Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-00046-32

Combined Assessment Program Review of the Memphis VA Medical Center Memphis, Tennessee

November 22, 2010

Washington, DC 20420

Why We Did This Review

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

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

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

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

Glossary

ACLS	Advanced Cardiac Life Support
ACR	American College of Radiology
BLS	Basic Life Support
C&P	credentialing and privileging
CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CEB	Clinical Executive Board
CLC	community living center
COC	coordination of care
CPR	cardiopulmonary resuscitation
EOC	environment of care
facility	Memphis VA Medical Center
FPPE	Focused Professional Practice Evaluation
FTE	full-time employee equivalents
FY	fiscal year
IC	infection control
JC	Joint Commission
LMS	Learning Management System
MI	manufacturers' instructions
MRI	magnetic resonance imaging
OI	Office of Information
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
OSHA	Occupational Safety and Health Administration
PI	performance improvement
PRRTP	Psychosocial Residential Rehabilitation Treatment Program
PTSD	post-traumatic stress disorder
QM	quality management
RME	reusable medical equipment
SOPs	standard operating procedures
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 Memphis VA Medical Center, Memphis, TN

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management (QM), and to provide crime awareness training. We conducted the review the week of July 12, 2010.

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

- Medication Management
- Suicide Prevention Safety Plans

Recommendations: We made recommendations in the following six activities:

QM: Committee minutes need to document action plans, assign responsibility, track open action items, and monitor implemented changes. Peer Review Committee minutes need to address data analysis, tracking and trending of care aspects, and tracking of action completion. Patient complaints need to be analyzed and reported, and patient safety reports need to include analysis of system or process issues. Medication reconciliation at discharge needs to be monitored. Resuscitation monitors need to include required items, and data needs to be compared. The facility needs a plan for care of patients held in temporary bed locations.

Reusable Medical Equipment: Standard operating procedures need to be available in the decontamination area.

Physician Credentialing and Privileging: Facility policy needs to include quality of care triggers for Focused Professional Practice Evaluation (FPPE). Profiles need to include FPPE data, and the Credentialing and Privileging Committee needs to follow up the FPPEs at the specified intervals. Clinical service chiefs need to define criteria for delineation of privileges.

Environment of Care: All medication rooms need to be secured, and appropriate staff need to receive annual respirator fit testing.

Coordination of Care: Staff need to complete inter-facility transfer documentation and monitor patient transfers.

Magnetic Resonance Imaging Safety: Staff need to document actions taken to evaluate positive responses on screening forms. Non-magnetic resonance imaging staff with access to the area need safety education at orientation.

Comments

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

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

Objectives and Scope

Objectives

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

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

Scope

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

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

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

The review covered facility operations for FY 2009 and FY 2010 through July 16, 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 Memphis VA Medical Center, Memphis, Tennessee,* Report No. 07-01408-197, September 11, 2007). During our follow-up review, we found sufficient evidence that program managers and staff had implemented appropriate actions to address the identified deficiencies. We consider these issues closed.

During this review, we also presented crime awareness briefings for 198 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

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 selected QM staff. 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 the allocation of resources to the program. However, we identified the following areas that needed improvement.

Committees. VHA policy requires each facility to provide oversight to ensure that QM components are implemented, integrated, communicated, and documented.[1] We found that the facility was collecting and reporting data in QM and PI committees. However, committee minutes did not clearly document action plans or monitor them until completion.

[1] VHA Directive 2009-043, *Quality Management System*, September 11, 2009.

Peer Review. VHA policy requires that facilities capture and report specific data elements related to peer review activities.[2] We found that Peer Review Committee meeting minutes did not reflect results of data analysis, tracking and trending of identified aspects of care, or tracking of action completion by service.

Patient Complaints. VHA policy requires that patient complaint data be critically analyzed, incorporated into the facility's QM program, and reported to leadership.[3] We found that while patient advocate staff gathered data regarding patient complaints, they did not critically analyze the data to determine patterns or trends and did not submit reports to leadership.

Patient Safety. The JC requires facilities to provide an annual report to leadership on specific components related to patient safety activities. We found that the annual report did not include any identified system or process issues.

