Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-01669-270

Combined Assessment Program Review of the Jesse Brown VA Medical Center Chicago, Illinois

August 16, 2013

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: www.va.gov/oig/hotline)

Glossary

CAP	Combined Assessment Program
CLC	community living center
CS	controlled substances
CSC	Construction Safety Committee
EHR	electronic health record
EOC	environment of care
facility	Jesse Brown VA Medical Center
FY	fiscal year
HPC	hospice and palliative care
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
PR	peer review
QM	quality management
RME	reusable medical equipment
SPS	Sterile Processing Service
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

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 May 6, 2013.

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

- Coordination of Care – Hospice and Palliative Care

The facility's reported accomplishments were a partnership with the Chicago Housing Authority to reduce homelessness for Chicago area veterans and their families and the Project Red Initiative, a program designed to reduce readmission rates of congestive heart failure patients.

Recommendations: We made recommendations in the following six activities:

Quality Management: Revise the local observation bed policy to include how the service and physician responsible for the patient are determined. Consistently scan results of non-VA diagnostic tests into electronic health records. Include the results of proficiency testing, peer reviews when transfusions do not meet criteria, and inspections by government and private (peer) entities in the blood usage and review process. Perform and document patient assessments following blood product transfusions.

Environment of Care: Require that Infection Prevention and Control Committee minutes reflect discussion of high-risk areas and actions implemented to address those areas and that committee members or their designees participate in meetings. Ensure Infection Prevention and Control Committee minutes reflect discussion of hand hygiene compliance, follow-up actions, and action results. Include endotoxins in monthly hemodialysis dialysate testing. Ensure Sterile Processing Service employees receive annual competency assessments for all reusable medical equipment items they reprocess. Consistently document Sterile Processing Service temperature and humidity level monitoring.

Medication Management – Controlled Substances Inspections: Initiate actions to address the identified deficiency, and correct all deficiencies identified during annual physical security surveys.

Pressure Ulcer Prevention and Management: Revise the facility pressure ulcer policy to address prevention for outpatients. Include pressure ulcer data analysis in Infection Prevention and Control Committee minutes. Establish staff pressure ulcer education requirements.

Nurse Staffing: Monitor the staffing methodology that was implemented in February 2013.

Construction Safety: Require the Construction Safety Committee to continue to meet and to ensure appropriate oversight of construction and renovation activities. Ensure all Construction Safety Committee members or their designees consistently attend required meetings. Conduct a contractor tuberculosis risk assessment prior to construction project initiation. Ensure construction site inspections are conducted at the facility's required frequency and documented. Require designated employees to receive initial and ongoing construction safety training. Verify contractor safety training prior to project initiation.

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 18–25, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities:

- QM
- EOC
- Medication Management – CS Inspections
- Coordination of Care – HPC
- Pressure Ulcer Prevention and Management
- Nurse Staffing
- 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 2011, FY 2012, and FY 2013 through May 9, 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 Jesse Brown VA Medical Center, Chicago, Illinois,* Report No. 11-01611-250, August 16, 2011).

During this review, we presented crime awareness briefings for 221 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 384 responded. We shared summarized 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

Homeless Veterans Program

The facility was selected by VA Central Office to establish a multidisciplinary program that serves homeless veterans and those at risk for homelessness. The facility partnered with the Chicago Housing Authority and the Department of Housing and Urban Development to help homeless veterans and their families secure long-term housing. The facility provides case management, supportive services, and permanent housing for veterans within a 60 mile radius of the facility. In 2012, approximately 500 homeless veterans and their families were placed into permanent housing.

Project Red Initiative

The facility collaborated with the Agency for Healthcare Research and Quality and The Joint Commission to implement a patient-centered program designed to enhance patient education and reduce congestive heart failure patients' hospital readmission rates. The program includes one-on-one patient education while the patient is hospitalized, enhanced patient education materials, referral to the telehealth program, reinforcement of patient education within 48 hours of discharge, and outpatient follow-up appointments within 1 week of discharge. The facility successfully lowered the congestive heart failure readmission rate from 37.8 percent during quarter 1 of FY 2012 to 16.7 percent during quarter 1 of FY 2013.

