Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 09-03277-214

Combined Assessment Program Review of the Tomah VA Medical Center Tomah, Wisconsin

July 28, 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 crime awareness briefings 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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Glossary

C&P	credentialing and privileging
CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CLC	community living center
EMS	Environmental Management Service
EOC	environment of care
facility	Tomah VA Medical Center
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
FTE	full-time employee equivalents
IC	infection control
JC	The Joint Commission
NCPS	National Center for Patient Safety
NFPA	National Fire Protection Association
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
OSHA	Occupational Safety and Health Administration
PI	performance improvement
PPE	personal protective equipment
QM	quality management
RME	reusable medical equipment
SOPs	standard operating procedures
SPD	Supply, Processing, and Distribution
UCC	Urgent Care Clinic
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the Tomah VA Medical Center, Tomah, Wisconsin

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of May 10, 2010.

Review Results: The review covered seven activities. We made no recommendations in the following activities:

- Medication Management
- Quality Management Program
- Suicide Prevention Safety Plans

Recommendations: We made recommendations in the following four activities:

Reusable Medical Equipment: Employees reprocessing reusable medical equipment need to follow standard operating procedures. Personal protective equipment needs to be properly donned in reprocessing areas. Training needs to be provided to staff responsible for low-level disinfection. Semi-annual environment of care rounds need to be conducted in Supply, Processing, and Distribution areas. Humidity in the Supply, Processing, and Distribution sterile storage area needs to be monitored, regulated, and maintained. Identified environment of care deficiencies in Supply, Processing, and Distribution decontamination and preparation areas need to be corrected.

Environment of Care: Rounds need to be conducted, and corrective actions for identified deficiencies need to be initiated and tracked to completion. Fire drills need to be conducted at all community based outpatient clinic locations within required timeframes. All designated staff need to complete Occupational Safety and Health Administration Bloodborne Pathogens and locked inpatient psychiatric unit environmental hazards training, and a process to monitor training completion needs to be established. A process for frequent inspections of patient care equipment and furniture needs to be established. Emergency call system functionality needs to be maintained, and vacant staff offices need to be secured.

Coordination of Care: Providers need to complete inter-facility transfer and discharge documentation and ensure patients receive written discharge instructions.

Physician Credentialing & Privileging: Provider profiles need to be in compliance with Veterans Health Administration requirements.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. 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

Objectives and Scope

Objectives

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 crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

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 selected 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 facility operations for FY 2009 and FY 2010 through May 10, 2010, and was done in accordance with OIG SOPs for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the*

Tomah VA Medical Center, Tomah, Wisconsin, Report No. 07-01230-210, September 25, 2007). We identified one repeat finding in EOC.

During this review, we also presented crime awareness briefings for 101 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.

Results

Review Activities With Recommendations

RME

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

We inspected SPD areas and equipment in Unit 402B (CLC – Rehabilitation) and the UCC. We determined that the facility had established appropriate guidelines. However, we identified the following areas that needed improvement.

SOPs. VHA policy[1] requires device-specific SOPs to be followed when reprocessing RME. During our inspection of the SPD decontamination area, we found that SOPs for dental equipment were present. However, the employee we observed cleaning the flat stainless steel instruments and handpieces did not follow the procedural steps dictated by the SOPs.

IC. VA policy[2] requires that PPE be donned before entering the decontamination area. PPE is approved head and hair

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

coverings, face shields, gloves, gowns, and shoe coverings. We found that SPD staff did not wear face shields.

Facility policy requires that appropriate hand hygiene and the required cleaning solution be used for low-level disinfection of the bladder scanner. We observed staff cleaning equipment in the CLC and UCC and noted that staff did not follow facility policy.

EOC Rounds. VHA policy[3] requires that all sites within the facility be inspected by the rounds team at least semi-annually. We reviewed the EOC rounds location roster for calendar year 2009 and noted that rounds were conducted only once in SPD.

Environment. VA policy[4] requires that humidity in SPD sterile storage areas be maintained between 35 and 75 percent. The facility utilizes an electronic system that monitors humidity levels every 15 minutes, 24 hours a day, 7 days a week. We inspected the SPD sterile storage area on May 11 and noted that the electronic monitoring system had been turned off since May 1 and that manual recordings were not maintained. Managers were unaware that the electronic monitoring system had not been functioning.

Prior to installation of the electronic monitoring system, manual recordings were completed once a day Monday through Friday. We reviewed the manual humidity log for January 4–April 30 and found that 66 (68 percent) of 97 readings were not in the required range.

Additionally, we observed penetrated and damaged ceiling tiles in the SPD decontamination and preparation areas.

