Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-01782-222

Combined Assessment Program Review of the Erie VA Medical Center Erie, Pennsylvania

August 16, 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

ACLS	Advanced Cardiac Life Support
BCMA	Bar Code Medication Administration
BLS	Basic Life Support
C&P	credentialing and privileging
CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CLC	community living center
EOC	environment of care
facility	Erie VA Medical Center
FTE	full-time employee equivalents
FY	fiscal year
ICU	intensive care unit
MOD	Medical Officer of the Day
OEF/OIF	Operation Enduring Freedom/Operation Iraqi Freedom
OIG	Office of Inspector General
OR	operating room
PI	performance improvement
PM	preventative maintenance
QM	quality management
RME	reusable medical equipment
RN	registered nurse
SOP	standard operating procedure
SPD	Supply, Processing, and Distribution
SRC	system redesign coordinator
TJC	The Joint Commission
VASQIP	VA Surgical Quality Improvement Program
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Erie VA Medical Center, Erie, Pennsylvania

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 seven activities. We made no recommendations in the following activities:

- Medication Management
- Physician Credentialing and Privileging
- Suicide Prevention Safety Plans

The facility's reported accomplishments were related to system redesign and included leadership's commitment to implementation and enrollment process improvements.

Recommendations: We made recommendations in the following four activities:

Quality Management: Track open action items until resolution and evaluate action plans for effectiveness. Revise facility policy to define staff requirements to maintain current life support certification, provide a mechanism to track certification, and establish consequences for staff who do not maintain certification. Collect and analyze data for all invasive procedures occurring outside of the operating room.

Reusable Medical Equipment: Implement interim measures to maintain Supply, Processing, and Distribution (SPD) area temperature and humidity ranges in accordance with VA policy. Establish standard operating procedures that are consistent with manufacturers' instructions. Ensure that SPD employees receive training and competency evaluations for dental and orthopedic instruments. Schedule and complete preventative maintenance in accordance with manufacturers' instructions and VA policy.

Environment of Care: Secure treatment carts and Bar Code Medication Administration computers when not in active use.

Coordination of Care: Ensure that staff complete required inter-facility transfer documentation and implement processes to monitor and evaluate transfers.

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 13, 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*

Erie VA Medical Center, Erie, Pennsylvania, Report No. 07-03081-54, January 8, 2008). We had identified improvement opportunities in the following activities (1) QM and (2) EOC. During our follow-up review, we found sufficient evidence that program managers and staff had implemented appropriate actions to address the identified deficiencies in these areas. We consider these issues closed.

During this review, we also presented crime awareness briefings for 169 employees onsite and an undetermined number of CBOC employees by video-teleconference. 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

Leadership's Commitment to Implementation of System Redesign

In an effort to provide maximum value to veterans and exceed their expectations related to access, safety, and quality care, facility leadership recognized the need for a cohesive strategy to implement system redesign principles. By collaborating with the SRCs, leadership developed a system redesign strategic plan that includes identifying key processes, creating and continuously reviewing value stream maps, documenting standard work processes, defining roles, and using standardized problem solving methodology to improve processes. Leadership currently holds weekly planning meetings with the SRCs to discuss dissemination of system redesign principles and implementation progress.

System Redesign in the Enrollment Process of Non-OEF/OIF Veterans

The facility's goal was to decrease cycle time (measured from time of application to the date and time of the first available offered appointment) of the new enrollee process from 14.6 days to fewer than 3 days for non-OEF/OIF veterans. A veteran was added to the facility's system redesign team to provide a patient's perspective of the enrollment process. The scope of change primarily included the Eligibility Office and the Call Center. The goal was achieved in April 2009 and maintained through the remainder of the FY by reducing or eliminating non-value added steps

and redefining roles throughout the process. The team envisions a reduction of lead time to the point that, in many cases, a veteran could apply in person and be seen in primary care the same day.

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 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 and evaluation of PI initiatives and through allocation of resources to the program. However, we identified the following QM and risk management areas that needed improvement.

Tracking and Evaluating Open Action Items. When problems are identified or performance does not meet goals or targets, TJC requires that corrective actions be taken and evaluated for effectiveness. We found that problems had been identified and that actions had been implemented. However, we found that open action items were not tracked until resolution. Also, actions were not evaluated for effectiveness in several program areas, including peer review, outcomes from resuscitation, and medical record review.