Medication Reconciliation. The JC requires monitoring of performance in compiling a complete list of each patient's medications at specific points in the patient's care. We found that the facility did not monitor medication reconciliation at the time of discharge.

Review of Resuscitation and Its Outcomes. VHA policy requires that facilities measure performance of relevant processes in responding to resuscitation episodes.[4] We found that the facility's analysis of resuscitation efforts did not include errors or deficiencies in technique or instances of malfunctioning equipment. In addition, data was not compared with internal or external benchmarks.

System Redesign/Patient Flow. The JC requires facilities to have a plan to address the delivery of care to patients who might be held in temporary bed locations. We found that the facility did not have the required plan in place.

Recommendations

1. We recommended that QM and PI committee minutes document clear action plans, assign responsibility, track open action items, and monitor implemented changes.

[2] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.
[3] VHA Handbook 1003.4, *VHA Patient Advocacy Program*, September 2, 2005.
[4] VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.

2. We recommended that Peer Review Committee minutes address data analysis, tracking and trending of identified aspects of care, and tracking of action completion by service.

3. We recommended that patient advocate staff analyze patient complaints to determine patterns or trends and provide quarterly reports to leadership.

4. We recommended that the facility's annual patient safety report to leadership include analysis of system or process issues.

5. We recommended that the facility monitor medication reconciliation at the time of discharge.

6. We recommended that the facility monitor all required items, including errors or deficiencies in technique and malfunctioning equipment, for all resuscitation efforts and compare that data to internal or external benchmarks.

7. We recommended that the facility have a plan to address the delivery of care to patients held in temporary bed locations.

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 a safe environment. 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 clean and decontamination rooms in SPD and the reprocessing areas in the genitourinary clinic and the gastrointestinal laboratory. We determined that the facility had established appropriate guidelines and monitored compliance with those guidelines. In addition, the facility had a process in place to track RME should a sterilization failure occur.

We reviewed the competency folders and training records of employees who demonstrated or verbalized cleaning procedures and found that annual competencies and training were current. (Some competencies were completed during

the week of our site visit.) However, we identified the following area that needed improvement.

SOPs. VHA requires that device-specific RME SOPs are established in accordance with the MI and are available in the decontamination area for staff use.[5] We requested the SOPs and MI for 11 types of RME. Managers were able to provide us with an SOP for all 11 pieces of equipment. However, the SOPs for the laparoscope and the stainless steel surgical instruments were not available in the decontamination area.

Recommendation

8. We recommended that SOPs for all types of RME be readily available in the decontamination area.

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 elements in C&P files and provider profiles.[6] We also reviewed meeting minutes during which discussions about the physicians took place.

We reviewed the C&P files and profiles of 10 physicians who were granted either initial or renewal of privileges in the past 12 months. We found that licenses were current and that primary source verification had been obtained. However, we identified the following areas that needed improvement.

FPPE. VHA policy requires facilities to evaluate the privilege-specific competence of a practitioner who does not have documented evidence of competently performing the requested privileges at the facility. FPPE should be considered at the time of initial appointment or when new privileges are requested. We found that facility policy did not include quality of care triggers for FPPE. In addition, we found that for the two newly hired physicians:

- C&P and profile folders did not contain evidence of FPPE.
- C&P Committee minutes did not reflect 6-month FPPE follow-up, as defined and agreed upon by committee members.

[5] VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.
[6] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

OPPE. VHA policy requires facilities to reevaluate privilege-specific competence for all existing privileged physicians. We found that PI data for OPPE was minimal and tended to focus on workload and compliance with documentation requirements. We also noted that service chiefs did not consistently define criteria for assessing an individual's capacity to perform specified privileges. Five of the seven clinical services represented in our sample had not designated criteria or PI monitors to determine provider ability and competence relative to specified privileges.

Recommendations

9. We recommended that facility policy be updated to include quality of care triggers for FPPE.

10. We recommended that profiles include FPPE data and that the C&P Committee follow up the FPPEs at the specified intervals.

