Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-00431-173

Combined Assessment Program Review of the William S. Middleton Memorial Veterans Hospital Madison, Wisconsin

April 12, 2013

Washington, DC 20420

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

Glossary

CAP	Combined Assessment Program
CLC	community living center
CS	controlled substances
ED	emergency department
EHR	electronic health record
EOC	environment of care
facility	William S. Middleton Memorial Veterans Hospital
FY	fiscal year
HPC	hospice and palliative care
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of February 25, 2013.

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

- Quality Management
- Environment of Care
- Coordination of Care – Hospice and Palliative Care
- Long-Term Home Oxygen Therapy
- Nurse Staffing

The facility's reported accomplishments were the Coordinated-Transitional Care Program designed to improve care coordination and outcomes among veterans with high-risk conditions discharged to community settings and the Septic Shock Protocol designed for immediate recognition and management of patients who present to the emergency department with signs and symptoms of sepsis or shock.

Recommendations: We made recommendations in the following three activities:

Medication Management – Controlled Substances Inspections: Ensure controlled substances inspectors consistently perform and document reconciliation of 1 day's dispensing from the pharmacy to each automated unit, and monitor compliance.

Preventable Pulmonary Embolism: Initiate protected peer review for the one identified patient, and complete any recommended review actions.

Construction Safety: Post exit signs identifying alternate routes for egress within construction sites. Remove sprinkler head paint protectors as soon as possible, and in the event the protectors remain on in unattended areas for longer than 4 hours within a 24-hour period, implement a fire watch.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 17–20, for the full text of the Directors' comments.) We consider all recommendations closed.

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 quality and the EOC.
- 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 compliance with requirements related to patient care quality and the EOC. 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:

- QM
- EOC
- Medication Management – CS Inspections
- Coordination of Care – HPC
- Long-Term Home Oxygen Therapy
- Nurse Staffing
- Preventable Pulmonary Embolism
- Construction Safety

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2012 and FY 2013 through February 28, 2013, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin*, Report No. 11-02713-43, December 7, 2011).

During this review, we presented crime awareness briefings for 91 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.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 202 responded. We shared survey results with facility managers.

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

Coordinated-Transitional Care Program

The Coordinated-Transitional Care (C-TraC) Program was designed to improve care coordination and outcomes among veterans with high-risk conditions discharged to community settings. Under the program, patients work with nurse case managers on care and health issues, including medication reconciliation, before and after hospital discharge. All contacts are made by phone once the patient is at home. Patients who received the program's protocol experienced one-third fewer rehospitalizations than those in a baseline comparison group. This resulted in an estimated net savings of $1,225 per patient for programmatic costs. This model requires a relatively small amount of resources to operate and may represent a viable alternative for hospitals seeking to offer improved transitional care as encouraged by the Affordable Care Act. In particular, the model may be attractive for providers in rural areas or other care settings challenged by wide geographic dispersion of patients or by constrained resources.

Septic Shock Protocol

ED registered nurses developed a protocol for the immediate recognition and management of patients who present to the ED with signs and symptoms of sepsis or shock. ED staff were educated, and the protocol was implemented. Post protocol implementation revealed a 73 percent decrease in the progression of sepsis. Additionally, patient wait times in the ED decreased by 10 minutes, and the average costs per bed day decreased by $14,465 for a 55 percent reduction in costs. In the first 6 months post implementation, 38 patients were identified who met either the severe sepsis or septic shock criteria.

The protocol was disseminated to a broader nursing audience at the Clinical Nurse Leader Conference in New York City and was awarded the "Best Project Poster" at the 2012 Wisconsin Nurses Association Conference and Annual Meeting.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility complied with selected requirements within its QM program.[1]

We interviewed senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement, and it included the required members.	
	There was evidence that Inpatient Evaluation Center data was discussed by senior managers.	
	Corrective actions from the protected peer review process were reported to the Peer Review Committee.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners complied with selected requirements.	
	Local policy for the use of observation beds complied with selected requirements.	
	Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	Appropriate processes were in place to prevent incidents of surgical items being retained in a patient following surgery.	
	The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	
	There was an EHR quality review committee, and the review process complied with selected requirements.	
	The EHR copy and paste function was monitored.	

NC	Areas Reviewed (continued)	Findings
	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	
	Use and review of blood/transfusions complied with selected requirements.	
	CLC minimum data set forms were transmitted to the data center with the required frequency.	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.	
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility complied with any additional elements required by VHA or local policy.	

