Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No.10-01523-200

Combined Assessment Program Review of the Portland VA Medical Center Portland, Oregon

July 21, 2010

Washington, DC 20420

Why We Did This Review

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

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

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

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

Glossary

ACR	American College of Radiology
BLS	Basic Life Support
C&P	credentialing and privileging
CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CLC	community living center
COC	coordination of care
CRD	chronic renal disease
ED	emergency department
EOC	environment of care
ESA	erythropoiesis stimulating agent
facility	Portland VA Medical Center
FDA	United States Food and Drug Administration
FPPE	Focused Professional Practice Evaluation
FTE	full-time employee equivalents
FY	fiscal year
g/dL	grams per deciliter
GCW	glycemic control workgroup
GEMS	Green Environmental Management System
ICU	intensive care unit
JC	Joint Commission
MH	mental health
MRI	magnetic resonance imaging
MSC	Medical Staff Committee
OIG	Office of Inspector General
OR	operating room
OSHA	Occupational Safety and Health Administration
PI	performance improvement
QM	quality management
RME	reusable medical equipment
SOP	standard operating procedure
SPD	Supply, Processing, and Distribution
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Portland VA Medical Center, Portland, Oregon

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

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

- Reusable Medical Equipment

The facility's reported accomplishments included a strong green environmental management system and two diabetes-specific electronic programs—a web-based patient registry and a glucose monitoring software for inpatients—to help improve the care and management of diabetic patients.

Recommendations: We made recommendations in the following seven activities:

Quality Management: Report peer review findings quarterly and complete peer reviews within 120 days or request extensions. Ensure that designated staff maintain current Basic Life Support training and that the local policy is revised to specify what actions will be taken when required training is not current.

Environment of Care: Consistently monitor hand hygiene practices and analyze data for performance improvement. Ensure that eyewash stations are tested weekly.

Magnetic Resonance Imaging Safety: Ensure that patients and staff are appropriately screened and that staff who are granted access to the area receive safety training. Conduct a comprehensive risk assessment of the magnetic resonance imaging area.

Physician Credentialing and Privileging: Document the timeframe for physicians' Focused Professional Practice Evaluations and ensure results are reported to the appropriate committee.

Medication Management: Take and document actions when chronic renal disease patients' hemoglobin levels exceed 12 grams per deciliter.

Suicide Prevention Safety Plans: Develop safety plans for all patients at high risk for suicide.

Coordination of Care: Integrate patient transfers into the facility's quality management program.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

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

Objectives and Scope

Objectives

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

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

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

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

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

The review covered facility operations for FY 2009 and FY 2010 through April 30, 2010, and was done in accordance with OIG SOPs for CAP reviews. We also followed up on selected recommendations from our prior

CAP review of the facility (*Combined Assessment Program Review of the Portland VA Medical Center, Portland, Oregon,* Report No. 07-02081-17, October 30, 2007). The facility had addressed all the recommendations, and we consider them closed.

During this review, we also presented crime awareness briefings for 331 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.

Reported Accomplishments

GEMS Program

The facility's GEMS program has been in place since 2004. In 2009, GEMS accomplishments included:

- Reducing bio-hazardous waste by 20.3 percent
- Recycling over 1,900 pounds of batteries
- Increasing energy conservation by 13 percent
- Converting housekeeping chemicals to green-based materials

The GEMS program has received recognition both locally and nationally. In 2009, the program received the Environmental Protection Agency's Performance Track Award, and in 2010, it received the VA Sustainability Achievement Award.

Diabetic Patient Registry

The facility developed and implemented a web-based chronic disease registry to improve care and management of its diabetic patient population. The registry was developed using evidence-based guidelines for diabetes and existing VHA performance measure targets.

The registry provides reports that are used to identify and triage patients for completion of the annual monitoring tests and to identify patients requiring better management of their diabetes. Individual report cards feature detailed results on all pertinent diabetes care quality measures. Since its

implementation, across-the-board improvements have been demonstrated in all diabetes measures. The registry is currently being implemented throughout VISN 20 facilities.