Life Support Certification. VHA policy requires that the facility have a policy governing BLS and ACLS certification for designated clinical staff as well as a mechanism in place to ensure staff compliance with BLS and ACLS education requirements.[1] Facility policy did not address life support certification for medical providers, a mechanism to track staff certification, or consequences for staff members who do not maintain life support certification.

[1] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.

Operative and Other Procedures. TJC requires facilities to collect and analyze data on operative or other procedures that place patients at risk for harm. The facility collected data on procedures occurring within the OR; however, data was not collected on invasive procedures occurring outside of the OR.

Recommendations

1. We recommended that the facility track open action items until resolution and evaluate action plans for effectiveness.

2. We recommended that facility policy be revised to define staff requirements to maintain life support certification, provide a mechanism to track staff certification, and establish consequences for staff members who do not maintain current life support certification.

3. We recommended that the facility collect and analyze data for all invasive procedures occurring outside of the OR.

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, Occupational Safety and Health Administration, and TJC's standards.

We inspected the OR and SPD. We determined that the facility had established appropriate guidelines and monitored compliance with those guidelines.

VA requires that areas within SPD comply with specific environmental standards for air exchanges, emergency plans, and sanitation.[2] During our tour of the areas in SPD, we found the following conditions that required staff attention:

- A minimum of 10 air exchanges was not maintained in a sterile storage area; however, the sterile storage area was relocated to a room that had the required number of air exchanges.

[2] VA Handbook 7176, *Supply, Processing and Distribution (SPD) Operational Requirements*, August 16, 2002.

- The ethylene oxide[3] sterilizer did not have ethylene oxide emergency plans posted nearby; however, managers posted the emergency plans appropriately.
- The SPD area had dust and dirt under storage racks and around baseboards; however, the facility developed an action plan to improve cleaning.

The facility corrected these conditions while we were onsite; therefore, we did not make recommendations for these findings. However, we identified the following areas that needed improvement.

SPD Sterile Storage Area. VA policy requires sterile items to be stored in carefully controlled conditions that are protective of extreme temperature and humidity.[4] Temperature must be maintained between 65 and 72 degrees Fahrenheit, and humidity must be maintained between 35 and 75 percent. We reviewed the March 1 through May 11, 2010, SPD temperature and humidity logs; of the 52 days, the temperature was out of range on 7 days (13 percent), and the humidity was out of range on 42 days (81 percent). The facility had previously identified this problem, conducted a risk assessment, and developed short-term plans to monitor sterile packages for humidity-induced damage and long-term plans for a construction project to install humidity controls in SPD.

SOPs. VHA requires device-specific SOPs for RME to be established in accordance with the manufacturers' instructions.[5] We requested the SOPs and manufacturers' instructions for nine pieces of RME. Four of the SOPs were consistent with manufacturers' instructions. The SOPs for the colonoscope, the cystoscope, and the laparoscope were not consistent with the manufacturers' instructions. In addition, we found that the SOP for Cidex® OPA Solution was not consistent with manufacturer's instructions.[6] Also, staff were unable to provide us with SOPs for dental and orthopedic instruments.

Competencies and Training. VHA requires that competencies are evaluated and that training is provided

[3] Ethylene oxide is a potentially hazardous gas.
[4] VA Handbook 7176.
[5] VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.
[6] A solution that is used for high-level disinfection in reprocessing heat sensitive medical devices.

annually on the set-up, use, reprocessing, and maintenance of specific RME.[7] We reviewed the competency folders and training records of four SPD employees and found no documentation of annual competencies and training for the orthopedic and dental instruments.

PM. VA policy requires that sterilizers and reprocessors have scheduled and reoccurring PM.[8] We found that the two ethylene oxide sterilizers and the two washer/disinfectors did not have the manufacturer required quarterly PM.

Recommendations

4. We recommended that the facility implement interim measures to maintain temperature and humidity ranges in accordance with VA policy until construction is completed.

5. We recommended that RME SOPs be established and consistent with manufacturers' instructions.

6. We recommended that SPD employees receive training and competency evaluations for dental and orthopedic instruments.

7. We recommended that PM is scheduled and completed in accordance with manufacturers' instructions and VA policy.

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, Occupational Safety and Health Administration, National Fire Protection Association, and TJC's standards.