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements.[2]

We inspected the medicine, surgery, intensive care, and locked mental health units; the CLC; the ED; the women's health clinic located in a general primary care clinic; and two physical medicine and rehabilitation therapy clinics. Additionally, we reviewed relevant documents and interviewed key employees and managers. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	The facility had a policy that detailed cleaning of equipment between patients.	
	Patient care areas were clean.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Sensitive patient information was protected, and patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for the Women's Health Clinic	
	The Women Veterans Program Manager completed required annual EOC evaluations, and the facility tracked women's health-related deficiencies to closure.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	

NC	Areas Reviewed for the Women's Health Clinic (continued)	Findings
	Medication safety and security requirements were met.	
	Patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Physical Medicine and Rehabilitation Therapy Clinics	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Medication Management – CS Inspections

The purpose of this review was to determine whether the facility complied with requirements related to CS security and inspections.[3]

We reviewed relevant documents and interviewed key employees. We also reviewed the training files of all CS Coordinators and 10 CS inspectors and inspection documentation from 10 CS areas and the inpatient and outpatient pharmacies. We did not review inspection documentation for the pharmacy emergency drug cache because that area was under construction, and the emergency cache was temporarily located at another facility. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	Facility policy was consistent with VHA requirements.	
	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	
X	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	Automated dispensing machine inspection instructions reviewed: • Although instructions required reconciliation of 1 day's dispensing from the pharmacy to each automated unit, this was not documented.
	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	
	CS Coordinator position description(s) or functional statement(s) included duties, and CS Coordinator(s) completed required certification and were free from conflicts of interest.	
	CS inspectors were appointed in writing, completed required certification and training, and were free from conflicts of interest.	
	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	
	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

1. We recommended that processes be strengthened to ensure that CS inspectors consistently perform and document reconciliation of 1 day's dispensing from the pharmacy to each automated unit and that compliance be monitored.

Coordination of Care – HPC

The purpose of this review was to determine whether the facility complied with selected requirements related to HPC, including PCCT, consults, and inpatient services.[4]

We reviewed relevant documents, 20 EHRs of patients who had PCCT consults (including 10 HPC inpatients), and 25 employee training records (10 HPC staff records and 15 non-HPC staff records), and we interviewed key employees. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	A PCCT was in place and had the dedicated staff required.	
	The PCCT actively sought patients appropriate for HPC.	
	The PCCT offered end-of-life training.	
	HPC staff and selected non-HPC staff had end-of-life training.	
	The facility had a VA liaison with community hospice programs.	
	The PCCT promoted patient choice of location for hospice care.	
	The CLC-based hospice program offered bereavement services.	
	The HPC consult contained the word "palliative" or "hospice" in the title.	
	HPC consults were submitted through the Computerized Patient Record System.	
	The PCCT responded to consults within the required timeframe and tracked consults that had not been acted upon.	
	Consult responses were attached to HPC consult requests.	
	The facility submitted the required electronic data for HPC through the VHA Support Service Center.	
	An interdisciplinary team care plan was completed for HPC inpatients within the facility's specified timeframe.	
	HPC inpatients were assessed for pain with the frequency required by local policy.	
	HPC inpatients' pain was managed according to the interventions included in the care plan.	
	HPC inpatients were screened for an advanced directive upon admission and according to local policy.	
	The facility complied with any additional elements required by VHA or local policy.	

Long-Term Home Oxygen Therapy

The purpose of this review was to determine whether the facility complied with requirements for long-term home oxygen therapy in its mandated Home Respiratory Care Program.[5]

We reviewed relevant documents and 34 EHRs of patients enrolled in the home oxygen program (including 1 patient deemed to be high risk), and we interviewed key employees. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	There was a local policy to reduce the fire hazards of smoking associated with oxygen treatment.	
	The Chief of Staff reviewed Home Respiratory Care Program activities at least quarterly.	
	The facility had established a home respiratory care team.	
	Contracts for oxygen delivery contained all required elements and were monitored quarterly.	
	Home oxygen program patients had active orders/prescriptions for home oxygen and were re-evaluated for home oxygen therapy annually after the first year.	
	Patients identified as high risk received hazards education at least every 6 months after initial delivery.	
	NC high-risk patients were identified and referred to a multidisciplinary clinical committee for review.	
	The facility complied with any additional elements required by VHA or local policy.	

Nurse Staffing

The purpose of this review was to determine the extent to which the facility implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on a selected acute care unit.[6]

We reviewed relevant documents and 63 training files, and we interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for acute care unit 4A for 50 randomly selected days (holidays, weekdays, and weekend days) between October 1, 2011, and September 30, 2012. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	The unit-based expert panels followed the required processes.	
	The facility expert panel followed the required processes and included all required members.	
	Members of the expert panels completed the required training.	
	The facility completed the required steps to develop a nurse staffing methodology by September 30, 2011.	
	The selected units' actual nursing hours per patient day met or exceeded the target nursing hours per patient day.	
	The facility complied with any additional elements required by VHA or local policy.	

