Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No.10-01173-203

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

July 22, 2010

Washington, DC 20420

Why We Did This Review

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

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

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

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Executive Summary

Introduction

During the week of March 15–19, 2010, the OIG conducted a Combined Assessment Program (CAP) review of the Dayton VA Medical Center (the medical center), Dayton, OH. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 261 employees. The medical center is part of Veterans Integrated Service Network (VISN) 10.

Results of the Review

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

- Surgical Process Improvement

We made recommendations in three of the activities reviewed. For these activities, the medical center needed to ensure compliance with Veterans Health Administration (VHA) policies and other external standards related to:

- Reusable Medical Equipment (RME)
- Coordination of Care (COC)
- Physician Credentialing and Privileging (C&P)

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

- Environmental of Care (EOC)
- Magnetic Resonance Imaging (MRI) Safety
- Medication Management
- QM
- Suicide Prevention Safety Plans

This report was prepared under the direction of Donna Giroux, Associate Director, Washington, DC, Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 13–16, 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 medical center is a tertiary care facility located in Dayton, OH, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at four community based outpatient clinics in Lima, Middletown, and Springfield, OH, and in Richmond, IN. The medical center is part of VISN 10 and serves a veteran population of about 150,000 throughout Ohio and Indiana.

Programs. The medical center provides inpatient and outpatient health care services, including nursing home, domiciliary, and home health. It has 120 acute care beds, 265 community living center (CLC) beds, and 115 domiciliary beds.

Affiliations. The medical center is affiliated with Boonshoft School of Medicine at Wright State University and provides training for 275 residents. The medical center also provides training for other disciplines, including nursing students.

Resources. In fiscal year (FY) 2009, medical care expenditures totaled $288.3 million. The FY 2010 medical care budget is $288.1 million. FY 2009 staffing was 1,738 full-time employee equivalents (FTE), including 118 physician and 535 nursing FTE.

Workload. In FY 2009, the medical center treated 35,760 unique patients and provided 25,538 inpatient days in the hospital and 46,750 inpatient days in the CLC. The inpatient care workload totaled 4,904 discharges, and the average daily census was 39 for acute care, 88 for the domiciliary, and 128 for the CLC. Outpatient workload totaled 390,100 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:

- COC
- EOC
- Medication Management
- MRI Safety
- Physician C&P
- QM
- RME
- Suicide Prevention Safety Plans

The review covered medical center operations for FY 2009 and FY 2010 through March 15, 2010, and was done in accordance with OIG standard operating procedures (SOPs) for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the Dayton VA Medical Center, Dayton, Ohio,* Report No. 07-00917-163, July 6, 2007). The medical center had corrected all findings from the prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 261 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 Strength

Surgical Process Improvement

Medical center review of mortality data for general surgery procedures performed during FY 2009 revealed an increase over FY 2008. A systems redesign process was initiated, which included a review of the surgical program by a surgical consultant, analysis of National Surgical Quality Improvement Program data, and performance of a root cause analysis (RCA). The review focused concerns on pre-operative assessments and post-operative airway management. Corrective actions included:

- Limiting complex general surgery procedures
- Strengthening pre-operative assessment to identify potential airway management issues
- Expanding out-of-operating room airway management training
- Providing 24/7, in-house Certified Registered Nurse Anesthetist coverage for all codes
- Implementing a Transitional Care Unit

The implementation of these corrective actions, developed through the system redesign process, has significantly improved surgical mortality rates.

Results

Review Activities With Recommendations

Reusable Medical Equipment

The purpose of this review was to evaluate whether the medical center had processes in place to ensure effective reprocessing of RME. Improper reprocessing of RME may transmit pathogens to patients and affect the functionality of the equipment. VHA facilities are responsible for minimizing patient risk and maintaining an environment that is safe. The medical center's Supply, Processing, and Distribution (SPD) and satellite reprocessing areas are required to meet VHA, Association for the Advancement of Medical Instrumentation, Occupational Safety and Health Administration (OSHA), and Joint Commission (JC) standards.

