Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 09-03744-233

Combined Assessment Program Review of the VA Montana Health Care System Fort Harrison, Montana

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

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

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Glossary

AD	Associate Director
C&P	credentialing and privileging
CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CLC	community living center
CRD	chronic renal disease
EOC	environment of care
ESAs	erythropoiesis-stimulating agents
facility	VA Montana Health Care System
FPPE	Focused Professional Practice Evaluation
FTE	full-time employee equivalents
FY	fiscal year
g/dL	grams per deciliter
GI	gastrointestinal
ICU	intensive care unit
JC	Joint Commission
MH	mental health
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
OR	operating room
OSHA	Occupational Safety and Health Administration
PI	performance improvement
PPE	personal protective equipment
QM	quality management
RME	reusable medical equipment
SOP	standard operating procedure
SPD	Supply, Processing, and Distribution
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the VA Montana Health Care System, Fort Harrison, Montana

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 25, 2010.

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

- Physician Credentialing and Privileging
- Suicide Prevention Safety Plans

Recommendations: We made recommendations in the following five activities:

Environment of Care: Comply with environment of care rounds attendance requirements. Ensure all at-risk staff receive annual respirator fit testing, training, and medical evaluation. Secure confidential patient information, and eliminate duplicate paper records. Complete required patient elopement system checks. Update the local hand hygiene policy, and monitor compliance.

Reusable Medical Equipment: Ensure standard operating procedures are consistent with manufacturers' instructions and reflect current practice. Implement guidelines for non-critical equipment. Complete and document initial training and annual competency assessments. Correct identified environmental conditions in the gastrointestinal reprocessing and decontamination areas. Store personal protective equipment outside the decontamination area, ensure staff entering the decontamination area use appropriate personal protective equipment, and monitor compliance.

Quality Management: Report results of reviews for discussion, analysis, and recommendation of any corrective actions, and ensure actions taken are tracked and evaluated for effectiveness.

Coordination of Care: Complete inter-facility transfer documentation, and implement quality management processes to monitor and evaluate transfers.

Medication Management: Consistently take and document actions when chronic renal disease patients' hemoglobin levels exceed 12 grams per deciliter, and consistently document all required influenza vaccine elements.

Comments

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

(original signed by:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objectives and Scope

Objectives

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

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

Scope

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

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

- Coordination of Care
- EOC
- Medication Management
- Physician C&P
- QM
- RME
- Suicide Prevention Safety Plans

The review covered facility operations for FY 2009 and FY 2010 through May 28, 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 VA*

Montana Health Care System, Fort Harrison, Montana, Report No. 07-00171-15, October 29, 2007). We identified one repeat finding that is discussed in the QM section of this report.

During this review, we also presented crime awareness briefings for 69 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Results

Review Activities With Recommendations

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.

We inspected the emergency department, outpatient clinic areas, the same day surgery area, the inpatient medical and surgical units, and the ICU. The facility maintained a generally clean and safe environment. Staff and nurse managers expressed satisfaction with the responsiveness of the housekeeping staff on their units. However, we identified the following conditions that needed improvement.

EOC Rounds. The Director or AD is required to lead weekly EOC rounds that include representatives from designated disciplines.[1] Although weekly EOC rounds occurred, the Director or AD did not consistently lead them, and representatives from designated disciplines did not always attend.

Respirator Fit Program. Local policy and OSHA require that staff identified as at risk for exposure to a harmful atmosphere, such as tuberculosis, receive annual respirator fit testing, training, and medical evaluation. We found that

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

14 (70 percent) of 20 selected staff at risk for exposure did not receive the required annual respirator fit testing, training, and medical evaluation.

Patient Privacy. The Health Insurance Portability and Accountability Act requires confidential patient information to be secured. VHA policy[2] requires a complete transition to an electronic medical record. We found five unattended computers and papers in public view that displayed patient information. Also, although the facility had implemented the Computerized Patient Record System, we found unsecured duplicate paper records—too numerous to count—in one of the outpatient clinic areas.

Patient Elopement System. Local policy requires a basic check of the electronic patient elopement system every day and a complete system check annually. Staff had not completed the daily and annual system checks.

Hand Hygiene. VHA policy[3] requires a local hand hygiene policy that identifies the process for monitoring health care workers' practice and hand hygiene compliance in all direct patient care areas. The local hand hygiene policy did not include the process for monitoring health care workers' adherence to the required hand hygiene practices, and hand hygiene compliance data was not consistently collected for all direct patient care areas.