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 conversed with 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. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

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 PR process were reported to the PR Committee.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners complied with selected requirements.	
X	Local policy for the use of observation beds complied with selected requirements.	• The facility's policy did not include how the service and physician responsible for the patient were determined.
	Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent, or the facility had reassessed observation criteria and proper utilization.	
	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
X	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	Thirty EHRs of patients who had non-VA purchased diagnostic tests reviewed: • Nine test results (30 percent) were not scanned into the EHRs.
X	Use and review of blood/transfusions complied with selected requirements.	Three quarters of the Blood Usage Review Committee meeting minutes reviewed: • The review process did not include the results of proficiency testing, of PRs when transfusions did not meet criteria, and of inspections by government or private (peer) entities. Thirty-five EHRs of patients who received blood products reviewed: • There was no documentation in eight EHRs (23 percent) of a patient assessment following the transfusion.
	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.	

Recommendations

1. We recommended that the local observation bed policy be revised to include how the service and physician responsible for the patient are determined.

2. We recommended that processes be strengthened to ensure that the results of non-VA purchased diagnostic tests are consistently scanned into EHRs.

3. We recommended that processes be strengthened to ensure that the blood usage and review process includes the results of proficiency testing, of PRs when transfusions do not meet criteria, and of inspections by government or private (peer) entities.

4. We recommended that processes be strengthened to ensure that clinicians perform and document patient assessments following blood product transfusions.

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 and whether selected requirements in the hemodialysis and SPS areas were met.[2]

We inspected the locked mental health, intensive care, and medical/surgical units; the CLC; the emergency room; the red primary care clinic; the inpatient and outpatient hemodialysis units; and SPS. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 26 employee training and competency files (10 hemodialysis, 10 operating room, and 6 SPS). The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

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.	
X	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	Infection prevention risk assessment and 12 months of Infection Prevention and Control Committee meeting minutes reviewed: • Minutes did not reflect consistent discussion of high-risk areas or actions that were implemented to address these areas.
X	Infection Prevention and Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	Twelve months of Infection Prevention and Control Committee meeting minutes reviewed: • Inconsistent committee member participation resulted in agenda item discussions and follow-up actions being deferred. • Hand hygiene compliance, follow-up actions, and action results were not consistently documented in minutes.
	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.	
NC	**Areas Reviewed for Hemodialysis**	**Findings**
	The facility had policy detailing the cleaning and disinfection of hemodialysis equipment and environmental surfaces and the management of infection prevention precautions patients.	

NC	Areas Reviewed for Hemodialysis (continued)	Findings
X	Monthly biological water and dialysate testing was conducted and included required components, and identified problems were corrected.	Six months of testing documentation reviewed: • Monthly dialysate testing did not include endotoxins.
	Employees received training on bloodborne pathogens.	
	Employee hand hygiene monitoring was conducted, and any needed corrective actions were implemented.	
	Selected EOC/infection prevention/safety requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for SPS/RME	
	The facility had policies/procedures/guidelines for cleaning, disinfecting, and sterilizing RME.	
	The facility used an interdisciplinary approach to monitor compliance with established RME processes, and RME-related activities were reported to an executive-level committee.	
	The facility had policies/procedures/guidelines for immediate use (flash) sterilization and monitored it.	
X	Employees received required RME training and competency assessment.	• Of the 6 SPS employees on duty for more than 2 years, there was no evidence that 2 received their annual competency assessment for 1 of 4 selected RME items.
	Operating room employees who performed immediate use (flash) sterilization received training and competency assessment.	
	RME standard operating procedures were consistent with manufacturers' instructions, procedures were located where reprocessing occurs, and sterilization was performed as required.	
	Selected infection prevention/environmental safety requirements were met.	
X	Selected requirements for SPS decontamination and sterile storage areas were met.	Two months of SPS temperature and humidity tracking logs reviewed: • The April temperature and humidity tracking log had missing dates and values.
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations:

5. We recommended that processes be strengthened to ensure that Infection Prevention and Control Committee minutes reflect discussion of high-risk areas and actions implemented to address these areas.

6. We recommended that processes be strengthened to ensure that all Infection Prevention and Control Committee members or their designees participate in meetings and that compliance be monitored.

7. We recommended that processes be strengthened to ensure that Infection Prevention and Control Committee minutes reflect discussion of hand hygiene compliance, follow-up actions, and action results.

8. We recommended that processes be strengthened to ensure that monthly hemodialysis dialysate testing includes endotoxins.

