Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-00045-207

Combined Assessment Program Review of the Carl Vinson VA Medical Center Dublin, Georgia

July 26, 2010

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

During the week of April 19–22, 2010, the OIG conducted a Combined Assessment Program (CAP) review of the Carl Vinson VA Medical Center (the facility), Dublin, GA. 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 203 employees. The facility is part of Veterans Integrated Service Network (VISN) 7.

Results of the Review

The CAP review covered seven operational activities. We identified the following organizational strength:

- Transitioning Levels of Care

We made recommendations in six of the activities reviewed; one QM recommendation was a repeat recommendation from the last two CAP reviews. For these activities, the facility needed to ensure that:

- Supply, Processing, and Distribution (SPD) staff clean reusable medical equipment (RME) according to the manufacturers' instructions.
- SPD standard operating procedures (SOPs) for RME cleaning and disinfection are consistent with manufacturers' instructions.
- Annual competencies for SPD employees are completed timely and documented.
- Clinicians develop timely, comprehensive suicide safety plans, as required by Veterans Health Administration (VHA) guidelines.
- QM oversight committee minutes reflect discussion of improvement opportunities and track actions to completion.
- Annual patient safety reports include all required elements.
- Focused Professional Practice Evaluation (FPPE) is initiated and documented, as required by VHA policy.
- Clinicians consistently document all elements for each influenza vaccine given, as required by VHA policy.
- Appropriate staff receive annual respirator fit testing.

The facility complied with selected standards in the following activity:

- Coordination of Care (COC).

This report was prepared under the direction of Susan Zarter, Associate Director, Atlanta Office of Healthcare Inspections.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 14–18, for full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Profile

Organization. The facility is designated as a Veterans Rural Access Hospital. It is located in Dublin, GA, and provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at three community based outpatient clinics in Albany, Macon, and Perry, GA. The facility serves a veteran population of about 125,000 throughout 52 counties in Georgia and is part of VISN 7.

Programs. The facility provides behavioral health, long-term care, home care, and acute care services. It has 25 acute care, 145 domiciliary, and 161 community living center (CLC) beds.

Affiliations. The facility has no current academic affiliations. Discussions are underway with Mercer University School of Medicine to develop a family/medical residency rotation in surgery. The facility partners with Dwight David Eisenhower Army Medical Center in Fort Gordon, GA, for cardiovascular and orthopedic services.

Resources. In fiscal year (FY) 2009, medical care expenditures totaled about $155.6 million. The FY 2010 medical care budget is approximately $159 million. FY 2009 staffing was 851 full-time employee equivalents (FTE), including 37 physician and 104 registered nursing FTE.

Workload. In FY 2009, the facility treated 29,737 unique patients and provided 5,748 inpatient days in the hospital, 45,086 days in the domiciliary, and 53,804 inpatient days in the CLC units. The inpatient care workload totaled 2,349 discharges, and the average daily census, including CLC and domiciliary patients, was 287. Outpatient workload totaled 239,403 visits.

Objectives and Scope

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

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.

- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

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

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

- COC
- Environment of Care (EOC)
- Medication Management
- Physician Credentialing and Privileging (C&P)
- QM
- RME
- Suicide Prevention Safety Plans

The review covered facility operations for FY 2009 and FY 2010 through April 22, 2010, and was done in accordance with OIG SOPs for CAP reviews. We also followed up on selected recommendations from two previous CAP reports (*Combined Assessment Program Review of the Carl Vinson VA Medical Center, Dublin, Georgia,* Report No. 07-00795-99, March 14, 2007, and *Combined Assessment Program Review of the Carl Vinson VA Medical Center, Dublin, Georgia,* Report No. 04-03028-49, December 13, 2004.) The facility had corrected most health care findings from our prior CAP reviews; however, one QM condition still existed.

During this review, we also presented fraud and integrity awareness briefings for 203 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. The activity in the "Review Activity Without Recommendations" section had no findings requiring corrective actions.

Organizational Strength

Transitioning Levels of Care

In 2009, the facility initiated the Transitioning Levels of Care project to improve patient flow from acute care to the CLC units. The project was developed in response to VHA Systems Redesign efforts and began with a designated process improvement team flowcharting the process, analyzing baseline data for consultation and transition times from acute care to the CLC units, identifying improvement goals, and evaluating process changes.

