Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 09-03745-250

Combined Assessment Program Review of the Fargo VA Medical Center Fargo, North Dakota

September 20, 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

C&P	credentialing and privileging
CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CLC	community living center
COC	coordination of care
EOC	environment of care
ESA	erythropoiesis-stimulating agent
facility	Fargo VA Medical Center
FPPE	Focused Professional Practice Evaluation
FTE	full-time employee equivalents
FY	fiscal year
GI	gastrointestinal
JC	Joint Commission
MH	mental health
MRI	magnetic resonance imaging
MSDS	material safety data sheets
MSIT	Multidisciplinary Safety Inspection Team
NFPA	National Fire Protection Association
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
OR	operating room
OSHA	Occupational Safety and Health Administration
PI	performance improvement
PRRTP	Psychosocial Residential Rehabilitation Treatment Program
RME	reusable medical equipment
QM	quality management
SOP	standard operating procedure
SPD	Supply, Processing, and Distribution
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WOW	Wishes on Wings

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Executive Summary: Combined Assessment Program Review of the Fargo VA Medical Center, Fargo, North Dakota

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management. We conducted the review the week of June 28, 2010.

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

- Coordination of Care
- Physician Credentialing and Privileging
- Quality Management
- Suicide Prevention Safety Plans

The facility's reported accomplishment was the community living center "Wishes on Wings" program where a veteran on hospice status can request to have a wish granted.

Recommendations: We made recommendations in the following four activities:

Reusable Medical Equipment: Annual competency assessments and training need to be completed and documented for applicable staff, and all standard operating procedures for reusable medical equipment need to reflect current practice.

Environment of Care: Weekly rounds data needs to be consistently tracked, trended, and reported to the oversight committee quarterly. Annual respirator fit testing, training, and medical evaluation need to be completed for all identified staff. The local hand hygiene policy needs to be updated, and clinical staff need to receive feedback. All staff who work on the locked mental health unit and members of the Multidisciplinary Safety Inspection Team need to receive training on environmental hazards that pose a risk to suicidal patients.

Magnetic Resonance Imaging Safety: The local magnetic resonance imaging safety policy needs to include emergency procedures unique to the area, and staff need to be aware of how to respond to those emergencies.

Medication Management: Community living center clinicians need to document all required influenza vaccine elements. A consistent process for documenting the retrospective review of medication orders placed when the onsite pharmacy is closed needs to be implemented.

Comments

The Acting 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 objective of the CAP review is to:

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

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 July 2, 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 Fargo VA Medical Center, Fargo, North Dakota,* Report No. 07-00169-166, July 11, 2007). The facility had

addressed the previous recommendations, and we consider them closed.

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 Accomplishment

WOW

The facility's Cultural Transformation Committee has developed and implemented a WOW initiative to meet the unique desire or wish of a CLC resident at the end of life. CLC residents on hospice status can request to have a wish granted, and every effort is made to ensure that it is an unforgettable experience for the resident and his/her family. One granted wish was a helicopter ride for a resident. The wish can become a means by which residents realize their inspiration for enjoying each day, increase their quality of life, and develop memories for themselves and their family members.

Results

Review Activities With 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 and the GI and OR satellite reprocessing areas. We determined that the facility had established appropriate guidelines and monitored compliance with those guidelines. VA requires[1] MSDS to be accessible in designated work areas, such as decontamination areas, where employees are using chemicals. We found that MSDS were not kept in the GI satellite reprocessing area. Because the MSDS were immediately placed in the area, we made no recommendation for this finding. However, we identified the following areas that needed improvement.

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

Competencies and Training. VHA requires[2] competencies to be evaluated and training to be provided annually on the set-up, use, reprocessing, and maintenance of specific RME. We reviewed the competency folders and training records of two SPD employees who demonstrated the cleaning and reprocessing of seven pieces of RME correctly. Annual competencies for the colonoscope, the bronchoscope, the cystoscope, and the orthopedic instruments had not been completed. We noted that the competency for the dental instruments was completed the day before our observation. Annual training for the cystoscope had not been completed, and annual training for dental and orthopedic instruments was completed while we were onsite. Managers told us that the training and re-evaluation of competencies was purposely delayed until July 2010 when SOPs were scheduled to be updated.