11. We recommended that clinical service chiefs define the criteria for delineation of privileges as required by VHA policy.

EOC

The purpose of this review was to determine whether the facility 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 acute inpatient surgical (3F), medical (2S), critical care (2 and 3), spinal cord injury (1W), locked mental health (1C), and palliative care (4F) units. We also inspected the Women's Clinic and the hemodialysis unit. The facility maintained a generally clean and safe environment. The IC program monitored data and appropriately reported that data to relevant committees. However, we identified the following areas that needed improvement.

Medication Security. The JC requires that all medications be secured from access by unauthorized persons. We found unattended keys in the Women's Clinic medication room door.

Respirator Fit Testing. OSHA requires that staff at risk for exposure to airborne pathogens, such as swine flu or tuberculosis, have annual respirator fit testing. We found

that 6 (40 percent) of 15 selected staff had not received annual respirator fit testing.

Recommendations

12. We recommended that all medication rooms be secured.

13. We recommended that appropriate staff receive annual respirator fit testing.

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 policy and JC standards require that providers include information regarding medications, diet, activity level, and follow-up appointments in written patient discharge instructions.[7] We reviewed the medical records of 10 discharged patients and determined that clinicians had generally documented the required elements and that follow-up appointments occurred within the timeframes specified.

VHA also requires that the facility 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 areas that needed improvement.

Inter-Facility Transfers. VHA policy requires specific information (such as the reason for transfer, mode of transportation, and informed consent to transfer) be recorded in the transfer documentation.[8] In addition, VHA 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 unit, emergency department, or urgent care clinic to another facility and found that providers did not document all required information for any of the patients. In addition, we found that patient transfers were not monitored as part of the QM program.

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

Recommendation

14. We recommended that staff complete inter-facility transfer documentation and monitor patient transfers, as required.

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. We determined that the facility had adequate safety policies and had appropriately conducted a risk assessment of the environment, as required by The JC.

The facility had appropriate signage and 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. Additionally, mock fire and emergency response drills had been conducted in the MRI area.

VHA policy requires a signed informed consent for high-risk patients undergoing an MRI scan with gadolinium contrast media (used to enhance the image quality of the exam).[9] We reviewed the medical records of 10 patients who received an MRI scan. One high-risk patient had intravascular gadolinium; however, there was no documented informed consent prior to the patient's MRI scan. Managers acknowledged that they did not have an informed consent process for high-risk patients who receive intravascular contrast media during their MRI scans. During our site visit, staff revised the facility's informed consent policy to comply with VHA policy; therefore, we made no recommendation for this finding. However, we identified two areas that needed improvement.

Screening. VHA requires screening of patients using a standard screening questionnaire.[10] A positive response on the questionnaire, such as an implanted device, must be evaluated for safety before a patient is scanned. We found

[9] VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures,* August 14, 2009.
[10] VA Radiology "Online Guide," <http://vaww1.va.gov/Radiology/page.cfm?pg=167>, updated December 20, 2007, Secs. 4.1–4.3.

that positive responses were not evaluated in 3 (30 percent) of the 10 patient records we reviewed.

MRI Safety Education. The ACR requires that non-MRI personnel who have access to the MRI area receive appropriate MRI safety training at orientation and annually thereafter. We reviewed the training records of six non-MRI staff who have occasional access to Zone III of the MRI suite. We determined that for the two staff hired in the past 2 years, MRI safety education was not included as part of initial orientation, as required. However, all six staff received the required annual training.

Recommendations

15. We recommended that MRI staff document actions taken to evaluate any positive responses identified on screening questionnaires.

16. We recommended that MRI safety education be provided during orientation for non-MRI staff who have access to the MRI area.

Review Activities Without Recommendations

Medication Management

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

The facility had implemented a practice guideline governing the maintenance of chronic renal disease patients who receive erythropoiesis-stimulating agents.[11] We found that clinical staff had appropriately identified and addressed elevated hemoglobin levels in the 10 patients whose medical records we reviewed. In addition, we found that the pharmacy operated 24 hours a day, 7 days a week and had qualified staff to answer questions. 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, identify warning signs preceding crisis, and define internal coping strategies. They should also identify when patients should seek non-professional support, such as from family

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

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.