Recommendations

1. We recommended that the Director or AD lead weekly EOC rounds and that representatives from all designated disciplines attend the rounds.

2. We recommended that staff identified as at risk for exposure to a harmful atmosphere receive annual respirator fit testing, training, and medical evaluation.

3. We recommended that confidential patient information be secured and that the duplicate paper record system be eliminated.

4. We recommended that staff complete the daily and annual checks for the electronic patient elopement system.

[2] VHA Handbook 1907.01, *Health Information Management and Health Records,* August 25, 2006.
[3] VHA Directive 2005-002, *Required Hand Hygiene Practices*, January 13, 2005.

5. We recommended that staff update the local hand hygiene policy and monitor hand hygiene compliance in all direct patient care areas.

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 the SPD and the GI reprocessing areas and the OR RME storage area. We found that all areas were clean and that the separation of clean from dirty was maintained to assist in preventing cross-contamination.

VA[4] requires that temperature and humidity levels in areas where RME is stored be maintained within specific ranges. We found that the hygrometer (visual monitor) in the OR storage area was not within the specified ranges; however, the facility had an automated system that also monitored temperature and humidity levels in the OR. We reviewed the data from the automated system for the month of May 2010 and found that the readings were within the required ranges. The hygrometer was recalibrated while we were onsite; therefore, we made no recommendation for this finding. However, we identified the following areas that needed improvement.

SOPs. VHA[5] requires that device-specific SOPs for RME be established in accordance with the manufacturers' instructions. We requested the SOPs and manufacturers' instructions for eight pieces of RME. Managers were unable to provide us with the manufacturer's instructions for the laparoscope. Also, we found conflicting information in the laparoscope SOP, and the SOP was not consistent with current practice. The SOP for surgery and dental instruments did not contain steps for manual cleaning, as specified by the manufacturer's instructions. In addition, the

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

facility did not have any guidelines in place for cleaning non-critical RME (items that touch the skin).

Competency and Training. VHA[6] requires that all employees involved in the use and reprocessing of RME have documented training on the set-up, use, reprocessing, and maintenance of specific equipment to ensure initial competency and have competency validation on an annual basis. We found no documentation of training for one SPD employee, and two SPD employees did not have documentation of competencies for the bronchoscope and laparoscope.

VHA[7] requires a training program to be provided when a new SOP is implemented. We found that the facility had purchased four Olympus cystoscopes. Managers provided us with the SOP; however, they could not provide evidence of any training that occurred prior to staff reprocessing these scopes. It is important to note that at the time of our review, the facility had temporarily stopped using these cystoscopes for unrelated reasons. The facility agreed that these scopes had been used in the past.

Environment. OSHA requires that employees who work with or around chemicals have access to an emergency eyewash station. There was no eyewash station in the GI reprocessing area where chemicals were used.

VA[8] requires negative pressure airflow in the decontamination area to minimize the movement of microorganisms from dirty to clean areas. The GI decontamination area was not under negative pressure.

Also, we found that the automatic door separating the GI reprocessing area from the procedure area was not operational. We observed an employee cleaning a colonoscope with the door open. While we were onsite, a work order to repair the automatic door was initiated.

PPE. VA[9] requires that PPE be stored outside the decontamination area and that staff wear PPE at all times while in the decontamination area. PPE required in this area

[6] VHA Directive 2009-004.
[7] VHA Directive 2009-031, *Improving Safety in the use of Reusable Medical Equipment through Standardization of Organizational Structure and Reprocessing Requirements,* June 26, 2009.
[8] VA Handbook 7176.
[9] VA Handbook 7176.

includes gown, gloves, shoe covers, and face mask. We found PPE stored inside the SPD decontamination room. Also, we observed an employee enter the SPD decontamination area without appropriate PPE while an employee was reprocessing RME.

Recommendations

6. We recommended that SOPs be consistent with manufacturers' instructions and reflect current practice and that guidelines be implemented for all non-critical RME.

7. We recommended that initial training on RME SOPs and annual competency assessments be completed and documented for all staff responsible for reprocessing RME.

8. We recommended that the environmental conditions identified in the GI reprocessing and decontamination areas be corrected.

9. We recommended that PPE be stored outside the SPD decontamination area, that all staff entering the SPD decontamination area be required to utilize appropriate PPE, and that compliance be monitored.