Recommendations

1. We recommended that all employees responsible for reprocessing RME follow SOPs, as required by VHA policy.

2. We recommended that PPE be properly donned by anyone entering the RME reprocessing area.

3. We recommended that training be provided to staff who are responsible for low-level disinfection.

[3] Deputy Under Secretary for Health for Operations and Management, "Environmental Rounds," memorandum, March 5, 2007.
[4] VA Handbook 7176.

4. We recommended that EOC rounds be conducted semi-annually in the SPD areas, in accordance with VHA policy.

5. We recommended that humidity in the SPD sterile storage area be monitored, regulated, and maintained in accordance with VHA policy.

6. We recommended that identified EOC deficiencies in the SPD decontamination and preparation areas be corrected.

EOC

The purpose of this review was to determine whether VHA facilities maintained a safe and clean health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, NCPS, OSHA, NFPA, and JC standards.

We inspected patient care areas 408A (Acute Psychiatric), 408N (CLC – Psychiatric), 406B (CLC), 400A (Acute Medical), 400T (Transitional Medical), 402B (CLC – Rehabilitation), 404 (Residential Program), the UCC, and the Blue and Red Team Primary Care clinics. We also inspected the Operation Enduring Freedom/Operation Iraqi Freedom, Podiatry, Dermatology, and Women's Health specialty clinic areas. The facility maintained a generally clean and safe environment, and managers were responsive to deficiencies identified during the inspection. We identified the following conditions that needed improvement.

EOC Rounds and Deficiency Tracking. VHA policy[5] requires the Director or the Associate Director to lead weekly EOC rounds. Participants should include managers in nursing, building management, engineering, safety, patient safety, IC, and information security. Because the facility did not maintain attendance rosters, we were unable to validate rounds attendance.

EOC inspection findings are to be referred to the appropriate service for correction, and the status and completion of corrective efforts should be appropriately tracked. We reviewed EOC rounds deficiency tracking spreadsheets and noted that abatement dates were not consistently added. Consequently, the facility was unable to provide valid statistics to support deficiency correction rates.

[5] Deputy Under Secretary for Health for Operations and Management, "Environmental Rounds," memorandum, March 5, 2007.

During our prior CAP review, we recommended that the EOC rounds team conduct semi-annual inspections of the CBOC locations. We reviewed the 2009 EOC rounds schedule and noted that semi-annual inspections were not scheduled for the Wausau or Wisconsin Rapids CBOC locations. We were provided documentation to support that inspections were completed at the Wausau CBOC in November 2009 and March 2010. There were no inspections of the Wisconsin Rapids CBOC. The Loyal and LaCrosse CBOCs were inspected semi-annually, as required. For those inspections that were completed, we were unable to validate whether required managers were in attendance. This was a repeat finding from our prior CAP review.

Fire and Life Safety. The NFPA requires fire drills to be conducted every 12 months in buildings designated as business occupancies. The facility's four CBOCs are all business occupancies. We reviewed fire drill records for calendar year 2009 and noted that two of the CBOCs did not have timely drills.

Training. Designated employees are required to complete annual OSHA Bloodborne Pathogens training. For two selected patient care areas, we reviewed calendar year 2009 training records for 10 clinical staff and all EMS staff who may have been assigned to work in those areas. We found that 5 (50 percent) of the 10 clinical staff and 20 (49 percent) of the 41 EMS staff completed the training.

VHA policy[6] requires staff training on the recognition of environmental hazards in locked inpatient psychiatric units. This training is to be completed during employee orientation to the unit. Additionally, unit staff and members of the Multidisciplinary Safety Inspection Team must complete training annually. We reviewed training records for calendar year 2009 and noted that environmental hazards training was not conducted. Although the facility initiated action to complete this training for required staff in 2010, managers must ensure that a process is established to maintain this training requirement.

IC. Patient care equipment and furniture must be regularly inspected, and items with compromised surfaces need to be repaired or removed from service. We noted compromised

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

surfaces on wheelchairs, specialty chairs, and furniture in patient care areas.

Safety. During patient care area inspections, we noted emergency call system cords that were looped around or tied to handrails. The system failed to activate when the cords were pulled from the floor level. Additionally, we noted that staff did not consistently secure their offices. Consequently, contents such as sensitive patient information, valuables, and computer systems were vulnerable.

Recommendations

7. We recommended that required managers conduct EOC rounds and that corrective actions for identified deficiencies be initiated and tracked to completion in accordance with VHA policy.

8. We recommended that fire drills be conducted at all CBOC locations in accordance with NFPA timeframes.

9. We recommended that all designated staff complete OSHA Bloodborne Pathogens and locked inpatient psychiatric unit environmental hazards training and that a process be established to monitor training completion.