9. We recommended that processes be strengthened to ensure that SPS employees receive annual competency assessments for all RME items they reprocess.

10. We recommended that processes be strengthened to ensure that SPS temperature and humidity level monitoring is consistently documented and that compliance be monitored.

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 conversed with key employees. We also reviewed the training files of all CS Coordinators and 10 CS inspectors and inspection documentation from 10 CS areas, the inpatient and outpatient pharmacies, and the emergency drug cache. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
	Facility policy was consistent with VHA requirements.	
X	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	Annual physical security surveys for past 2 years reviewed: • One deficiency identified on the past two surveys had not been corrected, and managers did not have action plans or an explanation for why the item remained unresolved.
	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	
	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

11. We recommended that managers initiate actions to address the identified deficiency and that processes be strengthened to ensure that all deficiencies identified during annual physical security surveys are corrected.

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, 10 EHRs of patients who had PCCT consults, and 24 employee training records (9 HPC staff records and 15 non-HPC staff records), and we conversed with key employees. The table below shows the areas reviewed for this topic. Any 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.	
NA	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.	
NA	An interdisciplinary team care plan was completed for HPC inpatients within the facility's specified timeframe.	
NA	HPC inpatients were assessed for pain with the frequency required by local policy.	
NA	HPC inpatients' pain was managed according to the interventions included in the care plan.	
NA	HPC inpatients were screened for an advanced directive upon admission and according to local policy.	
NA	The facility complied with any additional elements required by VHA or local policy.	

Pressure Ulcer Prevention and Management

The purpose of this review was to determine whether acute care clinicians provided comprehensive pressure ulcer prevention and management.[5]

We reviewed relevant documents, 12 EHRs of patients with pressure ulcers (5 patients with hospital-acquired pressure ulcers, 4 patients with community-acquired pressure ulcers, and 3 patients with pressure ulcers at the time of our onsite visit), and 10 employee training records. Additionally, we inspected three patient rooms. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
X	The facility had a pressure ulcer prevention policy, and it addressed prevention for all inpatient areas and for outpatient care.	Facility pressure ulcer prevention policy reviewed: • The policy did not address prevention for outpatients.
	The facility had an interprofessional pressure ulcer committee, and the membership included a certified wound care specialist.	
X	Pressure ulcer data was analyzed and reported to facility executive leadership.	Minutes of the Infection Prevention and Control Committee (committee that oversees interprofessional pressure ulcer committee activities) for past 6 months reviewed: • Minutes did not reflect pressure ulcer data analysis.
	Complete skin assessments were performed within 24 hours of acute care admissions.	
	Skin inspections and risk scales were performed upon transfer, change in condition, and discharge.	
	Staff were generally consistent in documenting location, stage, risk scale score, and date acquired.	
	Required activities were performed for patients determined to be at risk for pressure ulcers and for patients with pressure ulcers.	
	Required activities were performed for patients determined to not be at risk for pressure ulcers.	
	For patients at risk for and with pressure ulcers, interprofessional treatment plans were developed, interventions were recommended, and EHR documentation reflected that interventions were provided.	
	If the patient's pressure ulcer was not healed at discharge, a wound care follow-up plan was documented, and the patient was provided appropriate dressing supplies.	

NC	Areas Reviewed (continued)	Findings
	The facility defined requirements for patient and caregiver pressure ulcer education, and education on pressure ulcer prevention and development was provided to those at risk for and with pressure ulcers and/or their caregivers.	
X	The facility defined requirements for staff pressure ulcer education, and acute care staff received training on how to administer the pressure ulcer risk scale, conduct the complete skin assessment, and accurately document findings.	• The facility had not developed staff pressure ulcer education requirements.
	The facility complied with selected fire and environmental safety, infection prevention, and medication safety and security requirements in pressure ulcer patient rooms.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

12. We recommended that the facility pressure ulcer policy be revised to address prevention for outpatients and that compliance with the revised policy be monitored.

13. We recommended that processes be strengthened to ensure that Infection Prevention and Control Committee minutes include pressure ulcer data analysis.

14. We recommended that the facility establish staff pressure ulcer education requirements and that compliance be monitored.

