Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-02315-332

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

September 26, 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
CARF	Commission on Accreditation of Rehabilitation Facilities
CI	cochlear implant
CLC	community living center
COC	coordination of care
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	Edward Hines, Jr. VA Hospital
FY	fiscal year
HPC	hospice and palliative care
ICC	Infection Control Committee
MMU	mobile medical unit
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
QM	quality management
RME	reusable medical equipment
SCI/D	spinal cord injury and disorders
SPS	Sterile Processing Service
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 July 15, 2013.

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

- Quality Management
- Pressure Ulcer Prevention and Management
- Nurse Staffing

The facility's reported accomplishments were launching the veterans mobile medical unit, achieving perfect accreditation with exemplary conformance from the Commission on Accreditation of Rehabilitation Facilities International, implementing the cochlear implant program, and implementing the da Vinci® Surgical System.

Recommendations: We made recommendations in the following four activities:

Environment of Care: Ensure Infection Control Committee minutes reflect discussion of high-risk areas and actions implemented to address these areas. Require that operating room employees who perform immediate use sterilization receive annual competency assessments.

Medication Management – Controlled Substances Inspections: Ensure inspectors consistently verify the three identified required drug destruction activities.

Coordination of Care – Hospice and Palliative Care: Include a dedicated administrative support person on the Palliative Care Consult Team.

Construction Safety: Conduct a contractor tuberculosis risk assessment prior to construction 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 19–22, for the full

text of the Directors' comments.) We consider recommendation 2 closed. We will follow up on the planned actions for the open recommendations 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

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met 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
- COC – 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 July 18, 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 Edward Hines, Jr. VA Hospital, Hines, Illinois,* Report No. 10-02384-33, November 22, 2010).

During this review, we presented crime awareness briefings for 220 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 278 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

Veterans MMU

On June 12, 2013, the facility's MMU received recognition from the Chicago Federal Executive Board as one of three finalists for the Agency of the Year award. The 38-foot veterans MMU was launched on September 29, 2012. It travels throughout the Chicago metropolitan area to assist veterans with enrollment in VA health care and to provide information and top-quality health care. The MMU features two separate exam areas, a counseling room, and on-the-spot enrollment. Since its deployment, the MMU and its staff have attended 38 outreach events, 27 of which were in rural counties; registered or provided information to 369 veterans; enrolled 144 veterans, including a former World War II Prisoner of War who enrolled for the first time; and completed 49 vesting exams.

Perfect CARF Accreditation with Exemplary Conformance

On September 11, 2012, the facility was accredited for 3 years by CARF International and received no recommendations in the 8 rehabilitation programs that were surveyed. This is an extraordinary accomplishment as only 3 percent of CARF surveys result in no recommendations. The programs that were surveyed are the Substance Abuse Residential Rehabilitation Treatment Program, the Psychosocial Rehabilitation and Recovery Center, the Compensated Work Therapy Program, the Health Care for Homeless Veterans Program, the SCI/D System of Care, inpatient physical medicine and rehabilitation, the inpatient amputation program, and the Central Blind Rehabilitation Center. Additionally, CARF specified three areas of exemplary conformance. They are state-of-the-art orthotic and prosthetic services, the SCI/D telehealth program that uses state-of-the-art video technology, and a vocational rehabilitation program that uses a specially-designed computer laboratory to aid SCI/D patients in gaining greater independence.

CI Program

A CI is a surgically implanted electronic device that provides a sense of sound to a person who is profoundly deaf or severely hard of hearing. The CI program at the facility treated its first patient on February 14, 2012, and serves as the referral site for patients from all VISN 12 facilities. Since the program's inception, 14 CIs have been completed. At the June 12, 2013, Chicago Federal Executive Board award ceremony, the CI Team received recognition as a nominee for the Outstanding Team award.

The da Vinci® Surgical System

The da Vinci® Surgical System is a sophisticated robotic platform that offers a state-of-the-art minimally invasive option for major surgery. The first surgery using this technology was performed at the facility in February 2012. During FY 2012, this technology was used for 37 surgeries, and in FY 2013 through July 31, 2013, it was used for 65 surgeries. In the future, patients from other VISN 12 facilities will benefit from this improved method of providing care.

