Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-02384-33

Combined Assessment Program Review of the Edward Hines, Jr. VA Hospital Hines, Illinois

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.

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Glossary

ACLS	Advanced Cardiac Life Support
ACR	American College of Radiology
BLS	Basic Life Support
C&P	credentialing and privileging
CAP	Combined Assessment Program
CHF	congestive heart failure
CLC	community living center
COC	coordination of care
ENT	ear, nose, and throat
EOC	environment of care
EtO	ethylene oxide
facility	Edward Hines, Jr. VA Hospital
FPPE	Focused Professional Practice Evaluation
FTE	full-time employee equivalents
FY	fiscal year
GI	gastrointestinal
IC	infection control
JC	Joint Commission
MEC	Medical Executive Committee
MRI	magnetic resonance imaging
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
PII	personally identifiable information
PM	preventative maintenance
PSB	Professional Standards Board
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

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Executive Summary: Combined Assessment Program Review of the Edward Hines, Jr. VA Hospital, Hines, Illinois

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 August 2, 2010.

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

- Suicide Prevention Safety Plans

The facility's reported accomplishment was the Farmers' Market. The Farmers' Market improves the health of employees and patients by increasing access to fresh local produce.

Recommendations: We made recommendations in the following seven activities:

Quality Management: Track corrective actions to completion, and conduct post-implementation evaluations. Improve life support training tracking, and revise local policy to include consequences for lapsed certifications.

Physician Credentialing and Privileging: Review Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation results, and document Professional Standards Board discussions. Ensure Medical Executive Committee documentation of review and approval of privileges. Apply approved service-specific criteria for Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation, and include supporting data in physician profiles.

Reusable Medical Equipment: Establish comprehensive standard operating procedures consistent with manufacturers' instructions, and ensure staff compliance. Document annual training and sterilizer maintenance.

Coordination of Care: Complete inter-facility transfer documentation in accordance with Veterans Health Administration policy.

Medication Management: Document all required influenza vaccine elements.

Environment of Care: Require participation in environment of care rounds. Correct safety, crash cart, personally identifiable information, cleanliness, and temperature and humidity deficiencies.

Magnetic Resonance Imaging Safety: Review screening questionnaires, document follow-up of positive responses for patients receiving a scan, restrict Zone III and IV access, fully implement safety measures, and train personnel with area access.

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.

JOHN D. DAIGH, JR., M.D.
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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 August 6, 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 Edward Hines, Jr. VA Hospital, Hines, Illinois,* Report No. 07-00767-34, December 7, 2007). The facility had corrected all findings from our previous review.

During this review, we also presented crime awareness briefings for 345 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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

Reported Accomplishment

Farmers' Market

The Farmers' Market improves the health and wellness of employees, patients, and the community by increasing access to fresh local produce.

Dietician and dietetic interns brought the Farmers' Market to life over the past 2 years. Farmers provide fresh vegetables and fruits to employees, visitors, and patients by holding a produce market on the grounds of the facility. The market has been a great success and is a Thursday morning ritual for many patients, employees, and visitors. One special veteran serves as the Farmers' Market manager due to his strong passion for local farming and his interest in serving veterans. Most of the farmers are veterans, and this Farmers' Market affords them the opportunity and venue for agricultural success.

Results

Review Activities With Recommendations

QM

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

The QM program was comprehensive in providing oversight of the facility's quality of care. It was also evident that senior managers supported the program through participation in

committees and provision of resources. However, we identified two areas that needed improvement.

Tracking and Evaluation of Corrective Actions. VHA requires[1] that the QM program identify opportunities for improvement and implement and evaluate actions until problems are resolved or improvements are achieved. The facility gathered and analyzed data, compared data with goals or targets, and initiated actions when performance fell short of the goals. However, we found inconsistent tracking of corrective actions and post-implementation evaluation for effectiveness. For example, although staff education was often stated as a corrective action, the provision of education was not tracked to completion nor was it evaluated for effectiveness in addressing the identified issues. The standardized tracking form was used inconsistently and did not include all open action items.

Life Support Training. VHA policy[2] requires that all clinically active staff have life support education and that a system is in place to monitor compliance with ACLS and BLS training or certification. In addition, VHA policy requires managers to delineate actions to be taken for noncompliance. The centralized monitoring system did not adequately track certification requirements for all staff designated to have this training. Also, the local policy did not include specific actions to be taken for employees who did not meet the BLS and ACLS certification requirements, and we found no evidence of any actions taken for those employees whose certifications had expired.

Recommendations

1. We recommended that QM corrective actions be tracked to completion and that post-implementation evaluations be conducted.

2. We recommended that staff improve life support training tracking and revise the local policy to include consequences when training or certification expires.

Physician C&P

The purpose of this review was to determine whether the facility maintained consistent processes for physician C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and provider profiles. We

[1] VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
[2] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.

also reviewed meeting minutes during which the physicians' privileges were discussed and recommendations were made.

We reviewed 20 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. All profiles reviewed had adequate data to meet current requirements. However, we identified two areas that needed improvement.

Documented Review of Providers. VHA policy[3] requires that the results of FPPE and OPPE be reported to the MEC for consideration in making the recommendation on physicians' privileges. Although FPPEs had been appropriately initiated for new hires and physicians who requested new privileges, the results were not reported to the MEC. Also, PSB meeting minutes that contained the discussion of providers undergoing the reprivileging process lacked individualized documentation of OPPE results and individual competence to support the renewal of privileges. Additionally, MEC minutes did not document any review or approval of providers' privileges, as required.