SOPs. VHA requires[3] device-specific SOPs for RME to be established in accordance with the manufacturers' instructions. We requested the SOPs and manufacturers' instructions for 10 pieces of RME. Managers were unable to provide us with an SOP for the Scope Buddy™ (an automatic endoscope flushing device used in place of manual flushing). While the SOP in place for the colonoscope outlined the procedure for manual flushing, manual flushing was no longer used, and the SOP did not include the procedure for the Scope Buddy™.

Recommendations

1. We recommended that competencies be evaluated and that training be provided annually for all pieces of RME and that competencies and training be documented.

2. We recommended that managers ensure that all RME SOPs reflect current operating procedures.

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, NFPA, and JC standards.

We inspected the emergency department, the outpatient clinic areas, the hemodialysis unit, all inpatient (locked MH,

[2] VHA Directive 2009-031, *Improving Safety in the Use of Reusable Medical Equipment through Standardization of Organizational Structure and Reprocessing Requirements*, June 26, 2009.
[3] VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.

medical/surgical, and intensive care) units, and the CLC. 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. Facility managers conducted quarterly MH EOC assessments for the locked MH unit and were pursuing any needed corrective actions. We identified the following conditions that needed improvement.

Weekly EOC Rounds Data. Local policy requires that weekly EOC rounds data be tracked, trended, and reported to the facility EOC Committee each quarter. EOC rounds data was not consistently tracked and trended, and data had been reported to the facility EOC Committee for only 1 of the 3 quarters reviewed.

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. Six (30 percent) of 20 selected staff at risk for exposure did not receive the required annual respirator fit testing, training, and medical evaluation.

Hand Hygiene. VHA requires[4] that facilities have a local hand hygiene policy with an identified process to monitor health care workers' hand hygiene practices and to provide feedback to clinical staff. The local hand hygiene policy did not include a process to monitor health care workers' adherence to the required hand hygiene practices, and clinical staff were not aware of the facility's hand hygiene compliance data.

MH Environmental Hazards Training. Employees assigned to the locked inpatient MH unit and members of the MSIT are required[5] to undergo annual training on the identification of environmental hazards that pose a risk to suicidal patients. Six (38 percent) of 16 selected staff had not completed the required annual MH environmental hazards training.

Recommendations

3. We recommended that staff consistently track, trend, and report the weekly EOC rounds data to the facility EOC Committee, as required by local policy.

[4] VHA Directive 2005-002, *Required Hand Hygiene Practices*, January 13, 2005.
[5] Deputy Under Secretary for Health for Operations and Management, "Mental Health Environment of Care Checklist," memorandum, August 27, 2007.

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

5. We recommended that staff update the local hand hygiene policy and provide feedback to clinical staff.

6. We recommended that all staff who work on the locked inpatient MH unit and members of the MSIT receive annual training on the identification of environmental hazards that pose a risk to suicidal patients.

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.

We inspected the MRI area, examined medical and training records, reviewed relevant policies, and interviewed key personnel. The facility had appropriate barriers to prevent unauthorized or accidental access to the MRI area. Patients in the magnet room were directly observed at all times. Two-way communication was available between the patient and the MRI technologist, and the patient had access to a push-button call system while in the scanner.

We reviewed the training records of six MRI employees and six non-MRI employees and found that all had completed MRI safety training. We reviewed the medical records of 10 patients who received an MRI prior to our visit and found that all 10 records contained the MRI screening form. We identified the following area that needed improvement.

MRI Emergency Procedures. VA guidelines[6] require that procedures are in place for specific emergency situations that could occur in the MRI area. The local MRI safety policy did not include emergency procedures for all emergencies unique to the MRI area, and MRI staff were unable to articulate how they would respond to specific emergency situations.

Recommendation

7. We recommended that managers revise the local MRI safety policy to include all emergency procedures unique to

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

the MRI area and ensure that staff are aware of how to respond to those emergencies.

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 ESAs.[7] We found that clinical staff had appropriately identified and addressed elevated hemoglobin levels in the 10 patients whose medical records we reviewed. However, we identified the following two areas that needed improvement.

CLC Influenza Vaccinations. VHA requires[8] several items to be documented for each influenza vaccine given, including the route, site, and date of administration. We reviewed the medical records of 10 CLC residents and found that none of the records contained documentation of all the required elements.