Glucose Monitoring Software

In 2006, the facility's inpatient GCW developed software that aggregates real-time, patient-specific glucose control data into a single display that can be viewed by any clinician at the point of care. The Glycemic Monitoring Window software graphically displays data, such as medications administered, glucose values, nutritional intake, current insulin and diet orders, glucose targets, and total insulin received during the past 24 hours. The inclusion of the automatic insulin dose calculators for transitioning from insulin infusion to subcutaneous insulin is one example of real-time clinical decision support. In 2009, the GCW applied for and was awarded a grant to further expand the software's functionality to include subcutaneous insulin order menus, decision support, and documentation tools.

Results

Review Activities With Recommendations

QM

The purpose of this review was to evaluate whether the facility's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the facility's Director, Chief of Staff, and Chief of QM. We also interviewed QM personnel and several service chiefs. We evaluated plans, policies, and other relevant documents.

The QM program was generally effective in providing oversight of the facility's quality of care. Also, it was evident that senior managers supported the program through participation in PI initiatives and provision of resources. However, we identified two areas that needed improvement.

Peer Review. VHA requires[1] peer review findings to be reported to the MSC on a quarterly basis and final reviews of cases to be completed within 120 days from the date it was determined that a peer review was needed. We noted that the peer review process was comprehensive and generally in compliance with VHA requirements. However, we found that peer review findings were discussed at the MSC in only 1 out of the past 4 quarters. Additionally, eight peer reviews were completed beyond the 120-day limit, and requests for

[1] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.

extensions from the facility Director occurred after the time limit had already run out.

Resuscitation and Its Outcomes. VHA[2] and local policies require all clinically active staff to have BLS training. We found that 38 (10.5 percent) of the 361 independent practitioners had no current BLS training. Also, VHA requires that mechanisms be in place to ensure compliance with BLS training. The local policy did not denote actions to be taken when BLS training or certification is not current.

Recommendations

1. We recommended that peer review findings be reported to the MSC quarterly and that peer reviews are either completed within 120 days or extensions are requested timely and granted.

2. We recommended that all designated clinical staff maintain current BLS training and that the local policy is revised to include the actions to be taken when BLS training or certification is not current.

EOC

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

At the Portland campus, we inspected all inpatient (medical, surgical, intensive care, and MH) units, the ED, and the dialysis unit. At the Vancouver campus, we inspected the CLC and primary care clinics. In the CLC, we found several air ventilation outlets with dust build-up. In the primary care reception area, we identified a potential privacy issue when a patient checks in. While we were onsite, the air ventilation outlets in the CLC were cleaned, and we suggested that program managers consider arranging the furniture in the primary care reception area to ensure patient privacy. Therefore, we did not make any recommendations related to these findings. However, we identified the following conditions that needed improvement.

Hand Hygiene. VHA requires[3] monitoring of staff adherence to hand hygiene practices. We reviewed documentation for

[2] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.
[3] VHA Directive 2005-002, *Required Hand Hygiene Practices*, January 13, 2005.

calendar year 2009. We found inconsistent documentation of staff compliance in the CLC, the gastrointestinal unit, the OR, and the OR pre-operative holding area.

Eyewash Stations. Local policy requires weekly testing of all emergency eyewash stations. We found eyewash stations in SPD and the ICU that had not been tested weekly, as required.

Recommendations

3. We recommended that hand hygiene practices be consistently monitored in all patient care areas and that data be analyzed for PI.

4. We recommended that all eyewash stations be tested weekly.

MRI Safety

The purpose of this review was to evaluate whether the facility 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. VA's MRI safety policy is detailed in an online resource guide that establishes requirements for safe MRI practices.[4]

We inspected the MRI area, examined patient and employee records, reviewed relevant policies, and interviewed key personnel. We found appropriate signage. We noted that patients are directly observed during an MRI exam. Two-way communication is available between the patient and the MRI technologist, and patients have access to a push-button call system. However, we identified the following areas that needed improvement.

Safety Screening. VA[5] and the ACR require screening of patients undergoing MRI and personnel who have access to the MRI area using a standard screening questionnaire. MRI technologists are required to review the questionnaires, and any positive ("yes") response must be addressed before a patient is scanned. We reviewed the medical records of 15 patients who underwent an MRI exam. MRI technologists did not review four patients' questionnaires. Two of the four questionnaires had positive responses. In addition, we did not find completed screening questionnaires for non-MRI personnel who have daily or periodic access to the MRI area.

[4] VA "Radiology Online Guide," <http://vaww1.va.gov/Radiology/page.cfm?pg=167>, updated December 20, 2007, Secs. 4.1–4.3.
[5] VA "Radiology Online Guide."