10. We recommended that managers establish a process for frequent inspections of patient care equipment and furniture to ensure compliance with IC standards.

11. We recommended that emergency call system functionality be maintained and that staff offices be secured when vacated.

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 requires that facilities 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 facility had an appropriate transfer policy and that transfers were monitored and evaluated as part of the QM program. However, we identified the following areas that needed improvement.

Inter-Facility Transfers. VHA policy[7] requires specific information (such as the reason for transfer, mode of transportation, and informed consent to transfer) to be recorded in the transfer documentation. We reviewed transfer documentation for 10 patients transferred from the facility's acute medical unit and UCC to another facility. We found that providers did not document all the required information for 7 (70 percent) of the 10 patients. Missing information included documentation of the level of services required and the requirements during transport.

Discharges. VHA policy[8] requires that providers include information regarding medications, diet, activity level, and follow-up appointments in patient discharge instructions. In addition, The JC requires that clinicians provide patients with written discharge instructions.

We reviewed the medical records of 20 discharged patients and found deficiencies in 11 (55 percent) of the records. Two patients were discharged with activity restrictions; however, we did not find documentation that the patients or caregivers received education regarding these restrictions. In addition, 9 (82 percent) of the 11 medical records with deficiencies had no documentation that the patients received written discharge instructions.

Recommendations

12. We recommended that providers complete inter-facility transfer documentation in accordance with VHA policy.

13. We recommended that providers complete discharge documentation in accordance with VHA policy and that patients receive written discharge instructions.

Physician C&P

The purpose of this review was to determine whether VHA facilities had consistent processes for physician C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and physician profiles.[9] We also reviewed meeting minutes during which discussions about the physicians took place.

We reviewed 10 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. Service-specific criteria for OPPE had been developed and approved. Meeting minutes

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

consistently documented thorough discussions of the physicians' privileges and performance data prior to recommending renewal of or initial requested privileges. However, we identified the following areas that needed improvement.

FPPE. Facility FPPE plans specified that evaluations were to be conducted for 90 days after completion of initial orientation. We reviewed FPPEs for four physicians hired within the past 12 months and found that timeframes for FPPEs were not clearly documented. Also, FPPE plans included reviewing five medical records per week for each physician. This requirement was not achieved for the four physicians we reviewed.

OPPE. VHA policy[10] requires thorough written plans with specific criteria for OPPE for all privileged physicians. One of six physician profiles reviewed lacked sufficient OPPE data to meet current requirements.

Recommendation

14. We recommended that provider profiles be in compliance with VHA requirements.

Review Activities Without 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 facility participates in the VISN 12 Medication Use Evaluation, which governs the maintenance of chronic renal disease patients who receive erythropoiesis-stimulating agents.[11] We found that clinical staff had appropriately identified and addressed elevated hemoglobin levels in the nine patients whose medical records we reviewed. In general, influenza vaccinations were documented adequately for CLC residents, and clinical staff followed the established protocol when a delay in receipt of vaccines was experienced. Also, although the pharmacy is not open 24 hours a day, 7 days a week, we found that the facility had appropriately provided a qualified pharmacist from the William S. Middleton Memorial Veterans Hospital in Madison, WI, to answer questions during the time the facility's pharmacy was closed. Additionally, managers had an

[10] VHA Handbook 1100.19.
[11] Drugs that stimulate the bone marrow to make red blood cells; used to treat anemia.

adequate retrospective review process. We made no recommendations.

QM Program

The purpose of this review was to evaluate whether the facility had a comprehensive QM program designed to monitor patient care quality and whether senior managers actively supported the program's activities. We interviewed the facility's Director, the Chief of Staff, the PI Director, and key staff. We evaluated plans, policies, PI data, and other relevant documents.

The QM program was effective and well-managed. Senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. Meaningful data were analyzed, trended, and utilized to improve patient care. We made no recommendations.

Suicide Prevention Safety Plans

The purpose of this review was to determine whether clinicians had developed safety plans that provided strategies to mitigate or avert suicidal crises for patients assessed to be at high risk for suicide. Safety plans should have patient and/or family input, be behavior oriented, and identify warning signs preceding crisis and internal coping strategies. They should also identify when patients should seek non-professional support, such as from family and friends, and when patients need to seek professional help. Safety plans must also include information about how patients can access professional help 24 hours a day, 7 days a week.[12]

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

We reviewed the medical records of 10 patients assessed to be at high risk for suicide and found that clinicians had developed timely safety plans that included all required elements for 8 (80 percent) of the 10 patients. We also

[12] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
[13] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009;* Report No. 09-00326-223; September 22, 2009.

found evidence to support that the patients and/or their families participated in the development of the plans. In our review of the two records without safety plans, we found that one patient declined to participate in the development of a safety plan and that one patient had been hospitalized in a non-VA facility and did not have a safety plan. The Suicide Prevention Coordinators recognized that tracking patients hospitalized outside the VA and reminding VA providers of the need for timely development of safety plans required additional planning. An action plan was submitted while we were onsite; therefore, we made no recommendations.