We reviewed the medical records of 10 patients assessed to be at high risk for suicide within the past 6 months. In one case, clinicians made repeated but unsuccessful attempts to contact the patient and family to address the safety plan. In the remaining nine cases, clinicians had developed timely safety plans that included appropriate elements. Therefore, we made no recommendations.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 15–23, for the full text of the Directors' comments.) We consider Recommendations 8 and 12 closed. We will follow up on the planned actions for the open recommendations until they are completed.

[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.

Facility Profile[14]		
Type of Organization	Tertiary care medical center	
Complexity Level	1a	
VISN	9	
CBOCs	Bolivar, TN Byhalia, MS Dyersburg, TN Helena, AR Jonesboro, AR Savannah, TN Smithville, TN Jackson, TN North Clinic, Memphis, TN South Clinic, Memphis, TN	
Veteran Population in Catchment Area	206,000	
Type and Number of Total Operating Beds: • **Hospital, including PRRTP**	184	
• **CLC/Nursing Home Care Unit**	N/A	
• **Other**	60 spinal cord injury, 11 residential substance abuse, and 5 residential PTSD	
Medical School Affiliation	University of Tennessee Health Sciences Center, Memphis, TN	
• **Number of Medical Residents**	124	
	Current FY through July 2010	**Prior FY**
Resources (in millions):		
• **Total Medical Care Budget**	$358 (projected)	$326.2
• **Medical Care Expenditures**	$284.8	$322.5
Total Medical Care FTE	2,073	2,018
Workload:		
• **Number of Station Level Unique Patients**	53,414	53,854
• **Inpatient Days of Care:**		
o **Acute Care**	52,993	58,989
o **CLC/Nursing Home Care Unit**	N/A	N/A
Hospital Discharges	5,654	6,639
Total Average Daily Census (including all bed types)	180	181
Cumulative Occupancy Rate	60.5%	67.7%
Outpatient Visits	478,162	577,156

[14] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation? Y/N**
QM			
1. Adverse events are evaluated and disclosed appropriately.	Facility has a policy on adverse event disclosure. The Peer Review Committee discusses all Level 3 cases for disclosure consideration.	Y	N
2. Peer review process complies with facility and VHA policy.	Currently 98 percent compliant with VHA policy in 120-day completion requirement. 100 percent compliant in reviewing a representative sample of Level 1 reviews.	Y	N
3. Root cause analysis process is completed in accordance with VHA policy.	100 percent in compliance with VHA policy.	Y	N
4. CEB minutes reflect discussion and evaluation of subordinate committee findings from high-risk processes.	CEB sub-committees are required to present to the CEB a report detailing the sub-committee's actions and activities. These high-risk processes, peer review (monthly report), blood use, mortality assessment report, surgical case/quality improvement, medication use, and CPR, are reported quarterly. Other processes are reported as deemed necessary by the Chief of Staff and the sub-committee chair and as scheduled (at least annually).	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
5. Monitoring in place for BLS/ACLS training.	Employees required to maintain BLS and ACLS certification are in the LMS database. LMS reminds employees and supervisors when certification status is within 1 month of expiration and allows printing names of all certified and delinquent employees. This information was provided to service chiefs and the CPR Committee chair on multiple occasions this year and is being provided monthly. Service chiefs will continue to provide semi-annual updates of employees requiring certification and will certify to the CPR Committee chair that all those requiring certification have completed the appropriate training. The facility is 99 percent compliant in BLS and 98 percent compliant in ACLS.	Y	N
EOC			
6. Ensure security of confidential patient information is maintained.	Privacy screens were installed on workstations during FY 2007–2008, but a number of them now need to be replaced. First order for new screens was received on 7/2/2010. Second batch is expected to be delivered soon. (The VISN Acquisition Office delayed the processing of the new order for privacy screens.)	Y	N
Computerized Patient Record System Business Rules			
7. Continued compliance with VHA policy and the October 2004 OI guidance regarding the altering of signed notes.	The business rule was deleted in 2007 as a result of the last OIG CAP Review. The facility agreed that no business rule would ever be written regarding the altering of signed notes.	Y	N

