Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-00026-146

Combined Assessment Program Review of the VA Northern Indiana Health Care System Marion, Indiana

April 19, 2011

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

ALOS	average length of stay
BCC	Bedside Care Collaborative
C&P	credentialing and privileging
CAP	Combined Assessment Program
CEB	Clinical Executive Board
CLC	community living center
COC	coordination of care
CPR	cardiopulmonary resuscitation
CPRS	Computerized Patient Record System
CWAD	Crisis, Warning, Allergies and/or Adverse Reactions, and Directives
EOC	environment of care
facility	VA Northern Indiana Health Care System
FY	fiscal year
JC	Joint Commission
MDRO	multidrug-resistant organisms
NCPS	National Center for Patient Safety
OI	Office of Information
OIG	Office of Inspector General
PCSB	Patient Care Safety Board
PI	performance improvement
PR	peer review
QLC	Quality Leadership Council
QM	quality management
RCA	root cause analysis
SARRTP	Substance Abuse Residential Rehabilitation Treatment Program
SDS	same day surgery
SHEP	Survey of Healthcare Experiences of Patients
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the VA Northern Indiana Health Care System, Marion, IN

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 February 7, 2011.

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

- Medication Management

The facility's reported accomplishments were its participation in a national Bedside Care Collaborative in 2009 and 2010 and receipt of the Gold Cornerstone Award from the National Center for Patient Safety in 2010.

Recommendations: We made recommendations in the following six activities:

Management of Test Results: Ensure facility policy defines timeframes for communicating critical pathology results. Ensure diagnostic pathology clinicians document communication of critical results to ordering providers. Communicate normal and critical test results to patients, and document the communication in the medical record. Document patient understanding of critical test results in the medical record.

Coordination of Care: Discuss advance care planning with patients, and document discussions using approved progress note titles. Ensure that discharge instructions include all required elements and that orders are correctly transcribed into discharge instructions.

Management of Multidrug-Resistant Organisms: Provide infection prevention strategies education to patients infected or colonized with multidrug-resistant organisms and their families, and document the education.

Physician Credentialing and Privileging: Ensure physician clinical privileges are setting specific.

Environment of Care: Identify and resolve environmental deficiencies. Secure confidential patient information.

Quality Management: Ensure all required items are included in health record reviews. Require the health record review committee to meet at least quarterly. Monitor the copy and paste functions.

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

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

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

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

- COC
- EOC
- Management of MDRO
- Management of Test Results
- Medication Management
- Physician C&P
- QM

The review covered facility operations for FY 2010 and FY 2011 through February 7, 2011, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the VA Northern Indiana Health Care System, Fort Wayne and Marion, Indiana,*

Report No. 07-03185-82, February 25, 2008.) The facility had corrected all findings. (See Appendix B for further details).

During this review, we also presented crime awareness briefings for 211 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 Accomplishments

BCC

The facility participated in a national BCC in 2009 and 2010. The goal was to optimize inpatient flow and improve processes as well as empower clinical care teams to engage in continuous quality improvement activities. One objective identified in 2009 was to decrease the ALOS for congestive heart failure patients by 0.5 days. The facility implemented quality improvement processes that resulted in a decrease in the ALOS from 6.8 days during quarter 2 of FY 2009 to 3.2 days by the end of quarter 4 of FY 2010.

Gold Cornerstone Award

In 2010, the facility received the Gold Cornerstone Award from the NCPS for completing all RCAs in 2009 within the 45-day timeframe required by VHA.

Results

Review Activities With Recommendations

Management of Test Results

The purpose of this review was to follow up on a previous review that identified improvement opportunities related to documentation of notification of abnormal test results and follow-up actions taken.[1]

We reviewed the facility's policies and procedures, and we reviewed medical records. We identified the following areas that needed improvement.

Policy. VHA requires that facilities develop a written policy defining the acceptable length of time between the

[1] *Healthcare Inspection Summary Review – Evaluation of Veterans Health Administration Procedures for Communicating Abnormal Test Results,* Report No. 01-01965-24, November 25, 2002.

availability of critical tests, values, or results and receipt by the responsible provider.[2] Facility policy did not specify reporting timeframes for critical results for non-frozen pathology specimens.