Preventable Pulmonary Embolism

The purpose of this review was to evaluate the care provided to patients who were treated at the facility and developed potentially preventable pulmonary embolism.[7]

We reviewed relevant documents and 38 EHRs of patients with confirmed diagnoses of pulmonary embolism[a] January 1–June 30, 2012. We also interviewed key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
X	Patients with potentially preventable pulmonary emboli received appropriate anticoagulation medication prior to the event.	• One patient was identified as having a potentially preventable pulmonary embolism because the patient had a risk factor and had not been provided anticoagulation medication.
	No additional quality of care issues were identified with the patients' care.	
	The facility complied with any additional elements required by VHA or local policy/protocols.	

Recommendation

2. We recommended that managers initiate protected peer review for the one identified patient and complete any recommended review actions.

[a] A sudden blockage in a lung artery usually caused by a blood clot that travels to the lung from a vein in the body, most commonly in the legs.

Construction Safety

The purpose of this review was to determine whether the facility maintained infection control and safety precautions during construction and renovation activities in accordance with applicable standards.[8]

We inspected the sterilization processing upgrade construction project. Additionally, we reviewed relevant documents and 51 training records (30 contractor records and 21 employee records), and we interviewed key employees and managers. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	There was a multidisciplinary committee to oversee infection control and safety precautions during construction and renovation activities and a policy outlining the responsibilities of the committee, and the committee included all required members.	
	Infection control, preconstruction, interim life safety, and contractor tuberculosis risk assessments were conducted prior to project initiation.	
	There was documentation of results of contractor tuberculosis skin testing and of follow-up on any positive results.	
	There was a policy addressing Interim Life Safety Measures, and required Interim Life Safety Measures were documented.	
	Site inspections were conducted by the required multidisciplinary team members at the specified frequency and included all required elements.	
	Infection Control Committee minutes documented infection surveillance activities associated with the project(s) and any interventions.	
	Construction Safety Committee minutes documented any unsafe conditions found during inspections and any follow-up actions and tracked actions to completion.	
	Contractors and designated employees received required training.	
	Dust control requirements were met.	

NC	Areas Reviewed (continued)	Findings
X	Fire and life safety requirements were met.	• There were no exit signs inside the project area to identify routes of egress for staff and contractors in the event of an emergency. • Plastic sprinkler head paint protectors, which inhibit sprinkler head effectiveness, covered sprinkler heads in the project area. Contractors did not remove the protectors when the area was unsupervised for longer than 4 hours.
	Hazardous chemicals requirements were met.	
	Storage and security requirements were met.	
	The facility complied with any additional elements required by VHA or local policy or other regulatory standards.	

Recommendations

3. We recommended that processes be strengthened to ensure that exit signs identifying routes for egress are posted within construction sites.

4. We recommended that processes be strengthened to ensure that sprinkler head paint protectors are removed as soon as possible and that in the event the protectors remain on in unattended areas for longer than 4 hours in a 24-hour period, a fire watch be implemented.

Facility Profile (Madison/607) FY 2012[b]	
Type of Organization	Tertiary
Complexity Level	1b-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$295.2
Number of:	
• **Unique Patients**	39,485
• **Outpatient Visits**	375,326
• **Unique Employees[c] (as of last pay period in FY 2012)**	1,693
Type and Number of Operating Beds:	
• **Hospital**	90
• **CLC**	26
• **Mental Health**	12
Average Daily Census: (through August 2012)	
• **Hospital**	69
• **CLC**	10
• **Mental Health**	12
Number of Community Based Outpatient Clinics	5
Location(s)/Station Number(s)	Janesville, WI/607GC Baraboo, WI/607GD Beaver Dam, WI/607GE Freeport, WI/607GF Rockford, IL/607HA
VISN Number	12

[b] All data is for FY 2012 except where noted.
[c] Unique employees involved in direct medical care (cost center 8200).

VHA Patient Satisfaction Survey

VHA has identified patient 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 for FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2012		FY 2012			
	Inpatient Score Quarters 1–2	Inpatient Score Quarters 3–4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	73.3	75.7	60.0	60.1	59.8	60.6
VISN	68.2	66.0	59.2	59.0	57.4	59.6
VHA	63.9	65.0	55.0	54.7	54.3	55.0

Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[d] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2008, and June 30, 2011.[e]

Table 2

	Mortality			Readmission		
	Heart Attack	Heart Failure	Pneumonia	Heart Attack	Heart Failure	Pneumonia
Facility	16.1	10.9	12.5	20.1	24.5	17.8
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

[d] A heart attack occurs 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 timely, the heart muscle becomes damaged. Heart failure is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[e] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

Appendix C

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 2, 2013

From: Director, VA Great Lakes Health Care System (10N12)

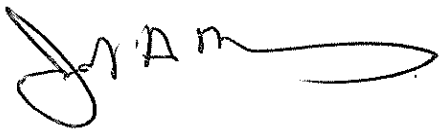
Subject: **CAP Review of the William S. Middleton Memorial Veterans Hospital, Madison, WI**

To: Director, Denver Office of Healthcare Inspections (54DV)

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

I have reviewed the document and concur with the response as submitted.