QM

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

The QM program was generally effective in providing oversight of the facility's quality of care, and senior managers supported the program through participation in PI initiatives and through allocation of resources to the program. However, we identified the following area that needed improvement and was a repeat finding from the prior CAP review.

Discussion of QM Reviews and Evaluation of Corrective Actions. The facility PI plan requires that defined oversight committees review, discuss, and analyze data and recommend corrective actions when performance does not meet established goals. The facility lacked a consistent process for reporting, discussing, and analyzing QM data. As a result, opportunities to improve performance were not consistently identified or addressed. QM staff collected

relevant data, but this data did not always get reported to oversight committees even when data indicated less than optimal performance. Staff need to present all QM review activities in a multidisciplinary forum to allow for discussion and analysis of data.

The facility PI plan also requires that actions taken are tracked and evaluated for effectiveness. Although different committee minutes identified planned corrective actions to improve processes, subsequent minutes did not reflect monitoring to see whether the actions were implemented or effective. One example involved a key performance improvement project initiated as a result of quality of care data that indicated that the facility was an outlier within VISN 19 for opioid usage. Even though monthly reports were required and narcotic refill was in the top three concerns veterans voiced to the patient advocate, there was no documentation on the status of this project.

Recommendation

10. We recommended that QM staff report results of all reviews to a multidisciplinary forum for discussion, analysis, and recommendation of any corrective actions and ensure that actions taken are tracked and evaluated for effectiveness.

Coordination of Care

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

VHA policy[10] requires that providers include information regarding medications, diet, activity level, and follow-up appointments in patient discharge instructions. In addition, The JC requires that clinicians provide patients with written discharge instructions. We reviewed the medical records of 10 discharged patients and determined that providers had generally documented the required elements. Also, we found that follow-up appointments occurred within the timeframes specified.

VHA requires that facilities have a policy that ensures the safe, appropriate, and timely transfer of patients. We determined that the facility had an appropriate transfer

[10] VHA Handbook 1907.01.

policy. However, we identified the following area that needed improvement.

Inter-Facility Transfers. VHA policy[11] requires specific information (such as the reason for transfer, mode of transportation, and informed consent to transfer) to be recorded in the transfer documentation. VHA also requires inter-facility transfers to be monitored and evaluated as part of the QM program.

We reviewed transfer documentation for 10 patients transferred from the facility's acute inpatient units to another facility. We found that providers did not complete the locally required physician transfer note template for 7 (70 percent) of the 10 patients. As a result, providers did not document all required information. Missing information included documentation of patient consent to transfer, mode of transportation, and the reason for transfer. In addition, we did not find evidence that patient transfers were monitored and evaluated as part of the QM program.

Recommendation

11. We recommended that providers complete inter-facility transfer documentation and that QM processes be implemented to monitor and evaluate transfers.

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.

Although the pharmacy is closed from 10:00 p.m. to 6:00 a.m. daily, we found that the facility had appropriately provided a qualified pharmacist to answer questions during those hours and had an adequate medication dispensing and review process. However, we identified the following two areas that needed improvement.

Management of ESAs. In November 2007, the U.S. Food and Drug Administration issued a safety alert stating that for CRD patients, ESAs[12] 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 record of the one outpatient with CRD who had hemoglobin levels

[11] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.
[12] These are drugs that stimulate the bone marrow to make red blood cells. They are used to treat anemia.

greater than 12g/dL and found that clinicians did not document an action to address the hemoglobin levels.

CLC Influenza Vaccinations. VHA requires several items to be documented for each influenza vaccine given, including the route, site, and edition and date of the Vaccine Information Statement.[13] If the patient refuses vaccination, documentation must indicate the refusal. We reviewed the medical records of 10 CLC residents. Two records contained documentation of refusal. None of the remaining eight records contained documentation of all the required elements.

Recommendations

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

13. We recommended that clinicians consistently document all required influenza vaccine elements.

Review Activities Without Recommendations

Physician C&P

The purpose of this review was to determine whether VHA facilities had consistent processes for physician C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and physician profiles.[14] We also reviewed meeting minutes during which discussions about the physicians took place.