Pharmacy Processes. JC standards require several processes to be in place at health care facilities where the onsite pharmacy is not open 24 hours a day, 7 days a week. These processes include review by a qualified health professional in the absence of a pharmacist and retrospective review of all medication orders during this period by a pharmacist for allergies, appropriateness, and interactions. The pharmacy at the facility operates from 7:30 a.m. to 12:00 a.m. Monday through Sunday. A pharmacist was available at another location to review new orders, but the retrospective review process was inconsistent and did not include all required elements.

Recommendations

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

9. We recommended that a consistent process be implemented for documenting retrospective review of all medication orders that were placed during the time the onsite pharmacy was not open.

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

Review Activities Without Recommendations

COC

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

VHA requires[9] that facilities have a policy that ensures the safe, appropriate, and timely transfer of patients and that transfers are monitored and evaluated as part of the QM program. We determined that the facility had an appropriate transfer policy and that acceptable monitoring was in place.

VHA requires specific information (such as the reason for transfer and services required) to be recorded in the transfer documentation. We reviewed documentation for 10 patients who transferred from the facility's acute inpatient unit, emergency department, or urgent care clinic to another facility. We determined that clinicians consistently documented the required information for the patient transfers reviewed.

VHA policy[10] 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 12 discharged patients and determined that clinicians had generally documented the required elements. Also, we found that follow-up appointments occurred within the timeframes specified. We made no recommendations.

Physician C&P

The purpose of this review was to determine whether the facility had consistent processes for physician C&P. For a sample of physicians, we reviewed selected VHA required[11] elements in C&P files and physician profiles. We also reviewed meeting minutes during which discussions 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. FPPE was appropriately implemented for newly hired physicians. Service-specific criteria for OPPE

[9] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.
[10] VHA Handbook 1907.01, *Health Information Management and Heath Records*, August 25, 2006.
[11] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

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.

QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program designed to monitor patient care quality and whether senior managers actively supported the program's activities. We evaluated policies, PI data, and other relevant documents. We also interviewed appropriate senior managers and the QM Coordinator.

The QM program was generally effective, and senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. Appropriate review structures were in place for required QM activities. 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.[12]

A previous OIG review of suicide prevention programs in VHA facilities found a 74 percent compliance rate with safety plan development.[13] 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.

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

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

Comments

The Acting VISN Director and Facility Director agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 12–16, 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.

Facility Profile[14]		
Type of Organization	VA medical center	
Complexity Level	2	
VISN	23	
CBOCs	Williston,ND Bemidji, MN Bismarck, ND Fergus Falls, MN Grafton, ND Grand Forks, ND Jamestown, ND Minot, ND	
Veteran Population in Catchment Area	85,136	
Type and Number of Total Operating Beds: • **Hospital, including PRRTP**	42	
• **CLC/Nursing Home Care Unit**	38	
• **Other**	0	
Medical School Affiliation(s)	University of North Dakota	
• **Number of Residents**	21.5	
	Current FY (through June 2010)	**Prior FY**
Resources (in millions):		
• **Total Medical Care Budget**	$144	$135.6
• **Medical Care Expenditures**	$120.4	$114.7
Total Medical Care FTE	843	824
Workload:		
• **Number of Station Level Unique Patients**	24,558	28,752
• **Inpatient Days of Care:**		
o **Acute Care**	5,290	8,892
o **CLC/Nursing Home Care Unit**	6,005	8,700
Hospital Discharges	1,104	2,023
Total Average Daily Census (including all bed types)	49.2	48.2
Cumulative Occupancy Rate	59.4	58
Outpatient Visits	122,265	187,789

[14] All data provided by facility management.