Comments

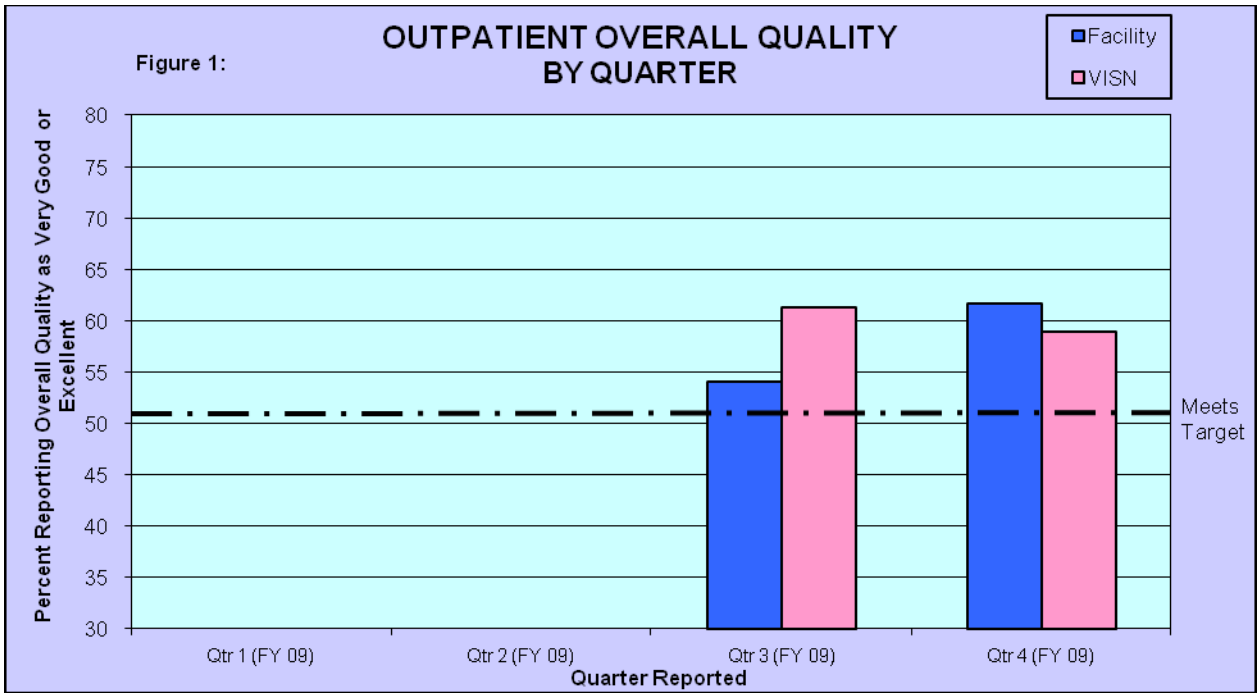
The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 14–23, for the full text of the Directors' comments.) We consider Recommendations 1, 2, 6, 8, and 14 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[14]		
Type of Organization	Medical center with primary care, rehabilitation, extended care, and mental health services	
Complexity Level	3	
VISN	12	
CBOCs	La Crosse, WI Loyal, WI Wausau, WI Wisconsin Rapids, WI	
Veteran Population in Catchment Area	59,142	
Type and Number of Operating Beds: • **Acute care**	26	
• **CLC**	200	
• **Psychosocial Residential Rehabilitation**	45	
Medical School Affiliation(s)	None	
• **Number of Residents**	0	
	Current FY	**Prior FY**
Resources (in millions):		
• **Budget**	$125	$113
• **Medical Care Expenditures**		$115
FTE		879
Workload:		
• **Number of Unique Patients**		23,084
• **Inpatient Days of Care:**		
o **Acute Care**		3,712
o **CLC**		67,375
o **Psychosocial Residential Rehabilitation**		14,022
Hospital Discharges		934
Cumulative Average Daily Census (including CLC and Psychosocial Residential Rehabilitation patients)		233
Cumulative Occupancy Rate		93%
Outpatient Visits		171,675

[14] All data provided by facility management.