We reviewed nine C&P files and profiles and found that licenses were current and that primary source verification had been obtained. FPPE was appropriately implemented for newly hired physicians. Service-specific criteria for OPPE 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 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

[13] VHA Directive 2009-058, *Seasonal Influenza Vaccine Policy for2009–2010*, November 12, 2009.
[14] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

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.[15]

A previous OIG review of suicide prevention programs in VHA facilities[16] 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 of the vast geography of the facility's catchment area and because the facility has no inpatient MH beds, MH clinicians have established processes to ensure that contract or referral staff complete safety plans for at-risk patients. We reviewed the medical records of nine 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.

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 14–19, for the full text of the Directors' comments.) We consider Recommendation 8 closed. We will follow up on the planned actions for the open recommendations until they are completed.

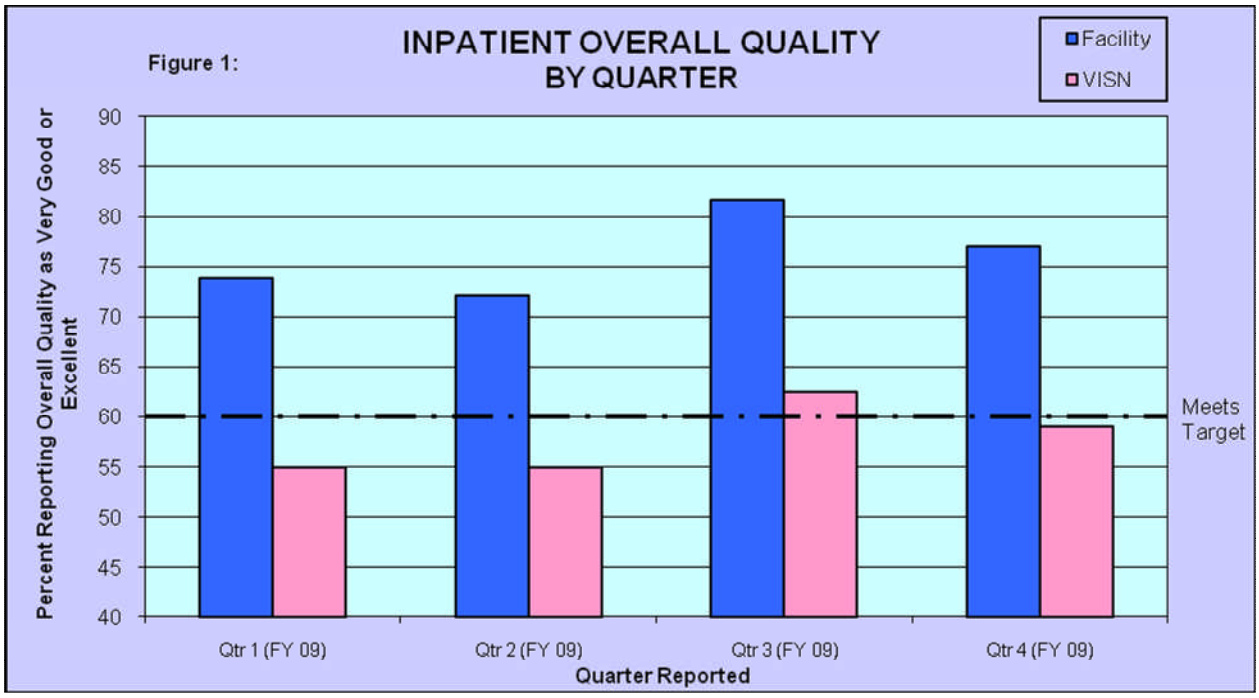
[15] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
[16] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009;* Report No. 09-00326-223;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

Facility Profile[17]		
Type of Organization	VA medical center	
Complexity Level	2	
VISN	19	
CBOCs	Anaconda, MT Billings, MT Bozeman, MT Cut Bank, MT – Contract Glasgow, MT Glendive, MT Great Falls, MT Havre, MT Kalispell, MT Lewistown, MT Missoula, MT Miles City, MT Plentywood, MT – Planned Hamilton, MT – Planned	
Veteran Population in Catchment Area	107,000	
Type and Number of Operating Beds: • **Acute care**	45	
• **CLC**	30	
• **Other**	0	
Medical School Affiliation(s)	Northwestern College Of Chiropractic	
• **Number of Residents**	0	
	Current FY (through April 2010)	**Prior FY**
Resources (in millions):		
• **Budget**	188.4	162
• **Medical Care Expenditures**	153.2	129.6
FTE	899.3	864.4
Workload:		
• **Number of Unique Patients**	29,599	31,774
• **Inpatient Days of Care:**		
o **Acute Care**	6,064	9,603
o **CLC**	5,922	9,692
Hospital Discharges	1,269	2,107
Cumulative Average Daily Census (including CLC patients)	56.54	52.86
Cumulative Occupancy Rate	75.4 inpatient + CLC	70.5 inpatient + CLC
Outpatient Visits	192,205	282,355