Safety Training. The ACR requires that MRI and non-MRI personnel who have access to the MRI area receive appropriate MRI safety training. We reviewed the training records of six imaging personnel, and we did not find consistent evidence of ongoing safety training. In addition, until a few weeks prior to our site visit, there was no evidence of initial or ongoing annual training for non-MRI staff (such as housekeeping staff, police officers, and code team members). Program managers agreed that training for these individuals had not been consistent.

Risk Assessment. The JC requires facilities to identify safety and security risks associated with the MRI environment. The Imaging Chief told us that he had performed a risk assessment of the MRI area to identify potential vulnerabilities. We determined that a more comprehensive assessment, preferably by a multidisciplinary team, is needed. Program managers agreed to convene a team to conduct a more comprehensive risk assessment of the MRI area to analyze risk and implement strategies to supplement existing safety procedures.

Recommendations

5. We recommended that MRI technologists review screening questionnaires, document follow-up on positive responses on the questionnaires, and ensure that non-MRI personnel with periodic access to the MRI area complete safety screening questionnaires.

6. We recommended that personnel who have access to the MRI area receive the appropriate level of MRI safety training, as required.

7. We recommended that a multidisciplinary team conduct a comprehensive risk assessment of the MRI area.

Physician C&P

The purpose of this review was to determine whether the facility maintained 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 the physicians' privileges were discussed and recommendations were made.

We reviewed 11 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been appropriately obtained.

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

Service-specific criteria for Ongoing Professional Practice Evaluation had been developed and approved. We found sufficient performance data to meet current requirements. Meeting minutes consistently documented thorough discussions of the physicians' privileges and performance data prior to recommending renewal of or initial requested privileges. We identified the following area that needed improvement.

FPPE. VHA policy requires a time-limited FPPE review process to ensure the competence of newly hired physicians. VHA policy also requires that the results of FPPE be reported to the appropriate committee. We found that the timeframe for the physicians' FPPEs had not been consistently documented and that results were not reported to the MSC.

Recommendation

8. We recommended that managers consistently document the timeframe for the physicians' FPPEs and ensure results are reported to the MSC.

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.

VHA requires several items to be documented for each influenza vaccine given to CLC residents, including the route, site, and date of administration.[7] In general, influenza vaccinations were documented adequately, and clinical staff followed the established protocol when a delay in receipt of vaccines was experienced. However, we identified the following area that needed improvement.

Management of ESAs. In November 2007, the FDA issued a safety alert stating that for CRD patients, ESAs[8] should be used to maintain hemoglobin levels between 10 and 12g/dL. Hemoglobin levels greater than 12g/dL increase the risk of serious conditions and death. We reviewed the medical records of 10 outpatients with CRD who had hemoglobin levels greater than 12g/dL. We determined that clinicians did not document an action to address the hemoglobin level in 3 (30 percent) of the 10 cases.

[7] VHA Directive 2009-058, *Seasonal Influenza Vaccine Policy for2009–2010*, November 12, 2009.
[8] Drugs that stimulate the bone marrow to make red blood cells; used to treat anemia.

Recommendation

9. We recommended that clinicians take and document appropriate actions when CRD patients' hemoglobin levels exceed 12g/dL.

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.[9]

A previous OIG review of suicide prevention programs in VHA facilities[10] 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. We determined that the safety plan note template did not contain a field to document when a patient is given a copy of the safety plan. While we were onsite, program managers immediately revised the note template to reflect this requirement. Therefore, we did not make a recommendation related to this finding. However, we identified the following area that needed improvement.

Safety Plans. We found that clinicians did not develop safety plans for 3 (30 percent) of the 10 patients assessed as being at high risk for suicide.

Recommendation

10. We recommended that clinicians develop safety plans for all patients at high risk for suicide.

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

COC

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[11] 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 15 discharged patients and determined that clinicians had generally documented the required information.

VHA policy[12] requires specific information (such as the reason for transfer, advance directive acknowledgment, and informed consent to transfer) to be recorded in the transfer documentation. We reviewed documentation for 10 patients who transferred from the facility's ED to another facility. For patients with advance directives on file, clinicians did not address the patient's advance directive prior to transfer. Program managers told us that this information is included in the transfer packet that accompanies each patient. While we were onsite, managers updated the inter-facility transfer note template to include a field for advance directives. Therefore, we did not make a recommendation related to this finding. However, we identified the following area that needed improvement.