We inspected the ICU; the acute medicine unit; the CLC unit; the outpatient clinics and construction area; and selected spaces in the laboratory, radiology, and OR areas. The facility maintained a generally clean and safe environment. However, we identified the following conditions that needed improvement.

Medication Security. TJC's standards require all medications to be secured from access by unauthorized persons. We

[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.

found two treatment carts on the CLC unit unlocked, and there were no staff in the vicinity.

Patient Privacy. The Health Insurance Portability and Accountability Act requires confidential patient information to be secured. Although computer screens had been fitted with privacy screen covers, we found an unattended BCMA computer on a CLC unit displaying patient information.

Recommendations

8. We recommended that treatment carts be secured when not in active use.

9. We recommended that BCMA computers be secured when not in active use.

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

VHA policy and TJC's standards require that providers include information regarding medications, diet, activity level, and follow-up appointments in written patient discharge instructions.[9] We reviewed the medical records of 10 discharged patients and determined that clinicians had generally documented the required elements. Also, we found that follow-up appointments occurred within the timeframes specified.

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

Inter-Facility Transfers. VHA policy requires specific information, such as informed consent to transfer, to be recorded in the transfer documentation.[10] VHA also requires inter-facility transfers to be monitored and evaluated as part of the QM program. Additionally, the facility's local transfer policy requires the use of specific forms for the

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

documentation of informed consent and the patient's signature when the patient is transferred "as VA pay."[11]

We reviewed transfer documentation for 10 patients transferred from the facility's acute inpatient unit or ICU to another facility. We found that providers did not document informed consent to transfer, as required by VHA, and did not use the specified forms, as required by local policy. In addition, we did not find evidence that patient transfers were monitored and evaluated as part of the QM program.

Recommendations

10. We recommended that staff complete required inter-facility transfer documentation and implement processes to monitor and evaluate transfers.

Review Activities Without Recommendations

Medication Management

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

The facility had implemented a practice guideline governing the maintenance of chronic renal disease patients who receive erythropoiesis-stimulating agents.[12] 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. Also, although the pharmacy is closed from 6:00 p.m. to 6:00 a.m. daily, the facility had appropriately provided a qualified pharmacist to answer questions during those hours and had an adequate retrospective review process. We made no 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.[13] We also reviewed meeting minutes during which discussions

[11] According to the local policy, the patient may be transferred "as VA pay" when the patient requires specialized care that cannot be provided at the facility. The facility will pay those bills that arise from the current admission or episode of care.
[12] Drugs that stimulate the bone marrow to make red blood cells; used to treat anemia.
[13] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

about the physicians took place.

We reviewed 10 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 newly hired physicians. 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.

VHA requires that the settings in which care is delivered dictate the type(s) of care, treatment, and services or procedures that a practitioner will be authorized to perform.[14] We found that a telemedicine consultant was granted privileges to perform onsite procedures at the facility; however, the facility took action and removed all but consultative privileges. Therefore, 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.[15]

A previous OIG review of suicide prevention programs in VHA facilities found a 74 percent compliance rate with safety plan development.[16] 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

[14] VHA Handbook 1100.19.
[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.

agreed to follow up on the prior findings.

We reviewed the medical records of 11 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 14–20, for the full text of the Directors' comments. We will follow up on the planned actions until they are completed.