Profiles. VHA requires that service chiefs select criteria specific to physicians working in the service and submit the criteria to the MEC for approval. Service-specific criteria had been in use for the past year but had not been presented to and approved by the MEC until late July 2010. Criteria on the forms used during the past 12 months differed from the criteria approved recently. Standardized FPPE criteria were used for a variety of physicians but needed to be individualized to each physician. Also, performance data was not consistently present in profiles.

Recommendations

3. We recommended that FPPE and OPPE results be fully reviewed, that individualized discussions be documented in PSB meeting minutes, and that the MEC document the review and the approval of privileges.

4. We recommended that approved service-specific criteria for FPPE and OPPE be consistently applied and that each physician's profile contain adequate supporting data.

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

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

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 Joint Commission standards.

We inspected the SPD, ENT, and GI reprocessing and sterile supply areas, the OR, and the hemodialysis units. We determined that the facility had established appropriate guidelines and monitored compliance with those guidelines. We noted that traffic in the SPD areas was restricted to authorized personnel and that appropriate personal protective equipment was donned prior to entering the reprocessing areas, as required. However, we identified the following areas that needed improvement.

SOPs. VHA policy[4] requires that RME reprocessing SOPs reflect manufacturers' instructions and that SOPs be followed. We reviewed the SOPs and manufacturers' instructions for nine pieces of RME. We also observed employees demonstrate the cleaning procedures for the nine pieces of RME. We found that the SOPs for the orthopedic and dental instrumentation were not fully consistent with the manufacturers' instructions. The SOP for the orthopedic instruments did not contain the complete instructions for the drying time and inspection of the instruments. The manufacturer instructions for the Hu-Friedy dental instruments state that metal brushes are not to be used. We observed an employee use a metal brush while cleaning the dental equipments. This step was questioned by the inspector, and the nurse manager validated that the metal brush should not be used on this brand of dental equipment. For the bronchoscope, the employee failed to soak the equipment in cleaning solution for the required 5–10 minutes, and for the monopolar cautery (laprascope), the employee failed to flush the interior channels. These procedural steps were recommended by the manufacturer and/or the SOP.

Training. VHA policy[5] requires that all employees involved in the use and reprocessing of RME have documented training on the setup, use, reprocessing, and maintenance of the specific equipment leading to initial competency and

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

validation of that competency, which includes training, on an annual basis. We reviewed the competency records of 20 OR registered nurses responsible for conducting flash sterilization and the competency record of the employee who demonstrated reprocessing the colonoscope. Annual competencies and training for the colonoscope had been completed and properly documented. Managers told us that annual training had been completed for flash sterilization but had not been documented.

PM. VA requires[6] that PM is done on a scheduled basis and that detailed information is maintained by biomedical engineering for all sterilizers and washers. The facility was unable to provide PM documentation for three steam sterilizers, three EtO sterilizers, and three hydrogen peroxide gas plasma sterilizers in SPD; three Steris One machines in GI; and one Steris One machine in the ENT clinic.

Recommendations

5. We recommended that managers establish comprehensive device-specific SOPs that are consistent with manufacturers' instructions and ensure that employees follow the SOPs.

6. We recommended that annual training be completed and properly documented for all staff responsible for reprocessing RME.

7. We recommended that biomedical engineering complete and document PM for all sterilizers, as required by VA policy.

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. We reviewed the medical records of 18 discharged patients and determined that clinicians had generally documented the required elements. Also, we found that follow-up appointments usually occurred within the

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

timeframes specified. Additionally, we found evidence that QM staff monitored and evaluated patient transfers, as required by VHA policy. However, we identified the following area that needed improvement.

Inter-Facility Transfers. VHA policy[7] requires specific information (such as advance directives) to be recorded in the transfer documentation. We reviewed transfer documentation for 10 patients transferred from the facility's inpatient units and emergency department to other facilities. We found that none of the 10 patient records had all required documentation.

Recommendation

8. We recommended that staff complete inter-facility transfer documentation in accordance with VHA policy.

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.[8] We found that clinical staff had appropriately identified and addressed elevated hemoglobin levels in the 10 patients whose medical records we reviewed. We identified the following area that needed improvement.

CLC Influenza Vaccinations. VHA policy[9] requires several elements 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 to determine whether the influenza vaccination had been administrated. According to the records, one resident refused the influenza vaccination. Documentation of the administration route was omitted in three of the nine remaining records. The facility revised their influenza immunization template to include this element during our site visit.

Recommendation

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

[7] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.
[8] Drugs that stimulate the bone marrow to make red blood cells; used to treat anemia.
[9] VHA Directive 2009-058, *Seasonal Influenza Vaccine Policy for 2009–2010*, November 12, 2009.

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 two medical-surgical, the intensive care, the rehabilitation, the CLC, the hospice, the spinal cord injury, the acute mental health, and the dialysis units; the emergency department; and two outpatient clinics. The facility maintained a generally clean and safe environment; however, we identified the following areas that needed improvement.

EOC Rounds. VHA policy[10] requires the Director or Associate Director to lead weekly EOC rounds. Participants should include managers in nursing, building management, engineering, safety, patient safety, IC, and information security. We reviewed weekly EOC rounds attendance rosters and noted that rounds did not include all required participants.

Safety. NFPA standards require annual maintenance on all portable fire extinguishers. The facility's contract for annual fire extinguisher maintenance expired in June 2010, rendering a status of noncompliance. During our site visit, we were informed that the contract had been renewed and that the deficiency would be corrected.