Documentation of Ordering Provider Notification. VHA requires that diagnostic pathology clinicians document in the medical record the time and means of critical test result communication and the name of the ordering provider contacted.[3] We reviewed the medical records of nine patients who had critical results and found that there was documentation that the ordering provider was notified in only four of the records.

Communication of Normal and Critical Results. VHA requires facilities to communicate normal results to patients no later than 14 calendar days from the date that the results were available to the ordering provider.[4] We reviewed the medical records of 20 patients who had normal results and found that only 16 of the records contained documented evidence that the facility had communicated the results to the patients.

For communications where it is important for the patient to quickly take some kind of action, such as a change in medication or a return to the facility for further evaluation, VHA requires facilities to document that communication was received by the patient and understood.[5] We reviewed the medical records of 29 patients who had critical results and found that only 19 of the 29 records contained documented evidence that the patients had been notified.

Recommendations

1. We recommended that the facility define in policy timeframes for communicating critical pathology results.

2. We recommended that diagnostic pathology clinicians consistently document communication of critical results to ordering providers.

3. We recommended that normal and critical test results be consistently communicated to patients and documented in

[2] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.
[3] VHA Directive 2009-019.
[4] VHA Directive 2009-019.
[5] VHA Directive 2009-019.

the medical record and that patient understanding of critical test results be documented in the medical record.

COC

The purpose of this review was to evaluate whether the facility managed advance care planning, advance directives, and discharges in accordance with applicable requirements.

We reviewed patients' medical records for evidence of advance care planning, advance directives, and discharge instructions. We identified the following areas that needed improvement.

Advance Care Planning and Progress Note Titles. VHA requires that primary care providers discuss advance care planning with all patients who have decision-making capacity.[6] VHA also requires that staff use specific progress note titles when documenting advance care planning discussions with patients and link these notes to the CWAD posting in the electronic medical record. We reviewed 10 patient records and found documentation of advanced care planning discussion or a completed advance care document for only 5 of the 10 patients. Additionally, the facility used the required progress note titles in only three of the five records with advance care planning documentation.

Discharge Instructions. VHA requires that upon discharge from the facility, providers include information regarding medications, diet, activity level, and follow-up appointments in instructions to patients.[7] In addition, The JC requires that clinicians provide patients with written discharge instructions.

We reviewed the medical records of 10 discharged patients and found that only 7 of the records addressed all required elements. In one record, the diet and activity level recommendations were incorrectly transcribed from the orders to the discharge instructions. In two records, the diet recommendations were not addressed in the discharge instructions.

Recommendations

4. We recommended that staff discuss advanced care planning with all patients and document the discussions using approved progress note titles linked to the CWAD posting.

[6] VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, July 2, 2009.
[7] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

5. We recommended that processes be strengthened to ensure that discharge instructions include all required elements and that orders are correctly transcribed into the discharge instructions.

Management of MDRO

The purpose of this review was to evaluate whether the facility had developed a safe and effective program to reduce the incidence of MDRO in its patient population in accordance with applicable requirements.

We inspected the CLC unit at the Marion campus and a medicine unit at the Fort Wayne campus, and we interviewed four employees. We identified no deficits in either the inspections or staff interviews. However, we identified the following area that needed improvement.

Patient/Family Education. The JC requires that patients infected or colonized[8] with MDRO and their families receive education on infection prevention strategies, such as hand washing and the proper use of personal protective equipment. We reviewed 16 medical records and found that only 10 of the records had documented evidence of MDRO education.

Recommendation

6. We recommended that infection prevention strategies education be provided to patients infected or colonized with MDRO and their families and be documented.

Physician C&P

The purpose of this review was to determine whether the facility had consistent processes for physician C&P that complied with applicable requirements.

We reviewed 11 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. However, we identified the following area that needed improvement.

Setting-Specific Clinical Privileges. VHA requires that clinical privileges be specific for each clinical site.[9] We found that one of the physicians whose profile we reviewed had been granted clinical privileges that were not supported by the physician's practice setting.

[8] Colonization is the presence of bacteria in the body without causing clinical infection.
[9] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

Recommendation

7. We recommended that physician clinical privileges be setting specific.

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements.