Inter-Facility Transfers. VHA policy also requires inter-facility transfers to be monitored and evaluated as part of the QM program. We did not find evidence that inter-facility transfers were integrated in the facility's QM program. Facility managers agreed to monitor inter-facility transfers and identified the UM Committee as the appropriate venue to review, assess, and implement PI activities related to patient transfers.

Recommendation

11. We recommended that program managers ensure that patient transfers are consistently reported, monitored, and evaluated in the UM Committee.

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

Review Activity Without Recommendations

RME

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

We inspected SPD, the hemodialysis unit, and an OR flash sterilization area. We determined that the facility had established appropriate guidelines and monitored compliance with those guidelines. Also, the facility had a process in place to track RME should a sterilization failure occur.

In general, we found that SOPs were current and consistent with the manufacturers' instructions. Also, employees were able to either demonstrate the cleaning procedures in the SOPs or verbalize the steps. We reviewed the competency folders and training records of the employees who demonstrated or verbalized the cleaning procedures and found that annual competencies and training were current and consistently documented.

We reviewed 8 months (September 2009–April 2010) of OR flash sterilization (a shorter sterilization process) documentation. We noted that the facility had significantly reduced its flash sterilization rate from 10.6 percent in September 2009 to 4.63 percent in March 2010. However, the rate in April 2010 was 12.3 percent, and there were 68 documented incidents of flash sterilization. Program managers had identified the issues that contributed to the increased flash sterilization rate and have taken appropriate corrective actions. Therefore, we made no recommendations.

Comments

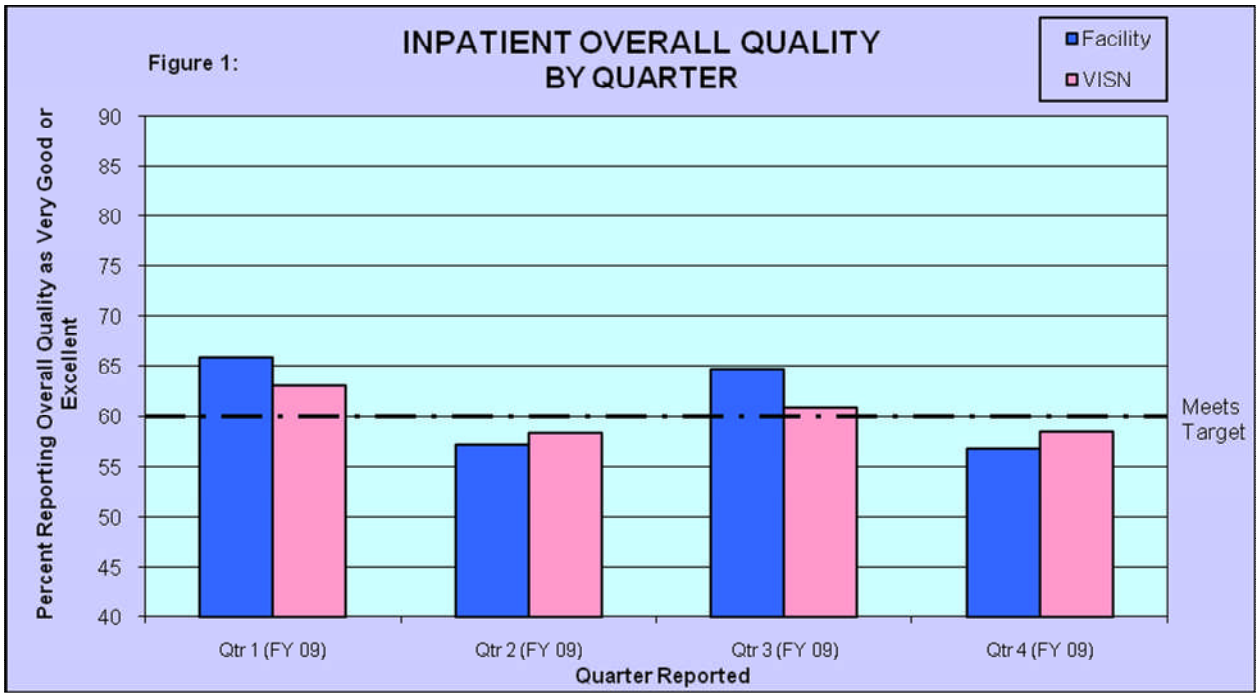
The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 14–20, for the full text of the Directors' comments.) We consider Recommendations 5 and 10 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[13]		
Type of Organization	Tertiary care medical center	
Complexity Level	1a	
VISN	20	
CBOCs	Warrenton, OR Bend, OR Salem, OR East Portland, OR Hillsboro, OR Dalles, OR	
Veteran Population in Catchment Area	381,691	
Type and Number of Operating Beds: • **Hospital, including PRRTP**	160	
• **CLC/Nursing Home Care Unit**	72	
• **Other**	N/A	
Medical School Affiliation(s)	Oregon Health and Sciences University	
• **Number of Residents**	450	
	Current FY	**Prior FY**
Resources (in millions):		
• **Total Medical Care Budget**		$486.6
• **Medical Care Expenditures**		$477.2
FTE		2,788
Workload:		
• **Number of Station Level Unique Patients**		66,765
• **Inpatient Days of Care:**		
o **Acute Care**		49,159
o **CLC/Nursing Home Care Unit**		26,375
Hospital Discharges		9,286
Total Average Daily Census (including all bed types)		207
Cumulative Occupancy Rate		89.2%
Outpatient Visits		633,944