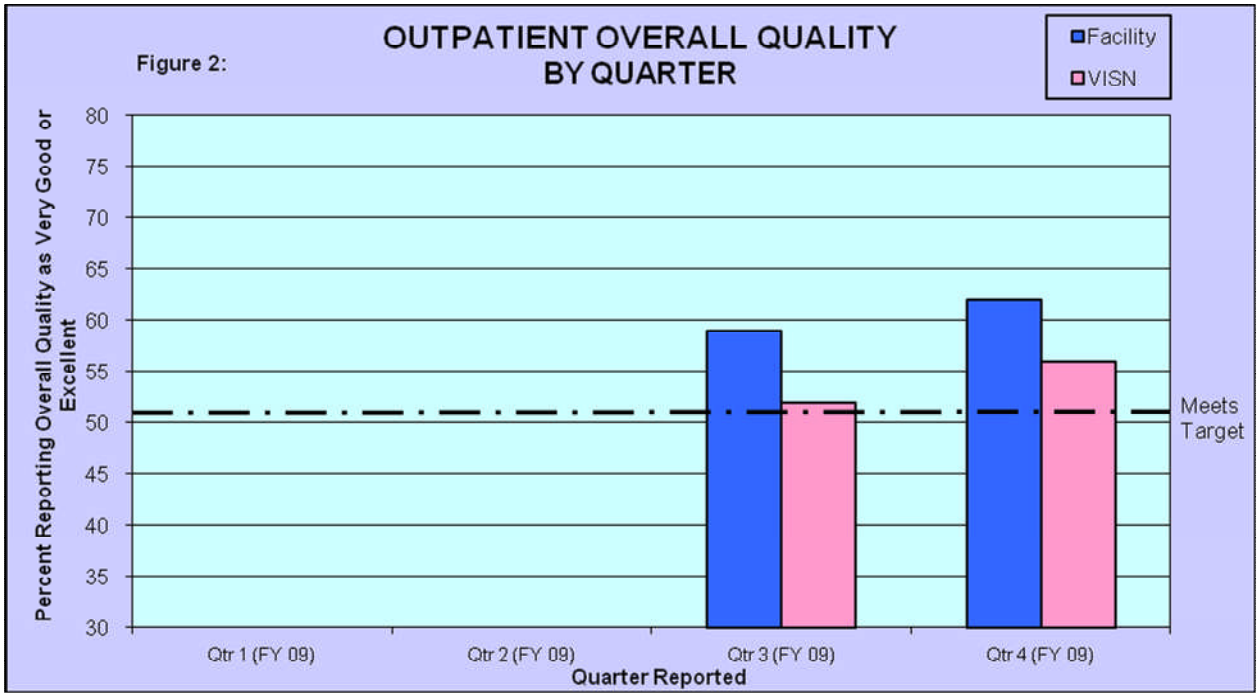
[17] All data provided by facility management.