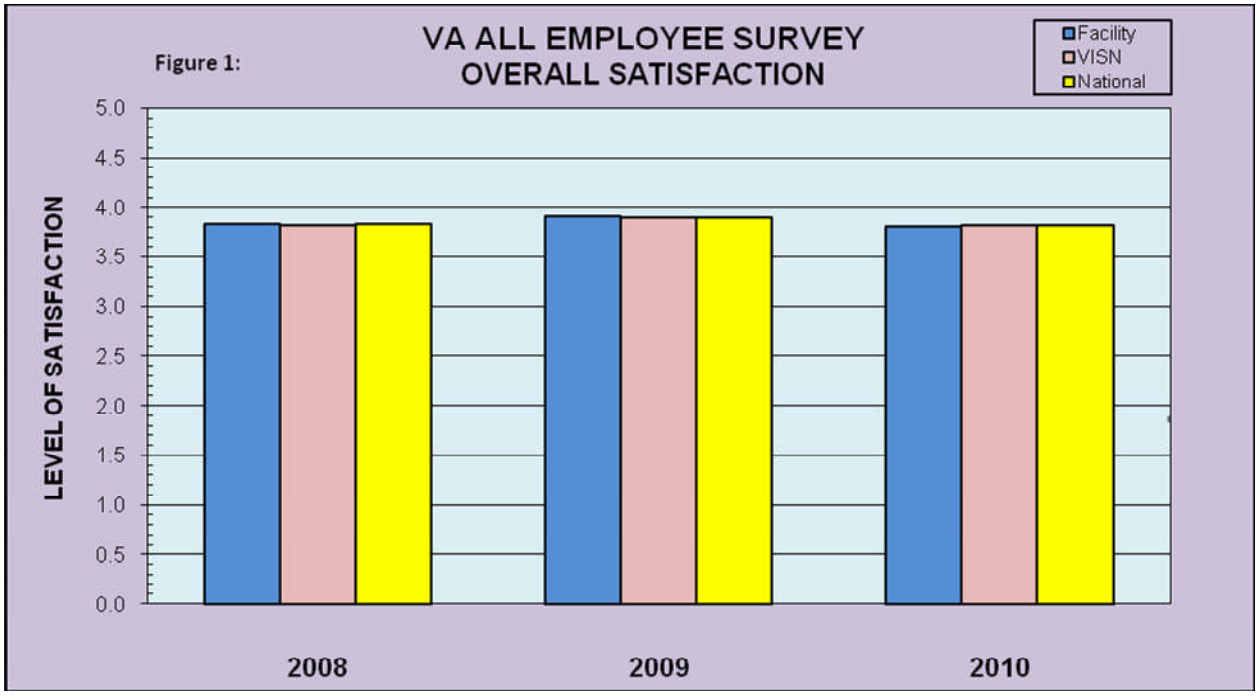
VHA Satisfaction Surveys

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 facility, VISN, and VHA calibrated overall inpatient and outpatient satisfaction scores for FY 2009 and overall inpatient and outpatient satisfaction scores and targets for the 1st and 2nd quarters of FY 2010.

Table 1

	FY 2009		FY 2010 (inpatient target = 64; outpatient target = 56)			
	Inpatient Score	Outpatient Score	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	56.51	43.77	59.1	52.7	51.2	56.7
VISN	62.62	49.17	62.2	61.2	55.5	56.5
VHA	65.01	52.87	63.3	63.9	54.7	55.2

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2008, 2009, and 2010. 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: October 29, 2010

From: Director, VA Mid South Healthcare Network (10N9)

Subject: CAP Review of the Memphis VA Medical Center, Memphis, TN

To: Director, Atlanta Office of Healthcare Inspections (54AT)

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

1. I concur with the findings and recommendations of this Office of Inspector General Combined Assessment Program Review of the Memphis VA Medical Center, Memphis, Tennessee, as well as the action plan developed by the facility.