We inspected the SPD reprocessing area and the operating room. We determined that the medical center had established appropriate guidelines and monitored compliance with those guidelines.

VHA policy[1] requires that all employees involved in the use and reprocessing of RME have documented training on the set-up, use, reprocessing, and maintenance of the specific RME leading to initial competency and validation of that competency on an annual basis. We reviewed SPD employees' training records and competency folders for the transesophageal echocardiography (TEE) probe and found that the training from the manufacturer had occurred within the year, but there was no documentation of the annual competencies. While we were onsite, annual competency training for the TEE probe was provided to SPD employees. We also reviewed the competency folders of nine operating room (OR) staff who operate the flash sterilizer and found that all had an annual competency; however, it was not SOP specific. The medical center had self identified this, and all SOP specific competencies were completed while we were onsite. Therefore, we made no recommendation for these findings. However, we identified the following areas that needed improvement.

Flash Sterilization. VA policy[2] requires full sterilization procedures to be used for all surgical instruments. Flash sterilization (a shorter sterilization process) is to be used during a surgical procedure only in case of emergency, such as a dropped sterilized instrument. We reviewed the medical center's policies on flash sterilization and found that the medical center was in compliance with its own policies; however, its policies were less restrictive than required by VA. We reviewed 12 months of OR flash sterilization log documentation and found that flash sterilization was used in non-emergent situations, such as for loaned instrumentation. The medical center had identified an increased number of flash sterilizations and had developed action plans, including ordering new equipment and using disposable equipment. Over the last 3 months, flash sterilization has decreased.

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

SOPs. VHA policy[3] requires device-specific SOPs for RME to be established in accordance with the manufacturers' instructions. We requested the SOPs and manufacturers' instructions for 10 pieces of RME. We determined that the SOPs for a colonoscope, a bronchoscope, and orthopedic and dental instrumentation were not fully consistent with the manufacturers' instructions. The cleaning of the instrumentation was appropriate; however, SOP documentation did not fully reflect current practices. For example, the colonoscope was being flushed with new equipment that did an automated flush instead of a manual flush; this change was not reflected in the SOP. The bronchoscope SOP missed some steps in the manufacturers' instructions and combined others; however, the staff member we observed demonstrated and followed the manufacturers' instructions for cleaning. Manual rinsing of instrumentation was required by the SOP for orthopedic and dental instruments; however, this was not demonstrated. Prior to sterilization of the instruments, ultrasonic cleaning and the use of the washer-disinfector unit were added to the manual cleaning process. The SOP did not reflect this process.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that the local flash sterilization policy is consistent with VHA policy and that flash sterilization continues to be monitored to improve the rate.

The VISN and Medical Center Directors concurred with the findings and recommendation. The local flash sterilization policy has been revised to match the requirements of VA policy, and flash sterilization monitoring is ongoing. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that SOPs are consistent with manufacturers' instructions and with the technologies and practices being utilized.

The VISN and Medical Center Directors concurred with the findings and recommendation. The SOPs have been revised and are now consistent with manufacturers' instructions and

[3] VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.

with current practices. The corrective actions are acceptable, and we consider this recommendation closed.

Coordination of Care

The purpose of this review was to evaluate whether inter-facility transfers and discharges were coordinated appropriately over the continuum of care and met VHA and JC requirements. Coordinated transfers and discharges are essential to an integrated, ongoing care process and optimal patient outcomes.

VHA requires that medical centers have a policy that ensures the safe, appropriate, and timely transfer of patients. We determined that the medical center had an appropriate transfer policy that was monitored and evaluated as part of the QM program. In addition, JC standards require that clinicians provide patients with written discharge instructions. We determined that clinicians met this standard.

VHA policy[4] requires specific information (such as the reason for transfer, mode of transportation, and informed consent to transfer) to be recorded in the transfer documentation. We reviewed transfer documentation from November and December 2009 for 10 patients transferred from the medical center's intensive care unit (ICU), emergency department, and medical and surgical units to non-VA facilities. We found that providers did not document all required information for 7 (70 percent) of the 10 patients. Missing information included documentation of the advanced directive, equipment required during transfer, and behavioral stability of the patient. The medical center recognized the deficiencies in January and instituted a 100 percent review of all inter-facility transfers. Within 30 days of the review, almost all units had achieved a 90 percent compliance rate or higher. Therefore, we made no recommendation for this finding. However, we identified the following area that needed improvement.