In 2010, the American College of Physician Executives selected the project as a best practice because of the outcomes. Through improved communication, individual accountability, and feedback, the facility was able to: (a) reduce average wait times for transfer from acute care to the CLC units from 3.7 to 1.6 days, (b) reduce acute care lengths of stay from 4.9 to 3.2 days, (c) reduce the average wait time for CLC admission (from an outpatient status) from 55 to zero days, and (d) reduce consultation response times from 3.1 to 1.6 days. These efforts have enabled the facility to serve more veterans in need of rehabilitation.

Results

Review Activities With Recommendations

Reusable Medical Equipment

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

We inspected the SPD storage area, the clean room, and the decontamination room. We determined that the facility had established appropriate guidelines and monitored compliance with those guidelines. However, we identified the following areas that needed improvement.

Observations. VHA policy[1] requires that staff clean RME according to manufacturers' instructions. We observed that staff did not follow the proper procedures when reprocessing three of the eight pieces of RME reviewed. We observed a staff member improperly hook up one of the three hoses attached to the Endo-Flush,[2] which risked exposing the internal channels of the colonoscope to contaminated water. SPD staff and managers confirmed this improper hose placement. Upon identification of the issue, SPD staff reprocessed the previously cleaned colonoscopes following the manufacturer's instructions for proper Endo-Flush usage. In addition, the employees we observed cleaning the dental kit and the bronchoscope did not follow all of the procedural steps dictated by the SOPs for the respective instruments.

SOPs. VHA policy[3] requires facilities to establish device-specific SOPs for reprocessing RME in accordance with the manufacturers' instructions. We compared the device-specific SOPs and manufacturers' instructions for eight pieces of RME. We found that for three of the eight pieces of RME reviewed, the SOPs were current but inconsistent with the manufacturers' instructions.

Competencies and Training. VHA policy[4] requires that all employees involved in the reprocessing of RME have documented training on the set-up, use, reprocessing, and maintenance of the specific RME and that competencies are documented and validated on an annual basis. We reviewed the competency folders and training records of four SPD employees and found that three folders lacked documentation of the annual competencies for one or more of the eight RME we reviewed. While we were onsite, one overdue competency was completed; however, the competency was completed by another staff member who

[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] Compact electrical pumping system designed to flush the internal channels of specific Olympus flexible endoscopes.
[3] VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.
[4] VHA Directive 2009-004.

had an overdue competency. Managers assured us that they would take appropriate actions to ensure that competencies were updated as soon as possible for all SPD employees.

Recommendation 1 We recommended that the VISN Director ensure that the Facility Director requires that SPD staff clean RME according to the manufacturers' instructions.

The VISN and Facility Directors concurred with the findings and recommendation. Staff competencies were reviewed and completed, and special emphasis was placed on the ability to articulate/demonstrate proper cleaning of all RME used and processed in the facility. The implementation plans are acceptable, and we will follow up until the planned actions are completed and quarterly monitors reflect that the actions have been effective.

Recommendation 2 We recommended that the VISN Director ensure that the Facility Director requires that SOPs for RME cleaning and disinfection are consistent with manufacturers' instructions.

The VISN and Facility Directors concurred with the finding and recommendation. The facility is reviewing all SOPs and making revisions to ensure consistency with manufacturers' instructions. The implementation plans are acceptable, and we will follow up until the planned actions are completed.

Recommendation 3 We recommended that the VISN Director ensure that the Facility Director requires the timely completion and documentation of annual competencies for SPD employees.

The VISN and Facility Directors concurred with the finding and recommendation. The facility is revising the process to ensure that section chiefs/supervisors review annual competencies and ensure timely completion. The implementation plans are acceptable, and we will follow up until the planned actions are completed and quarterly monitors reflect that the actions have been effective.

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

A previous OIG review of suicide prevention programs in VHA facilities[6] found a 74 percent compliance rate with safety plan development. The safety plan issues identified in that review were that plans were not comprehensive (did not contain the above elements), were not developed timely, or were not developed at all. At the request of VHA, the OIG agreed to follow up on the prior findings.