VHA Satisfaction Surveys

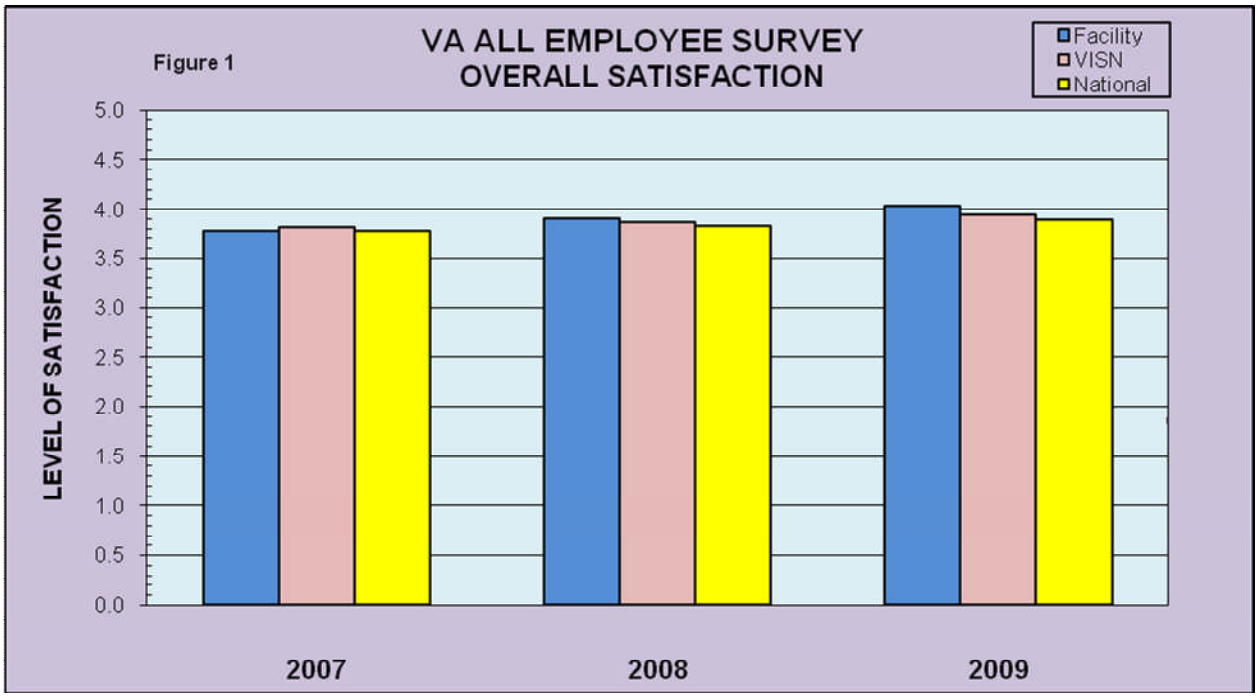
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. VHA is currently in the process of transitioning to the Consumer Assessment of Healthcare Providers and Systems survey. As a result, data for FY 2009 have been summarized for the entire year. Table 1 below shows the facility's and VISN's calibrated overall inpatient and outpatient satisfaction scores for FY 2009 and overall outpatient satisfaction score and target for the 1st quarter of FY 2010.

Table 1

	FY 2009		FY 2010
	Inpatient Score	Outpatient Score	Outpatient Score 1st Quarter
Facility	76.61	58.76	65.1 (target 56)
VISN	67.54	54.33	56.5 (target 56)

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2007, 2008, and 2009. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1



Acting VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 13, 2010

From: Acting Director, VA Midwest Health Care Network (10N23)

Subject: **CAP Review of the Fargo VA Medical Center, Fargo, ND**

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

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

I have reviewed the comments provided by the Fargo VAMC and concur with the responses and action plans.

VISN 23 appreciates the review as part of our continuing efforts to improve our services and care to this nation's veterans.

(original signed by:)
Barry D. Sharp, Acting Network Director

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 13, 2010

From: Director, Fargo VA Medical Center (437/00)

Subject: **CAP Review of the Fargo VA Medical Center, Fargo, ND**

To: Acting Director, VA Midwest Health Care Network (10N23)

Attached is the Fargo VAMC response to the 9 recommendations from the OIG CAP review. I have reviewed and concur with the action plans for correction and continuous improvement.

(original signed by:)
Michael J. Murphy, FACHE

Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 1. We recommended that competencies be evaluated and that training be provided annually for all pieces of RME and that competencies and training be documented.

Concur

Target date for completion: September 15, 2010

Training and competency for all SOP's have been completed for SPD staff during the time frame of June 29th–July 23rd, 2010. The documentation of training and competency has been verified and all dates reflect training was completed prior to the competency assessment. A schedule has been established for the ongoing monitoring and validation of annual training and competencies in all areas of RME use. The process and documentation formats were reviewed and approved at the July 16, 2010 RME Committee meeting. Annual review of RME SOP's was completed and based upon changes in the manufacturer instructions, new RME SOP's are being devised with training to follow in the Operating Room and GI procedures area to meet the annual training and competency requirement.