VHA Satisfaction Surveys

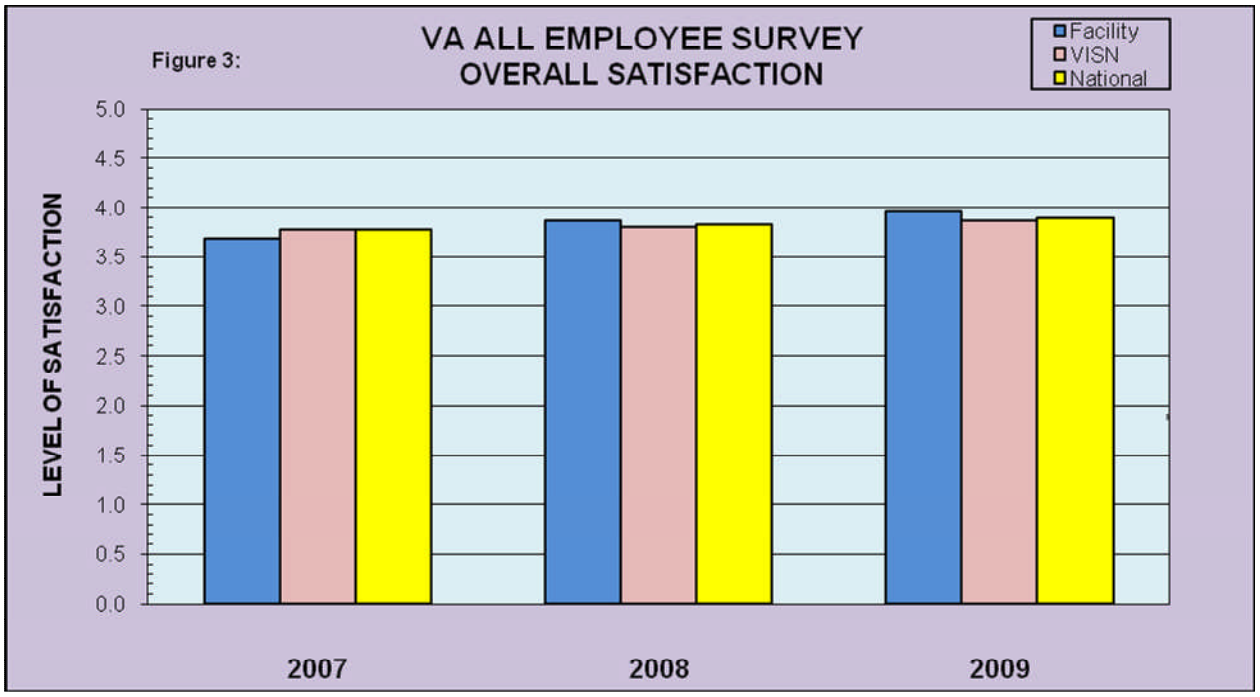
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 below shows the facility's and VISN's overall inpatient satisfaction scores for quarters 1–4 of FY 2009. Figure 2 on the next page shows the facility's and VISN's overall outpatient satisfaction scores for quarters 3 and 4 of FY 2009.[18] The target scores are noted on the graphs.



[18] 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: August 3, 2010

From: Director, Rocky Mountain Network (10N19)

Subject: **CAP Review of the VA Montana Health Care System, Fort Harrison, MT**

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

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

Attached are the responses to the recommendations for the CAP Review of the VA Montana Health Care System. I have reviewed and concurred on the responses.

If you have any questions, please contact Ms. Susan Curtis, VISN 19 HSS at (303) 639-6995.

Glen W. Grippen, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 27, 2010

From: Director, VA Montana Health Care System (436/00)

Subject: **CAP Review of the VA Montana Health Care System, Fort Harrison, MT**

To: Director, Rocky Mountain Network (10N19)

Attached are the responses to the recommendations for the CAP Review of the VA Montana Health Care System.

Robin L Korogi

ROBIN L. KOROGI, MS HRM
Director, VA Montana Health Care System

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 Director or AD lead weekly EOC rounds and that representatives from all designated disciplines attend the rounds.

Concur

Target date for completion: September 30, 2010

The Director or AD will attend all the remaining scheduled rounds at Fort Harrison and the remaining CBOC scheduled rounds. If neither are available, the Acting Director or Acting AD will attend.

Recommendation 2. We recommended that staff identified as at risk for exposure to a harmful atmosphere receive annual respirator fit testing, training, and medical evaluation.

Concur

Target date for completion: September 30, 2010

The safety department fit tests and trains staff at risk to TB exposure as identified by Infection Control. Once a supervisor has identified a person and notified safety, respiratory protection training, fit testing and a medical evaluation are provided. The safety department maintains records of annual fit testing, training and medical evaluations. The safety department sends reminders to supervisors and blocks time for fit testing and training. Staff members can call the safety department as well to schedule fit testing and training.

Efforts have increased to ensure requirements are met. Record keeping has been improved. The Safety Manger will review the process and ensure that needed changes are implemented no later than September 30, 2010. Process improvements will be brought to Infection Control and the Safety Committee.

Recommendation 3. We recommended that confidential patient information be secured and that the duplicate paper record system be eliminated.

Concur

Target date for completion: October 31, 2010

All records will be relocated permanently to the medical file room and will be scanned as appropriate. The facility has already started this process. Since the OIG visit, an electronic EKG system has been implemented and in current use, eliminating the need for any paper product.

Recommendation 4. We recommended that staff complete the daily and annual checks for the electronic patient elopement system.