In addition, multiple patient care areas were not sufficiently lighted, and other areas needed light bulbs replaced. Proper lighting should be supplied and maintained in patient care areas.

Crash Cart. We found an unused crash cart stored on the mental health unit. Crash carts should be removed from patient care areas when not in use.

PII. Federal law requires the protection of sensitive patient information. We found PII stored in two unattended patient medication carts located in the inpatient care areas. PII should be stored and maintained in a secured fashion.

IC and Cleanliness. The JC requires clean and dirty items to be stored separately. During our inspection of inpatient care

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

areas, we observed items and boxes on the floors in the medication and clean storage rooms and in the linen and housekeeping closets. In the housekeeping closets, we found large holes in two ceilings and in one wall. We observed dirty floors in most storage areas, including the electrical and information resource management closets. In addition, unclean oxygen tanks were stored in several SPD clean supply storage rooms. During our site visit, we were informed that a process is in place to clean oxygen tanks prior to delivering them to clean supply storage rooms.

Temperature and Humidity Controls. VA requires[11] temperature to be maintained between 65 and 72 degrees and humidity to be maintained between 35 and 75 percent in all areas where sterile items are stored. Sterile equipment cannot be assured if temperature and humidity are not maintained at prescribed levels. We found that temperature and humidity were not monitored in some of the SPD storage areas located in the patient care areas. During our site visit, we were provided with a plan to correct this deficiency.

Recommendation

10. We recommended that the identified EOC rounds participation, safety, crash cart, PII, IC and cleanliness, and temperature and humidity controls deficiencies be corrected.

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 (with two machines in one suite), examined medical and training records, reviewed relevant policies, and interviewed key personnel. We determined that the facility had adequate safety policies and had conducted a risk assessment of the environment, as required by The JC.

We found that patients in the magnet rooms 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 panic button while in the scanner.

We reviewed the medical records of 10 patients who received an MRI. Patients received appropriate initial screening. Three patients received MRI with contrast. Since

[11] VA Handbook 7176.

these three patients were not high risk, signed informed consents were not required. We identified the following areas that needed improvement.

Safety Screening. VA[12] and ACR guidelines require screening of patients undergoing MRI. MRI technologists are required to review the questionnaires, address any positive ("yes") responses, and sign and date the forms before patients are scanned. Of the 10 patients who underwent an MRI exam, a technician did not sign and date the screening forms for 4 (40 percent) of the patients. Also, these four forms were not scanned into the patients' medical records. However, the remaining six patients (60 percent) had completed screening forms scanned into their medical records. In June, the facility converted all MRI patient screening from paper to a comprehensive iMedConsent™[13] form. Additionally, each patient is now scanned with a hand held metal detector prior to entering the magnet room.

Safety. ACR guidelines require zones of magnetic field hazards to be clearly delineated and access to be appropriately restricted. Zone II is the interface between the publically accessible, uncontrolled Zone I and the strictly controlled Zones III and IV. Zone III regions should be physically restricted from general public access by locking systems or any other reliable, physically restrictive method that can differentiate between MRI personnel and non-MRI personnel. All non-MRI personnel entering Zone III must pass an MRI safety screening and must be escorted by Level 2 MRI personnel at all times.

We found appropriate barriers to prevent unauthorized or accidental access to MRI Zones I and II. However, MRI Zones III and IV were not consistent with ACR guidelines. Zones within the MRI suite were not clearly defined by boundaries. There were paper signs taped to the wall identifying the zone areas; however, there was no clear definition between the zones and no barrier preventing access from Zone I to Zone II. For one MRI, there was no clear definition or barrier between Zone ll and Zones lll and lV. For both MRI machines, signage was only posted on the magnet room entrance doors. When the doors were

[12] VA "Radiology Online Guide," <http://vaww1.va.gov/Radiology/page.cfm?pg=167>, updated December 20, 2007.
[13] With iMedConsent™ technology, clinicians can review VA forms onscreen with patients, capture signatures with an electronic signature pad, and generate a note in VHA's Computerized Patient Record System.

open, there was no visible signage to identify the magnetic hazard inside.

The manufacturer conducted annual inspections of both MRI machines, including the panic alarm system. However, the facility did not routinely test or document testing of the panic alarm system. Also, The JC requires facilities to conduct fire and code drills in all patient areas. Managers reported that no fire or code drills were conducted in the MRI suite.

Training. ACR guidelines require personnel who have access to the MRI area to receive appropriate MRI safety training. We reviewed the training records of six MRI personnel and six support (non-MRI) personnel who had access to the MRI area and found that until a few weeks prior to our site visit, not all non-MRI personnel had received training. Additionally, there was no difference in the level of education and training provided to staff based on their access within the MRI suite.

Recommendations

11. We recommended that MRI technologists review screening questionnaires and document follow-up of positive responses on the questionnaires for all patients receiving an MRI scan.

12. We recommended that access to Zones III and IV of the MRI suite be further restricted.

13. We recommended that all remaining safety measures in the MRI suite be fully implemented.

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

Review Activity Without 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.[14]

A previous OIG review of suicide prevention programs in VHA facilities[15] found a 74 percent compliance rate with safety plan development. The safety plan issues identified in that review were that plans were not comprehensive (did not contain the above elements), were not developed timely, or were not developed at all. At the request of VHA, the OIG agreed to follow up on the prior findings.

We reviewed the medical records of 10 patients assessed to be at high risk for suicide 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 D and E, pages 19–29, for the full text of the Directors' comments). We consider all recommendations except for Recommendation 12 to be closed. We will follow up on the planned actions for Recommendation 12 until they are completed.