VHA Satisfaction Surveys

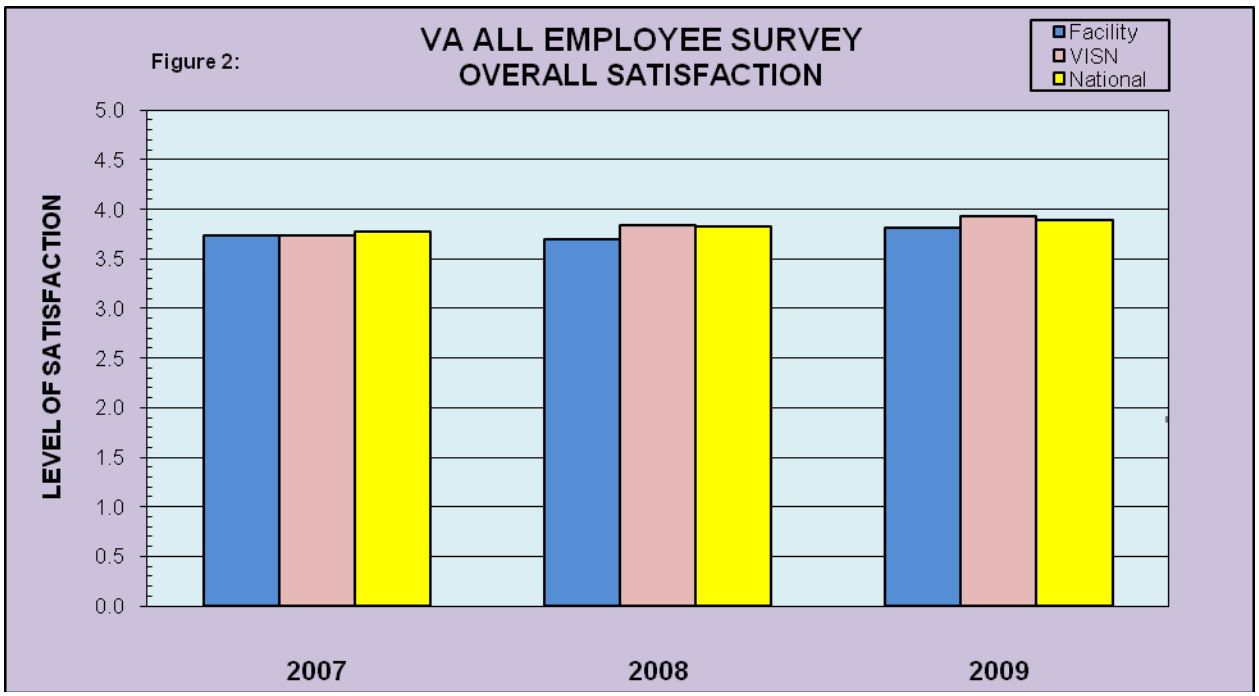
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. For FY 2009, the facility's inpatient satisfaction survey response was insufficient for data analysis; therefore, no inpatient survey scores are displayed. Figure 1 below shows the facility's and VISN's overall outpatient satisfaction scores for quarters 3 and 4 of FY 2009.[15] The target score is noted on the graph.



[15] 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 2 below shows the facility'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 2:



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 6, 2010

From: Director, VA Great Lakes Health Care System (10N12)

Subject: **CAP Review of the Tomah VA Medical Center, Tomah, WI**

To: Director, Chicago Healthcare Inspections Division (54CH)

Director, Management Review Service (VHA CO 10B5 Staff)

I have reviewed and concur with the attached response from Tomah VAMC.

JEFFREY MURAWSKY, M.D.

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 26, 2010

From: Director, Tomah VA Medical Center, (676/00)

Subject: **CAP Review of the Tomah VA Medical Center, Tomah, WI**

To: Director, VA Great Lakes Health Care System (10N12)

Please find the attached Tomah VA comments in response to the OIG findings and recommendations.

Jerald D. Molnar

JERALD D. MOLNAR

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 all employees responsible for reprocessing RME follow SOPs, as required by VHA policy.

Concur

Target date for completion: Closed

As of June 23, 2010, all staff members responsible for reprocessing were re-educated on Standard Operating Procedures (SOP) by the Supply Processing and Distribution (SPD) Coordinator and each of the four staff was observed three times to ensure compliance with Reusable Medical Equipment (RME) including dental equipment and hand pieces. Results of the observations revealed that all staff followed the required SOPs 100% of the time.

Regarding training, new employees are trained during orientation. Training of current staff is scheduled on an annual basis. Training rosters will be sent to the Education Department for coding. Quarterly status reports will be generated and presented by the Associate Director for Patient Care Services (ADPCS) to the RME Committee, which includes the Infection Control Officer, as well as to the Medical Staff Executive Committee.

