Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 09-03743-189

Combined Assessment Program Review of the VA Nebraska-Western Iowa Health Care System Omaha, Nebraska

July 12, 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.

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: http://www.va.gov/oig/contacts/hotline.asp**)**

Table of Contents

Executive Summary

Introduction

During the week of April 12–16, 2010, the OIG conducted a Combined Assessment Program (CAP) review of the VA Nebraska-Western Iowa Health Care System (the system), Omaha, NE. 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 33 system employees. The system is part of Veterans Integrated Service Network (VISN) 23.

Results of the Review

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

- Clinical Performance Measures
- Employee Satisfaction

We made recommendations in six of the activities reviewed. For these activities, the system needed to:

- Report reusable medical equipment (RME) activities to an executive-level committee and report results of biological spore tests on all sterilizers to the Infection Control (IC) Committee.
- Require that all standard operating procedures (SOPs) are consistent with manufacturers' instructions and reflect current practice.
- Require that a list of RME sterilized by ethylene oxide (EtO) be reviewed annually and approved by the Associate Director for Patient Care.
- Use flash sterilization in the operating room (OR) only in the case of an emergency and perform the Bowie Dick test daily on all pre-vacuum steam sterilizers.
- Conduct regular inventories for outdated items in the OR storage area.
- Correct identified eyewash conditions and ensure that Supply, Processing, and Distribution (SPD) humidity levels are maintained within the required ranges.
- Consistently complete and document biological testing of water and dialysate in the hemodialysis unit.

- Ensure that staff identified as at risk for exposure to a harmful atmosphere receive annual respirator fit testing, training, and medical evaluation.
- Require that all locked mental health (MH) unit staff and Multidisciplinary Safety Inspection Team (MSIT) members receive annual environmental hazard training.
- Update the local hand hygiene policy to include required monitoring and monitor hand hygiene compliance in all direct patient care areas.
- Require that Environmental Management Service (EMS) staff complete annual environment of care (EOC) training.
- Require that magnetic resonance imaging (MRI) support personnel complete annual MRI safety training.
- Clarify MRI safety policies and complete mock emergency response drills.
- Conduct a risk assessment of the MRI environment.
- Post MRI warning signs in all the identified MRI areas.
- Complete inter-facility transfer documentation and implement processes to effectively monitor and evaluate inter-facility transfers.
- Develop and implement a plan for Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE), collect provider-specific performance data, and document detailed discussions of physicians' performance data prior to reprivileging, as required by the Veterans Health Administration (VHA).
- Require that designated physicians who serve as advisors for the utilization management (UM) program complete VHA required training before assuming the responsibility.

The system complied with selected standards in the following two activities:

- Medication Management
- Suicide Prevention Safety Plans

This report was prepared under the direction of Karen Moore, Director, and Dorothy Duncan, Associate Director, Kansas City Office of Healthcare Inspections.

Comments

The Acting VISN and System Directors agreed with the CAP review findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 19–26, for the 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 system is comprised of two campuses located in Grand Island and Omaha, NE, and provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at seven community based outpatient clinics located in Lincoln, Grand Island, Bellevue, Holdrege, Norfolk, and North Platte, NE, and in Shenandoah, IA. The system is part of VISN 23 and serves a veteran population of about 166,700 in 104 counties in Nebraska and western Iowa and in parts of Kansas and Missouri.

Programs. The system provides a full range of patient care services and education. Comprehensive inpatient and outpatient health care is provided through primary care, medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, and geriatrics. The system has 136 hospital beds and 76 community living center (CLC) beds.

Affiliations and Research. The system is affiliated with the University of Nebraska Medical Center and Creighton University Medical Center and provides training for 118 residents in medicine, surgery, psychiatry, dentistry, pathology, and radiology. It also provides training for students in other disciplines, including nursing, pharmacy, and allied health. In fiscal year (FY) 2009, the system research program had 130 projects and a budget of $5.7 million. Important areas of research included MH, liver studies, experimental immunology laboratory, endocrine diabetes studies, and the pulmonary airways inflammation program.

Resources. In FY 2009, medical care expenditures totaled $255.1 million. The FY 2010 medical care budget is $272.6 million. FY 2009 staffing was 1,677 full-time employee equivalents (FTE), including 102 physician and 466 nursing FTE.

Workload. In FY 2009, the system treated 75,396 unique patients and provided 4,601 inpatient days in the hospital and 306 inpatient days in the CLC. The inpatient care workload totaled 6,516 discharges, and the average daily census, including CLC patients, was 140. Outpatient workload totaled 439,482 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
- RME
- Suicide Prevention Safety Plans

The review covered system operations for FY 2009 and FY 2010 through April 16, 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 system (*Combined Assessment Program Review of the VA Nebraska Western Iowa Health Care System, Omaha, Nebraska,* Report No. 07-00167-22,

November 13, 2007). The system had corrected all findings related to health care from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 33 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 reportable findings.

Organizational Strengths

Clinical Performance Measures

The system tied for 5th place nationally in the summary composite complexity ranking for FY 2009 VHA clinical performance measures. Sponsors, owners, and responsible managers take ownership of the management of performance measure data. The owners and responsible managers comprise a workgroup that regularly monitors clinical reminders and external peer review data for each measure. A team is responsible for implementing pilot tests for change to determine the best process improvements for the desired outcome. The team meets regularly with senior leadership (sponsors) to discuss barriers and needed resources for team success. Since implementing this process of ownership management at the lowest level, the system has risen from the bottom quartile of clinical performance measures in FY 2008 to among the highest ranking in FY 2009.