[14] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
[15] *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[16]		
Type of Organization	Tertiary care hospital	
Complexity Level	1a	
VISN	12	
CBOCs[17]	Aurora, IL Elgin, IL Joliet, IL LaSalle, IL Manteno, IL Oak Lawn, IL	
Veteran Population in Catchment Area	416,036	
Type and Number of Total Operating Beds: • **Hospital, including PRRTP[18]**	261	
• **CLC/Nursing Home Care Unit**	210	
• **Other**	NA	
Medical School Affiliation(s)	Loyola University	
• **Number of Residents**	1,300	
	Current FY (through August 2010)	**Prior FY**
Resources (in millions):		
• **Total Medical Care Budget**	$307	$468
• **Medical Care Expenditures**	$244	$357
Total Medical Care FTE	2,951	2,921
Workload:		
• **Number of Station Level Unique Patients**	48,104	47,918
• **Inpatient Days of Care:**		
o **Acute Care**	48,915	74,994
o **CLC/Nursing Home Care Unit**	33,810	55,498
Hospital Discharges	6,762	9,346
Total Average Daily Census (including all bed types)	268.9	438.4
Cumulative Occupancy Rate	71.55%	73.64%
Outpatient Visits	456,867	493,887

[16] All data provided by facility management.
[17] Community based outpatient clinics.
[18] Psychosocial Residential Rehabilitation Treatment Program.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation? Y/N**
CPRS[19] Business Rules			
1. Require managers to regularly review CPRS business rules to ensure compliance with VHA regulations.	Process changed to a semi-annual review of CPRS business rules by the CPRS Chart Compliance Committee, the Medical Record Committee to whom it reports, and the Medical Executive Committee that provides oversight for the Medical Records Committee. This was most recently done for FY 2010, quarter 2. The 6-month review was reported at the 02/22/10 Medical Records Committee meeting and the 3/12/10 Medical Executive Committee meeting. Access was appropriate. The next report is scheduled for October 2010.	Y	N
EOC			
2. Require that unattended medication carts on patient units be locked.	Periodic checks continue to be done during EOC rounds, ongoing patient tracer activities, and unannounced patient safety rounds. This was also included in the Executive Walkabout Guide that was adopted from VISN 20 and revised to meet Hines needs prior to being distributed to all supervisors in March 2010.	Y	N

[19] Computerized Patient Record System.

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
3. Require managers to correct identified IC risks and ensure that all pillows and footboards are appropriate for patient use.	Periodic checks continue to be done during EOC Rounds, which include an IC practitioner. These items were also included in the Executive Walkabout Guide distributed to all supervisors in March 2010. As noted in the follow-up response, Project 578-07-002 to remodel Building 217, Floor 1C was completed 8/10/09, and the floors subsequently underwent a Sani-glaze treatment to improve the overall appearance and make ongoing maintenance easier.	Y	N
4. Require managers to continue to address the identified safety concerns on the acute psychiatry unit.	Reassessments are conducted on a monthly basis as part of Multidisciplinary Safety Inspection Team rounds using the National Center for Patient Safety checklist. Tracking of the new issues identified and closure of previous issues is done using the tracking grid developed for VISN/National reporting. Reports are then provided to the Hospital Safety Committee.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
Research – Unlicensed Physicians			
5. Require principal investigators to provide scopes of practice for appropriate research employees under their supervision.	These continue to be reviewed on an annual basis to ensure that all are current and have been amended, as necessary, to reflect any changes in the research coordinator's duties/responsibilities, utilization guidelines, and/or hospital policies. Certification of this review has been included in the annual evaluation submitted to senior leadership. In addition, compliance with VHA Directive 2009-054 that extended the original requirement has been included for FY 2010 and is at 100 percent. Audits to provide independent oversight are provided by the research compliance officer.	Y	N
6. Require the Associate Chief of Staff for Research and Development to review and approve research employees' scopes of practice.	See response to Recommendation 5.	Y	N