Recommendation 2. We recommended that PPE be properly donned by anyone entering the RME reprocessing area.

Concur

Target date for completion: Closed

As of June 23, 2010, all staff members were re-educated by the SPD Coordinator regarding the use of Personal Protective Equipment (PPE) and each of the four staff was observed three times for compliance. Results indicated 100% compliance.

Recommendation 3. We recommended that training be provided to staff who are responsible for low-level disinfection.

Concur

Target date for completion: September 30, 2010

Cards with cleaning instructions about low-level disinfection were produced and distributed in June, 2010, to staff whose job functions include low-level disinfection. An SOP and a Competency Statement were written and distributed to nurse managers who are responsible for staff education and competency verification. There are approximately 388 active staff members who will need education and competency verification by direct observation. Staff training and competency verification of all active staff will be completed by August 13, 2010. At the September meeting of the RME Committee, the ADPCS will provide a report on the percentage of staff training and competency verification completed by August 13, 2010.

Recommendation 4. We recommended that EOC rounds be conducted semi-annually in the SPD areas, in accordance with VHA policy.

Concur

Target date for completion: September 17, 2010

In response to survey findings, a plan was developed and is in place to strengthen the organization and effectiveness of the rounding process. Actions addressed in the plan include: the development of a Medical Center Memorandum (MCM) specific to the Environment of Care (EOC) rounding process; the implementation of an automated system for scheduling rounds, recording surveyor attendees and their findings, and tracking actions to completion; and the training of staff required to participate in rounds. These actions are to be completed by September 1, 2010.

Findings from SPD EOC rounds will be summarized for presentation to the EOC Committee. Actions required will be tracked through the EOC Committee until completion.

Recommendation 5. We recommended that humidity in the SPD sterile storage area be monitored, regulated, and maintained in accordance with VHA policy.

Concur

Target date for completion: September 1, 2010

Immediately following the survey, the electronic TempTrak system to monitor temperature and humidity in SPD was activated. The SPD Coordinator was provided additional training related to the resetting of the alarms once activated. An SOP will be written by July 9, 2010 for use in training additional staff about TempTrak and the appropriate alarm response.

Daily monitoring will be documented and reports on temperature and humidity controls will be reported monthly to the RME Committee. Reports will include any corrective action taken when the system was out of range with timeframes for the action identified.

A purchase order for equipment, which will correct the problem of high humidity, has been processed, approved and signed as of June 23, 2010. Vendor will review the system and install the new component by August 23, 2010.

Recommendation 6. We recommended that identified EOC deficiencies in the SPD decontamination and preparation areas be corrected.

Concur

Target date for completion: Closed

The identified damaged and penetrated ceiling tiles were replaced on June 2, 2010.

Recommendation 7. We recommended that required managers conduct EOC rounds and that corrective actions for identified deficiencies be initiated and tracked to completion in accordance with VHA policy.

Concur

Target date for completion: September 17, 2010

As of June 1, 2010, all EOC rounds conducted require documentation of attendees, identified deficiencies/issues, due dates for completion of needed actions and tracking of follow-up. Reports of rounds and relevant findings will be presented quarterly to the EOC Committee and the Patient Safety/Regulatory Compliance Committee by the Safety Officer. Membership of the EOC rounds team is currently consistent with information in the "Environmental Rounds" memorandum from the Deputy Under Secretary for Health for Operations and Management (DUSHOM) dated March 5, 2007.

To increase the effectiveness of rounds, a corrective plan was developed for implementation August 23, 2010, which includes the following components:

a. The EOC inspection MCM is being revised to include the required composition of the survey team, the frequency and sites for rounds, the use of a new electronic tracking tool and reporting requirements. The MCM is expected to be submitted to the Director's office for signature by August 1, 2010.

b. An automated tracking system has been obtained for use. The tracking system will include the date of the rounds, names of surveyors in attendance, major findings, actions assigned, due dates and follow-up responses. The tracker is scheduled for full implementation by August 23, 2010.

c. Training of EOC inspectors and supervisors on the requirement for EOC inspections and the use of the automated system will be completed by August 23, 2010.

Recommendation 8. We recommended that fire drills be conducted at all CBOC locations in accordance with NFPA timeframes.

Concur

Target date for completion: Closed

As of June 25, 2010, a fire drill had taken place at each of the four Community Based Outpatient Clinics (CBOCs).

In order to insure that fire drills are conducted by the Fire Chief and/or Safety Officer at each CBOC every 12 months from the date of the last drill as required by National Fire Protection Association (NFPA) guidelines, the dates for future fire drills have been added to the EOC dashboard, and will be monitored quarterly for compliance by the Safety Officer and reported to the EOC Committee for review and action.