Because the facility does not operate inpatient beds, clinical staff must rely on other VISN facilities and private sector hospitals to provide psychiatric hospitalization when needed. Thus, communication and coordination are critically important to assure the safety of suicidal or potentially suicidal patients. Facility mental health managers reported that they have had difficulty in the past getting private sector hospitals to proactively notify them when VA patients were being discharged so that timely follow-up services could be initiated. In addition, they reported that they did not always receive treatment information or discharge summaries for those patients, which could negatively impact continuity of care. Managers have recently implemented corrective actions requiring private sector hospitals receiving VA payment for the care of suicidal patients to provide prompt notification of discharges and appropriate documentation of treatment provided. We identified the following area that needed improvement.

Inadequate Safety Plans. We reviewed the medical records of 10 patients assessed to be at high risk for suicide within the past 6 months. We found that clinicians had developed timely safety plans that included appropriate elements in only 7 (70 percent) of those 10 cases.

Recommendation 4 We recommended that the VISN Director ensure that the Facility Director requires that clinicians develop timely, comprehensive suicide prevention safety plans, as required by VHA guidelines.

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

The VISN and Facility Directors concurred with the finding and recommendation. The Patient Safety Coordinator submitted a revised FY 2009 annual patient safety report. The revised report includes process issues, number and type of sentinel events, and actions taken to improve safety. Leadership has reviewed and approved the report. The implementation plans are acceptable, and we will follow up until the planned actions are completed and quarterly monitors reflect that suicide prevention safety plans meet timeliness guidelines.

Quality Management

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 evaluated policies, performance improvement (PI) data, and other relevant documents, and we interviewed appropriate senior managers and the Quality Manager.

The QM program was generally effective, and senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. Appropriate structures were in place for 10 of the 12 program activities reviewed; however, we identified deficiencies in the following areas.

QM Oversight and Reporting. VHA policy[7] requires each facility to provide oversight to ensure that QM components are implemented, integrated, communicated, and documented. In addition, each facility is required to identify a leadership committee with responsibility for oversight of QM functions. The facility utilized a combination of the Medical Executive Committee, the Quality Leadership Team, and the Executive Leadership Team (ELT) to provide oversight and monitoring of clinical, administrative, and PI activities. However, documentation in the oversight committee meeting minutes did not reflect discussion of opportunities for improvement or track corrective actions to completion. While we found similar conditions in our 2004 and 2007 CAP reports, we noted some improvements.

Annual Patient Safety Report. The JC requires an annual written report of patient safety activities that includes specific reporting elements. We noted that the annual written report was provided to facility management; however, it did not

[7] VHA Directive 2009-043, *Quality Management System*, September 11, 2009.

include system and process failures; number and type of sentinel events; disclosures to families, if applicable; and actions taken to improve safety.

Recommendation 5 We recommended that the VISN Director ensure that the Facility Director requires QM oversight committee minutes to reflect discussion of improvement opportunities and to track actions to completion.

The VISN and Facility Directors concurred with the findings and recommendation. The facility has developed a policy that addresses the flow of information to and from the ELT. The template has been revised to reflect follow-up and communication with major committees. The implementation plans are acceptable, and we will follow up until the planned actions are completed and quarterly monitors reflect that the actions have been effective.

Recommendation 6 We recommended that the VISN Director ensure that the Facility Director requires inclusion of all required elements in annual patient safety reports.

The VISN and Facility Directors concurred with the findings and recommendation. In May 2010, the facility revised the annual safety plan to include sentinel events, process issues, and actions taken. The implementation plans are acceptable, and we will follow up until the planned actions are completed.

Physician Credentialing and Privileging

The purpose of this review was to determine whether the facility had consistent processes for physician C&P. For a random sample of physicians, we reviewed selected VHA required elements in C&P files and physician profiles.[8] We also reviewed meeting minutes during which discussions about the physicians took place.

We reviewed the C&P files and profiles of 12 physicians who were granted either initial privileges or renewal of privileges in the past 12 months. We found that licenses were current and that primary source verification had been obtained. Service-specific criteria for Ongoing Professional Practice Evaluation (OPPE) had been developed and approved. We found that all five of the applicable physician profiles reviewed contained adequate supporting evidence of OPPE

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

prior to reprivileging. However, we identified the following area that needed improvement.

FPPE. FPPE is a process whereby the facility evaluates the privilege-specific competence of a practitioner, such as a newly hired physician who does not have documented evidence of competently performing the requested privileges at the facility. FPPE should be considered at the time of initial appointment or when new privileges are requested. We found that the C&P files and profiles for 2 (20 percent) of the 10 applicable physicians did not contain evidence of FPPE.