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. 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
	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, or the facility had reassessed observation criteria and proper utilization.	
	Staff performed continuing stay reviews of 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.	
NA	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 and whether selected requirements in the hemodialysis and SPS areas were met.[2]

We inspected the locked mental health, SCI/D, surgical intensive care, and surgical units; one CLC unit; the outpatient hemodialysis unit; the pulmonary outpatient clinic; the emergency department; and SPS. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 30 employee training and competency files (10 hemodialysis, 10 operating room, and 10 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 ICC meeting minutes reviewed: • Minutes did not reflect consistent discussion of high-risk areas or actions that were implemented to address these 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.	
	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 Hemodialysis	
	The facility had policy detailing the cleaning and disinfection of hemodialysis equipment and environmental surfaces and the management of infection prevention precautions patients.	
	Monthly biological water and dialysate testing was conducted and included required components, and identified problems were corrected.	

NC	Areas Reviewed for Hemodialysis (continued)	Findings
	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.	
	Employees received required RME training and competency assessment.	
X	Operating room employees who performed immediate use (flash) sterilization received training and competency assessment.	• All 10 operating room employees performed immediate use sterilization and had been on duty for more than 2 years; there was no evidence that 8 received annual competency assessments.
	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.	
	Selected requirements for SPS decontamination and sterile storage areas were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

1. We recommended that processes be strengthened to ensure that ICC minutes reflect discussion of high-risk areas and actions implemented to address these areas.

2. We recommended that processes be strengthened to ensure that operating room employees who perform immediate use sterilization receive annual competency assessments.

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.	
	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	
	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.	
X	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	Documentation of pharmacy CS inspections during the past 6 months reviewed: • Inspectors did not consistently verify the audit trail by comparing drugs held for destruction with the destroyed drugs report. • Inspectors did not consistently verify that drug destructions were completed at least quarterly. • Audit trails for destruction of 10 randomly selected drugs were not consistently verified.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

3. We recommended that processes be strengthened to ensure that inspectors consistently verify the three identified required drug destruction activities and that compliance be monitored.

COC – 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 conversed with key employees. 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	A PCCT was in place and had the dedicated staff required.	List of staff assigned to the PCCT reviewed: • An administrative support person had not been dedicated to the PCCT.
	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.	

NC	Areas Reviewed (continued)	Findings
NA	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

4. We recommended that processes be strengthened to ensure that the PCCT includes a dedicated administrative support person.

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, 30 EHRs of patients with pressure ulcers (10 patients with hospital-acquired pressure ulcers, 10 patients with community-acquired pressure ulcers, and 10 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. 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
	The facility had a pressure ulcer prevention policy, and it addressed prevention for all inpatient areas and for outpatient care.	
	The facility had an interprofessional pressure ulcer committee, and the membership included a certified wound care specialist.	
	Pressure ulcer data was analyzed and reported to facility executive leadership.	
	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.	
	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 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.	

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 49 training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for acute medical/surgical unit 7E, CLC unit 2C, and mental health unit 2S 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. 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
	The facility completed the required steps to develop a nurse staffing methodology by the deadline.	
	The unit-based expert panels followed the required processes and included all required members.	
	The facility expert panel followed the required processes and included all required members.	
	Members of the expert panels completed the required training.	
	The 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.	

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 "second floor deficiencies" project. 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 area marked as NC needed improvement. Any 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.	
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.
	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.	
	ICC 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.	
	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.	