Concur

Target date for completion: August 30, 2010

The wander guard system installed on the 3rd and 4th floors will be checked on a daily basis by Patient Care Services. The Environment of Care committee will verify during EOC rounds. Bio-Med has also been asked to verify the logs on a weekly basis.

Recommendation 5. We recommended that staff update the local hand hygiene policy and monitor hand hygiene compliance in all direct patient care areas.

Concur

Target date for completion: Clinical area monitoring – Complete, policy update target completion August 1, 2010

All clinical areas have been added to the Survey Monkey Hand Hygiene monitoring tool (non-clinical areas were removed as recommended) initiated June 2010. Hand Hygiene policy has been updated and is on the 7/23/10 Infection Control Committee agenda for approval.

Recommendation 6. We recommended that SOPs be consistent with manufacturers' instructions and reflect current practice and that guidelines be implemented for all non-critical RME.

Concur

Target date for completion: August 20, 2010

SOPs identified were reviewed along with manufactures' instructions for inclusion of manual cleaning instructions as well the ultrasonic portion. Edits made and are ready for August RME Committee and IC Committee review. Non-critical RME has cleaning guidelines available based on manufactures' instructions, complete listing of all non-critical items state-wide in progress and policy in development.

Recommendation 7. We recommended that initial training on RME SOPs and annual competency assessments be completed and documented for all staff responsible for reprocessing RME.

Concur

Target date for completion: Completed

SPD staff audit of training and competency conducted, with quarterly reviews planned. The separation of the documentation of training and competency is now in place.

Recommendation 8. We recommended that the environmental conditions identified in the GI reprocessing and decontamination areas be corrected.

Concur

Target date for completion: Completed

The air flow in the endoscopy reprocessing area has been converted to negative pressure and the door has been repaired and in use during reprocessing activities.

Recommendation 9. We recommended that PPE be stored outside the SPD decontamination area, that all staff entering the SPD decontamination area be required to utilize appropriate PPE, and that compliance be monitored.

Concur

Target date for completion: Completed

Cabinet for relocation of PPE outside of decontamination has been obtained and is mounted outside of decontamination for staff to don the appropriate PPE outside of decontamination. Use of appropriate PPE will be monitored during periodic leadership rounds to SPD.

Recommendation 10. We recommended that QM staff report results of all reviews to a multidisciplinary forum for discussion, analysis, and recommendation of any corrective actions and ensure that actions taken are tracked and evaluated for effectiveness.

Concur

Target date for completion: October 1, 2010

The Quality Management and Chief of Staff Offices have developed a reporting flow sheet for all required reports. Reports have been divided into those required for Medical Executive Committee, Director's Staff meeting, or the Governing Body Executive Committee. The spreadsheet distributes the reporting times throughout the year so that only 3–4 reports will be due at any one meeting. Reports are to be in the Conclusions, Recommendations, Actions, Evaluation (CRAE) format and are to be distributed at least a week prior to the meeting where discussion will occur. Minutes of discussion, recommendations and actions from each of the meetings are recorded in a standardized format that assists in tracking actions to conclusion. Reports may occur on a monthly, quarterly, semiannual or annual basis depending upon the content of the report and subject requirements.

Recommendation 11. We recommended that providers complete inter-facility transfer documentation and that QM processes be implemented to monitor and evaluate transfers.

Concur

Target date for completion: August 1, 2010

Hospitalist staff has been instructed that the interfacility transfer brief is to be filled out on all patients that are transferred. This had been done, but not consistently. This standard has been emphasized. QM will conduct audits for August and September to ensure compliance.

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

Concur

Target date for completion: October 1, 2010

CRD patients receiving erythropoietin stimulating agents for anemia will have this discontinued when the hemoglobin level reaches 12g/dl. This will be standardized once the erythropoietin clinic is fully functional. A policy for a pharmacy managed erythropoietin clinic is in process of development for MEC approval.

Recommendation 13. We recommended that clinicians consistently document all required influenza vaccine elements.

Concur

Target date for completion: September 1, 2010

This is one of our performance measures. Even though a veteran refuses the immunization, the documentation for this reminder is consistently entered. This performance measure and the process will be reviewed with the staff.

OIG Contact and Staff Acknowledgments

Contact	Dorothy Duncan, Associate Director Kansas City Office of Healthcare Inspections (816) 997-6966
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VA Distribution

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Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Max Baucus, Jon Tester
U.S. House of Representatives: Dennis Rehberg

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