Recommendation 7 We recommended that the VISN Director ensure that the Facility Director requires that FPPE is initiated and documented, as required by VHA policy.

The VISN and Facility Directors concurred with the finding and recommendation. In April 2010, the facility revised the record tracking process for privileged staff to include evidence of FPPE activities. This revision will ensure that Professional Standards Board minutes reflect FPPE and OPPE monitoring. The implementation plans are acceptable, and we will follow up until the planned actions are completed and quarterly monitors reflect that the actions have been effective.

Medication Management

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

Although the pharmacy is closed from 6:00 p.m. to 7:00 a.m. Monday–Friday and on holidays and weekends, the facility appropriately provided a qualified pharmacist to answer questions during those hours and had implemented an adequate retrospective review process.

Per the U.S. Food and Drug Administration, erythropoiesis-stimulating agents (ESAs)[9] should be used to maintain hemoglobin (Hg) levels between 10 and 12 grams per deciliter (g/dL). Hg levels greater than 12g/dL increase the risk of serious conditions and death. We reviewed the medical records of nine outpatients with chronic renal disease who had Hg levels greater than 12g/dL at some point

[9] ESAs are used to treat anemia by stimulating the bone marrow to make red blood cells.

during the timeframe July 2009–February 2010. Clinicians documented an action to address the Hg level in only six of the nine cases. While we were onsite, we referred the remaining three cases to the Chief of Pharmacy for evaluation and any indicated action. Managers told us that during the previous 6 months, they have implemented a quick order medication template for ESAs and the use of a national medication evaluation data tool to identify patients and Hg levels. Therefore, we made no recommendation for this finding. However, we identified the following area that needed improvement.

CLC Influenza Vaccinations. VHA policy[10] requires several elements to be documented for each influenza vaccine given, including the route, site, date of administration, and patient education. We reviewed the medical records of 10 CLC residents and found that 9 had received the influenza vaccine during the timeframe September–December 2009. One resident refused the vaccine. We found that only six of the remaining nine records contained documentation of all the required elements.

Recommendation 8 We recommended that the VISN Director ensure that the Facility Director requires that clinicians consistently document all elements for each influenza vaccine given, as required by VHA policy.

The VISN and Facility Directors concurred with the finding and recommendation. The facility is currently implementing clinical reminders that contain all the required elements cited in VHA's directive. Education sessions on the process change have been completed. The implementation plans are acceptable, and we will follow up until the planned actions are completed and quarterly monitors reflect that the actions have been effective.

Environment of Care

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

We inspected the primary care (women's and blue) clinics and the acute inpatient (13B), domiciliary (female), critical

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

care (9B), and CLC (19B) units. The facility maintained a generally clean and safe environment. However, we identified the following condition that needed improvement.

Respirator Fit Testing. OSHA requires that staff at risk for exposure to airborne pathogens, such as swine flu or tuberculosis, have annual respirator fit testing. We found that 6 (50 percent) of 12 selected staff had not received annual respirator fit testing in the past 12 months.

Recommendation 9 We recommended that the VISN Director ensure that the Facility Director requires that appropriate staff receive annual respirator fit testing.

The VISN and Facility Directors concurred with the finding and recommendation. The facility revised the process for identifying staff in need of fit testing to ensure timely completion. The implementation plans are acceptable, and we will follow up until the planned actions are completed and monitoring reflects compliance.

Review Activity Without Recommendations

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[11] that facilities have a policy that ensures the safe, appropriate, and timely transfer of patients and that transfers are monitored and evaluated as part of the QM program. We determined that the facility had an appropriate transfer policy and that acceptable monitoring was in place.

VHA requires specific information (such as the reason for transfer and services required) to be recorded in the transfer documentation. We reviewed documentation for 10 patients who transferred from the facility's intensive care and acute inpatient units to another facility during the timeframe December 2009–February 2010. We determined that clinicians consistently documented the required information for the patient transfers reviewed.