2. If you have questions or require additional information from the Network, please do not hesitate to contact Tammy Williams, RN, Continuous Readiness Coordinator at 615-695-2143 or Pamela R. Kelly, Staff Assistant to the Network Director at 615-695-2205 or me at 615-695-2206.

(original signed by:)

John Dandridge, Jr.

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 28, 2010

From: Director, Memphis VA Medical Center (614/00)

Subject: CAP Review of the Memphis VA Medical Center, Memphis, TN

To: Director, VA Mid South Healthcare Network (10N9)

1. Attached please find the VA Medical Center at Memphis' response to the Office of Inspector General Combined Assessment Program (OIG – CAP) Review conducted July 12–16, 2010.

2. If you have any questions regarding the information provided, please contact Jan Slate, Accreditation Manager, Quality Management and Performance Improvement. Mrs. Slate can be reached at (901) 577-7379 menu choice #5.

(original signed by:)

JAMES L. ROBINSON, III, PSY.D
Medical Center Director

Attachment

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 QM and PI committee minutes document clear action plans, assign responsibility, track open action items, and monitor implemented changes.

Concur

Target date for completion: 11/30/2010

1. The Chief, QM&PI conducted training on minutes in the month of August with 133 attendees that included Service Chief, Committee Chairs, and Support Staff. A new meeting minute template was reviewed that clearly identifies responsible individuals, due dates, and an open/closed column for tracking purposes. Training concluded on 8/30/2010.

2. A SharePoint Site was created on 8/30/2010 to post common forms, templates, and training power point.

3. Audits of minutes to ensure the use of the correct format will begin in November 2010.

4. Randomly select two boards and one committee monthly to begin tracking for required information including monitoring implementation of changes. Results of these audits will be reported to the Quality Executive Board.

Recommendation 2. We recommended that Peer Review Committee minutes address data analysis, tracking and trending of identified aspects of care, and tracking of action completion by service.

Concur

Target date for completion: 12/1/2010

1. Effective in the January 2010 minutes a section was added to track all open action items. The open items remain in the minutes until closure/completion by the person or the service assigned. Quarterly data is currently reported to the Peer Review Committee and addressed in Peer Review minutes.

2. Beginning with the November meeting, the Risk Manager will include data trend analysis, as well as aspects of care in the quarterly report.

Recommendation 3. We recommended that patient advocate staff analyze patient complaints to determine patterns or trends and provide quarterly reports to leadership.

Concur

Target date for completion: 2/1/2011

1. Patient Advocates track complaints through the Patient Advocates Tracking System (PATS). Three new Patient Advocates were hired October 2010 and are being trained on PATS. Beginning with 1st Quarter FY11, quarterly reports will be prepared, data analyzed, and sent to the newly re-organized Customer Service Committee for review, identification of trends, defined action plans. This will be presented in the January 18, 2011 Committee.

2. Following Customer Service Committee review, monthly reports will be shared with the Executive Management Board and all Services with actions and/or recommendations on how to address trends.

Recommendation 4. We recommended that the facility's annual patient safety report to leadership include analysis of system or process issues.

Concur

Target date for completion: 12/30/2010

An analysis of system and/or process issues will be included in the facility's 2010 Annual Patient Safety Report to Executive Leadership Board at the December meeting.

Recommendation 5. We recommended that the facility monitor medication reconciliation at the time of discharge.

Concur

Target date for completion: 11/30/2010

Medication Reconciliation is contained within the written discharge instructions generated at the time of the inpatient's discharge from the clinical setting as described in MCM 119-06, Medication Reconciliation Process. All current medications and any changes to medications are clearly delineated within these instructions. Clinical pharmacists review the document and dispense new prescriptions for home medications and check for any prescription refill needs upon receipt of the discharge instructions. The written discharge instructions given to the patient serve as the medication reconciliation reminder to the next provider of outpatient care if outside the VA system or the completed list is located under the reports tab in CPRS if the outpatient provider is VA based. As part of the medical center's Customer Service Program, phone calls are made to a percentage of discharged patients. Patients are asked they received a copy of the discharge instructions prior to discharge. August and