At the Fort Wayne campus, we inspected the intensive care unit, a medical unit, the urgent care area, SDS, the cardiopulmonary clinic, and radiology (imaging and nuclear medicine). At the Marion campus, we inspected CLC-1B, CLC-1C, the SARRTP area, acute mental health, radiology, the cardiopulmonary clinic, and occupational therapy. The facility maintained a generally clean and safe environment. However, we identified the following areas that needed improvement.

Environmental Safety. At the Fort Wayne campus, several patient rooms on the medical unit had damaged drywall surfaces and peeling paint and cracked plaster around the windows. In SDS, we found missing floor tiles in the patient recovery area. At the Marion campus, several doorframes that provided direct access to the outside had penetrating corroded areas with sharp edges.

Patient Privacy. The Health Insurance Portability and Accountability Act requires confidential patient information to be secured. In passing admissions desks and nursing stations on 13 units we inspected, we observed that on 7 of the units, the computer monitors located on these desks and stations did not have privacy screens and could be viewed by the public.

Recommendations

8. We recommended that processes be strengthened to ensure that environmental deficiencies are identified and resolved.

9. We recommended that processes be strengthened to ensure that confidential patient information is secured.

QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program in accordance with applicable requirements and whether senior managers actively supported the program's activities.

We interviewed senior managers and QM personnel, and we evaluated policies, meeting minutes, and other relevant

documents. We identified the following area that needed improvement.

Health Record Review. VHA requires facilities to conduct health record reviews that include specific items, to report results to the health record review committee at least quarterly, and to monitor the copy and paste functions.[10] The health record review committee provides oversight of the review process and analyzes reports. While the facility had performed health record reviews, we found that they did not include all required items. Additionally, the health record review committee did not meet quarterly nor did they receive and analyze results. Also, the facility did not monitor the copy and paste functions in the electronic medical record.

Recommendation

10. We recommended that health record review processes be strengthened to ensure that all required items are included, that the health record review committee meet at least quarterly, and that the copy and paste functions be monitored.

Review Activity Without Recommendations

Medication Management

The purpose of this review was to determine whether the facility employed safe practices in the preparation, transport, and administration of hazardous medications, specifically chemotherapy, in accordance with applicable requirements.

We observed the compounding and transportation of chemotherapy medications and the administration of those medications in the oncology clinic, and we interviewed employees. We determined that the facility safely prepared, transported, and administered the medications. 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 15–20 for full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

[10] VHA Handbook 1907.01.

Facility Profile[11]		
Type of Organization	Two campus medical facility (Fort Wayne and Marion, IN)	
Complexity Level	3	
VISN	11	
Community Based Outpatient Clinics	Goshen, IN South Bend, IN Muncie, IN Peru, IN	
Veteran Population in Catchment Area	140,625	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	131	
• **CLC/Nursing Home Care Unit**	150	
	Current FY (through October 2010)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$224	$237.3
• **Medical Care Expenditures**	$23	$236.3
Total Medical Care Full-Time Employee Equivalents	1,422	1,425
Workload:		
• **Number of Station Level Unique Patients**	20,985	41,537
• **Inpatient Days of Care:**		
o **Acute Care**	1,124	7,220
o **CLC/Nursing Home Care Unit**	6,894	45,216
Hospital Discharges	424	2,423
Total Average Daily Census (including all bed types)	227.1	227.8
Cumulative Occupancy Rate (in percent)	80.5	76.5
Outpatient Visits	60,481	330,937