Employee Satisfaction

The system tied for 1st place nationally (out of 140 VHA facilities) in the FY 2009 Organizational Assessment Instrument of the annual All Employee Survey (AES). The system also ranked in the top two facilities in the country in the areas of innovation, leadership, employee development, work/family balance, and psychological safety of employees. These high scores are a result of a "2x2" process where every supervisor throughout the system is provided with their workgroup-level AES data and is expected to review that data with their staff over the course of two meetings and to develop two action plans to improve employee satisfaction within their individual work unit. The system has ranked

higher than the national average for employee satisfaction since FY 2007.

Results

Review Activities With Recommendations

Reusable Medical Equipment

The purpose of this review was to evaluate whether the system 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 system's SPD and satellite reprocessing areas are required to meet VHA, Association for the Advancement of Medical Instrumentation (AAMI), Occupational Safety and Health Administration (OSHA), and Joint Commission (JC) standards.

At the Omaha campus, we inspected SPD, the gastrointestinal (GI) reprocessing area, and the OR reprocessing and storage areas. At the Grand Island campus, we inspected SPD. We found that all areas were clean and that the separation of clean from dirty was maintained to assist in the prevention of cross-contamination. However, we identified the following areas that needed improvement.

Reporting Process. VHA requires[1] specific RME activities to be reported to an executive-level committee. These activities include validation of initial and on-going competency of staff, results of compliance with established SOPs, results of infection prevention and control monitoring, and risk management related activities. We found that the system did not have a process in place for reporting the required elements.

VA requires[2] the reporting of results of biological spore tests conducted on all sterilizers to the IC committee. We found that the results of biological spore tests were not reported to the IC committee.

[1] VHA Directive 2009-031, *Improving Safety in the Use of Reusable Medical Equipment through Standardization of Organizational Structure and Reprocessing Requirements*, June 26, 2009.
[2] VA Handbook 7176; *Supply, Processing and Distribution (SPD) Operational Requirements*; August 16, 2002.

SOPs. VHA requires[3] facilities to establish device-specific SOPs for RME in accordance with the manufacturers' instructions. We requested the SOPs and manufacturers' instructions for eight pieces of RME. We determined that the SOP for the dental surgery cassette did not have any steps for cleaning. The SOP for the endoscope had steps for manual flushing with a syringe; however, the system was currently using an Endo-Flush system.

The manufacturer's instructions for Cidex® OPA (ortho-phthalaldehyde)[4] required testing of liquid disinfectant prior to each use to ensure minimal effective concentration of active ingredients. We found that the system was not testing liquid disinfectants according to the manufacturer's instructions.

SPD. VA requires[5] that a list of RME sterilized by EtO is reviewed annually and approved by the Associate Director for Patient Care. We found that the system had a current list; however, the list was not approved.

OR. VA requires[6] that full sterilization procedures be used for all surgical instruments. Flash sterilization (a shorter sterilization process) is to be used during a surgical procedure only in the case of an emergency, such as a dropped sterilized instrument. We reviewed OR flash sterilization log documentation from March 2009 to March 2010 and found that flash sterilization was used in non-emergent situations, such as insufficient instruments.

VA requires[7] that the Bowie Dick test (determines proper functioning of the sterilizer) is done daily on all pre-vacuum steam sterilizers. We found that the system did not perform the Bowie Dick test on the pre-vacuum steam sterilizers in the OR.

Environment. VHA requires that inventory in all clean and sterile storage areas be verified on a regular basis for outdated, damaged, or obsolete items.[8] We found one tray and three pieces of equipment with expired dates on the

[3] VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.
[4] A liquid chemical germicide that is a high-level disinfectant.
[5] VA Handbook 7176.
[6] VA Handbook 7176.
[7] VA Handbook 7176.
[8] VHA Handbook 1761.02, *VHA Inventory Management*, October 20, 2009.

shelf in the OR storage area. Management took immediate action, and the items were returned for reprocessing.

The American National Standards Institute requires that eyewash stations be checked weekly. We found that eyewash stations were checked monthly instead of weekly in the GI reprocessing area (Omaha campus) and in SPD (Grand Island campus). Additionally, the eyewash station in SPD was not operational.

We also found that the eyewash stations in all reprocessing areas were attached to the hot water source. OSHA requires that the water temperature delivered by the units be lukewarm. Prior to our visit, the system had begun installing thermostatic valves in the eyewash fixtures to automatically regulate the water temperatures.

VA requires[9] that temperature and humidity levels in SPD be maintained within specific ranges. We reviewed documentation of humidity levels and found that in the SPD storage area at the Grand Island campus, the readings were consistently below the specified range.

Recommendation 1 We recommended that the Acting VISN Director ensure that the System Director requires that RME activities be reported to an executive-level committee and that results of biological spore tests on all sterilizers be reported to the IC Committee.

The Acting VISN and System Directors concurred with the findings and recommendation. RME activities and results of biological spore tests will be reported to the IC Committee. The Medical Executive Committee will review all IC Committee minutes. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 2 We recommended that the Acting VISN Director ensure that the System Director requires that all SOPs are consistent with manufacturers' instructions and reflect current practice.

The Acting VISN and System Directors concurred with the findings and recommendation. The system will conduct an annual review of all SOPs for consistency with manufacturers' instructions and current practice. The

[9] VA Handbook 7176.

implementation plan is acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 3 We recommended that the Acting VISN Director ensure that the System Director requires that a list of RME sterilized by EtO be reviewed annually and approved by the Associate Director for Patient Care.

The Acting VISN and System Directors concurred with the finding and recommendation. A list of RME sterilized by EtO was developed, reviewed, and signed by the Associate Director for Patient Care. The corrective action is acceptable, and we consider this recommendation closed.