September 2010 data reflect 98.3% and 98.7%, respectively, of patients who were contacted after discharge and answered yes to the question. Inpatient Medication Reconciliation data is currently reported quarterly to the Patient Safety Committee which is reported up to the Quality Management Board and the Executive Management Board. The Customer Service Program Manager is required to enter inpatient discharge medication reconciliation information into the IPEC database on a monthly basis. The Customer Service Program Manager also attends the Executive Management Board and will report this information each month beginning in November 2010. External Peer Review Process (EPRP) data for May and July reflect compliance to "reconciled list of discharge meds reviewed with patient" at 98.7% and 100%, respectively. EPRP data is reviewed at each formal Exit Briefing with Executive Leadership.

Recommendation 6. We recommended that the facility monitor all required items, including errors or deficiencies in technique and malfunctioning equipment, for all resuscitation efforts and compare that data to internal or external benchmarks.

Concur

Target date for completion: 1/28/2011

1. Malfunctioning equipment has been included as part of the CPR review. Beginning in 3rd quarter FY10, malfunctioning equipment issues were reported in the Blue Alert Quarterly Report dated July 30.

2. Per medical center policy 100% of Blue Alert forms are reviewed by the CPR Committee to ensure documentation is complete, to include errors/deficiencies in technique, and that the ACLS protocol is followed. These 1st quarter FY11 results will be reported in the Blue Alert Quarterly Report.

3. Currently, our national benchmarks are first dose of Epinephrine within 5 minutes and required defibrillation within 3 minutes. Our data is compared to these national benchmarks monthly and reported quarterly at the CPR Committee.

Recommendation 7. We recommended that the facility have a plan to address the delivery of care to patients held in temporary bed locations.

Concur

Target date for completion: 11/30/2010

Medical Center Policy 11-06, Medical Center Admissions, will be amended and approved to address the issue of care delivery to patients held in temporary bed location. The amendment will discuss overflow locations and patient care delivery that is assured to be consistent with the level of care provided on the ward/unit to which the patient will be transferred.

Recommendation 8. We recommended that SOPs for all types of RME be readily available in the decontamination area.

Concur

Target date for completion: Completed

Medical center practice requires that all RME SOPs be available in decontamination areas. SOPs for laparoscope and stainless steel instruments are maintained in the decontamination area; however, during the OIG CAP site visit, the SOPs were not available in the area. The Chief, SPD placed the SOPs back into the area on July 16, 2010, and at the same time reminded staff that the SOPs are not to be removed from the decontamination area. Random audits of decontamination areas will be conducted to ensure SOPs are in place. Audit results will be reported quarterly to the Quality Executive Board.

Recommendation 9. We recommended that facility policy be updated to include quality of care triggers for FPPE.

Concur

Target date for completion: 11/30/2010

Medical Center Policy 11-21, Credentialing and Privileging, will be amended and approved to include quality of care triggers that will initiate an FPPE.

Recommendation 10. We recommended that profiles include FPPE data and that the C&P Committee follow up the FPPEs at the specified intervals.

Concur

Target date for completion: 11/30/2010

Medical Center Policy 11-21, Credentialing and Privileging, will be amended and approved to define the process and the time interval for the submission of the FPPE reports to the Credentialing & Privileging Committee for new hires and the addition of privileges.

Recommendation 11. We recommended that clinical Service chiefs define the criteria for delineation of privileges as required by VHA policy.

Concur

Target date for completion: 11/30/2010

Review, compare, and amend the local Medical Center Bylaws, medical center policy, 11-21, Credentialing and Privileging, in accordance with the VHA Handbook 1100.19, Credentialing & Privileging, regarding criteria for delineation of privileges.

Recommendation 12. We recommended that all medication rooms be secured.

Concur

Target date for completion: Completed

Staff are aware of the process of securing the medication room. The Nurse Manager reviewed this with the individual who left the key in the door during the OIG CAP site visit and all staff during the July Women's Clinic Staff Meeting. Licensed RNs and LPNs have individual keys, and RN and LPN staff are accountable for removing the key from the door on entering the medication room and making sure door is secured upon leaving the medication room. Random observation audits will be conducted to ensure a secure medication room. Appropriate disciplinary action will be enforced when the security process is not followed. From the OIG CAP visit in July to date, no other incidents have occurred.