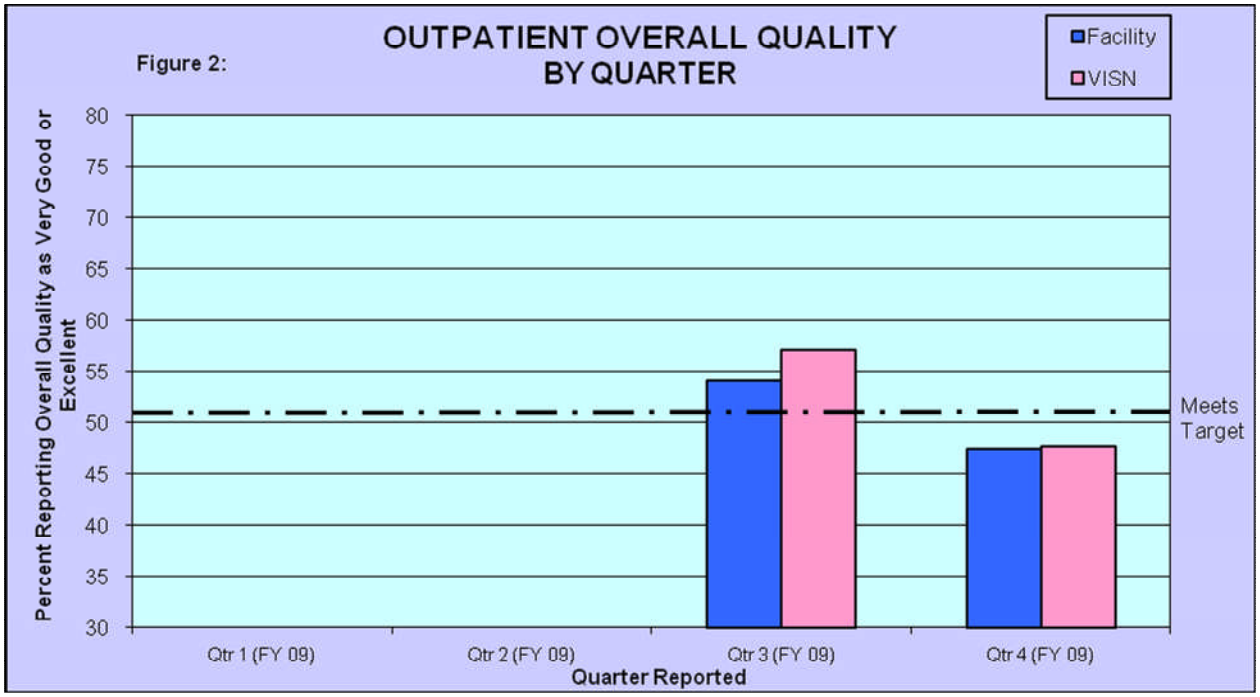
[13] All data provided by facility management.