VHA Satisfaction Surveys

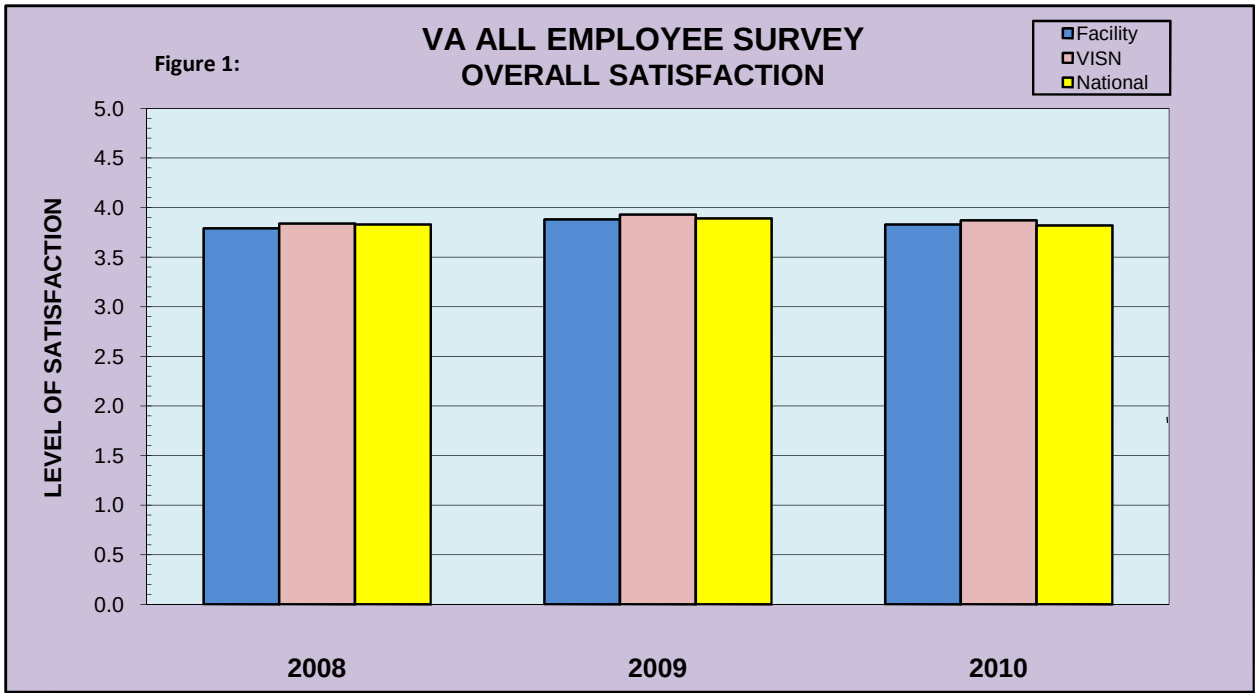
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. VHA is currently in the process of transitioning to the Consumer Assessment of Healthcare Providers and Systems survey. As a result, data for FY 2009 have been 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	58.13	61.99	50.4	63.5	59.0	61.1
VISN	66.09	55.43	62.0	64.9	55.5	58.6
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.

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions[20] received hospital care. The mortality (or death) rates focus on whether patients died within 30 days of their hospitalization. The rates of readmission focus on whether patients were hospitalized again within 30 days. Mortality rates and rates of readmission show whether a hospital is doing its best to prevent complications, teach patients at discharge, and ensure patients make a smooth transition to their home or another setting. The hospital mortality rates and rates of readmission are based on people who are 65 and older. These comparisons are "adjusted" to take into account their age and how sick patients were before they were admitted to the VA facility. Table 2 below shows the facility's Hospital Outcome of Care Measures for FYs 2006–2009.

Table 2

	Mortality			Readmission		
	Heart Attack	CHF	Pneumonia	Heart Attack	CHF	Pneumonia
Facility	13.74	9.51	15.32	21.22	22.87	15.3
VHA	13.31	9.73	15.08	20.57	21.71	15.85

[20] CHF is a weakening of the heart's pumping power. With heart failure, your body doesn't get enough oxygen and nutrients to meet its needs. A heart attack (also called acute myocardial infarction) happens when blood flow to a section of the heart muscle becomes blocked and the blood supply is slowed or stopped. If the blood flow is not restored in a timely manner, the sedition of the heart muscle becomes damaged from lack of oxygen. Pneumonia is a serious lung infection that fills your lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 30, 2010

From: VISN 12 Network Director

Subject: **CAP Review of the Edward Hines, Jr. VA Hospital, Hines, IL**

To: Director, Dallas Healthcare Inspections Division (54DA)

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

Attached please find the Hines VA Hospital CAP review response. I have reviewed and concur with the recommendations of the Office of Inspector General and the actions taken by Hines VA Hospital.

Jeffrey A. Murawsky, M.D.

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 28, 2010

From: Facility Director, Edward Hines, Jr. VA Hospital

Subject: **CAP Review of the Edward Hines, Jr. VA Hospital, Hines, IL**

To: VISN 12 Director

1. This is to acknowledge receipt and review of the findings and recommendations of the Office of the Inspector Combined Assessment Program Review conducted August 2–August 5, 2010.

2. The team members conducted a very thorough review and required us to take a critical look at our systems and processes. Actions taken are included in our response and we request that the recommendations be closed with the exception of #12 that is due to be completed by November 30, 2010.

(original signed by:)
Sharon M. Helman, MBA

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 corrective actions be tracked to completion and that post-implementation evaluations be conducted.

Concur

Target Completion Date: Completed.

An audit tool was created at Hines in September 2009 and used to conduct internal audits for all clinical councils and committees that involve activities referenced in VHA Directive 2009-043 Quality Management System and which VHA has since distributed as a best practice. The results of the audit were reported at the Executive Council of the Governing Board Meeting November 23, 2009 and the report included several opportunities for improvement. Revisions were made in the format used for the minutes to include a tracking grid, committee bulletins were revised in FY10-Q1 and FY10-Q2 and Policy Memo 578-02-011-046 (R-2) Healthcare System Performance Improvement was published June 1, 2010. Changes were implemented in FY10-Q3. While we concur that the standardized tracking form was not utilized consistently and there was not a 12 month track record of full compliance, documentation provided for review as part of the OIG CAP visit showed that all open items for the committees reviewed had been addressed. While staff education may be one action, it is rarely the only action as it is not considered to be a "strong action".

A revised template to be used for minutes was approved by the Executive Council of the Governing Board on August 9, 2010 in order to be more explicit regarding the contents of the minutes and the application of CRAE (Conclusions, Recommendations, Action and Evaluation) format and to make tracking of issues to closure easier. This revised template includes a change in the column header for Old Business from "Conclusions/Recommendations" to "Follow-up Status/Evaluation/Recommendations" and requires explicit references to the previous actions for all follow-up reports. The type of follow-up evaluation may vary and the template indicates "When appropriate, the evaluation should indicate an assessment of the effectiveness of the action, e.g. audit data, in addition to the status of the action" since an assessment of "effectiveness" is not required for all actions.