[11] 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. Require that assault data is critically analyzed when presented to the PI Committee.	Assault data is trended and analyzed by the Prevention and Management of Disruptive Behavior Committee. Data is forwarded to the PI Committee and the QLC through the PCSB.	Y	N
2. Ensure that the facility's Director takes action to meet VHA requirements for PRs.	Processes have been implemented to ensure that all PRs are tracked and that potential delinquencies are communicated to the reviewer, the reviewer's supervisor, and the Chief of Staff. A review of all PRs assigned after August 2010 shows 100 percent compliance with VHA's 45- and 120-day timeframes.	Y	N
3. Require that patient complaint data is critically analyzed and compared to data from the SHEP survey and that findings are reported to the PI Committee for corrective action.	Patient complaint data is reviewed weekly in the Director's report and monthly at the QLC. A revised version of the Patient Complaint/SHEP report was presented at the December 2010 QLC meeting.	Y	N
4. Require that clinically active staff receive CPR training in accordance with VHA and facility policy.	A new process has been implemented to closely monitor compliance. Updated reports are provided quarterly to the QLC and the CEB.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
5. Require that contract employees' background investigations are completed in accordance with VHA policy.	Background checks for contract providers are required before providers report for duty. All contracts and copies of updated background checks are maintained in the Human Resource office.	Y	N
6. Require that blood usage data is critically analyzed for the PI Committee to take action.	Blood usage data is critically analyzed, and the information is provided to the CEB and the QLC. In addition, a Transfusion Utilization Committee has been implemented.	Y	N
7. Take action to establish a collaborative disclosure process to ensure that patients are informed of their right to file claims.	The facility implemented the use of the standardized CPRS template for institutional disclosures that includes the right to file a claim. Disclosures are monitored by Risk Management and reported quarterly to the QLC. A review of disclosure notes for FYs 2008–2010 shows 100 percent compliance.	Y	N
8. Require that RCAs are completed in accordance with VHA and facility policy.	All RCAs are completed within the 45-day timeframe as required by VHA policy. The facility received the Bronze Cornerstone Award in FY 2009 and the Gold Cornerstone Award in FY 2010 from the NCPS for completing RCAs in a timely manner.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
EOC			
9. Require that safety vulnerabilities in the locked acute mental health unit are addressed.	Mental health EOC rounds are conducted quarterly and reviewed by the PCSB and the Director. All deficiencies are corrected when identified.	Y	N
10. Require that refrigerator temperatures are monitored and that corrective actions are documented when temperatures are outside the acceptable range. Ensure that shower curtains are inspected and properly cleaned and disinfected. Require that air system vents are cleaned.	Medication refrigerators are centrally monitored by pharmacy while nutrition refrigerators are centrally monitored by dietary supervisors. Warnings are received when temperatures vary. Supervisors are required to log in corrective action(s). Environmental Management Service has implemented an action plan for routine cleaning of shower curtains and ceiling vents. Cleanliness is monitored through EOC rounds.	Y	N
11. Require that emergency crash cart checks are completed in accordance with facility policy and that sharp items are secured.	Emergency crash cart checks are monitored by hospital education staff and are reported quarterly to the Critical Care Committee and the QLC. All sharp items are properly secured, and sharps safety is monitored monthly by the Infection Control Committee.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
CPRS Business Rules			
12. Require that CPRS business rules comply with VHA policy and OI guidance.	Ongoing quarterly reviews and monitoring for compliance of business rules is done by the Medical Record Committee and reported to the CEB.	Y	N
Follow-Up on Moderate Sedation Practices			
13. Require that contract physicians who administer moderate sedation receive moderate sedation and CPR training in accordance with VHA policy.	All contract providers have received training in accordance with VHA policy.	Y	N