VHA Satisfaction Surveys

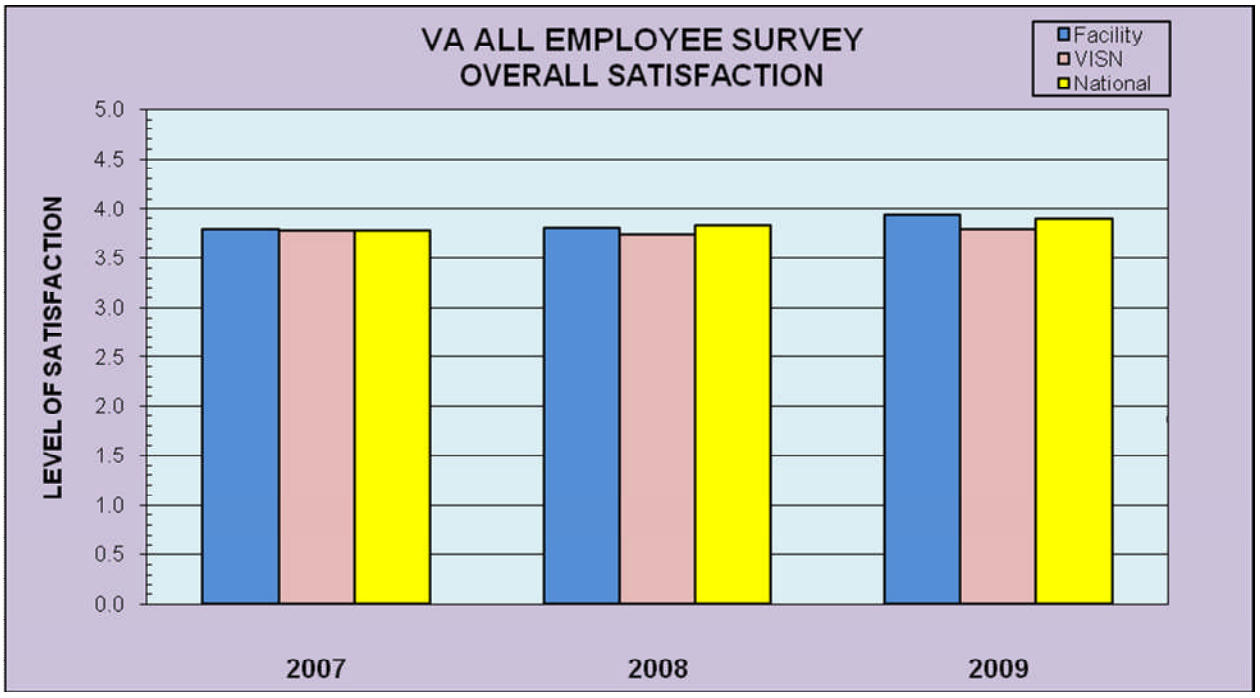
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 below shows the facility's and VISN's overall inpatient satisfaction scores for quarters 1–4 of FY 2009. Figure 2 on the next page shows the facility's and VISN's overall outpatient satisfaction scores for quarters 3 and 4 of FY 2009.[14] The target scores are noted on the graphs.



[14] 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 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.



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 25, 2010

From: Network Director, VISN 20 (10N20)

Subject: CAP Review of the Portland VA Medical Center, Portland, OR

To: Director, Los Angeles Healthcare Inspections Division (54LA)

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

1. Thank you for the opportunity to provide a status report on follow-up to the findings from the Combined Assessment Program Review of the Portland VA Medical Center, Portland, Oregon.

2. Attached please find the facility concurrences and response to each of the findings from the review.

3. If you have additional questions or need further information, please contact Nancy Benton, Quality Management Officer, VISN 20 at (360) 619-5949.

(original signed by:)
Susan Pedergrass, DrPH

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 22, 2010

From: Director (648/P1DIR), VA Portland VA Medical Center

Subject: CAP Review of the Portland VA Medical Center, Portland, OR

To: Network Director, VISN 20 (10N20)

I have reviewed the attached action plans for the areas of improvement recommended by the Office of Inspector General Combined Assessment Program and I concur with all recommended improvement action.

(original signed by:)
DAVID STOCKWELL, MHA
Acting Medical Center Director

Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 1. We recommended that peer review findings be reported to the MSC quarterly and that peer reviews are either completed within 120 days or extensions are requested timely and granted.