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 three inpatient units (acute medical/surgical, long-term care, and mental health).[6]

We reviewed relevant documents and 25 training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for acute medical/surgical unit 5E, CLC unit 6W, and mental health unit 7E/7W for 52 randomly selected days (holidays, weekdays, and weekend days) between October 1, 2012, and March 31, 2013. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
X	The facility completed the required steps to develop a nurse staffing methodology by the deadline.	• The staffing methodology was not implemented until February 2013.
NA	The unit-based expert panels followed the required processes and included all required members.	
NA	The facility expert panel followed the required processes and included all required members.	
NA	Members of the expert panels completed the required training.	
NA	The actual nursing hours per patient day met or exceeded the target nursing hours per patient day.	
NA	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

15. We recommended that nursing managers monitor the staffing methodology that was implemented in February 2013.

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.[7]

We inspected the "upgrade cardiology" project, which was initiated in August 2012. Additionally, we reviewed relevant documents and 20 training records (10 contractor records and 10 employee records), and we conversed with key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
X	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.	• The facility did not establish a CSC to oversee construction and renovation activities until December 2012. Three months of CSC minutes reviewed: • CSC members or their designees did not consistently attend meetings.
X	Infection control, preconstruction, interim life safety, and contractor tuberculosis risk assessments were conducted prior to project initiation.	Risk assessments reviewed: • A contractor tuberculosis risk assessment was not conducted prior to project initiation.
NA	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.	
X	Site inspections were conducted by the required multidisciplinary team members at the specified frequency and included all required elements.	Site inspection documentation for 4 months reviewed: • Local policy required weekly site inspections were not consistently conducted and documented.
	Infection Control Committee minutes documented infection surveillance activities associated with the project(s) and any interventions.	
	CSC minutes documented any unsafe conditions found during inspections and any follow-up actions and tracked actions to completion.	

NC	Areas Reviewed (continued)	Findings
X	Contractors and designated employees received required training.	Employee and contractor training records reviewed: • Three employee records did not contain evidence of initial VHA or Occupational Safety and Health Administration construction safety training. • Two employee records did not contain evidence of at least 10 hours of construction safety-related training in the past 2 years. • The facility did not verify that contractor safety training was completed prior to project initiation.
	Dust control requirements were met.	
	Fire and life safety requirements were met.	
	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

16. We recommended that the CSC continues to meet and ensures appropriate oversight of construction and renovation activities.

17. We recommended that processes be strengthened to ensure that all CSC members or their designees consistently attend required meetings and that compliance be monitored.

18. We recommended that processes be strengthened to ensure that a contractor tuberculosis risk assessment is conducted prior to construction project initiation.

19. We recommended that processes be strengthened to ensure that construction site inspections are conducted at the facility's required frequency and documented.

20. We recommended that processes be strengthened to ensure that designated employees receive initial and ongoing construction safety training and that compliance be monitored.

21. We recommended that processes be strengthened to ensure that contractor safety training is verified prior to project initiation.

Facility Profile (Chicago/537) FY 2013 through March 2013[a]	
Type of Organization	Tertiary
Complexity Level	1b
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$380.1
Number (through April 2013) of:	
• **Unique Patients**	37,005
• **Outpatient Visits**	338,498
• **Unique Employees**[b]	1,916
Type and Number of Operating Beds:	
• **Hospital**	148
• **CLC**	22
• **Mental Health**	40
Average Daily Census:	
• **Hospital**	112
• **CLC**	18
• **Mental Health**	33
Number of Community Based Outpatient Clinics	4
Location(s)/Station Number(s)	Auburn-Gresham/537HA Chicago Heights/537GA Crown Point/537BY Lakeside/537GD
VISN Number	12

[a] All data is for FY 2013 through March 2013 except where noted.
[b] 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	69.7	60.2	60.3	51.1	48.3	53.4
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.[c] 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.[d]

Table 2

	Mortality			Readmission		
	Heart Attack	Heart Failure	Pneumonia	Heart Attack	Heart Failure	Pneumonia
Facility	13.7	8.0	12.4	20.3	28.4	24.9
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

[c] 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.

[d] 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.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 5, 2013

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

Subject: **CAP Review of the Jesse Brown VA Medical Center, Chicago, IL**

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

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

1. I concur with the Office of Healthcare Inspections recommendations as well as the corrective action plans developed by the Jesse Brown VA Medical Center.

2. Thank-you for the opportunity to review the findings enclosed in this report.

Renee Oshirst

(For and in the absence of:)
Jeffrey A. Murawsky, M.D.