Recommendation 4 We recommended that the Acting VISN Director ensure that the System Director requires that flash sterilization is used in the OR only in the case of an emergency and that the Bowie Dick test is performed daily on all pre-vacuum steam sterilizers.

The Acting VISN and System Directors concurred with the findings and recommendation. A local policy addressing the use of flash sterilization was revised on April 19, 2010, and staff have been educated regarding policy changes. The OR Invasive Procedure Committee is reviewing and analyzing monthly tracking of flash sterilization to determine whether additional instruments are needed. Staff are now performing the Bowie Dick test as required. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 5 We recommended that the Acting VISN Director ensure that the System Director requires that regular inventories for outdated items are conducted in the OR storage area.

The Acting VISN and System Directors concurred with the finding and recommendation. SPD and OR staff will place only one date on sterilized RME. Weekly audits are being conducted for outdated supplies. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 6 We recommended that the Acting VISN Director ensure that the System Director requires that the identified eyewash

conditions are corrected and that SPD humidity levels are maintained within the required ranges.

The Acting VISN and System Directors concurred with the findings and recommendation. The scope of work for correcting eyewash conditions has been sent out for bids. The eyewash station at the Grand Island campus has been replaced. SPD humidity levels are being monitored daily, and work orders are being submitted when levels are out of range. The implementation 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 VHA facilities 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 conducted onsite inspections of the hemodialysis unit; the locked MH unit; the emergency department (ED); outpatient clinic areas; and inpatient medical, surgical, intensive care, and CLC units. The system maintained a generally clean and safe environment. Staff and nurse managers expressed satisfaction with the responsiveness of the housekeeping staff on their units. System managers conducted quarterly MH EOC assessments for the locked MH unit and were pursuing corrective actions. However, we identified the following conditions that needed improvement.

Hemodialysis Unit. The AAMI requires monthly biological testing of water and dialysate[10] used for hemodialysis. We reviewed 13 months of culture reports (water and dialysate) and found that staff inconsistently performed and documented biological testing.

Respirator Fit Testing. Local policy and OSHA require that staff identified as at risk for exposure to a harmful atmosphere, such as tuberculosis, receive annual respirator fit testing, training, and medical evaluation. We found that 8 (47 percent) of 17 selected staff at risk for exposure did not receive the required annual respirator fit testing, training, and medical evaluation.

[10] Liquid used to clean waste by pulling toxins from the blood during dialysis.

MH Environmental Hazard Training. Employees assigned to locked inpatient MH units and members of the MSIT are required to undergo annual training on the identification of environmental hazards that pose a risk to suicidal patients.[11] We found that 12 (92 percent) of 13 selected staff had not completed the required annual MH environmental hazard training.

Hand Hygiene. VHA policy[12] requires that the system have a local hand hygiene policy with an identified process to monitor health care workers' hand hygiene practices and hand hygiene compliance in all direct patient contact areas. The local hand hygiene policy did not include a process for monitoring health care workers' adherence to the required hand hygiene practices, and hand hygiene compliance data were not consistently compiled for all direct patient care areas.

Annual EOC Training. Local policy and The JC require that staff receive training on specific job duties. We found that 8 (80 percent) of 10 selected EMS staff had not completed the required annual EOC training.

Recommendation 7 We recommended that the Acting VISN Director ensure that the System Director requires staff to consistently complete and document biological testing of water and dialysate in the hemodialysis unit.

The Acting VISN and System Directors concurred with the finding and recommendation. The Infection Prevention Practitioner is now responsible for reviewing documentation submitted by hemodialysis technicians to ensure compliance with requirements. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 8 We recommended that the Acting VISN Director ensure that the System Director requires that staff identified as at risk for exposure to a harmful atmosphere receive annual respirator fit testing, training, and medical evaluation.

The Acting VISN and System Directors concurred with the finding and recommendation. Annual fit testing, training, and

[11] Deputy Under Secretary for Health for Operations and Management, "Mental Health Environment of Care Checklist," memorandum, August 27, 2007.
[12] VHA Directive 2005-002, *Required Hand Hygiene Practices*, January 13, 2005.

medical evaluations will be provided to identified staff. The EOC Committee will review quarterly reports to monitor compliance. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 9 We recommended that the Acting VISN Director ensure that the System Director requires that all locked MH unit staff and MSIT members receive annual environmental hazard training.

The Acting VISN and System Directors concurred with the finding and recommendation. Staff who either work in or enter the locked MH unit have received training. The EOC Committee will review an annual report of compliance for locked MH unit staff and MSIT members. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 10 We recommended that the Acting VISN Director ensure that the System Director requires staff to update the local hand hygiene policy to include required monitoring and to monitor hand hygiene compliance in all direct patient contact areas.

The Acting VISN and System Directors concurred with the findings and recommendation. The local hand hygiene policy was updated to include monitoring in all direct patient care areas, and a calendar was developed to ensure that all patient care areas are monitored. Data is being reported to the IC Committee. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 11 We recommended that the Acting VISN Director ensure that the System Director requires EMS staff to complete annual EOC training.

The Acting VISN and System Directors concurred with the finding and recommendation. The system is in the process of completing annual training, and a training plan has already been developed for FY 2011. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Magnetic Resonance Imaging Safety

The purpose of this review was to evaluate whether the system 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. The system had appropriate barriers to prevent unauthorized or accidental access to the MRI areas. 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 training records of six MRI personnel and found that all had completed MRI safety training. We reviewed the medical records of 10 patients who received an MRI prior to our visit and found that all contained the MRI screening form. We identified the following areas that needed improvement.

MRI Safety Training. Local policy requires support (non-MRI) personnel to complete annual MRI safety training. We reviewed the training records of six support personnel who had access to the MRI area and found that two had incomplete training documentation.