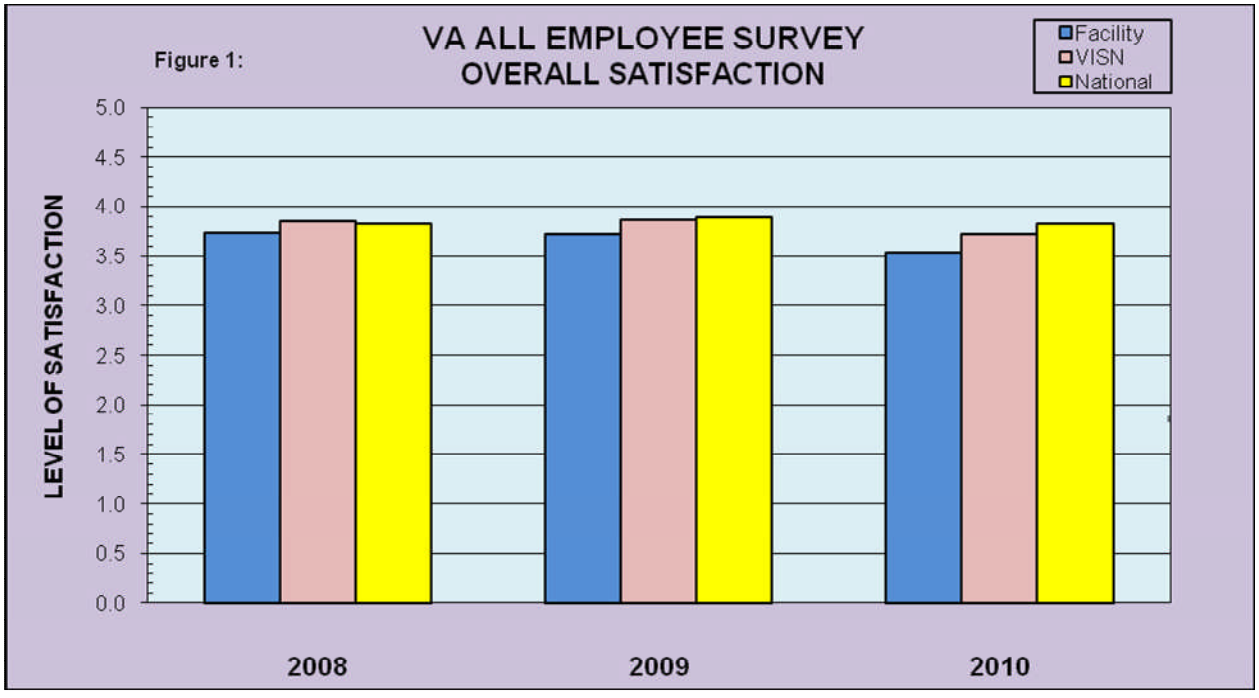
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2010.

Table 1

	FY 2010 (inpatient target = 64, outpatient target = 56)							
	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Inpatient Score Quarter 3	Inpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	65.1	55.4	62.7	58.7	55.4	56.5	54.8	52.6
VISN	67.4	66.1	65.6	70.1	53.4	54.5	56.3	55.7
VHA	63.3	63.9	64.5	63.8	54.7	55.2	54.8	54.4

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.



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions[12] 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 age 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	13.13	10.55	14.41	*	21.49	15.96
VHA	13.31	9.73	15.08	20.57	21.71	15.85

*Not enough cases

[12] Congestive heart failure (CHF) is a weakening of the heart's pumping power. With heart failure, your body does not 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 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: April 7, 2011

From: Network Director, Veterans in Partnership (10N11)

Subject: **CAP Review of the VA Northern Indiana Health Care System, Marion, IN**

To: Director, Chicago Office of Healthcare Inspections (54CH)

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

1. Attached, please find NIHCS response to the CAP review.

2. If you have any questions, please contact Kelley Sermak, Acting Quality Management Officer, at 734-222-4302.

MICHAEL S. FINEGAN

Attachment

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 7, 2011

From: Director, VA Northern Indiana Health Care System (610/00)

Subject: **CAP Review of the VA Northern Indiana Health Care System, Marion, IN**

To: Director, Veterans in Partnership (10N11)

If there is any additional information required, you may contact Barbara Lyons, Quality Manager, at 765-674-3321, extension 73344.

DANIEL D. HENDEE, FACHE

Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 1. We recommended that the facility define in policy timeframes for communicating critical pathology results.

Concur

Target date for completion: May 1, 2011

Facility will revise the local policy in order to define the timeframes for communicating critical pathology results.

Recommendation 2. We recommended that diagnostic pathology clinicians consistently document communication of critical results to ordering providers.

Concur

Target date for completion: April 30, 2011

1. Chief of Pathology & Laboratory Medicine Service has implemented a process to include in the cytology and surgical pathology report documentation the notification to the ordering provider. The notation will include the date/time of the notification. This will be monitored by laboratory and reported to CEB.

2. If ordering provider/designee cannot be reached within 2 hours of result of a frozen section, the provider's supervisor, service chief, or Chief of Staff in that order until a provider is notified.