Additional education was provided by the PI Manager for the council/committee chair, recorder and PI specialists for all committees, semi-annual audits have been completed. With special emphasis placed on tracking actions and reporting of follow-up. Results were reported to the Executive Council of the Governing Board on 10/18/10. 100% of

the clinical committees that provide oversight of quality management activities were completed and have specific follow-up action plans.

Minutes of the committees reviewed as part of the OIG CAP visit for the August, September and October meetings utilized the revised format and include post-implementation evaluations for the follow-up reports.

Recommendation 2. We recommended that staff improve life support training tracking and revise the local policy to include consequences when training or certification expires.

Concur

Target Completion Date: Completed.

Policy Memorandum 578-03-111-022 (R-3) was modified and published April 30, 2010 to clarify the definition of "all clinical staff" and it was noted that certification was to be completed by June 30, 2010 for those who were not previously included as required. That applied to social workers and dieticians, pharmDs, speech pathologists and psychologists. As of August 2, 2010, compliance was at 98.72% (1845/1869). The policy clearly stated clinical service chiefs/service line managers responsible for ensuring that staff has appropriate level of CPR training prior to making assignments and/or preparing schedules and feedback from supervisors indicated that that had occurred for those who had expired and none were involved in providing patient care in an isolated setting, i.e. one where there are not other BLS certified staff who could assist if needed; however, there was no specific delineation of the consequences or a requirement for documentation.

The process has been changed to include a mechanism for requesting an exemption of the requirement for BLS for specific individuals in one of the required types of clinical staff from the COS or AD/PCS. Instead of using a separate database LMS is now being utilized for tracking compliance effective September 1, 2010. Service Chiefs/Service Line managers were required to send the names of all staff required to have BLS certification in order Education Service to ensure that the American Heart Association BLS (Basic Life Support) Healthcare Provider Course was part of their Learning Plan no later than 9/30/10. Employees continue to be notified at 90 day, 60 days and 30 day intervals (includes a listing of upcoming classes). Compliance for September was 100% (1909/1912) with required documentation that the 3 staff (consultants) who expired as of 9/30/10 would not be allowed to provide direct patient care until they had current certification.

The Acute and Critical Care Committee has revised the policy to include detailed information on the process to notify employees, service chiefs and the appropriate member of senior leadership when action is to be taken in the event that the employee allows the required certification to expire. This revised policy is being widely disseminated for review before implementation, including union notification. Aggregated data will be presented to the Acute and Critical Care Committee; however, the tracking

of specific individuals who have expired and the documentation of disciplinary action taken for any such staff will be handled by the supervisor with oversight by the service chief/service line manager.

Recommendation 3. We recommended that FPPE and OPPE results be fully reviewed, that individualized discussions be documented in PSB meeting minutes, and that the MEC document the review and the approval of privileges.

Concur

Target Completion Date: Completed.

Effective with the July 23, 2010 meeting, (1) the PI Manager began attending the PSB and assisting in the review of the PI data, (2) the results of the FPPEs that had been completed were presented to the PSB and (3) the format of the PSB Minutes was modified to include both the review of all providers whose FPPE had been completed and the MEC discussion comments for each provider. Effective with the August 11, 2010 PSB meeting and the August 13, 2010 MEC meeting, individualized OPPE data was included for those providers being presented for reappointment and the types of data to be used for the FPPE were included for initial appointments. Those minutes are then forwarded to the Director for review/approval.

Recommendation 4. We recommended that approved service-specific criteria for FPPE and OPPE be consistently applied and that each physician's profile contain adequate supporting data.

Concur

Target Completion Date: Completed.

At the July 23, 2010 meeting, the MEC approved a new form for use with providers who have very low or no volume of PI data. The form was modeled on the sample provided by the Office of Quality and Performance and is sent to the provider's primary institution to complete. That form has been implemented and was utilized for providers reappointed in August 2010.

Expectations for the revised process were discussed at the Medical Executive Committee Meeting on August 13, 2010 to ensure that all Service Chiefs/Service Line Managers were aware of the expectations. As noted above, the PI Manager began attending the PSB and assisting in the review of the PI data. The OPPE forms in use were implemented in April 2010 and all providers reappointed in September 2010 and October 2010 had adequate supporting data or the new form provided by the provider's primary institution.

Recommendation 5. We recommended that managers establish comprehensive device-specific SOPs that are consistent with manufacturers' instructions and ensure that employees follow the SOPs.

Concur

Target Completion Date: Completed.

For the orthopedic instruments, the practice of trying to expedite the drying process observed at the time of the OIG CAP visit was discontinued on October 13, 2010. No change was needed in the SOP as the manufacturer's guidelines do not address drying.

In light of the confusion and miscommunication regarding the dental instruments being reprocessed at the time of the observation during the OIG CAP visit, the Patient Safety Manager reviewed the manufacturer's guidelines and the SOPs for both the W&H and Hu-Friedy instrumentation and spoke with the staff on October 26, 2010. Staff were clearly able to explain which instruments were to be brushed and which were not to be and to demonstrate the processes in accordance with the SOP. The W&H instrument observed during the OIG visit has a handle and is solid. Since no comparable Hu-Friedy instrumentation exists, it is clear that the discrepancy was between the type of instrumentation being observed and the SOP being used for the observation, not between the SOP and appropriate practice. Brushes are never used for the Hu-Friedy instruments.