Discharges. VHA[5] requires that providers include information regarding medications, diet, activity level, and follow-up appointments in patient discharge instructions. We reviewed the medical records of 10 discharged patients and found deficiencies in 4 (40 percent) of the records. Three patients had diets listed on the discharge instructions that were not consistent with the dietary orders. One patient had

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

special activity restrictions, but there was no documentation that the patient or caregiver received education regarding these instructions.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that staff ensure consistency between discharge instructions and dietary orders and that patients receive education regarding special diets and activities.

The VISN and Medical Center Directors concurred with the findings and recommendation. To ensure consistency, the Clinical Application Coordinator created electronic links from the discharge instructions to the discharge summary for diagnosis, diet, and activity level. Additionally a field for documentation of patient education was added for use when special diets or activities are ordered. The Medical Records Committee is monitoring consistency, and results will be reported to the Clinical Executive Board. 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.[6] We also reviewed meeting minutes during which discussions about the physicians took place.

We reviewed 14 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. Focused Professional Practice Evaluation was appropriately implemented for the two physicians hired within the past 12 months. Service-specific criteria for Ongoing Professional Practice Evaluation had been developed and approved. We found sufficient performance data to meet current requirements. However, we identified the following area that needed improvement.

Privileging. VHA policy requires that the medical center's Professional Standards Board (PSB) evaluate a physician's credentials to determine whether clinical competence is adequately demonstrated to support the granting of requested privileges. PSB meeting minutes must reflect the

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

documents reviewed and the rationale for a decision to grant or deny privileges. PSB meeting minutes did not reflect detailed discussions of the physicians whose files we reviewed. The medical center recognized this and had implemented a new form to help fully document these discussions. However, documentation was incomplete and inconsistent.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that detailed discussions of physicians' performance data be documented in meeting minutes, as required by VHA.

The VISN and Medical Center Directors concurred with the finding and recommendation. A template has been developed and is now being used to capture PSB meeting discussions. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

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 inspected the emergency department, the primary care clinic, the ICU, the medicine unit, and the same day surgery unit. The medical center maintained a generally clean and safe environment. The infection control program monitored data and appropriately reported that data to relevant committees. Safety guidelines were met, and risk assessments were in compliance with VHA standards. We made no recommendations.

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. We determined that the system had adequate

safety policies and had conducted a risk assessment of the MRI environment as required by JC standards.

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

Local policy and American College of Radiology guidelines require that personnel who have access to the MRI area receive appropriate MRI safety training. We reviewed the training records of 39 personnel and found that all had completed required safety training for their operational level.

We reviewed the medical records of 10 patients who received an MRI. All patients had inclusive MRI safety questionnaires that had been evaluated and signed by an MRI technician and had documentation of required lab tests available to assess risk. We made no recommendations.

Medication Management

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

The medical center had implemented a practice guideline governing the maintenance of chronic renal disease patients who receive erythropoiesis-stimulating agents.[7] We found that clinical staff had appropriately identified and addressed elevated hemoglobin levels in the 10 patients whose medical records we reviewed. In general, influenza vaccinations were documented adequately for CLC residents, and clinical staff followed the established protocol when a delay in receipt of vaccines was experienced. In addition, the pharmacy was open 24 hours a day, 7 days a week. We made no recommendations.

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

[7] Drugs that stimulate the bone marrow to make red blood cells; used to treat anemia.

medical center's Director and Chief of Staff and QM personnel. We evaluated plans, policies, performance improvement data, and other relevant documents. The medical center's QM program was effective and well managed. Senior managers supported the program through participation in and evaluation of performance improvement initiatives and through allocation of resources to the program. Meaningful data were analyzed, trended, and utilized to improve patient care. RCAs were being completed in a timely manner. 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.[8]

A previous OIG review of suicide prevention programs in VHA facilities[9] found a 74 percent compliance rate with safety plan development. The safety plan issues identified in that review were that plans were not comprehensive (did not contain the above elements), were not developed timely, or were not developed at all. At the request of VHA, the OIG agreed to follow up on the prior findings.