If additional information is needed please contact Jean Farrell-Holtan Organizational Improvement Manager at (608) 256-1901, x17718.



Jeffrey A. Murawsky, M.D.
Network Director, VISN 12

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 29, 2013

From: Director, William S. Middleton Memorial Veterans Hospital (607/00)

Subject: **CAP Review of the William S. Middleton Memorial Veterans Hospital, Madison, WI**

To: Director, VA Great Lakes Health Care System (10N12)

1. Thank you for the opportunity to review the draft report on the Combined Assessment Program Review at Wm. S. Middleton Memorial Veterans Hospital, Madison WI.

2. I have reviewed the document and concur with the recommendations. Corrective action plans have been established with planned completion dates, as detailed in the attached report.

(*original signed by*:)
JUDY K. MCKEE

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that CS inspectors consistently perform and document reconciliation of 1 day's dispensing from the pharmacy to each automated unit and that compliance be monitored.

Concur

Target date for completion: February 27, 2013

Facility response: The CSI process has been strengthened to ensure that CS inspectors perform and document reconciliation of 1 day's dispensing from pharmacy to each automated unit with every unit audit. Documentation of the reconciliation is reported on the monthly CSI reports. Inspectors are utilizing the "All events by Supply" report to document the action. We request this recommendation be closed.

Recommendation 2. We recommended that managers initiate protected peer review for the one identified patient and complete any recommended review actions.

Concur

Target date for completion: 3/12/13

Facility response: Peer review completed. We request this recommendation be closed.

Recommendation 3. We recommended that processes be strengthened to ensure that exit signs identifying alternate routes for egress are posted within construction sites.

Concur

Target date for completion: February 27, 2013

Facility response: Exit signs are posted within all existing construction sites. Alternate routes for both inside and outside the construction sites are documented on the Pre-Construction Risk Assessments. Monitoring of alternate egress routes and signage both inside and outside of the site is done during weekly construction rounds. Construction Safety Committee will track presence of signage as a standing agenda item with expectation that 100% of the time signs will be in place during rounds. Four weeks of data collected indicates that we are meeting 100% threshold. We request this recommendation be closed.

Recommendation 4. We recommended that processes be strengthened to ensure that sprinkler head paint protectors are removed as soon as possible and that in the event the protectors remain on in unattended areas for longer than 4 hours in a 24-hour period, a fire watch be implemented.

Concur

Target date for completion: February 27, 2013

Facility response: Sprinkler covers were removed at time of survey in the unattended construction site. For scheduled construction activities where the sprinkler system is taken out of service for more than 10 hours in a 24-hour period or the fire alarm system is taken out of service for more than 4 hours in a 24-hour period, when proper separation and appropriate ILSMs are in place, it is considered that no parties are left unprotected by the shutdown. Levels of fire protection required for each construction project will be reviewed at the time of the Pre-Construction Risk Assessment. Monitoring of compliance will be reviewed and documented during weekly construction safety rounds. If concerns arise, these will be addressed immediately by the COR and the construction project manager. All identified concerns will be tracked through the Construction Safety Committee. Four weeks of data collected indicates that we are meeting fire protection 100% of the time. We request this recommendation be closed.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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U.S. House of Representatives: Cheri Bustos, Adam Kinzinger, Thomas Petri, Mark Pocan, Paul Ryan, F. James Sensenbrenner

This report is available at www.va.gov/oig.

Endnotes

[1] References used for this topic included:
- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.
- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- VHA Directive 6300, Records Management, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.
- VHA Directive 2008-007, *Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, February 4, 2008; VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013.

[2] References used for this topic included:
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Handbook 1330.01, Health Care Services for Women Veterans, May 21, 2010.
- VA National Center for Patient Safety, "Ceiling mounted patient lift installations," Patient Safety Alert 10-07, March 22, 2010.
- Various requirements of The Joint Commission, the Centers for Disease Control and Prevention, the Occupational Safety and Health Administration, the National Fire Protection Association, the American National Standards Institute, the Association for the Advancement of Medical Instrumentation, and the International Association of Healthcare Central Service Material Management.

[3] References used for this topic included:
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.02, *Inspection of Controlled Substances*, March 31, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
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