On October 19, 2010, the Patient Safety Manager conducted observations of the same staff who had been observed at the time of the OIG CAP visit for the same type of equipment, i.e, the monopolar laparoscope equipment, the cystoscope and the bronchoscope. The observation included an evaluation of the manufacturer's guidelines, the SOP, the competency and the demonstration. In order to decrease their anxiety and to ensure that they were able to demonstrate a larger body of knowledge indicating understanding and competency on that SOP, they were asked to think of the PSM as a new employee they were trying to train. All 3 staff did an outstanding job of following steps and explaining how and why they were doing what they were doing. This return demonstration has been documented in LMS by the Clinical Nurse educator assigned to Sterile Processing.

In some instances where the manufacturer's guidelines are not as descriptive as they need to be, the SOP may not match the manufacturer's guidelines word for word. For example, the manufacturer's guidelines might say "thoroughly rinse in clean water" for which the SOP would better say "thoroughly rinse outside and inside of cannula using a syringe to flush the interior chamber of residual enzymatic fluid". In addition, staff use posters provided by the manufacturer which use pictures and fewer words, further complicating the desire to have all match. Hines Policy Memorandum 578-09-002-009 (R-1) Standard Operating Procedures for Reusable Medical Equipment was published August 1, 2010 to formalize the process to make the SOPs ISO9000 compliant in terms of format, revision and document control. Efforts are underway to standardize the

SOPs throughout the VISN and to take all of these complicating factors that lead to apparent discrepancies into consideration.

Recommendation 6. We recommended that annual training be completed and properly documented for all staff responsible for reprocessing RME.

Concur

Target Completion Date: Completed.

Training was documented for the original education. The annual training for flash sterilization had been completed, but the documentation of the training was not done correctly. Repeat annual training was completed and documented for all required staff as of September 27, 2010.

Recommendation 7. We recommended that biomedical engineering complete and document PM for all sterilizers, as required by VA policy.

Concur

Target Completion Date: Completed.

New section chief for Biomedical Engineering has been hired and is in place effective 8/2/10. The entire PM program is being revamped. As of 10/1/10, there are 11 sterilizers used for RME. The manufacturers' guidelines have been reviewed for all units and all require annual maintenance that is done by the vendor and documented in field service reports. The 4 steam sterilizers and the 2 ethylene oxide sterilizers had the annual maintenance completed in January 2010 (1/8/10-14/10). One of the Steris sterilizers had the annual maintenance completed in 1/13/10 and the other one was completed 7/29/10. One of the 3 new Sterrad sterilizers was completed 8/15/10 and the remaining 2 are scheduled to be done 10/29/10 under a new contract. The other 4 Steris machines have been removed from service. Reports on the status were provided to the SPD Task Force by the Biomedical Engineering team member at the October 2010 meeting on 10/26/10 and will continue to be provided on a quarterly basis.

Recommendation 8. We recommended that staff complete inter-facility transfer documentation in accordance with VHA policy.

Concur

Target Completion Date: Completed.

As part of the audit of the Inter-facility transfers, a significant compliance issue was identified with documentation and reported at the Medical Records Committee in conducted in April 2010. Although all of the other required elements were included in the templated progress note, advanced directives and patient consent for transfer were

problematic and documentation during off-tours was not being done using the same process.

Action plans were developed to address the various issues and staff were educated about the need to utilize the VAF-10-2649A Inter-facility Transfer form to document the advance directives and to ensure the 10-2649B MD Certification & Patient Consent form was used and scanned so it would be available as part of the patient's electronic record. Compliance improved based on these efforts; however, a Systems Redesign Team was charged in July 2010 to further streamline the process for transfers to/from Hines. Policy Memo 578-03-011-092 was revised August 27, 2010 to include to reflect the current process flow, the required documentation to meet the VHA Directives regarding inter-facility transfers and usage of iMed and the associated progress note titles. Audits of 100% sample of ED transfers for September showed 100% usage of VAF-10-2649A Inter-facility Transfer form and 100% compliance with usage of the 10-2649B MD Certification & Patient Consent such that all records had all required documentation. This will continue to be monitored on a monthly basis with reporting to the UM Committee.

Recommendation 9. We recommended that clinicians consistently document all required influenza vaccine elements.

Concur

Target Completion Date: Completed.

As noted, the template used as part of Influenza Vaccine Clinical Reminder was missing the administration route. The route was added to the existing template and an audit of 10 patients who received influenza vaccine as an outpatient was done and 10/10 (100%) contained all required influenza vaccine elements.

Recommendation 10. We recommended that the identified EOC rounds participation, safety, crash cart, PII, IC and cleanliness, and temperature and humidity controls deficiencies be corrected.

Concur

Target Completion Date: Completed.

Participation on EOC Rounds was actively addressed in FY10-Q2 and software for tracking attendance and documenting findings was implemented in May 2010. Based on the size of the campus, Hines has 2 teams for the main campus that do weekly rounds and a 3rd team for the CBOCs. Attendance for FY10-Q3 showed 100% attendance by the Associate Director for Team A and 82% for Team B. Attendance for FY10-Q4 through 9/22/10 showed 100% attendance by the Associate Director for both Team A and Team B as required. In addition, attendance by managers in nursing, building management, engineering, safety, patient safety, IC, and information security who should attend increased to 93.8% for Team A and 98.4% for Team B.

Annual fire extinguisher maintenance was completed 8/20/10.