Recommendation

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

Facility Profile (Hines/578) FY 2013 through May 2013[a]	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$555.8
Number (through June 2013) of:	
• **Unique Patients**	50,109
• **Outpatient Visits**	488,869
• **Unique Employees**[b]	3,754
Type and Number of Operating Beds:	
• **Hospital**	248
• **CLC**	210
• **Mental Health**	25
Average Daily Census:	
• **Hospital**	187
• **CLC**	141
• **Mental Health**	21
Number of Community Based Outpatient Clinics	6
Location(s)/Station Number(s)	Joliet/578GA Kankakee County/578GC Aurora/578GD Elgin/578GE Lasalle/578GF Oak Lawn/578GG
VISN Number	12

[a] All data is for FY 2013 through May 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 scores for quarters 3–4 of FY 2012 and quarters 1–2 of FY 2013 and overall outpatient satisfaction scores for FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2012	FY 2013	FY 2012			
	Inpatient Score Quarters 3–4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	64.4	62.3	62.1	61.7	58.1	62.3
VISN	66.0	67.0	59.2	59.0	57.4	59.6
VHA	65.0	65.5	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	15.2	9.8	13.0	19.5	26.9	23.4
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: August 27, 2013

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

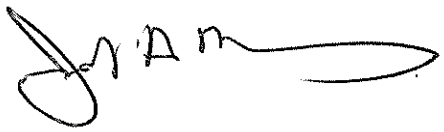
Subject: **CAP Review of the Edward Hines, Jr. VA Hospital, Hines, IL**

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 Hines VA Medical Center.

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



Jeffrey A. Murawsky, M.D.

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 27, 2013

From: Director, Edward Hines, Jr. VA Hospital (578/00)

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

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

1. I have reviewed the draft report for the Hines VA Hospital and concur with the findings and recommendations.

2. I appreciate the opportunity for this review as it provides for a continual process to improve care to our Veterans.

(original signed by:)
Joan M. Ricard, 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 processes be strengthened to ensure that ICC minutes reflect discussion of high-risk areas and actions implemented to address these areas.

Concur

Target date for completion: November 30, 2013

Facility response: All deemed high-risk areas assessed per the annual infection control risk assessment audit will be added as a standing agenda item to the monthly Infection Control Committee Meeting Agenda and documented in the committee minutes. All follow-up actions will be documented in the minutes and placed on the tracking tool until closure. Audits will be conducted by Quality and Systems Improvement quarterly to insure action items are closed within 90 days, if applicable.

Recommendation 2. We recommended that processes be strengthened to ensure that operating room employees who perform immediate use sterilization receive annual competency assessments.

Concur

Target date for completion: Completed August 23, 2013

Facility response: Training Schedules for annual competency assessments have been created, competency assessments have been conducted, and a Clinical Nurse Manager has completed an audit of the competencies, which reflects that all Operating Room employees have received annually competency assessments.

Recommendation 3. We recommended that processes be strengthened to ensure that inspectors consistently verify the three identified required drug destruction activities and that compliance be monitored.

Concur

Target date for completion: October 31, 2013

Facility response: Hines VA Hospital's Logistics, Controlled Substance Coordinator, and Pharma Logistics, a contractor, will strengthen the audit trail to show evidence of comparing drugs held for destruction with the destroyed drugs report. Logistics will witness Pharma Logistics' entry of the destruction into their database system and

forward the Drug Enforcement Administration (DEA) 41 Forms to the Controlled Substance Coordinator. The Controlled Substance Coordinator, along with the Controlled Substance Inspector, will complete audits of 10 drugs on each of 3 DEA forms submitted from Logistics. The Controlled Substance Coordinator will document all non-matching occurrences of controlled substance documentation from Logistics and Procurement and all audit results, along with action plans and resolutions, in the Monthly Controlled Substance Report. The Controlled Substance Coordinator will report quarterly to the Quality Council Committee to assure sustained adherence to the drug destruction process per Handbook 1108.02. Reporting to Quality Council will be reduced to twice per year after two compliant quarters are demonstrated.

Recommendation 4. We recommended that processes be strengthened to ensure that the PCCT includes a dedicated administrative support person.

Concur

Target date for completion: December 31, 2013

Facility response: Implement 0.25 dedicated staff by first quarter 2014.

Recommendation 5. 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 31, 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. Audits will be conducted by Facilities Management Service to insure that all ICRAs are complete and available within 60 days prior to the construction project start date.

OIG Contact and Staff Acknowledgments

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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 Materiel 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.