Recommendation 9. We recommended that all designated staff complete OSHA Bloodborne Pathogens and locked inpatient psychiatric unit environmental hazards training and that a process be established to monitor training completion.

Concur

Target date for completion: September 1, 2010

After survey, the Education Coordinator sent a message to all Service Line Managers, and Supervisors indicating that all staff members delinquent in meeting required Bloodborne Pathogen training and the Locked Inpatient Psychiatric Unit Environmental Hazards training are to complete the training by August 1, 2010. A list of staff deficient in one or both required trainings was included. Results of training by those deficient will be reported to the Executive Council meeting in August at which time 100% compliance is expected.

At the July Supervisory Forum, supervisors will be directed to verify that required training in these two areas for affected new employees was completed prior to their start in the assigned work area. Effective July 1, 2010, Bloodborne Pathogen and Mental Health (MH) EOC training will be priority training for new employees on Day Three of New Employee Orientation. The MCM PI-IC-021, Standard Precautions and Bloodborne Pathogen Exposure Control Plan, will be updated by August, 2010 to specify the training timeframe for new employees as being prior to carrying out position responsibilities in the work setting.

Quarterly updates of staff compliance with required Bloodborne and Psychiatric Unit Environmental Hazards training will be reported by the Education Coordinator at Executive Council meetings. Targets for both reports is 100% compliance. A monthly report of employees whose training date is due in 30 days will also be sent to Service Line Managers (SLM).

Recommendation 10. We recommended that managers establish a process for frequent inspections of patient care equipment and furniture to ensure compliance with IC standards.

Concur

Target date for completion: September 30, 2010

As of June 30, 2010, a complete assessment of all areas for furniture and patient use equipment with damaged surfaces was done with identification of those that need repair or replacement. Replacement furnishings/equipment, have been ordered. Repair kits were ordered for use on the units to repair damaged surfaces that do not come in contact with patients. Repairs are expected to be made by August 6, 2010.

Checking the integrity of upholstered furnishings and patient use equipment was added to the checklist used during monthly unit inspections with the Environment Management Service (EMS) supervisor and unit nurse managers. Routine cleaning of furnishings and checks of the integrity of upholstered furnishings was also added to the Housekeeping Aides Task List. Flyers were sent to supervisors for posting on unit bulletin boards in which assistance from staff in identifying compromised furniture or wheelchairs was requested along with directions on how to report findings to their supervisor.

The MCM PI-IC-04 was re-titled "Infection Control Procedures for Clinical Personnel" and updated to include relevant content on compromised upholstered furnishings and wheelchairs. The revised MCM will be sent to the Director's Office for signature by July 30, 2010. The revised policy will be reviewed with supervisors at the July Supervisory Forum. Supervisors will be directed to inform their staff of actions to take in a face-to-face meeting and/or instruct staff to read the content on compromised surfaces. Personnel will sign a roster attesting to the fact they have attended an in-service presented by their supervisor or that they read and understand the process in MCM PI-IC-04. Rosters will be submitted to Education Department by September 10, 2010.

Recommendation 11. We recommended that emergency call system functionality be maintained and that staff offices be secured when vacated.

Concur

Target date for completion: September 1, 2010

a. **Emergency Call System Functionality:** On May 17, 2010, the Safety Officer sent a notice to all nursing and housekeeping staffs and supervisors advising them not to loop or tie emergency assistance call cords to handrails. A rationale for the change in practice was included.

Inspection for Nurse Call cords tied to hand rails has been included in Nursing EOC rounds, housekeeping rounds, Safety Officer EOC rounds and patient tracers. All staff

involved with inspections as well as Zone Engineers and Housekeeping staff have been instructed to untie cords when found and educate staff on the proper procedure.

To monitor compliance, Performance Improvement (PI) staff will spot-check five patient rooms and five bathrooms on each unit in July, 2010. Compliance of 100% will close the action.

b. **Staff Office Security:** Deficiencies found during Security Rounds are communicated to the Director's Office by the Information Security Officer (ISO). Additionally, Security Incident tickets are logged with Network and Security Operations Center (NSOC) when security incidents are discovered during Security Rounds. Disciplinary actions are taken when warranted after further review of the incident. These actions will continue.

In addition, the need to lock office doors and computers in the clinical areas was discussed with providers and other clinical staff at the May Medicine Service staff meeting. An e-mail regarding the need to secure staff offices was also sent to all providers in late May, 2010.

In June, 2010, the Medicine SLM or designee began weekly rounds in the clinics to check for open computers/unlocked doors. Individual follow-up occurs with any employee found to have his/her computer open or office door unlocked when unoccupied. The Medicine Service Line will document rounds weekly on a spreadsheet and calculate percent compliance indicating number of offices checked and number of offices in compliance. Weekly rounds will continue until full compliance is achieved. The percentage of compliance will be reported to the Patient Safety/Regulatory Compliance Committee.