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 27, 2013

From: Director, Jesse Brown VA Medical Center (537/00)

Subject: **CAP Review of the Jesse Brown VA Medical Center, Chicago, IL**

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

1. I would like to express my appreciation to the Office of Inspector General (OIG) Survey Team for their professional and comprehensive CAP review conducted May 6–9, 2013. The results of their assessment validate the efforts of this Medical Center in providing high quality health care to our nation's Veterans.

2. I have reviewed the draft report for the Jesse Brown VA Medical Center and action plans are provided for the recommendations made in the six activities.

3. I appreciate the opportunity to submit this response in support of continuous improvement in health care services provided to our Veterans.

(original signed by:)
Mario V. DeSanctis, FACHE

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 the local observation bed policy be revised to include how the service and physician responsible for the patient are determined.

Concur

Target date for completion: August 7, 2013

Facility response: The Observation Beds Policy was updated to include how the service and physician assignment for patients are determined. The policy updates were provided to all bed service chiefs and will be discussed at the next Medical Executive Committee Meeting.

Recommendation 2. We recommended that processes be strengthened to ensure that the results of non-VA purchased diagnostic tests are consistently scanned into EHRs.

Concur

Target date for completion: October 1, 2013

Facility response: The results of the non-VA purchased diagnostic tests entered into the EHRs will be monitored and reported to the Medical Record Committee to ensure 90% compliance is achieved and sustained.

Recommendation 3. We recommended that processes be strengthened to ensure that the blood usage and review process includes the results of proficiency testing, of PRs when transfusions do not meet criteria, and of inspections by government or private (peer) entities.

Concur

Target date for completion: October 1, 2013

Facility response: The proficiency testing (quality controls) results will be added as a standing agenda item for the quarterly Blood Transfusion Committee and documented in the minutes. Peer reviews will be conducted on all blood transfusions that do not meet criteria. Peer reviews and all inspections by government or private (peer) entities will be presented at the Blood Transfusion Committee. The committee minutes will be monitored to ensure 90% compliance is achieved and sustained.

Recommendation 4. We recommended that processes be strengthened to ensure that clinicians perform and document patient assessments following blood product transfusions.

Concur

Target date for completion: October 1, 2013

Facility response: A progress note template is being developed to document patients' post blood transfusion patient's assessment. Electronic health record reviews will be conducted and monitored to ensure that 90% compliance is achieved and sustained.

Recommendation 5. We recommended that processes be strengthened to ensure that Infection Prevention and Control Committee minutes reflect discussion of high-risk areas and actions implemented to address these areas.

Concur

Target date for completion: September 1, 2013

Facility response: All high-risk areas have been added as standing agenda items to the Infection Prevention and Control Committee. Actions implemented to address the high-risk areas and follow-up will be discussed at meetings until actions are closed. Meeting minutes will be monitored to ensure documentation of discussions.

Recommendation 6. We recommended that processes be strengthened to ensure that all Infection Prevention and Control Committee members or their designees participate in meetings and that compliance be monitored.

Concur

Target date for completion: November 1, 2013

Facility response: The Infection Prevention and Control Committee attendance is tracked. Members are reminded to attend the meeting or send a representative. The Infection Prevention and Control Committee reports two consecutive absences to the Quality Leadership Council. Attendance will be monitored until 90% compliance is achieved and sustained.

Recommendation 7. We recommended that processes be strengthened to ensure that Infection Prevention and Control Committee minutes reflect discussion of hand hygiene compliance, follow-up actions, and action results.

Concur

Target date for completion: November 1, 2013

Facility response: A reporting template for monthly hand hygiene monitor audits was developed and shared with the Infection Control Facilitators and Nurse Managers. Completion of an action plan is required when hand hygiene results are less than 80% compliant. Actions plans are reported and monitored in the Infection Control Committee meeting minutes until closed.

Recommendation 8. We recommended that processes be strengthened to ensure that monthly hemodialysis dialysate testing includes endotoxins.

Concur

Target date for completion: July 18, 2013

Facility response: The hemodialysis dialysate testing for endotoxins was initiated during the survey in May 2013. Results are reviewed monthly for compliance and reported to the Infection Prevention and Control Committee.