Emergency Drills and Safety Policies. Mock emergency response drills were not completed every 2 months, as required by local policy. In addition, the system had multiple MRI safety policies that contained inconsistent procedures on how to handle MRI emergencies.

Environmental Risk Assessment. The JC requires completion of a risk assessment of the MRI environment. Staff were unable to provide documentation that a risk assessment had been completed.

MRI Warning Signs. Local policy requires MRI warning signs in identified areas. We found that staff had not posted MRI warning signs in all the identified MRI areas.

Recommendation 12 We recommended that the Acting VISN Director ensure that the System Director requires that MRI support personnel complete annual MRI safety training.

The Acting VISN and System Directors concurred with the finding and recommendation. An MRI policy is currently being developed. Once the policy is approved, support personnel will receive training based on their specific responsibilities. Compliance will be monitored through the EOC Committee. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 13 We recommended that the Acting VISN Director ensure that the System Director requires that MRI personnel clarify MRI safety policies and complete mock emergency response drills.

The Acting VISN and System Directors concurred with the finding and recommendation. An MRI policy is being developed, which will clarify safety policies and address emergency response drills. Compliance with MRI policy requirements will be monitored through the EOC Committee. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 14 We recommended that the Acting VISN Director ensure that the System Director requires that MRI personnel conduct a risk assessment of the MRI environment.

The Acting VISN and System Directors concurred with the finding and recommendation. An interdisciplinary team will complete the MRI risk assessment and report to the EOC Committee. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 15 We recommended that the Acting VISN Director ensure that the System Director requires that staff post MRI warning signs in all the identified MRI areas.

The Acting VISN and System Directors concurred with the finding and recommendation. Signs identifying the different zones have been posted. A sign noting when the MRI magnet is on will be posted. The implementation 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 discharges and inter-facility transfers were coordinated appropriately over the continuum of care and met VHA and

JC requirements. Coordinated discharges and transfers are essential to an integrated, ongoing care process and optimal patient outcomes.

VHA policy[13] 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 12 discharged patients and determined that clinicians had generally documented the required elements. Also, we found that follow-up appointments occurred within the timeframes specified.

VHA requires[14] that systems have a policy that ensures the safe, appropriate, and timely transfer of patients. We determined that the system had an appropriate transfer policy. However, we identified the following area that needed improvement.

Inter-Facility Transfers. VHA policy requires specific information (such as the reason for transfer, mode of transportation, and informed consent to transfer) to be recorded in the transfer documentation. Local policy requires that a credentialed provider either sign or counter sign a specific template note in the Computerized Patient Record System and that patients complete an informed consent to transfer. Additionally, VHA requires inter-facility transfers to be monitored and evaluated as part of the QM program.

We reviewed transfer documentation for 10 patients transferred from the system's acute inpatient units to another facility. We did not review documentation for patients transferred from the ED because managers were unable to provide that information. None of the 10 patient records contained all the required information. Examples of missing information included documentation of advanced directives, reason for transfer, and level of required care. In addition, we did not find evidence that patient transfers were monitored and evaluated as part of the QM program prior to March 2010.

Recommendation 16 We recommended that the Acting VISN Director ensure that the System Director requires staff to complete inter-facility

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

transfer documentation and implement processes to effectively monitor and evaluate inter-facility transfers.

The Acting VISN and System Directors concurred with the findings and recommendation. Clinical staff have been educated on the requirements for inter-facility transfer documentation. A daily monitoring process has been implemented, and reports will be submitted to oversight committees. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Physician Credentialing and Privileging

The purpose of this review was to determine whether 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 provider profiles.[15] 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. FPPE was implemented in accordance with VHA policy for the one physician hired within the past 12 months. However, we identified the following area that needed improvement.

OPPE and FPPE. VHA policy requires a thorough written plan with specific competency criteria for OPPE and FPPE for all privileged physicians. There was no document that defined the system's plan for OPPE or FPPE. The Chief of Staff stated that OPPE was in the early stages of development but had not been approved by the Executive Committee of the Medical Staff and had not been implemented.

We reviewed the profiles of nine physicians who had been reprivileged in the previous 12 months. Acceptable performance data for use in the reprivileging process was missing in all nine profiles. Examples of acceptable data include the number of procedures performed, complications from these procedures, and results of medical record reviews.

Recommendation 17 We recommended the Acting VISN Director ensure that the System Director requires that the system develop and

[15] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

implement a plan for OPPE and FPPE, collect provider-specific performance data, and document detailed discussions of physicians' performance data prior to reprivileging, as required by VHA.

The Acting VISN and System Directors concurred with the findings and recommendation. All service lines have developed and initiated the collection of provider-specific performance data. The implementation 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 system's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the senior management team and QM personnel. We evaluated plans, policies, and other relevant QM documents.

The QM program was generally effective in providing oversight of the system's quality of care, and senior managers supported the program. A review of committee minutes prior to October 2009 showed inconsistent documentation of items such as follow-up of action plans, completion dates, and assignments of staff responsible for tracking identified issues. In addition, the minutes lacked in-depth discussion of key QM activities. System leaders had identified the deficiencies and had implemented an action plan to revise the format for minutes. The current process provides evidence of tracking issues, follow-up, completion dates, and the names of responsible staff. We encouraged system leaders to continue the current process.

We evaluated 12 QM activities and determined that the system complied with VHA standards in 11 areas. We identified one area that needed improvement.

UM. VHA requires[16] that designated UM physician advisors complete training on the use of standardized review criteria. Although two designated physicians completed the required training during our site visit, there was no evidence that any physicians had completed the training prior to that time.