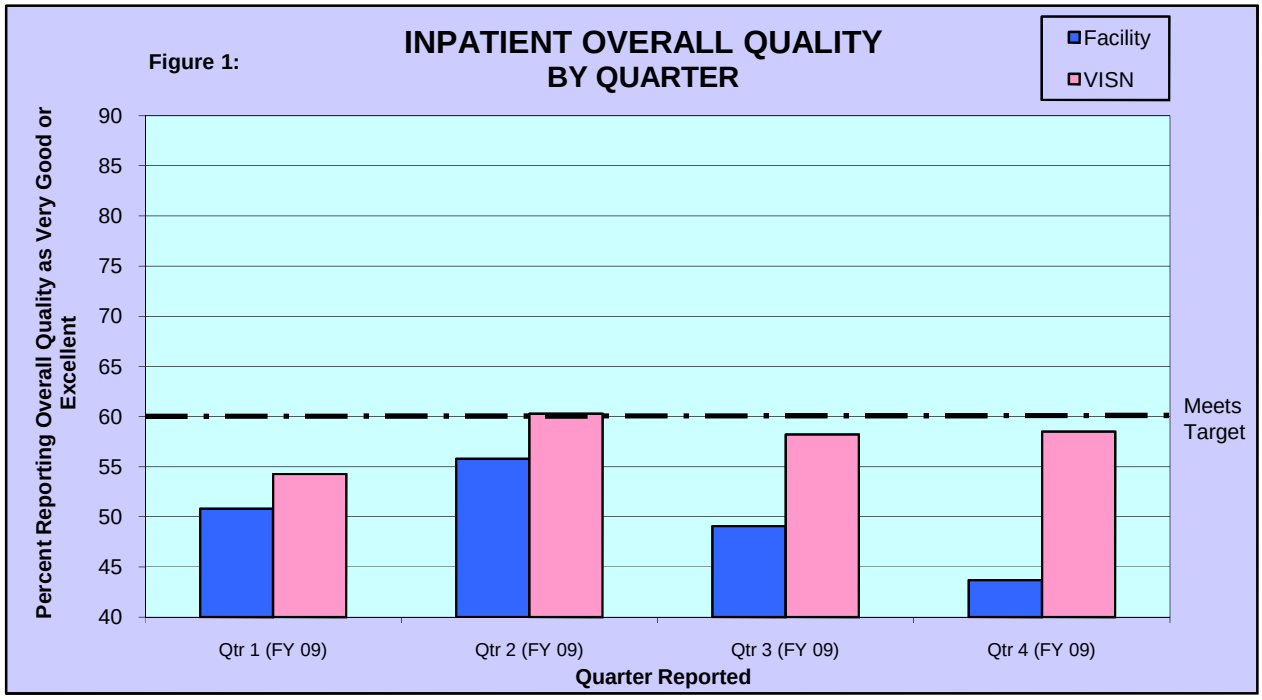
We reviewed the medical records of 10 patients assessed to be at high risk for suicide and found that clinicians had developed timely safety plans that included all required elements. We also found evidence to support that the patients and/or their families participated in the development of the plans. We made no recommendations.