Recommendation 9. We recommended that processes be strengthened to ensure that SPS employees receive annual competency assessments for all RME items they reprocess.

Concur

Target date for completion: September 1, 2013

Facility response: The two SPS personnel with incomplete competencies at the time of the OIG review completed their annual competencies on June 25, 2013. Competencies for all SPS employees are now 100% compliant. SPS employee competencies are monitored monthly as a standing agenda item for the Reusable Medical Equipment Committee.

Recommendation 10. We recommended that processes be strengthened to ensure that SPS temperature and humidity level monitoring is consistently documented and that compliance be monitored.

Concur

Target date for completion: September 1, 2013

Facility response: As a result of a VISN SPS audit, an automated temperature tracking system was ordered. Currently, SPS staff manually monitors temperature and humidity levels daily and documentation of the levels is verified by the lead SPS technician.

Recommendation 11. We recommended that managers initiate actions to address the identified deficiency and that processes be strengthened to ensure that all deficiencies identified during annual physical security surveys are corrected.

Concur

Target date for completion: September 1, 2013

Facility response: All identified deficiencies noted in the Annual Physical Security Survey have been corrected, including successfully testing the alarm systems. The annual Physical Security Assessment will be a standing agenda item for the Security Subcommittee. The action plans will be tracked, monitored and documented until closure. The Security Subcommittee reports bimonthly to the Environment of Care Committee.

Recommendation 12. We recommended that the facility pressure ulcer policy be revised to address prevention for outpatients and that compliance with the revised policy be monitored.

Concur

Target date for completion: October 1, 2013

Facility response: The Pressure Ulcer Policy is being revised to include outpatient pressure ulcer prevention program. The clinical reminder for performing Braden Scale and completion of a skin assessment annually for all outpatients will be incorporated in the new policy. Staff will receive training on the policy revisions. Electronic Health Record reviews will be completed to ensure 90% compliance is achieved and sustained.

Recommendation 13. We recommended that processes be strengthened to ensure that Infection Prevention and Control Committee minutes include pressure ulcer data analysis.

Concur

Target date for completion: November 1, 2013

Facility response: Pressure ulcer data analyses will be reported to the Infection Prevention and Control Committee bimonthly. Meeting minutes will be monitored to ensure documentation of Pressure Ulcer data analyses.

Recommendation 14. We recommended that the facility establish staff pressure ulcer education requirements and that compliance be monitored.

Concur

Target date for completion: October 1, 2013

Facility response: The pressure ulcer policy is being revised to include education requirements for nursing staff. Nursing competencies on pressure ulcer prevention and management will be reviewed monthly to ensure 90% compliance is achieved and sustained.

Recommendation 15. We recommended that nursing managers monitor the staffing methodology that was implemented in February 2013.

Concur

Target date for completion: July 1, 2013

Facility response: Each month the Associate Director Patient Care Services (ADPCS)/Nurse Executive reviews the previous month's staffing results and provides feedback to the Nurse Managers.

Recommendation 16. We recommended that the CSC continues to meet and ensures appropriate oversight of construction and renovation activities.

Concur

Target date for completion: September 1, 2013

Facility response: The Construction Safety Committee has been meeting monthly since December 2012. The oversight of construction and renovation is documented in the Construction Safety Committee meeting minutes

Recommendation 17. We recommended that processes be strengthened to ensure that all CSC members or their designees consistently attend required meetings and that compliance be monitored.

Concur

Target date for completion: August 1, 2013

Facility response: Meeting attendance requirements were reviewed with Construction Safety Committee members. Member attendance will be discussed during supervisor performance review meetings. Meeting attendance will be monitored until 90% compliance is achieved and sustained.

Recommendation 18. We recommended that processes be strengthened to ensure that a contractor tuberculosis risk assessment is conducted prior to construction project initiation.

Concur

Target date for completion: October 1, 2013

Facility response: The Infection Control Risk Assessments (ICRA) were expanded to include tuberculosis (TB) risk assessments. All construction projects have an ICRA completed prior to initiation of the project. The construction project database is monitored for completion by Engineering and Infection Control.

Recommendation 19. We recommended that processes be strengthened to ensure that construction site inspections are conducted at the facility's required frequency and documented.