Recommendation 13. We recommended that appropriate staff receive annual respirator fit testing.

Concur

Target date for completion: 12/30/10

Although it was unclear which staff reviewed had not been fit tested, it is recognized that fit testing is a continuous process. Current compliance rate is 77%. Changes by the Safety Officer in the fit testing procedures from 2008 to 2010 have resulted in an increase in the number of employees identified as appropriate for fit testing from 200 to 1000. The fit testing program has been enhanced to provide for a safe and healthful work environment. The Safety Officer offers an average of 10–12 fit test sessions each month, at various times of the day, so that staff on all shifts have the opportunity to attend. These sessions are published in an information bulletin and posted on the Intranet at the end of the month for the next month's sessions. Sessions are held in conference rooms near the nursing wards to minimize the impact on patient care. At the first of each month managers/supervisors are provided a list of staff overdue and staff who will be due for fit testing within the next 60 days. Managers/supervisors are also provided updates of staff compliance at their request. Fit test sessions are also provided at staff meetings/special sessions at the request of manager/supervisors. The Safety Officers forwards a quarterly report of compliance to the Infection Control Committee and the EOC/Safety Committee for review.

1. Beginning 11/1/2010, the Safety Officer will provide a monthly list of non-compliant employees to the respective Pentad (Executive Leadership) for follow-up.
2. Compliance progress will be tracked by the Safety Officer and the Pentad. Within 90 days it is expected that the level of compliance to the fit test requirement will be improved.

Recommendation 14. We recommended that staff complete inter-facility transfer documentation and monitor patient transfers, as required.

Concur

Target date for completion: 11/30/2010

1. The new Inter-facility Transfer form that includes all pertinent data requested in VA Form 10-2649A was converted into a template in CPRS on 10/25/2010.

2. The template will be audited on 10/28/2010 to assure all pertinent data points are met.

3. Training and Pilot Study of the use of the form in the ED will be conducted the week of 11/1/2010 and monitored by the Inter-facility Transfer Coordinator.

4. Results of the Pilot Study will be reported to the UM Committee at the November meeting.

An Inter-facility Transfer Coordinator has been in position since 9/27/2010. Documentation of patient transfers in CPRS is monitored by this position. Reports will be forwarded to the UM Committee each month.

Recommendation 15. We recommended that MRI staff document actions taken to evaluate any positive responses identified on screening questionnaires.

Concur

Target date for completion: 11/15/2010

1. If a positive response is received from a patient during the completion of the MRI Safety Screening Questionnaire, the MRI Tech must get an evaluation from the MRI Radiologist. The MRI Tech documents the evaluation on the screening questionnaire, and then the MRI clerical staff scan the completed questionnaire into CPRS. During the OIG CAP site visit the procedure was amended so the MRI Tech now also enters a progress note into CPRS documenting the results of the Radiologist's evaluation. The Supervisor, MRI met with the MRI Techs to ensure understanding of the amended procedure and has sent reminder email messages to the Techs.

2. Beginning in November 2010 each month the Supervisor, MRI will request the MRI clerical staff provide her a sample of the screening questionnaires (with positive responses) to ensure the Radiologist's evaluation was noted on the screening form in a timely manner and before being scanned into CPRS.

Recommendation 16. We recommended that MRI safety education be provided during orientation for non-MRI staff who have access to the MRI area.

Concur

Target date for completion: 12/15/2010

During the OIG CAP site visit it was noted that MRI Safety Training was not included in Police Service Orientation. Effective August 2010, MRI Safety Training was added to the Phase I Initial Police Officer orientation. The training includes discussion and a 20-minute MRI safety training video (action completed). The Supervisor, MRI is in process of contacting services with employees that may have occasional access to the MRI suite. Similar to Police Service the Supervisor, MRI will ensure the other services include the discussion and 20-minute training video as a part of service orientation. Radiology Service will purchase additional copies of the training video for these services.

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