Recommendation 12. We recommended that providers complete inter-facility transfer documentation in accordance with VHA policy.

Concur

Target date for completion: December 30, 2010

Prior to the Office of Inspector General (OIG) Combined Assessment Program (CAP) Survey, a Process Action Team had been convened by the PI Council to address deficiencies identified with inter-facility transfers, especially related to documentation. At the time of survey, the Team had flow mapped the current system and identified the major barriers to documentation. As of June 4, 2010, a Provider Transfer Order Set was developed which includes all required elements as outlined in Veterans Health Administration (VHA) Directive 2007-015, Inter-facility Transfer Policy. Education of nursing, provider and Medical Officer of the Day (MOD) staff working in Urgent Care and acute medical inpatient units about the revised transfer process and use of the order set occurred the week of June 28, 2010.

A pilot of the revised process will begin on July 6, 2010 to include 400A (Acute Care) and Urgent Care. The pilot will run through July 20, 2010, or longer if necessary, to

obtain data from a sufficient number of transfers. An audit will be done of data collected on all transfers occurring during the pilot with a target of 100% compliance on the documentation elements. These results will be available August 20, 2010. Modifications will be made to the process based on feedback received during the pilot. Auditing of documentation elements will continue on 50% of transfers occurring over the subsequent 90 days. The audit data will be reported quarterly to the Performance Improvement Council (PIC) with the first report of audit data due at the September meeting.

Recommendation 13. We recommended that providers complete discharge documentation in accordance with VHA policy and that patients receive written discharge instructions.

Concur

Target date for completion: October 30, 2010

a. **Provider actions:** The Discharge Note and Discharge Summary will be changed to reflect that instructions are given to the patient by the provider, which include information about medications, diet, activity level and follow-up appointments. Information and discussion will be presented to providers at the July, 2010 Chief of Staff Meeting with individual follow-up with providers by the Associate Chief of Staff or a representative for the Chief of Staff.

Beginning in August, monthly auditing of discharge summaries will be done by PI staff. Eight charts, five from the acute medical unit and three from the medical rehab unit, will be audited each month to determine if all required elements are included. Compliance of 100% will be required to close the action.

b. **Nursing actions:** Major changes in nursing documentation related to patient discharge are under development. A Performance Action Team on Nursing Documentation had been chartered by the PI Council in March, 2010 to make improvements to several components of documentation including discharge. Recommendations approved by nursing and underway include the addition of a section that says “discharge education given to the patient” along with a detailed description of the discharge education provided including handouts and sources used for the education. All fields on the discharge document will be made mandatory for completion. Changes in documentation will be completed by August 31, 2010. Education of nursing staff about the changes will be completed by September 30, 2010. By October 30, 2010, the nurse manager will provide written verification that each nurse on the unit has been educated about changes in discharge documentation and expected competencies related to discharge education have been met.

Changes in the MCM related to nursing documentation will be made to clarify required elements to be included in nursing discharge notes and circumstances when discharge education is needed including transfers. A revised MCM will be sent to the Director’s

office for signature by August 20, 2010. Nursing staff will be educated about the policy by their nurse manager by September 10, 2010.

The Associate Chief of Nursing for Acute/Ambulatory Care will report monthly, beginning in July, 2010, to the PI Council on progress made to complete documentation changes. Once completed, discharge education, as documented by nursing staff, will be included in the medical record audits done monthly. Results will be reported to the Medical Records Review Committee on an ongoing basis.

Recommendation 14. We recommended that provider profiles be in compliance with VHA requirements.

Concur

Target date for completion: Closed

The Credentialing and Privileging Coordinators will insure that all future Focused Professional Practice Evaluations (FPPEs) will include both a start date and an end date. Service Line Managers were instructed June 4, 2010, to add appropriate start dates to FPPEs already in process or recently completed. No new FPPEs have been initiated since the survey, but one will be initiated on July 1, 2010. A start and end date will be included on this and all future FPPE forms.

In the future for FPPEs, the Medical Staff Executive Council (MSEC) will determine the duration and number of cases to be reviewed on a case-by-case basis depending on the provider's position, how often working, etc. The information will be documented in MSEC minutes and on FPPE forms.

Medicine Service Line has added data to the Provider Profile spreadsheets for the Compensation and Pension (C&P) providers.

Given the availability of a new way to collect data for the Quality of Compensation and Pension Exam Criteria, the Credentialing Coordinator will review criteria quarterly and ensure new data is being entered.

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