will present aggregate and analyzed data with recommendations, as appropriate, to the Infection Control Committee on a monthly basis. Hand Hygiene is a standing agenda item for the monthly Infection Control Committee meetings. This recommendation is completed.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that designated employees receive N95 respirator fit testing and that compliance is monitored.

Concur

The Industrial Hygienist and the Infection Control Nurse have re-evaluated and identified all staff appropriate to be fit tested. To address the backlog of fittings and to ensure proper compliance in the future, the medical center now has a process in place to train additional medical center staff to conduct proper fit testing. Approximately 25 employees across the medical center will serve as fit testers (as a collateral duty). That staff will receive formal training during May 2010 and will begin addressing the backlogs immediately. In addition, the Industrial Hygienist has established full day fit test clinics to be held each month between May 2010 and August 2010. Schedules are also in place to address night and weekend staff. The Industrial Hygienist has a monitoring system in place now to ensure all the staff identified as needing fit testing are tested as required.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that locked inpatient MH unit employees and MSIT members receive required annual training.

Concur

All staff working on the locked inpatient MH unit and all MSIT members are compliant with the annual training requirement in FY2010. The review found deficiencies in training in prior fiscal years. On May 7, 2010, a list of employees who work on the locked mental health unit and MSIT members who are required to have the annual training was provided to Learning Resources. Learning Resources is in the process of assigning the training to the affected employees' training plans in the VA Learning Management System (LMS) for annual training beginning in FY2011. New employees who are assigned to the locked mental health unit are assigned the training in LMS as part of the new employee orientation process. New MSIT members are assigned the training upon assignment to the Team. The annual training requirement is then added to their LMS training plans. This recommendation is completed.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that FPPE and OPPE comply with VHA requirements.

Concur

The medical center policy on Professional Practice Evaluations has been updated. The new policy includes a process to track FPPE/OPPE. On May 7, 2010, the Chief of Staff sent out a memorandum notification to all physicians of the policy and the process steps. The Chief of Staff Office will be monitoring adherence to this process monthly and reporting to the Leadership Council quarterly on the degree of compliance. This recommendation is completed.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires that designated employees maintain current BLS training.

Concur

Currently nursing staff are scheduled BLS training throughout the year; this has been interpreted to meet the "annually" requirement specified in *Medical Center Policy 11-36 Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training.* These staff members are compliant with the American Heart Association which recognizes the training for a two (2) year time period. On a strict interpretation, they are not compliant with "annually" if the interpretation is that "annually" is specifically related to the previous date of training, and not within the year. To correct this, information has been sent to nursing supervisory staff that annual training is to be completed during the same month as previous training.

Additionally, Service Chiefs have been instructed that their Service Synquest/LMS administrator is to identify the currency of BLS training for each staff person identified per *Medical Center Policy 11-36, Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training.* If BLS training is due, the Service Synquest/LMS administrator is to appropriately schedule the staff for training. This training is required every two years during the same month as the staff member's previous training. (Note: Nursing staff and the VHA police are required to have annual training.)

To accommodate those who need BLS training, an additional 24 BLS classes were scheduled in April for VAMC staff. There were 200 attendees at these sessions. The number of staff compliant with BLS training has increased from 66 percent in March 2010 to 95 percent in April 2010.

There is a BLS instructor course scheduled on May 21, 2010 for new instructors. Services with staff needing BLS have been notified so they will be able to provide their own training. In October, 2010 Phase II of LMS will be implemented. Phase II will alert each staff member and their supervisor of the need for BLS training with a 30-day advance notice of expiration. This will assist in keeping the BLS training current. Staff who do not complete BLS training are to have this documented in annual performance appraisals or proficiencies. Overall compliance with service training is to be documented in the supervisor's evaluation.

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director requires that MRC functions adhere to VHA and local policy requirements.

Concur

The chairmanship of the MRC was recently changed and the committee is now meeting monthly and submitting minutes to the MSEC quarterly. The meeting agenda and minutes reporting format have been revised to include actions/recommendations which are reviewed at the Medical Records Committee meetings. Medical record reviews are regularly scheduled as of March 1, 2010 for each service and reported quarterly to the Medical Records Committee. Copying and pasting is now being monitored by the coding staff with education provided to appropriate providers as needed. This monitor is being reported to Medical Records Committee, Compliance Committee and to MSEC. This recommendation is completed.

Recommendation 10. We recommended that the VISN Director ensure that the Medical Center Director requires staff to complete inter-facility transfer documentation in accordance with VHA policy.

Concur

The medical center workgroup for Interfacility Transfers developed a template with required criteria in 4th quarter, FY09. This led to improvement of documentation. A field indicating Advance Directives has been added to the template as a mandatory field and this has led to significant improvement—41percent compliance in September, FY09 to 100 percent for February, FY10. This improvement will be continually monitored to assure it is sustained. Additionally, a new procedure has been implemented that involves the Nurse Expeditor and Administrative Officer of the Day making sure providers complete all required elements before contacting the facility for transfer. This recommendation is completed.

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