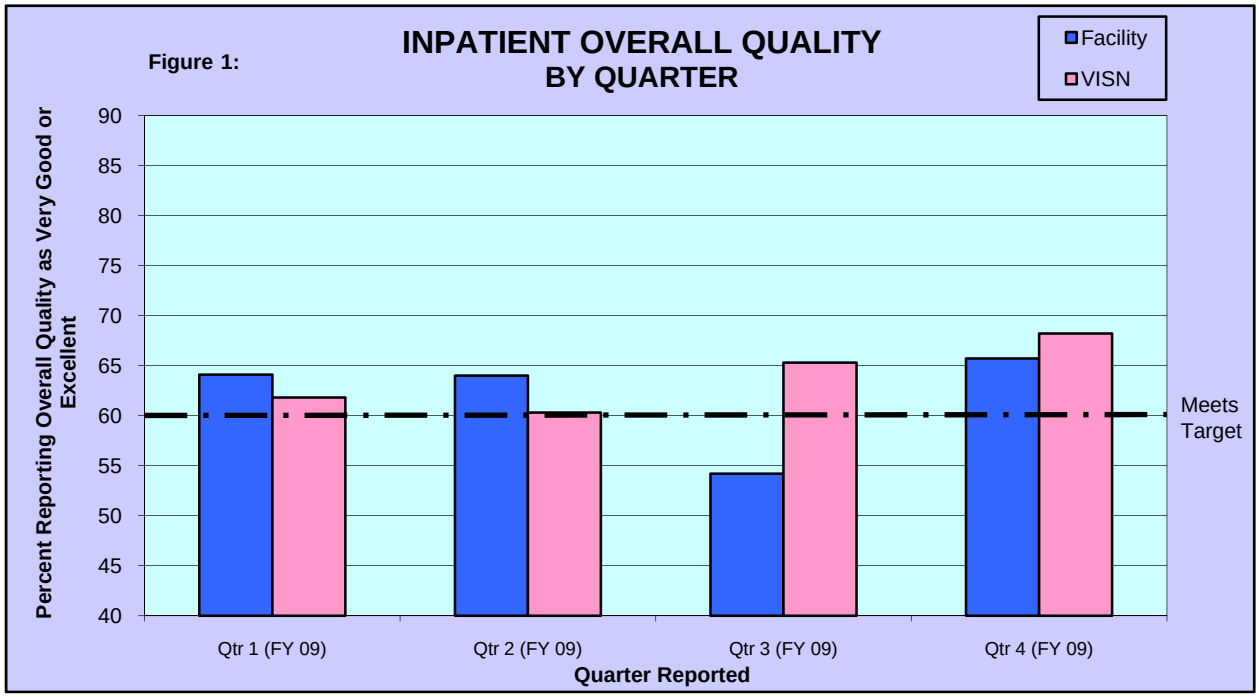
[11] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.

VHA policy[12] and JC standards require that providers include information regarding medications, diet, activity level, and follow-up appointments in written patient discharge instructions. We reviewed the medical records of 10 patients discharged during the timeframe January–April 2010 and determined that clinicians had generally documented the required elements. Also, we found that follow-up appointments occurred within the timeframes specified. We made no recommendations.