Recommendation 18 We recommended the Acting VISN Director ensure that the System Director requires that designated physicians who

[16] VHA Directive 2005-040, *Utilization Management Policy*, September 22, 2005.

serve as advisors for the UM program complete VHA required training before assuming the responsibility.

The Acting VISN and System Directors concurred with the finding and recommendation. All currently designated physicians have completed training, and any newly designated physicians will receive training. The corrective action is acceptable, and we consider this recommendation closed.

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 system had implemented a practice guideline governing the maintenance of chronic renal disease patients who receive erythropoiesis-stimulating agents.[17] 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. The pharmacy was open at all times to provide pharmacy support and answer questions. 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.[18]

A previous OIG review of suicide prevention programs in VHA facilities[19] found a 74 percent compliance rate with

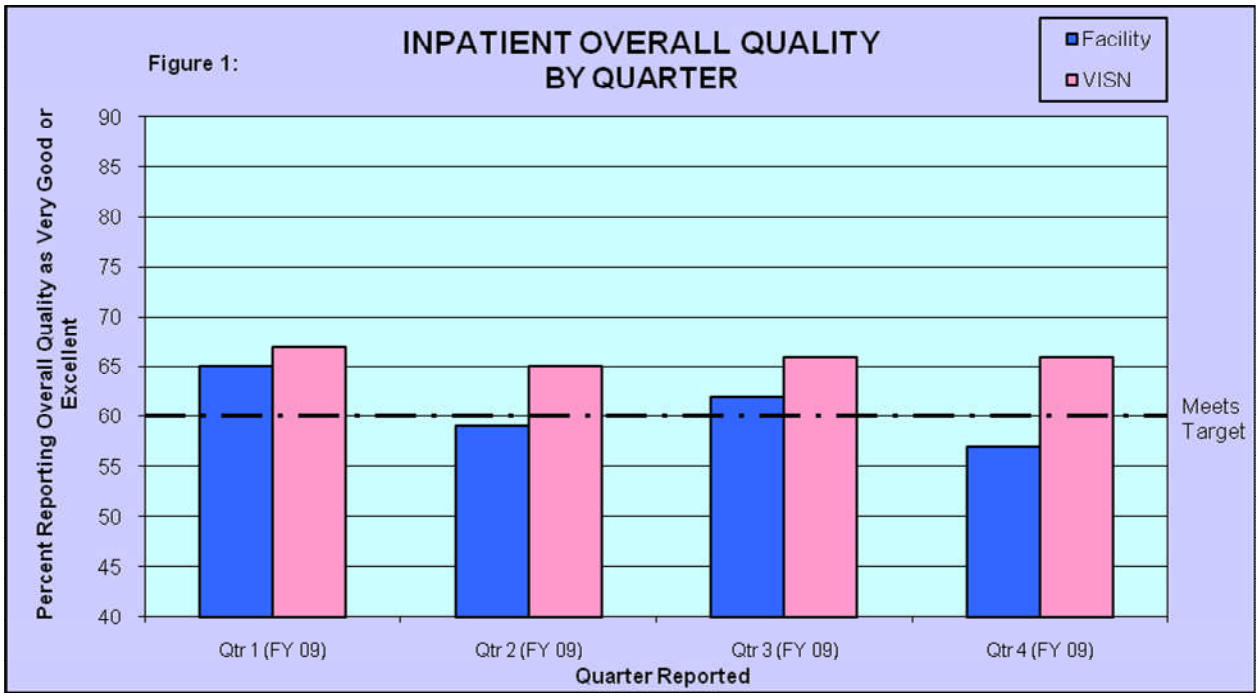
[17] Drugs that stimulate the bone marrow to make red blood cells; used to treat anemia.
[18] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
[19] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation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

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.

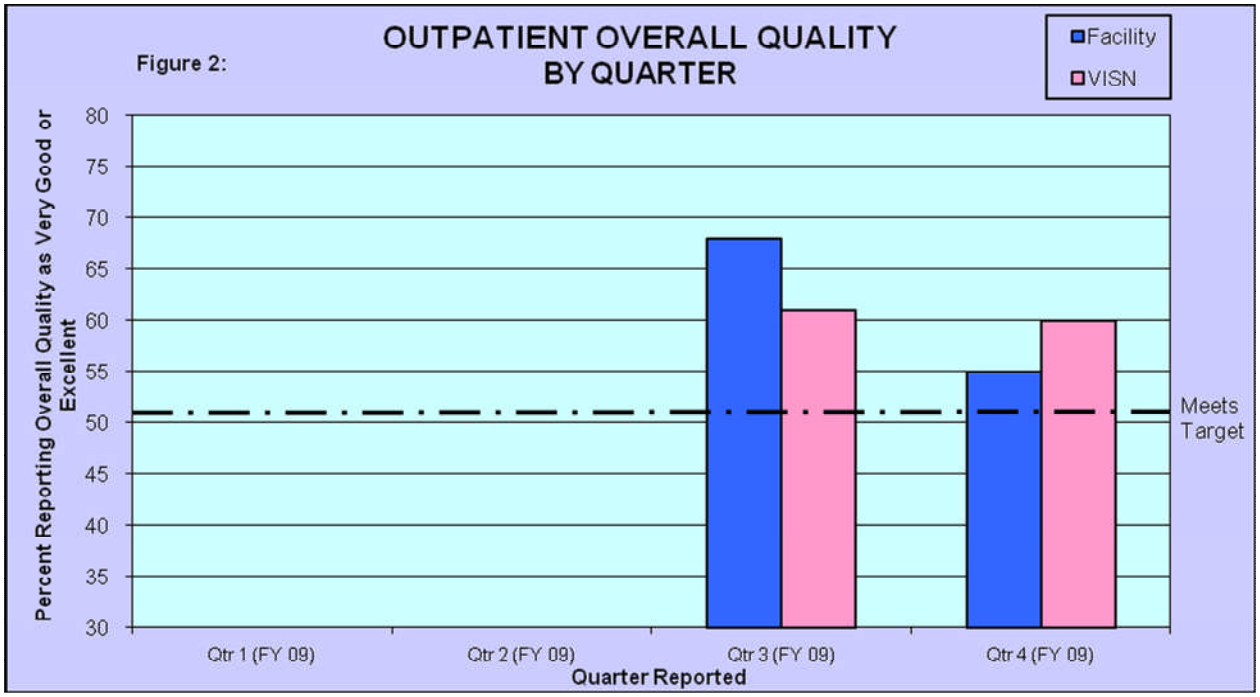
We reviewed the medical records of 10 patients assessed to be at high risk for suicide and found that clinicians had developed timely safety plans that included all required elements in 9 (90 percent) of the 10 records. One patient refused to complete a plan and transferred out of the VA for follow-up care. Also, we found evidence to support that the patients and/or their families participated in the development of the plans. We made no recommendations.