Recommendation 2. We recommended that managers ensure that all RME SOPs reflect current operating procedures.

Concur

Target date for completion: Completed July 2, 2010

A review was conducted on July 1–2, 2010 examining all the area SOP procedures with the finding of applicable SOP's current and present. With the annual update of endoscope SOP's the scope buddy SOP is being integrated versus having as a separate SOP. The facility has added the review of area RME SOP's as a component in the quarterly RME Committee rounds for ongoing oversight. There is an established schedule for the review and updating of SOP procedures through the RME Committee.

Recommendation 3. We recommended that staff consistently track, trend, and report the weekly EOC rounds data to the facility EOC Committee, as required by local policy.

Concur

Target date for completion: September 30, 2010

A new environmental rounds review form and reporting format has been established. The revised review form has been utilized for the past month and data is currently being aggregated from the past quarter and is scheduled to be reported at the September EOC committee meeting.

Recommendation 4. 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: August 31, 2010

A further risk assessment was conducted and the listing of those at risk for exposure was validated and expanded. Fit testing, training, and medical clearance for new and current staff has been conducted at scheduled sessions during July and August with 87 percent currently complete.

Recommendation 5. We recommended that staff update the local hand hygiene policy and provide feedback to clinical staff.

Concur

Target date for completion: Completed July 16, 2010

The facility Hand Hygiene policy has been revised to include the specifics of the facility hand hygiene monitoring plan and reporting. Revised policy was published July 16th, 2010. Infection Control has reinforced with the facility departments, the review and posting of their hand hygiene results that is distributed to the area quarterly. The review of staff knowledge of hand hygiene practices will continue as a component of the facility environment of care and readiness rounds.

Recommendation 6. We recommended that all staff who work on the locked inpatient MH unit and members of the MSIT receive annual training on the identification of environmental hazards that pose a risk to suicidal patients.

Concur

Target date for completion: September 30, 2010

All members of the MSIT have completed the required training as of July 18, 2010. A further facility-wide assessment is being conducted to identify all staff who may work on the locked inpatient Mental Health unit. Communications was completed with all supervisors on July 30, 2010 and a listing is being compiled and validated. The training requirement is being added to each identified staff members training plan to ensure completion of initial and annual training.

Recommendation 7. We recommended that managers revise the local MRI safety policy to include all emergency procedures unique to the MRI area and ensure that staff are aware of how to respond to those emergencies.

Concur

Target date for completion: September 30, 2010

The facility MRI policy has been revised to include all emergency response procedures. The policy is scheduled for final review at the September 8, 2010 MRI Safety Committee meeting. Publication will follow leadership concurrence.

Recommendation 8. We recommended that clinicians consistently document all required influenza vaccine elements.

Concur

Target date for completion: Completed July 14, 2010

The influenza immunization clinical reminder, that documents influenza immunizations in CPRS, has been edited to include the specific date of the Centers for Disease Control (CDC) 2009–2010 vaccine information provided to patients/caregiver. A link to the CDC influenza vaccine information statement (VIS) is also provided. The clinical reminder will be updated with each future change to the VIS.

Recommendation 9. We recommended that a consistent process be implemented for documenting retrospective review of all medication orders that were placed during the time the onsite pharmacy was not open.

Concur

Target date for completion: Completed July 7, 2010

A monitoring form was developed to include the quality assurance surveillance plan (QASP) elements, as identified in the pharmacy contract who provides processing of medication orders when the pharmacy is closed. This includes review of the number of orders processed and the number of orders meeting timeliness and accuracy. This is reviewed daily with an aggregated quarterly report to the Medical Contracts Committee. A report was provided at the July 7, 2010 Medical Contracts Committee meeting and is on a schedule for quarterly reporting the first month of each new quarter.

OIG Contact and Staff Acknowledgments

Contact	Dorothy Duncan, Director Kansas City Office of Healthcare Inspections (816) 997-6966
Contributors	James Seitz, Team Leader Jennifer Kubiak Clarissa Reynolds Laura Tovar Jennifer Whitehead
Report Preparation	Produced under the direction of Dorothy Duncan Director, Kansas City Office of Healthcare Inspections

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