VHA Satisfaction Surveys

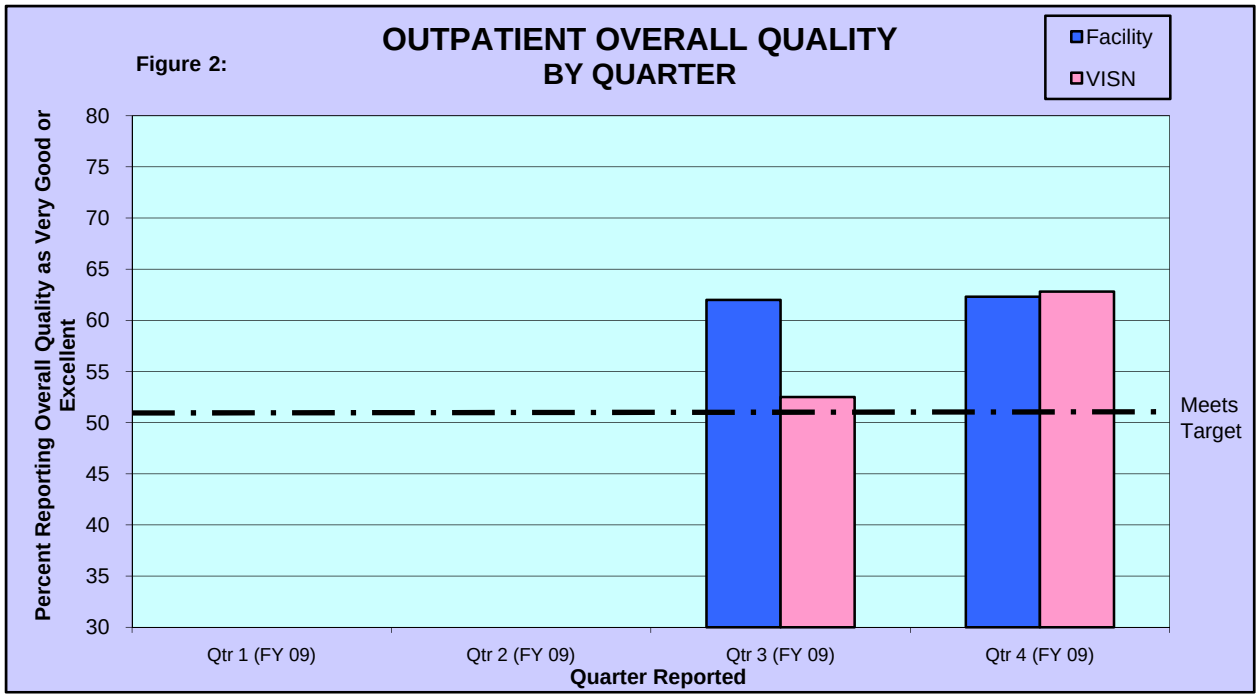
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 below shows the facility's and VISN's overall inpatient satisfaction scores for quarters 1–4 of FY 2009. Figure 2 on the next page shows the facility's and VISN's overall outpatient satisfaction scores for quarters 3 and 4 of FY 2009.[13] The target scores are noted on the graphs.

Figure 1:



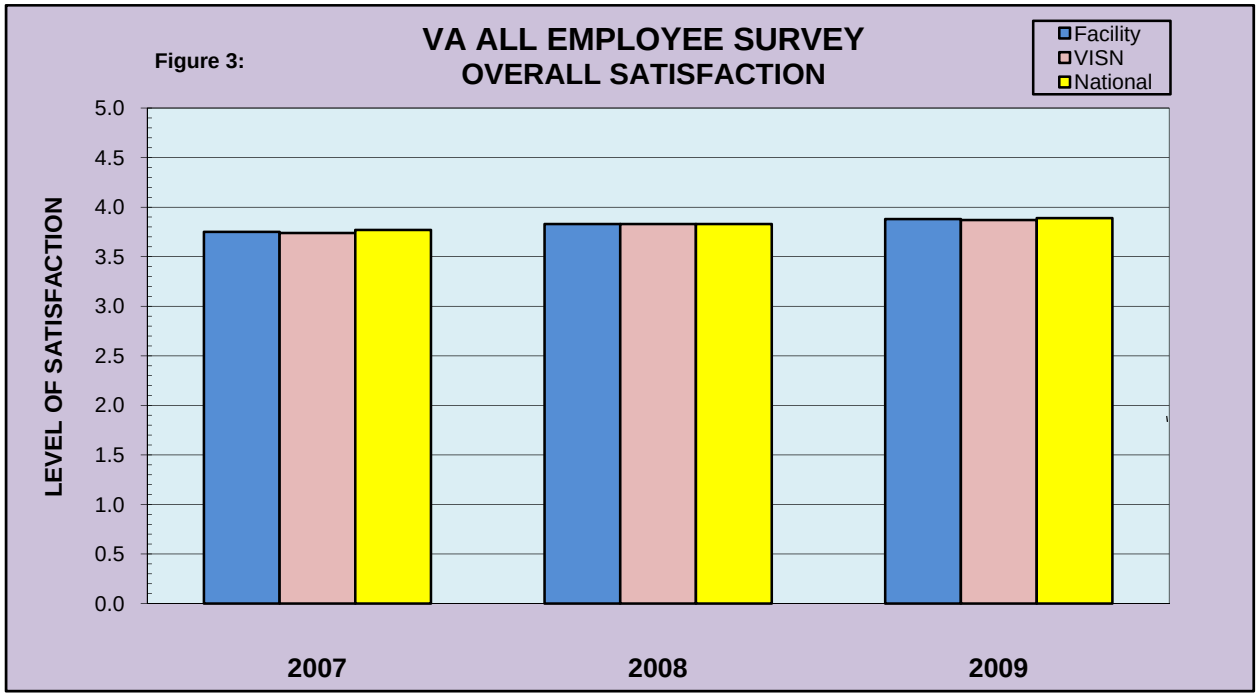
[12] VHA Handbook 1907.01, *Health Information Management and Heath Records,* August 25, 2006.
[13] Due to technical difficulties with VHA's outpatient survey data, outpatient satisfaction scores for quarters 1 and 2 of FY 2009 are not included for comparison.