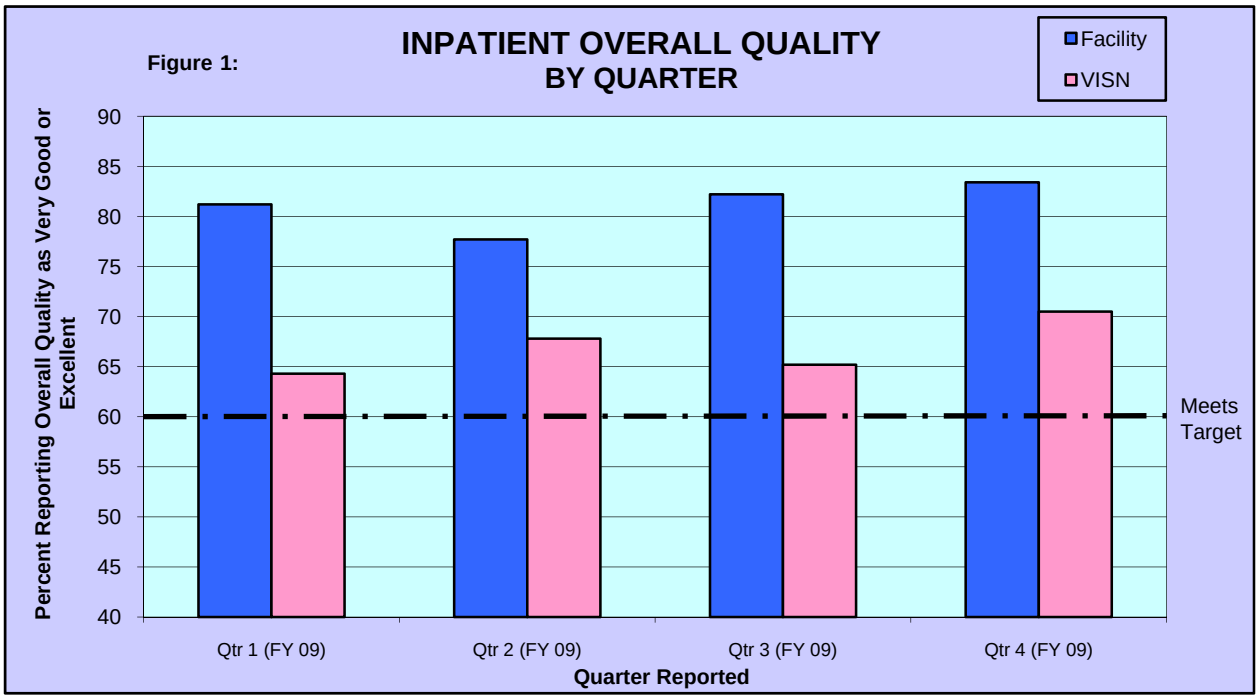
Facility Profile[17]		
Type of Organization	General medical/surgical facility	
Complexity Level	3	
VISN	4	
CBOCs	Ashtabula, OH Meadville, PA Franklin, PA Bradford, PA Warren, PA	
Veteran Population in Catchment Area	76,000	
Type and Number of Operating Beds: • **Acute care**	26	
• **CLC**	52 (13 out of service)	
• **Other**	NA	
Medical School Affiliation(s)	Lake Erie College of Osteopathic Medicine	
• **Number of Residents**	3 on rotating schedule	
	Current FY	**Prior FY**
Resources (in millions):		
• **Budget**	$114.6	$108.7
• **Medical Care Expenditures**		$82.9
FTE	636.68	606.75
Workload:		
• **Number of Unique Patients**		21,167
• **Inpatient Days of Care:**		
o **Acute Care**		4,878
o **CLC**		12,718
Hospital Discharges		1,404
Cumulative Average Daily Census (including CLC patients)		48.2
Cumulative Occupancy Rate		51.4% without observations beds
Outpatient Visits		243,396

[17] All data provided by facility management.