VHA Satisfaction Surveys

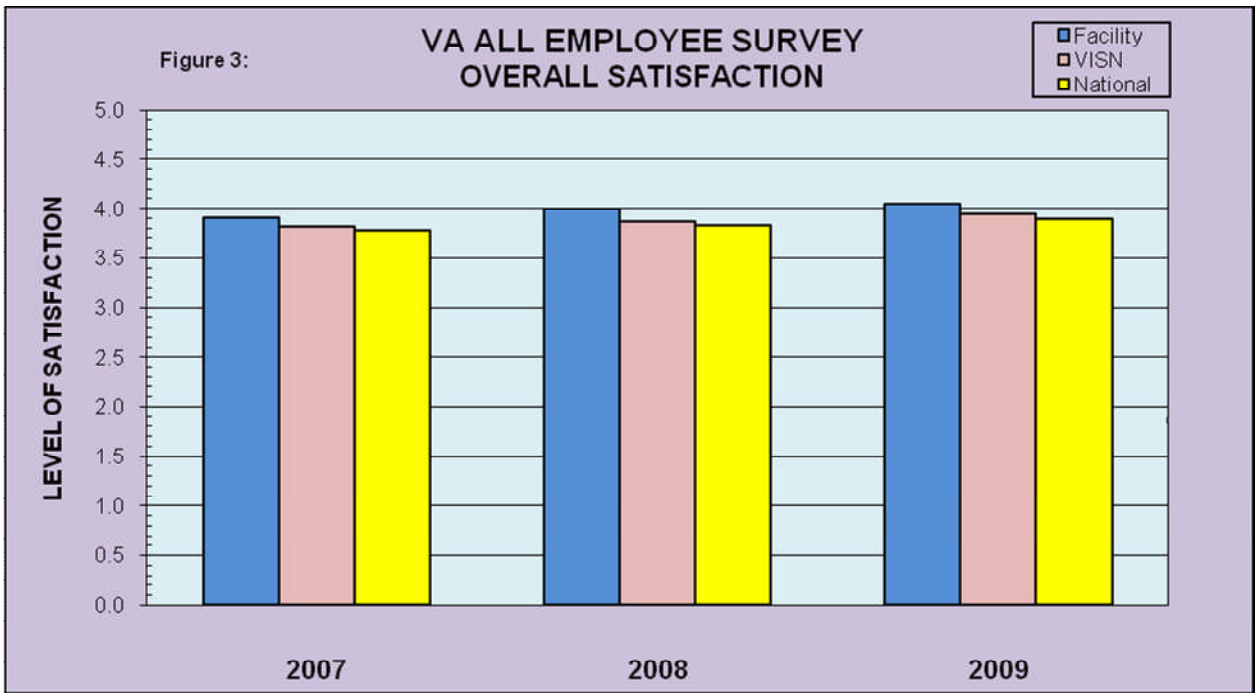
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 below shows the system's and VISN's overall inpatient satisfaction scores for quarters 1–4 of FY 2009. Figure 2 on the next page shows the system's and VISN's overall outpatient satisfaction scores for quarters 3 and 4 of FY 2009.[20] The target scores are noted on the graphs.



[20] 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 system'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.



Acting VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 11, 2010

From: Acting Director, VA Midwest Health Care Network (10N23)

Subject: **Combined Assessment Program Review of the VA Nebraska-Western Iowa Health Care System, Omaha, Nebraska**

To: Director, Kansas City Healthcare Inspections Division (54KC)

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

Thank you for the opportunity to review and provide comments in regard to the Combined Assessment Program review of VA Nebraska Western Iowa Healthcare System conducted April 12–16, 2010.

We concur with the action plans regarding the recommendations identified in this report.

Steven C. Julius, M.D.

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 11, 2010

From: Director, VA Nebraska-Western Iowa Health Care System (636/00)

Subject: **Combined Assessment Program Review of the VA Nebraska-Western Iowa Health Care System, Omaha, Nebraska**

To: Acting Director, VA Midwest Health Care Network (10N23)

1. This is to acknowledge the receipt and review of the findings and recommendations of the Office of Inspector General Combined Assessment Program review. Nebraska-Western Iowa Health Care System concurs with the findings and recommendations. Corrective action plans have been developed or implemented for all recommendations.

2. Our appreciation is extended to the OIG CAP team. The team was consultative, professional and provided constructive feedback to our staff. We appreciate the thorough review and the opportunity to further improve the quality of care we provide to our veterans.

AL WASHKO

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 Acting VISN Director ensure that the System Director requires that RME activities be reported to an executive-level committee and that results of biological spore tests on all sterilizers be reported to the IC Committee.