Concur

Target date for completion: October 1, 2013

Facility response: Construction site inspections are conducted weekly by the Safety Manager. The policy has been revised to allow for a Safety Department representative to conduct inspections in the absence of the Safety Manager. Weekly site inspections are monitored to ensure 90% compliance is achieved and sustained.

Recommendation 20. We recommended that processes be strengthened to ensure that designated employees receive initial and ongoing construction safety training and that compliance be monitored.

Concur

Target date for completion: October 1, 2013

Facility response: All designated personnel have been scheduled to complete construction safety training. Construction safety training will be monitored and reported monthly at the Construction Safety Committee meeting to assure 90% compliance is achieved and sustained.

Recommendation 21. We recommended that processes be strengthened to ensure that contractor safety training is verified prior to project initiation.

Concur

Target date for completion: August 1, 2013

Facility response: Contractors are now required to provide proof of construction safety training completion prior to working on a construction project. Contractor training completion will be documented in the construction project database for all projects and reported to the Construction Safety Committee to ensure 90% compliance is achieved and sustained.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Onsite Contributors	Debra Boyd-Seale, PhD, RN, Team Leader John Brooks Paula Chapman, CTRS Sheila Cooley, GNP, MSN Wachita Haywood, RN LaNora Hernandez, MSN, RN Laura Spottiswood, RN, MPH Roberta Thompson, LCSW
Other Contributors	Judy Brown Elizabeth Bullock Shirley Carlile, BA Lin Clegg, PhD Marnette Dhooghe, MS Matt Frazier, MPH Jeff Joppie, BS Victor Rhee, MHS Julie Watrous, RN, MS Jarvis Yu, MS

Report Distribution

VA Distribution

Office of the Secretary
VHA
Assistant Secretaries
General Counsel
Director, VA Great Lakes Health Care System (10N12)
Director, Jesse Brown VA Medical Center (537/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Daniel Coats, Joe Donnelly, Richard J. Durbin, Mark Kirk
U.S. House of Representatives: Danny K. Davis, Tammy Duckworth, Luis Gutierrez, Robin Kelly, Adam Kinzinger, Daniel Lipinski, Mike Quigley, Bobby L. Rush, Jan Schakowsky, Peter Visclosky, Jackie Walorski

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 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 Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.
- VHA Directive 2009-026, *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*, May 13, 2009.
- VA National Center for Patient Safety, "Look-Alike Hemodialysis Solutions," Patient Safety Alert 11-09, September 12, 2011.
- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
- 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, the International Association of Healthcare Central Service Material Management, and the Association for Professionals in Infection Control and Epidemiology.

[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.
- VHA, "Clarification of Procedures for Reporting Controlled Substance Medication Loss as Found in VHA Handbook 1108.01," Information Letter 10-2011-004, April 12, 2011.
- VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.
- VA Handbook 0730/2, *Security and Law Enforcement*, May 27, 2010.

[4] References used for this topic included:
- VHA Directive 2008-066, *Palliative Care Consult Teams (PCCT)*, October 23, 2008.
- VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008.
- VHA Handbook 1004.02, *Advanced Care Planning and Management of Advance Directives*, July 2, 2009.
- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.
- VHA Directive 2009-053, *Pain Management*, October 28, 2009.
- Under Secretary for Health, "Hospice and Palliative Care are Part of the VA Benefits Package for Enrolled Veterans in State Veterans Homes," Information Letter 10-2012-001, January 13, 2012.

[5] References used for this topic included:
- VHA Handbook 1180.02, *Prevention of Pressure Ulcers*, July 1, 2011 (corrected copy).
- Various requirements of The Joint Commission.
- Agency for Healthcare Research and Quality Guidelines.
- National Pressure Ulcer Advisory Panel Guidelines.
- The New York State Department of Health, et al., *Gold STAMP Program Pressure Ulcer Resource Guide*, November 2012.

[6] The references used for this topic were:
- VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.
- VHA "Staffing Methodology for Nursing Personnel," August 30, 2011.

[7] References used for this topic included:
- VHA Directive 2011-036, *Safety and Health During Construction*, September 22, 2011.
- VA Office of Construction and Facilities Management, *Master Construction Specifications*, Div. 1, "Special Sections," Div. 01 00 00, "General Requirements," Sec. 1.5, "Fire Safety."
- Various Centers for Disease Control and Prevention recommendations and guidelines, Joint Commission standards, and Occupational Safety and Health Administration (OSHA) regulations.