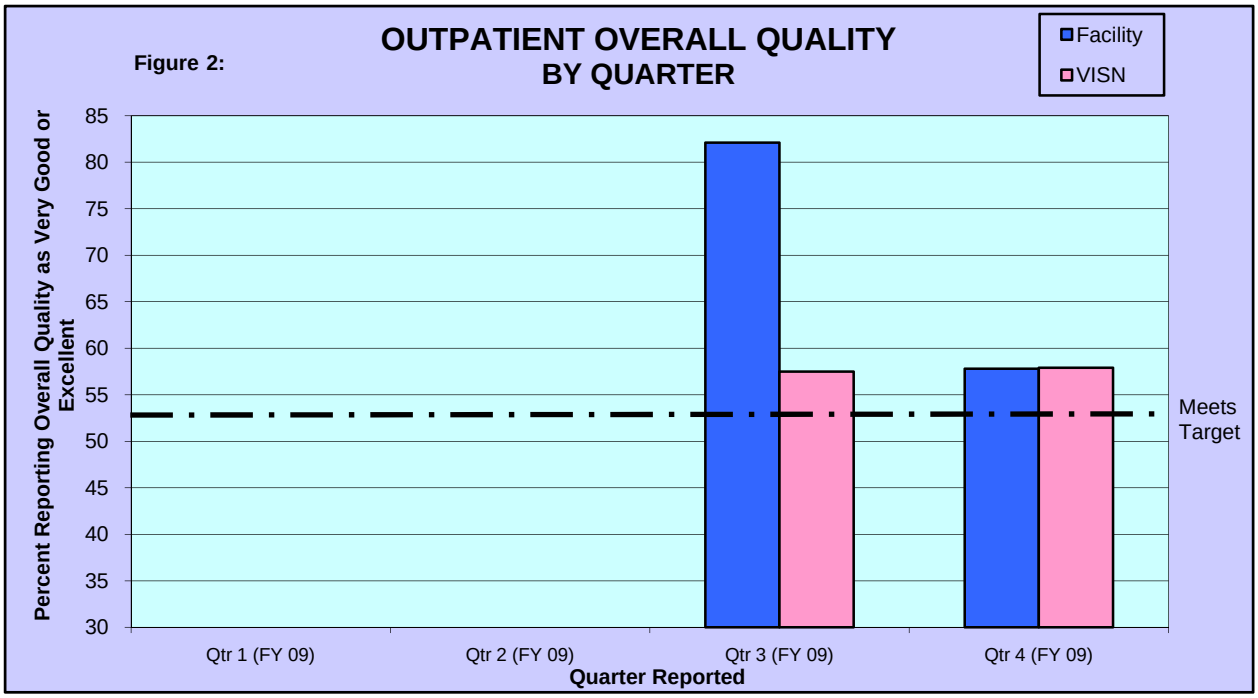
VHA Satisfaction Surveys

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.

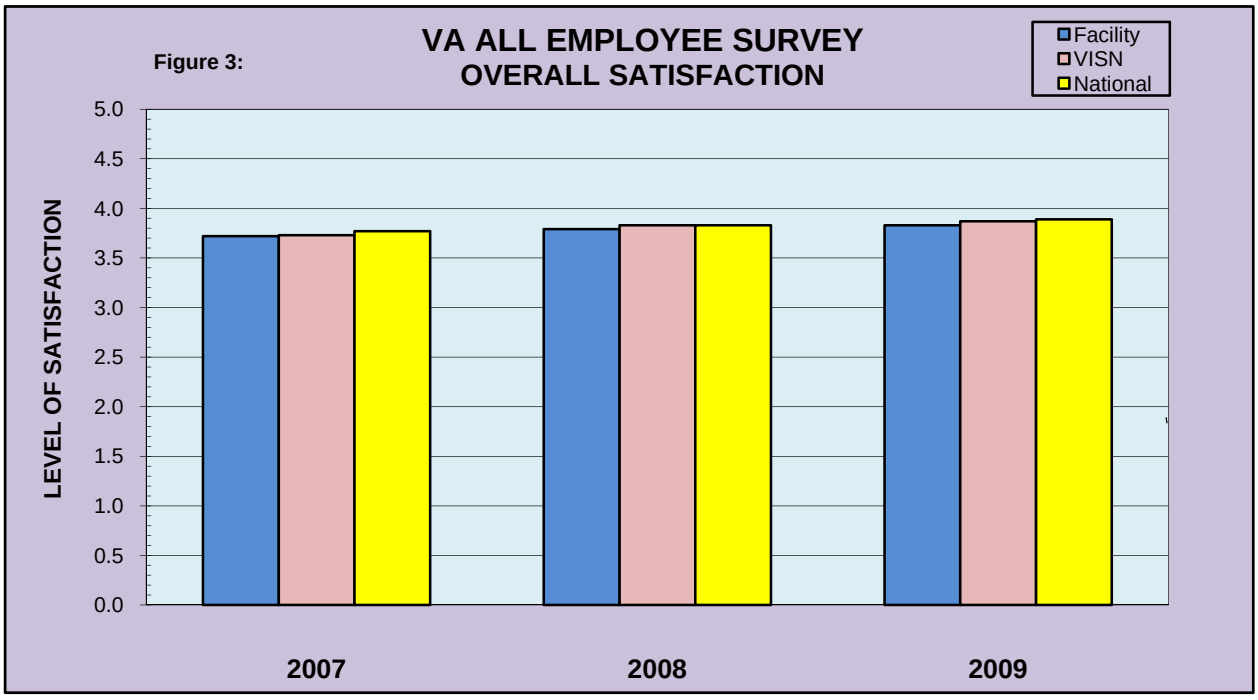
Figure 1:



[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: June 29, 2010

From: Director, VISN 4 (10N4)

Subject: **CAP Review of the Erie VA Medical Center, Erie, PA**

To: Director, Baltimore Healthcare Inspections Division (54BA)

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

I concur with the recommendations and actions planned by the medical center. We thank you for the opportunity to improve care for our nation's Veterans.