Concur

Target date for completion: November 30, 2010

Planned Action: Peer Review Committee Reports have been placed on the Medical Staff Council (MSC) agenda as a recurring agenda item to be reported in February, May, August, and November each year. First and second quarter FY10 reports were presented at MSC May 19, 2010. Currently we are monitoring all peer review cases to ensure timely extension requests. Since May 1, 2010, 10 out of 10 (100%) extensions have been requested and granted prior to the 120 day timeframe. We have created a database that is scheduled to roll out in July 2010. It will help save time with tracking and creating reports, and will prevent lost documentation. This will allow staff, service chiefs, and risk managers to review all information in real time. The system will alert the Risk Manager at each point of completion by other staff and give daily reports of items coming due. This allows more time to request extensions. It also will create reports by service and/or provider showing the amount of time for each step of the process required to complete each review. Risk Management will complete 100% review of all extensions requested and granted each month to ensure 100% compliance with the VHA Directive requirement of the 120 day timeframe.

Recommendation 2. We recommended that all designated clinical staff maintain current BLS training and that the local policy is revised to include the actions to be taken when BLS training or certification is not current.

Concur

Target date for completion: September 30, 2010

Planned Action: A BLS workgroup will be formed with members from the Medical Professional Service (MPS), Quality & Performance (Q&P), and the Clinical Service areas. This workgroup will develop a standard operating procedure (SOP) which will outline responsibilities of MPS in notifying Service Chiefs and clinical staff of upcoming BLS expiration and the responsibilities of the clinical service areas to ensure staff have BLS recertification. In addition, local policy will be revised to include what actions will be taken when BLS certifications expire. The Medical Staff Council will approve the actions to be taken and the policy will be changed to reflect this action by

August 31, 2010. With SOP completion and hospital policy update, expect all BLS certifications to be current by September 30, 2010.

Recommendation 3. We recommended that hand hygiene practices be consistently monitored in all patient care areas and that data be analyzed for PI.

Concur

Target date for completion: September 1, 2010

Planned Action: A multidisciplinary workgroup, including a physician and one executive, will meet in July to create a hand hygiene monitor. This group will review past monitoring plans and consider best practices when preparing the new plan. The monitoring plan will be presented to the Executive Leadership Board (ELB) in August for approval and leadership support in making sure participation in the monitoring process is optimal and timely. The new monitor will be in effect September 1st and the resultant hospital wide hand hygiene data will be reported to the Executive Quality Board (EQB) monthly starting October, 2010. Monthly data will be reviewed until the new process is fully implemented and then quarterly data will be updated in the Infection Control Committee quarterly reports, which will be reviewed by Medical Staff Council (MSC) and EQB on an ongoing basis.

Recommendation 4. We recommended that all eyewash stations be tested weekly.

Concur

Target date for completion: September 30, 2010

Planned Action: As part of our new eyewash directive, VHA Directive 2009-026, eyewash assessments are being completed for the entire medical center. In addition to the eyewash assessments, a spreadsheet will be created to identify locations of all eyewashes in the facility. As rounds are conducted (i.e. quarterly high hazards, weekly executive rounds, monthly operational rounds and semi-annual lab inspections), eyewashes will be continuously assessed to ensure weekly inspections are being completed. Staff are also receiving training during rounds if eyewashes are found not to be in compliance and corrective action will be taken. Data of deficient areas will be collected and added to the Safety and Risk Management Committee quarterly reports which are presented to the Executive Leadership Board (ELB), starting 1st Quarter FY11. In addition, an e-post message will be sent to remind staff of the importance and requirements for completing weekly eyewash inspections.

Recommendation 5. We recommended that MRI technologists review screening questionnaires, document follow-up on positive responses on the questionnaires, and ensure that non-MRI personnel with periodic access to the MRI area complete safety screening questionnaires.

Concur

Target date for completion: Completed

Planned Action: All patients and non-MRI personnel entering the MRI suite complete and sign screening questionnaires. MRI technologists review screening questionnaires and initial positive responses. MRI technologists document follow-up on these positive responses, and sign and date questionnaires. A sample of questionnaires is being reviewed weekly by the Chief Technologist, and results of the review are tracked in a spreadsheet.

Recommendation 6. We recommended that personnel who have access to the MRI area receive the appropriate level of MRI safety training, as required.

Concur

Target date for completion: December 31, 2010

Planned Action: Imaging Service is working with Education Service to develop online (intranet) training modules at two different levels with exams to demonstrate understanding upon completion of the modules. The modules will target MRI personnel and non-MRI personnel separately. The non-MRI personnel include Imaging's Housekeeping employees, Police Officers, Code Team, Biomedical Engineering, and all Imaging Service employees. These modules will be completed by December 31, 2010.