Recommendation 3. We recommended that normal and critical test results be consistently communicated to patients and documented in the medical record and that understanding of critical test results be documented in the medical record.

Concur

Target date for completion: June 30, 2011

A clinical reminder dialog note was developed and providers have been trained on telephone and letter notification.

A system is being developed to automate the printing capability to inform patients of normal test results by utilizing the Xerox printers.

Recommendation 4. We recommended that staff discuss advanced care planning with all patients and document the discussions using approved progress note titles linked to the CWAD posting.

Concur

Target date for completion: April 30, 2011

The Nursing Advance Directive Clinical Reminder was updated in February 24, 2011 to include expanded options to record need for follow-up by Social Work Service. Social Work note was expanded to include reminder for follow-up based on documentation in nursing admission note. Social Work will automatically receive a consult based on nursing assessment and the need for Social Work intervention. Social workers were educated on all updates to advance directives documentation changes February 24, 2011. Compliance will be tracked and documented in the Nurse Executive Advisory Board.

Recommendation 5. We recommended that processes be strengthened to ensure that discharge instructions include all required elements and that orders are correctly transcribed into the discharge instructions.

Concur

Target date for completion: May 1, 2011

The interdisciplinary treatment team reviewed the process and implemented the procedure where the nursing staff print the physician's discharge instructions and ensure the nursing discharge instructions adhere to the physician instructions. The plan is to develop an automated physician discharge note that will automatically upload into the nursing discharge instructions.

Recommendation 6. We recommended that infection prevention strategies education be provided to patients infected or colonized with MDRO and their families and be documented.

Concur

Target date for completion: May 31, 2011

Changes were made January 31, 2011 to the Nursing Patient Information section of the assessment to include patient and family education for MDRO. Informatics implemented April 1, 2011 a new patient education template that will also include MDRO education to the patient and families. Compliance will be tracked and documented in Infection Control Committee.

Recommendation 7. We recommended that physician clinical privileges be setting specific.

Concur

Target date for completion: April 30, 2011

The primary care clinical privilege forms will be modified to be CBOC specific. These forms will include only those procedures performed at the CBOCs to eliminate the ability to erroneously request a privilege that is not appropriate to that setting. The new form will be reviewed and approved by the CEB.

A 100% review of all CBOC provider privileges will be conducted with the list of procedures approved by the CEB. Any discrepancies between the approved list and the current granted privileges will be reviewed and administratively corrected by the Professional Standards Board with the approval of the CEB.

Recommendation 8. We recommended that processes be strengthened to ensure that environmental deficiencies are identified and resolved.

Concur

Target date for completion: April 30, 2011

a. Quarterly roundtable meetings will be held with EOC Rounds team members to review significant outstanding issues and to provide training and current trending to eliminate recurrent findings. This will be tracked through the EOC Board and will be initiated by April 15th.

b. A follow-up inspection will be completed 2 weeks after EOC Rounds to ensure that corrective actions have been taken. Any remaining open items will be tracked monthly through the EOC Board and reported to leadership until completed.

c. An updated EOC Rounds checklist that contains common deficiencies will be provided to supervisors by April 15th for ongoing departmental inspections.

Recommendation 9. We recommended that processes be strengthen to ensure that confidential patient information is secured.

Concur

Target date for completion: June 30, 2011

A comprehensive review of privacy and protection of confidential patient information was completed by February 28, 2011. Installation of 50 additional priority placement privacy screens was accomplished by March 18, 2011 and repositioning of monitors to increase privacy has occurred. Additional privacy screens will be purchased and placed

as appropriate by August 31st. This will be monitored during Leadership and EOC rounds.

Recommendation 10. We recommended that health record review processes be strengthened to ensure that all required items are included, that the health record review committee meet at least quarterly, and that the copy and paste functions be monitored.

Concur

Target date for completion: May 31, 2011

The Medical Records Management Committee has been meeting monthly since December 2010. The committee monitors the copy and paste functions on an on-going basis. A new Chief of Health Information Management Services has been assigned and will be working to meet the measures. The data will be reported to CEB.

OIG Contact and Staff Acknowledgments

Contact	Verena Briley-Hudson, NP, Director Chicago Office of Healthcare Inspections
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