(Original signed by:)
MICHAEL E. MORELAND, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 29, 2010

From: Director, Erie VA Medical Center (562)

Subject: **CAP Review of the Erie VA Medical Center, Erie, PA**

To: Director, VISN 4 (10N4)

1. I have reviewed the draft report of the Inspector General Combined Assessment Program (CAP) of the Erie VA Medical Center. I concur with the findings outlined in this report and have included corrective action plans for each recommendation.

2. I appreciate this process as it provides a fresh set of eyes to identify areas where we can improve the care and service we provide to our Veterans.

(Original signed by:)
MICHAEL D. ADELMAN, MD

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 facility track open action items until resolution and evaluate action plans for effectiveness.

Concur

Target date for completion: October 31, 2010

The minutes and agenda template currently used by the Executive Leadership Board to track open actions and follow up items to completion will be used by all committees and councils. Standardized work instructions will be developed to instruct the administrative support staff on the use of the minutes and agenda template for tracking open actions, follow up, and evaluation of effectiveness. Training will be provided for the administrative support staff and committee chairpersons regarding the standardized work instructions. The Quality Manager will monitor committee and council minutes for three months to ensure the standardized work instructions have been followed.

Recommendation 2. We recommended that facility policy be revised to define staff requirements to maintain life support certification, provide a mechanism to track staff certification, and establish consequences for staff members who do not maintain current life support certification.

Concur

Target date for completion: July 30, 2010

The Chief of Staff's Office has revised MCM 11-18, Cardiopulmonary Resuscitation and Advanced Life Support, to include the all life support certification requirements for medical staff providers, a mechanism to track staff certification, and consequences for staff members who do not maintain life support certification. This policy will be published following completion of the review process.

The Education Team has implemented a tracking process to ensure all required life support certifications are current. A master list of staff required to have BLS and ACLS certification with expiration dates is maintained. A process is in place to send reminders to appropriate supervisors regarding impending staff expirations. The supervisors will ensure that staff is scheduled for the appropriate life support certification classes. Education and Human Resources staff will monitor compliance and ensure that appropriate action is taken per the revised policy when certification is not current.

Recommendation 3. We recommended that the facility collect and analyze data for all invasive procedures occurring outside of the OR.

Concur

Target date for completion: July 30, 2010

The VASQIP RN has been collecting and reporting data for non-OR invasive procedures including the types of procedures, volumes, and compliance with the use of the "Timeout" and pre-procedure safety check list. The VASQIP RN will add to their review and reporting process a review of all inpatient high risk non-OR procedures and a random sample of outpatient non-OR invasive procedures for complications. This data will be reported at the Operative & Other Committee. Data analysis and recommendations will be reflected in the committee's minutes. These complications will also be referred by the VASQIP RN Reviewer to the Surgical Morbidity and Mortality Conference and Risk Manager, as appropriate, for inclusion in the Peer Review Process.

Recommendation 4. We recommended that the facility implement interim measures to maintain temperature and humidity ranges in accordance with VA policy until construction is completed.

Concur

Target date for completion: December 31, 2010

A non-recurring maintenance project, Sterile Processing Department (SPD) Temperature and Humidity Controls, bid opening is scheduled for July 26, 2010, with construction completion expected by December 31, 2010. In the interim, temperature and humidity are continuously measured and will alarm if out of range. Heating, Ventilation, and Air Conditioning staff is notified immediately when the temperature in SPD is out of range and adjustments are made to get the temperature within range. There is currently no method to adjust the humidity if out of range until the construction project is completed. There is currently no space available to relocate SPD which would meet the humidity and security requirements. The out of range humidity alarms are due to low humidity during the winter months because the ventilation system is direct to the outside. We cannot use humidifiers in SPD to correct the low humidity, as this would create an infection prevention concern because of the water mist.