All of these targeted employees have completed third party modules on CD or online, but have not completed an exam. While the internal modules are being developed, an exam will be given to everyone who previously completed the module to confirm understanding of the presented material. The target date for completion of this interim exam is August 20, 2010.

Recommendation 7. We recommended that a multidisciplinary team conduct a comprehensive risk assessment of the MRI area.

Concur

Target date for completion: October 15, 2010

Planned Action: A comprehensive risk assessment tool is being developed with the following participants: Chief, Imaging Service; Chief Technologist, Imaging Service; MRI Technologist; Chief, Biomedical Engineering; Facility Safety Manager or Safety Specialist; Patient Safety Officer; Housekeeping Supervisor; Primary Care or Internal Medicine Physician; Quality and Performance Representative; Radiation Safety Officer; and MRI Physicist. The comprehensive risk assessment of the MRI area will be completed by October, 2010.

Recommendation 8. We recommended that managers consistently document the timeframe for the physicians' FPPEs and ensure results are reported to the MSC.

Concur

Target date for completion: July 30, 2010

Planned Action: A 90 day timeframe will be added to all initial Focused Professional Practice Evaluations (FPPE) and monitored by Quality & Performance (Q&P) to ensure all initial FPPEs have a 90 day timeframe. The initial FPPE review will be added to Medical Staff Council's (MSC's) agenda. Medical Professional Services (MPS) will send a list of all newly Credentialed LIP's to Q&P's FPPE/OPPE staff to track in conjunction with the appropriate service's Administration Officer/designee. This will include the initiation and completion of the initial FPPEs which will be forwarded to MPS, who will present an FPPE report on all initial FPPEs to MSC.

Recommendation 9. We recommended that clinicians take and document appropriate actions when CRD patients' hemoglobin levels exceed 12g/dL.

Concur

Target date for completion: June 30, 2010

Planned Action: Processes for adjusting dosing of ESAs in CRD patients to maintain hemoglobin levels between 10 to 12 g/dL were reviewed. On a monthly basis hemoglobin levels and labs relevant to anemia management (such as iron stores and nutritional status) are checked. When levels are higher than 12, the overall clinical scenario is reviewed, including trends in hemoglobin and patient status. This is done in the general context of overall anemia management. ESA levels are adjusted with the ultimate aim to gain a hemoglobin level of 11–12, although with recent data, this target may be closer to 10–12 g/dL. Occasionally, a hemoglobin level > 12g/dL will not result in a change in ESA – for example when a hemoglobin is already trending downward after prior ESA changes. Monthly care conferences are held, at which time anemia management is included in the discussion. Rationale for changes or no changes is documented in the chart notes on a monthly basis.

Epoetin & Darbepoetin Use Guidelines were updated, reviewed, and approved by the Pharmacy & Therapeutics Committee on June 17, 2010.

Recommendation 10. We recommended that clinicians develop safety plans for all patients at high risk for suicide.

Concur

Target date for completion: Completed

Planned Action: Clinicians will be educated about the importance of developing safety plans with high risk veterans. In addition, the suicide prevention team began doing a

weekly check of the flagged "high risk for suicide" patients in May 2010. They check each patient's chart for a new or revised safety plan. If one is not present, they assure that a safety plan is completed. Additionally, the suicide prevention team will start sending quarterly reports about the Suicide Prevention program activities, which will include the number of flagged patients without safety plans. This report will go to the Patient Safety Committee quarterly and will be sent on to the Executive Leadership Board (ELB) for review.

Recommendation 11. We recommended that program managers ensure that patient transfers are consistently reported, monitored, and evaluated in the UM Committee.

Concur

Target date of completion: July 30, 2010

Planned Action: At the time of the CAP Survey, the decision was made to add review of transfers to the Utilization Management (UM) Committee. The UM charter was amended to add this type of review. At the May 26, 2010, UM Committee meeting, the charter change was approved and the OIG transfer data findings were discussed for advance directive documentation, as well as the VISN transfer timeliness data for 2nd Quarter. The transfer reviews will be a standing agenda item on the UM Committee agenda and will be reported on quarterly and annual reports. This transfer monitor data will be presented at the Executive Quality Board meeting quarterly.

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