Staff have been instructed to call the Work Order desk for all lighting issues in patient care areas. These are prioritized and are replaced within 1-24 hours depending on the area. In an effort to be more proactive, lighting has been added to the Building Maintenance Program so that it is checked on a monthly basis and replacement does not rely on work orders. In addition, FMS has developed a FY 2011 NRM Energy Management project to re-lamp the entire campus, removing (2) T-12 lights and replacing with a reflector, (2) T-8 bulbs and ballast, along with new lens cover. Although that project has an overall completion date of 9/30/11, patient care areas are priority and will be completed by in FY11-Q2.

Locations for the Crash Carts and the AEDs are determined by the CPR Coordinator and the Acute and Critical Care Committee. After further investigation, it was determined that the observation about the crash cart on the mental health unit that appeared to be unused was due to confusion about delivery location for that cart. No changes need to be made to the listing of designated locations and monthly checks have been conducted as required.

Staff have been educated about alternatives to allow access to information during medication passes while not leaving PII in the small open shelf area of the medication cart. Unannounced visits to all of the units on 9/28/10 and 10/8/10 showed 0 instances of inappropriate storage of PII. This will continue to be addressed through spot checks are done as part of on EOC rounds and as part of leadership "walk-abouts" to assess compliance.

IRM has created a Standard Operating procedure that addresses cleaning of all data/telecommunication closets on a recurring schedule, i.e. twice per year by IRM staff. As of 9/29/10, all telecommunications closets have been cleaned. Facilities Management Service defined a process to clean all electrical closets on a recurring schedule, i.e. twice per year. As of 10/7/10, all electrical closets have been cleaned.

As of 8/12/10, temperature and humidity monitoring was in place in all SPD storage areas. A review of the data for 8/12/10 through 9/21/10 shows that it is being recorded on a daily basis and that there is a system that allows the Chief, Logistics to monitor whether the values are within the acceptable ranges as detailed in VA Handbook 7176, i.e. 65-72 degrees and 35-75 percent humidity.

Recommendation 11. We recommended that MRI technologists review screening questionnaires and document follow-up of positive responses on the questionnaires for all patients receiving an MRI scan.

Concur

Target Completion Date: Completed.

In May 2010, the process for screening patients undergoing MRI was changed to have the MRI Safety Screening documentation scanned in order to make it a permanent part

of the record. Since that process was implemented, audits indicated that 6/6 (100%) were present. Those that were noted as missing were part of the retrospective review and had been done before the revised process was implemented. As noted, in June 2010, the process was further revised to convert all MRI patient screening from paper to a comprehensive iMedConsent™ form and each patient is also now scanned with a hand held metal detector prior to entering the magnet room. Audits of records showed 8/10 (80%) screenings documented for August and 10/10 (100%) for September and 0 positive responses for July-September to the screening questionnaires.

Recommendation 12. We recommended that access to Zones III and IV of the MRI suite be further restricted.

Concur

Target Completion Date: November 30, 2010.

Work Order SI100809-001 was completed 9/28/10 to post additional signage to prevent unauthorized or accidental access to the MRI area. Signs were to have both "STOP" and "No Metal Objects in MRI Room". In addition, "Zone 2-Patients must be accompanied by MRI personnel" signs will be added.

MRI Supervisor, Safety, Associate Director and our Interior Designer evaluated the floor plans to determine the best location for an additional barrier to prevent unauthorized access from Zone III into Zone IV. The blueprints were reviewed and the recommendation for door placement was received from the Interior designer was received on 8/13/10. A project has been created and a quote obtained to install a door to provide the additional barrier with an estimated installation of 6 weeks. In addition, the feasibility of installing a metal detector at the entrance to Zone IV is under evaluation.

Recommendation 13. We recommended that all remaining safety measures in the MRI suite be fully implemented.

Concur

Target Completion Date: Completed.

Fire drills were conducted on 9/29/10 and 9/30/10 and 100% of staff on both the AM and PM shifts participated. Results were evaluated and the one issue identified on the critique was subsequently addressed by staff education. MRI has been added to the list of locations to have an annual fire drill.

Mock codes were conducted by the RRT Team on 10/6/10 day tour and on 10/7/10 evening tour. Critiques were completed, results were evaluated and no issues were identified. MRI has been added to the list of locations to have an annual drill.

A process to test and document testing for patient panic alarms within each of the Zone IV areas on a regular basis was implemented 8/11/10. Results are reviewed by the Supervisor.

Recommendation 14. We recommended that personnel who have access to the MRI area receive the appropriate level of MRI safety training, as required.

Concur

Target Completion Date: Completed.

In accordance with the ACR Guidelines for Safe Practices, Level I and Level II training has been completed as required. MRI staff require Level II training and documentation shows 100% (8/8) of the MRI staff had been completed as of 10/31/09 for FY10. A new MRI Medical Director was appointed 10/27/10 and completed the Level II training the same day. Level I training for non-MRI Imaging staff was completed 9/1/10.

Based on their role in emergency response, the Police were identified as the only non-Imaging staff to require Level I training. Training for those staff was provided and documented in February 2010 and in April 2010 for the staff on duty at that time. Training has been provided for all new employees since then and as of 10/27/10, compliance remains at 100%.

Level I training for the local Fire Department was completed and documented in February 2010 and they will be provided with updated training materials in the near future; however, this training is only being recommended and is not mandated as they would always be accompanied when entering the area.

LMS is now being utilized for FY11 for all to ensure that this training is completed for new employees based on their occupation codes and annually for existing employees based on their Learning Plans. Future risk assessments and reports of compliance will be provided to the Hospital Safety Committee on an annual basis.

OIG Contact and Staff Acknowledgments

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