Concur Target Completion Date: August 31, 2010

NWI HCS agrees to require RME activities reported to an executive-level committee and results of biological spore tests on all sterilizers be reported to the IC Committee. RME activities and results of biological spore tests on all sterilizers will be reported to the Infection Control Committee. The Medical Executive Committee will review all Infection Control Committee minutes.

Recommendation 2. We recommended that the Acting VISN Director ensure that the System Director requires that all SOPs are consistent with manufacturers' instructions and reflect current practice.

Concur Target Completion Date: June 30, 2010

NWI HCS agrees that all SOPs should be consistent with current manufacturers' instructions and should reflect current practice. An annual review of all SOPs will be reviewed for consistency with the manufacturer's instructions and current practice.

Recommendation 3. We recommended that the Acting VISN Director ensure that the System Director requires that a list of RME sterilized by EtO be reviewed annually and approved by the Associate Director for Patient Care.

Concur Target Completion Date: Completed

NWI HCS agrees that the Associate Director for Patient Care should annually review and approve the list of RME sterilized by EtO. A list of RME sterilized by EtO was developed, reviewed and signed by the Associate Director for Patient Care. We consider this recommendation completed.

Recommendation 4. We recommended that the Acting VISN Director ensure that the System Director requires that flash sterilization is used in the OR only in the case of an emergency and that the Bowie Dick test is performed daily on all pre-vacuum steam sterilizers.

Concur Target Completion Date: August 31, 2010

NWI HCS agrees that flash sterilization in the OR should be utilized only in the case of emergencies and the Bowie Dick test should be performed daily on all pre-vacuum steam sterilizers. A flash sterilization policy addressing utilization of flash sterilization only for emergencies was revised and completed April 19, 2010. All OR staff were educated regarding the changes to the policy. Monthly tracking of all flash sterilization began in January 2010 and is reviewed by the OR Invasive Procedure Committee. Analysis regarding the use of flash sterilization is also an ongoing monthly assessment with ordering of additional instruments as needed.

The following items were initiated and completed on April 16, 2010: 1) the development of a SOP for the Bowie Dick test, 2) SPD educated the OR staff on the Bowie Dick test, 3) implementation of the Bowie Dick test.

Recommendation 5. We recommended that the Acting VISN Director ensure that the System Director requires that regular inventories for outdated items are conducted in the OR storage area.

Concur Target Completion Date: September 30, 2010

NWI HCS agrees that regular inventories for outdated items should be conducted in the OR storage area. The SPD and OR staff have been educated to place only one date on processed RME that have been through the sterilization process. The RME Oversight Committee will identify specific owners in the specialty areas to facilitate routine auditing for outdated RME supplies. These owners will be identified at the June 2010 meeting. Weekly audits are conducted for outdated supplies.

Recommendation 6. We recommended that the Acting VISN Director ensure that the System Director requires that the identified eyewash conditions are corrected and that SPD humidity levels are maintained within the required ranges.

Concur Target Completion Date: December 31, 2010

NWI HCS agrees that eyewash conditions should be corrected and SPD humidity levels should be maintained. The scope of work for correcting the eyewash conditions was finalized on June 4, 2010 and has been sent out for bids. The eyewash station in Grand Island was replaced on April 28, 2010. Weekly checks are being completed.

SPD humidity levels are monitored daily. A work order is submitted when the level is out of range. SPD is working with engineering on a long term solution. The SPD humidity levels and progress toward a long term solution will be reported and monitored monthly to the RME Oversight Committee. Work orders have been entered to Engineering for humidity levels out of range to ensure levels are maintained within the required ranges.

Recommendation 7. We recommended that the Acting VISN Director ensure that the System Director requires staff to consistently complete and document biological testing of water and dialysate in the hemodialysis unit.

Concur Target Completion Date: August 31, 2010

NWI HCS agrees to require staff consistently complete and document biological testing of water and dialysate in the hemodialysis unit. The following actions were taken the week of April 12-16, 2010: 1) documentation binder developed for 2010, 2) a lead dialysis tech was hired and part of responsibilities included ensuring testing completed and documented appropriately, 3) program support assistant scanning all lab results to network folder for review by Infection Prevention Practitioner, 4) weekly meetings with Infection Prevention Practitioner, 5) Dialysis manager attending monthly Infection Prevention Committee. The following actions are currently underway: 1) back-up staff for lead tech are being trained, 2) Dialysis Infection Prevention policy has been updated and is currently being reviewed by Infection Prevention Practitioner.

Recommendation 8. We recommended that the Acting VISN Director ensure that the System Director requires that staff identified as at risk for exposure to a harmful atmosphere receive annual respirator fit testing, training, and medical evaluation.

Concur Target Completion Date: August 27, 2010

NWI HIC agrees that staff identified as at risk of exposure to a harmful atmosphere received annual respirator fit testing, training, and medical evaluation. Annual fit testing and training will be provided to staff identified as being potentially exposed to a harmful exposure. A priority group of employees have been identified that will require this testing and training. New employees determined to be in the priority group will have fit testing conducted as part of the new employee pre-placement examination process. Medical evaluations will be completed annually on those staff identified at risk for exposure. Quarterly reports to monitor compliance that priority staff identified as risk of exposure to harmful atmosphere will be reviewed by the Environment of Care Committee.

Recommendation 9. We recommended that the Acting VISN Director ensure that the System Director requires that all locked MH unit staff and MSIT members receive annual environmental hazard training.