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

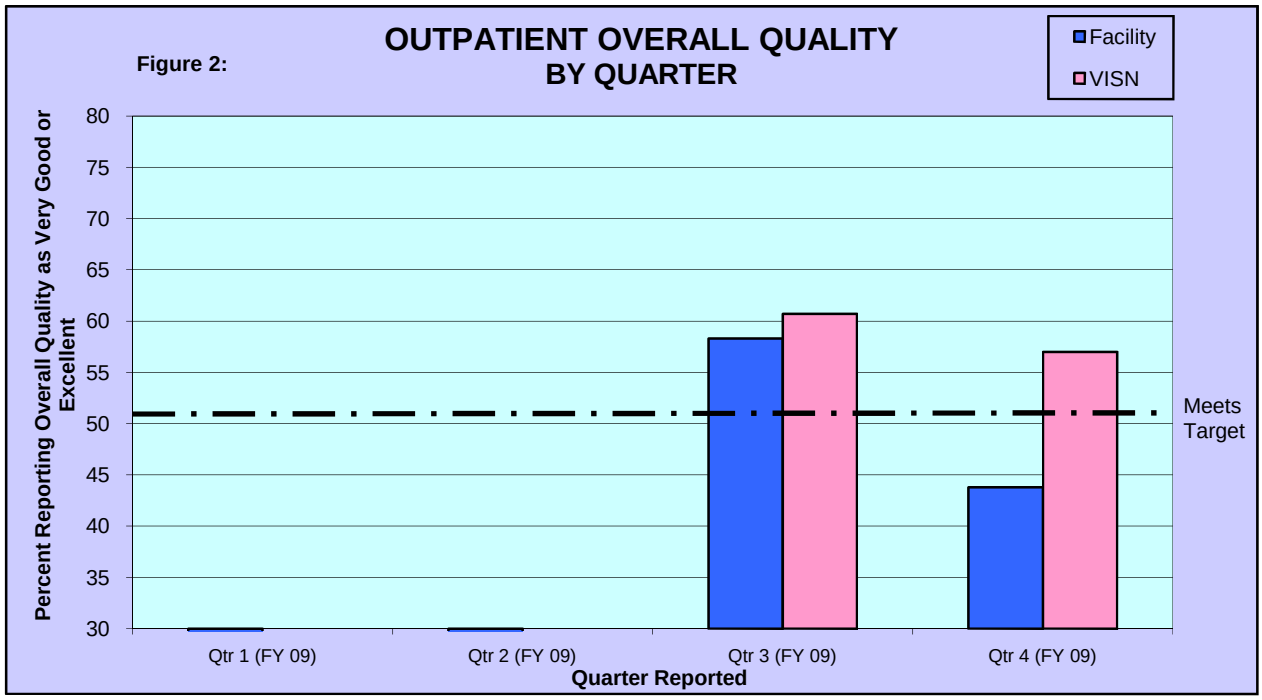
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 below shows the medical center's and VISN's overall inpatient satisfaction scores for quarters 1–4 of FY 2009. Figure 2 on the next page shows the medical center's and VISN's overall outpatient satisfaction scores for quarters 3 and 4 of FY 2009.[10] The target scores are noted on the graphs.

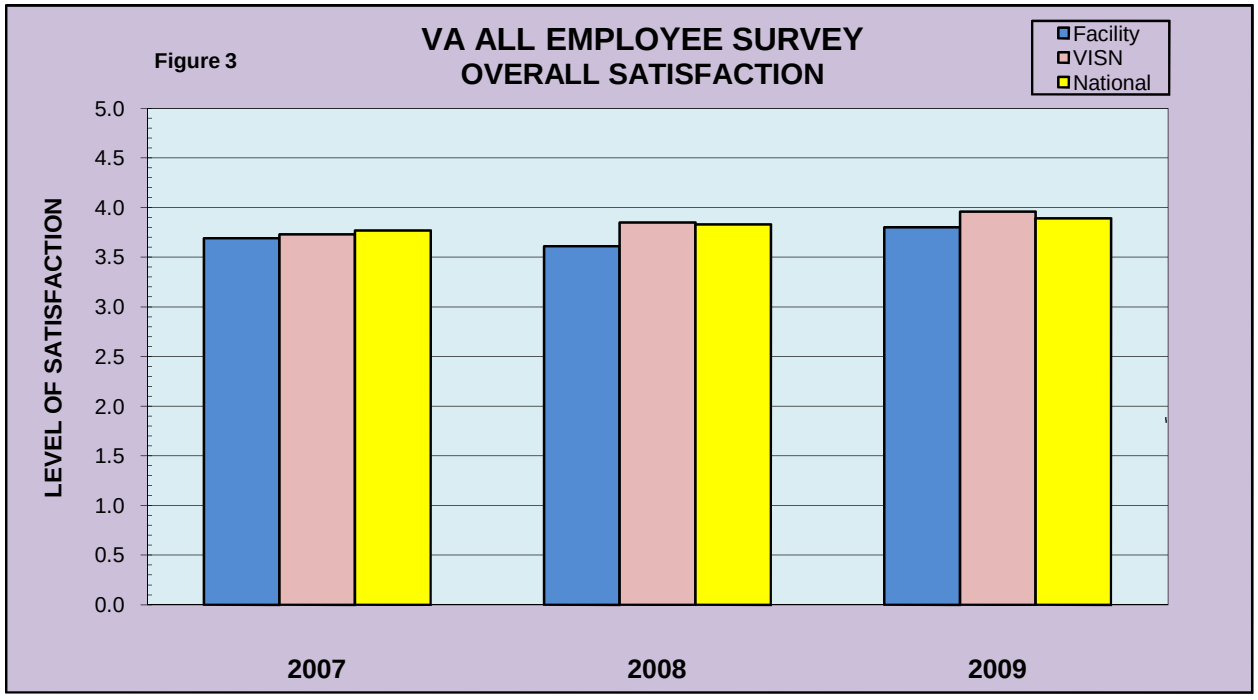
Figure 1:



[10] 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 on below shows the medical center's overall employee scores for 2007, 2008, and 2009. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 16, 2010

From: Network Director, VA Healthcare System of Ohio (10N10)

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

To: Director, Washington, DC, Office of Healthcare Inspections (54DC)

Director, Management Review Service (10B5)

Please find attached the comments from the Medical Center Director, VA Medical Center Dayton, Ohio on pages 13–16. VISN 10 appreciates the professionalism of the review team and their recommendations.

(original signed by:)

JACK G. HETRICK, FACHE

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 16, 2010

From: Director, Dayton VA Medical Center (552/00)

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

To: Network Director, VA Healthcare System of Ohio (10N10)

Please find attached our comments regarding the CAP review of the Dayton VA Medical Center on pages 13–16.

(original signed by:)

GUY B. RICHARDSON, MHSA, FACHE

Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires that the local flash sterilization policy is consistent with VHA policy and that flash sterilization continues to be monitored to improve the rate.

Concur Target Date of Completion: **Completed June 14, 2010**

The local Just in Time (Flash) Sterilization policy is revised to include the more restrictive language of current VHA Handbook 7176. Monitoring of items processed by rapid steam sterilization is continuously ongoing, and efforts to reduce the number of items sterilized by this process are implemented.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that SOPs are consistent with manufacturers' instructions and with the technologies and practices being utilized.

Concur Target Date of Completion: **Completed June 14, 2010**

SOP's are revised to be consistent with manufacturers' instructions and with the technologies and practices utilized.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that staff ensure consistency between discharge instructions and dietary orders and that patients receive education regarding special diets and activities.

Concur Target Date of Completion: **Completed May 24, 2010**

The clinical application coordinator created electronic objects that link medication, diet, activity level, and follow-up appointments from the discharge instructions to the discharge summary. This will ensure consistency between the two documents. Additionally, a field for documentation of patient education was added to the activity and diet instruction elements for use when special diets or activities are ordered. Medical Records Committee began monitoring the consistency between the discharge instructions and discharge summary in May 2010. This

monitor will continue on a monthly basis and results will be reported to the Clinical Executive Board quarterly.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that detailed discussions of physicians' performance data be documented in meeting minutes, as required by VHA.

Concur Target Date of Completion: **Completed April 12, 2010**

As stated in the summary, this issue was self identified prior to the CAP visit. A template form letter had been developed for documentation during the Professionals Standard Board (PSB) meetings. This form is completed for every provider and captures the PSB discussion regarding the following areas: Privileges/Scope of Practice, Variances, and Focused Professional Practice Evaluation/On Going Professional Practice Evaluation information. The form is now utilized for all new and renewal License Independent Practitioner applicants and is attached to the PSB minutes once completed.

OIG Contact and Staff Acknowledgments

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