The risk identified during our analysis for low humidity conditions was related to the risk of sterile package material becoming dry and brittle, which could result in damage to the integrity of the sterile packaging material. SPD staff has been monitoring the integrity of the sterile packaging materials since January 2010. To date, there has been no evidence of damage to any of the sterile packaging. On a daily basis SPD Staff carefully check the integrity of the packaging as sterile items are placed on surgical case carts and weekly when performing outdate checks. The OR nurses also visually inspect packages prior to opening them in the OR. SPD staff has also implemented a random inspection of twenty stored packages during a four week period for package

integrity. Results of these inspections are reported to the Medical Executive Committee.

Recommendation 5. We recommended that SOPs be established and consistent with manufacturers' instructions.

Concur

Target date for completion: July 30, 2010

The following SOP's have been reviewed against the latest manufacturer's instructions and have been updated:

- Olympus Colonoscopes
- GI Videoscope Serus 180
- Cleaning and High Level Disinfection of GlideScope Video Baton
- Use of Cidex OPA for High Level Disinfection on RME
- Quality Control (QC) Testing for Cidex OPA HDL Test Strips
- Dental, Orthopedic and General Instruments

All of the manufacturers have been identified and SOPs are being revised for the following equipment:

- Laparoscopes
- Cystoscopes

Staff education has begun for the revised SOPs. All education and staff competencies will be completed for the revised SOPs.

Recommendation 6. We recommended that SPD employees receive training and competency evaluations for dental and orthopedic instruments.

Concur

Target date for completion: July 30, 2010

The SOP and competency for cleaning and disinfecting dental and orthopedic instruments was completed and approved by RME Committee on 6/11/2010. Training and staff competencies will be completed.

Recommendation 7. We recommended that PM is scheduled and completed in accordance with manufacturers' instructions and VA policy.

Concur

Target date for completion: July 30, 2010

Biomedical engineering staff has been trained to perform preventive maintenance of the ETO sterilizers and this will be completed by June 30, 2010, and quarterly thereafter. A quote has been requested from the manufacturer to perform the preventive

maintenance for the pre-processers (washer/disinfector) and provide training for our biomedical engineering staff. Once received this PM will be scheduled as an emergency service and will be completed quarterly thereafter by our biomedical engineering staff.

This equipment will be included in the PM tracking system so that a work order can be generated for the biomedical engineering staff when the PM is due for the ETO sterilizers and pre-processors. When the PM is completed biomedical staff will label the processing equipment with a PM sticker. This will enable the SPD Chief to monitor completion of PM on a routine basis. The SPD Chief will monitor the need to perform PM's on all processing equipment in SPD on a monthly basis and report through a monthly monitoring dashboard.

Recommendation 8. We recommended that treatment carts be secured when not in active use.

Concur

Target date for completion: July 30, 2010

The Nurse Executive has communicated with all nursing staff via an e-mail message regarding the importance of securing treatment carts when not in active use and the consequences for not doing so. Random security inspections of treatment carts (minimum of 5 per month) will be completed on each nursing unit by a Nurse Manager. The data will be reported monthly by unit to the Nurse Executive Committee via the Nursing Scorecard with an expectation of 100% compliance. These random inspections will be completed in addition to the quarterly Administrative rounds.

Recommendation 9. We recommended that BCMA computers be secured when not in active use.

Concur

Target date for completion: July 30, 2010

The Nurse Executive has communicated with all nursing staff via an e-mail message regarding the importance of securing all patient information. Random security inspections of BCMA computers (minimum of 5 per month) will be completed on each nursing unit by a Nurse Manager. The data will be reported monthly by unit to the Nurse Executive Committee on the Nursing Scorecard with an expectation of 100% compliance. These random inspections will be completed in addition to the quarterly Administrative rounds.

Recommendation 10. We recommended that staff complete required inter-facility transfer documentation and implement processes to monitor and evaluate transfers.

Concur

Target date for completion: July 30, 2010

On 6/25/10, an e-mail message was sent out to MODs, Hospitalists, Surgeons, and Geriatrician stating that, effective immediately, they are to utilize Physician Certification and Patient Consent Form for all inpatient transfers to VA and non-VA facilities. Hard copies of the forms will be placed on the nursing units to be utilized if the IMed consent package is not functioning. Hard copies of the staff e-mail will be placed in visible areas (e.g., MOD room and hospitalists' offices) for reminder purposes.

Health Information Management staff will create a monthly monitor and collect data regarding compliance with the use of the transfer template and consent starting with June records. This data will be reported at the July Medical Records Review Committee and will become a standing agenda item for that committee.

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