Concur Target Completion Date: August 1, 2010

NWI HCS agrees that all locked MH unit staff and MSIT members need to receive annual environmental hazard training. Employees who either work or enter the locked mental health unit have been trained. A LMS curriculum has been developed for clinical and non clinical staff related to environment of care issues on the locked unit. Until the LMS curriculum is on-line (anticipated August 1, 2010) staff will be educated through the use of a VISN developed PowerPoint presentation. Annual report of compliance for locked MH unit staff and MSIT members will be reported to the Environment of Care Committee.

Recommendation 10. We recommended that the Acting VISN Director ensure that the System Director requires staff to update the local hand hygiene policy to include required monitoring and to monitor hand hygiene compliance in all direct patient contact areas.

Concur Target Completion Date: October 31, 2010

NWI HCS agrees to require an updated hand hygiene policy that includes the required monitoring and agrees to monitor hand hygiene compliance in all direct patient contact areas. The Hand Hygiene policy was updated to include required monitoring in all direct patient contact areas. This was concurred through the Medical Executive Committee in May 2010. A calendar was developed to ensure all patient care areas, inpatient and outpatient, are monitored. This data is reported to the Infection Prevention Committee on a monthly basis.

Recommendation 11. We recommended that the Acting VISN Director ensure that the System Director requires EMS staff to complete annual EOC training.

Concur Target Completion Date: August 31, 2010

A review of all employee records has been completed. Training will be conducted June through August to assure all training requirements are met for each of the NWI sites. To ensure all EMS personnel are trained annually to perform their respective duties a training plan has been developed for FY 11. Monthly topics have been identified for FY 11.

Recommendation 12. We recommended that the Acting VISN Director ensure that the System Director requires that MRI support personnel complete annual MRI safety training.

Concur Target Completion Date: September 30, 2010

NWI HCS agrees that MRI support personnel will complete annual MRI safety training. All MRI support personnel will be trained according the approved MRI policy. This training will be based upon their specific responsibilities according to the policy. A training plan will be developed once concurrence to the MRI policy is completed. Compliance to policy will be reported annually to the Environment of Care Committee.

Recommendation 13. We recommended that the Acting VISN Director ensure that the System Director requires that MRI personnel clarify MRI safety policies and complete mock emergency response drills.

Concur Target Completion Date: August 31, 2010

NWI HCS agrees that a MRI policy is developed and adherence to the policy is monitored. A MRI policy is currently being developed. Compliance to the requirements identified in the MRI policy will be monitored through the Environment of Care Committee.

Recommendation 14. We recommended that the Acting VISN Director ensure that the System Director requires that MRI personnel conduct a risk assessment of the MRI environment.

Concur Target Completion Date: November 30, 2010

NWI HCS agrees that a risk assessment of the MRI environment needs to be conducted. In collaboration with an interdisciplinary team, the risk assessment will be completed and reported to the Environment of Care Committee.

Recommendation 15. We recommended that the Acting VISN Director ensure that the System Director requires that staff post MRI warning signs in all the identified MRI areas.

Concur Target Completion Date: August 31, 2010

NWI HCS agrees that MRI warning signs in all the identified MRI areas need to be identified. During the OIG review, signs were posted identifying the different zones. A sign noting the MRI magnet is on will be posted.

Recommendation 16. We recommended that the Acting VISN Director ensure that the System Director requires staff to complete inter-facility transfer documentation and implement processes to effectively monitor and evaluate inter-facility transfers.

Concur Target Completion Date: September 30, 2010

NWI HCS agrees that staff need to complete the inter-facility transfer documentation and implement processes to monitor and evaluate the compliance. Physicians and residents have been educated on the requirement for inter-facility transfer documentation. Nursing staff have been also been educated regarding the process and assist in the reinforcement of required documentation. The Bed Coordinator reviews all transfers from the facility for appropriate documentation and follow-up is done at that time if incomplete. This report is shared in the morning report Monday-Friday. Reports will be made monthly to the Access and Service Chiefs committee meetings.

Recommendation 17. We recommended that the Acting VISN Director ensure that the System Director requires that the system develop and implement a plan for OPPE and FPPE, collect provider-specific performance data, and document detailed discussions of physicians' performance data prior to reprivileging, as required by VHA.

Concur Target Completion Date: September 30, 2010

NWI HCS agrees that provider-specific performance data be collected for OPPE and FPPE and detailed discussions of a physician's performance data prior to reprivileging is documented. All service lines have developed developing provider-specific performance data based upon the American College of Graduate Medical Education requirements. The new OPPE and FPPE assessment tools will be immediately implemented by each service line with their next review.

Recommendation 18. We recommended that the Acting VISN Director ensure that the System Director requires that designated physicians who serve as advisors for the UM program complete VHA required training before assuming the responsibility.

Concur Target Completion Date: Completed

NWI HCS agrees that designated physicians serving as advisors to the UM program complete the required VHA training before assuming responsibility. All current designated physicians have been trained with the training related to the UM Directive 2005-040. Because NWI had been a pilot site for implementation of the NUMI program, all currently designated physicians have also been trained with the upcoming LMS training. Any newly designated physicians will have one-on-one training with the Manager of patient Flow and Utilization Management until the LMS training is on-line. We consider this recommendation completed.

OIG Contact and Staff Acknowledgments

Contact	Dorothy Duncan, Associate Director Kansas City Office of Healthcare Inspections (816) 997-6966
Contributors	James Seitz, Team Leader Deborah Howard Jennifer Kubiak Karen Moore Reba B. Ransom James Werner, Office of Investigations

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Midwest Health Care Network (10N23)
Director, VA Nebraska-Western Iowa Health Care System (636/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Chuck Grassley, Tom Harkin, Mike Johanns, Ben Nelson
U.S. House of Representatives: Jeff Fortenberry, Steve King, Adrian Smith, Lee Terry

This report is available at http://www.va.gov/oig/publications/reports-list.asp.