Figure 2:



Employees are surveyed annually. Figure 3 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 3:



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 1, 2010

From: Director, VA Southeast Network, VISN 7 (10N7)

Subject: **Combined Assessment Program Review of the Carl Vinson VA Medical Center, Dublin, Georgia**

To: Associate Director, Atlanta Office of Healthcare Inspections (54AT)

Director, Management Review Service (10B5)

I have reviewed the corrective action plan and concur with the actions taken.

Lawrence Biro

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 25, 2010

From: Director, Carl Vinson VA Medical Center (557/00)

Subject: **Combined Assessment Program Review of the Carl Vinson VA Medical Center, Dublin, Georgia**

To: Director, VA Southeast Network (10N7)

1. I have reviewed the comments provided by the OIG team and I concur with the responses and proposed action plans to the 9 recommendations outlined in this report.

2. We appreciate the opportunity for this review as a continuing process to improve the care provided to our Veterans.

3. If further information is required, please contact Jahmel Yates, Quality Manager, (478) 272-1210 ext 2246.

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Facility Director requires that SPD staff clean RME according to the manufacturers' instructions.

Concur

Staff competencies have been reviewed and completed with special emphasis on the ability to articulate/demonstrate proper cleaning of all RME used and processed in the facility.

Recommendation 2. We recommended that the VISN Director ensure that the Facility Director requires that SOPs for RME cleaning and disinfection are consistent with manufacturers' instructions.

Concur

The facility has reviewed all standard operating procedures and completed revisions to ensure consistency with manufacturer's instructions.

Recommendation 3. We recommended that the VISN Director ensure that the Facility Director requires the timely completion and documentation of annual competencies for SPD employees.

Concur

The facility has revised the process to ensure the Section Chief/Supervisor review annual competencies and that they are completed for staff in a timely manner.

Recommendation 4. We recommended that the VISN Director ensure that the Facility Director requires that clinicians develop timely, comprehensive suicide prevention safety plans, as required by VHA guidelines.

Concur

Patient Safety Coordinator has submitted a revised FY 09 Annual Patient Safety Report. The revised annual report includes process issues,

number and type of sentinel events, and actions taken to improve safety. The report has been reviewed and approved by leadership.

Recommendation 5. We recommended that the VISN Director ensure that the Facility Director requires QM oversight committee minutes to reflect discussion of improvement opportunities and to track actions to completion.

Concur

QM oversight and reporting systems will be consistent. Documentation of committee oversight activities will reflect quality oversight. The facility has developed an MCM identifying the flow of information to and from ELT. The template has been revised to demonstrate follow-up and communication with major committees (ELC, MEC, QLT, etc.)

Recommendation 6. We recommended that the VISN Director ensure that the Facility Director requires inclusion of all required elements in annual patient safety reports.

Concur

The facility has revised the Annual Safety Plan. This update includes sentinel events, process issues and actions taken.

Recommendation 7. We recommended that the VISN Director ensure that the Facility Director requires that FPPE is initiated and documented, as required by VHA policy.

Concur

The facility has revised the process of tracking all records of privileged staff including evidence of FPPE activities. Additionally, The Professional Standards Board minutes will reflect FPPE and OPPE monitoring.

Recommendation 8. We recommended that the VISN Director ensure that the Facility Director requires that clinicians consistently document all elements for each influenza vaccine given, as required by VHA policy.

Concur

The facility has implemented the standard network clinical reminder that contains all the required elements cited in the Influenza directive. Policy revision and educations sessions of the process change have been completed.

Recommendation 9. We recommended that the VISN Director ensure that the Facility Director requires that appropriate staff receive annual respirator fit testing.

Concur

The facility has revised the process of identifying staff in need of testing to ensure annual respirator fit testing are completed timely.

OIG Contact and Staff Acknowledgments

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