Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-02316-322

Combined Assessment Program Review of the Richard L. Roudebush VA Medical Center Indianapolis, Indiana

September 23, 2013

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CLC	community living center
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	Richard L. Roudebush VA Medical Center
FY	fiscal year
GRACE	Geriatric Resources for Assessment and Care of Elders
HPC	hospice and palliative care
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
PI	performance improvement
QM	quality management
RME	reusable medical equipment
RN	registered nurse
SOP	standard operating procedure
SPS	Sterile Processing Service
TMS	Talent Management System
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 July 15, 2013.

Review Results: The review covered seven activities and one follow-up review area from the previous Combined Assessment Program review. We made no recommendations in the following two activities:

- Quality Management
- Coordination of Care – Hospice and Palliative Care

The facility's reported accomplishments were the implementation of the Geriatric Resources for Assessment and Care of Elders Program and the Mobile Prosthetic Van Program.

Recommendations: We made recommendations in the following five activities and follow-up review area:

Environment of Care: Ensure Environment of Care Committee minutes reflect discussion regarding deficiencies identified during environment of care rounds and actions taken in response to those deficiencies. Require employees to wear gloves when in contact with patients on the hemodialysis unit. Ensure operating room employees who perform immediate use sterilization receive annual competency assessments. Require reusable medical equipment standard operating procedures to be consistent with manufacturers' instructions, and reprocess reusable medical equipment in accordance with standard operating procedures and manufacturers' instructions. Check Sterile Processing Service eyewash stations weekly, and document the checks.

Medication Management – Controlled Substances Inspections: Ensure all controlled substances (CS) inspectors complete the CS Drug-Diversion Inspection Certification prior to beginning CS inspections. Inspect all required non-pharmacy areas with CS, sufficiently rotate inspectors in inspection assignments, and randomly schedule inspections with no distinguishable patterns. Consistently complete a physical count of 10 line items for all unit and clinic areas during the 2nd and 3rd month of each quarter. Include monthly verification of seals in pharmacy emergency cache inspections. Ensure CS inspectors and the Chief of Pharmacy or designee consistently complete monthly inspections of the inpatient and outpatient pharmacies.

Pressure Ulcer Prevention and Management: Perform and document a patient skin inspection and risk scale upon transfer, upon change in condition, and at discharge. Accurately document location, stage, risk scale score, and date pressure ulcer acquired

for all patients with pressure ulcers. Perform and document daily skin inspections, daily risk scales, and daily monitoring for a change in condition for patients at risk for or with pressure ulcers. Perform and document daily monitoring for a change in condition for all hospitalized patients identified as not being at risk for pressure ulcers. Ensure all patients discharged with pressure ulcers have wound care follow-up plans and receive dressing supplies prior to being discharged. Establish staff pressure ulcer education requirements, and ensure designated employees receive training on how to administer the pressure ulcer risk scale and how to accurately document findings.

Nurse Staffing: Ensure each unit-based expert panel and the facility expert panel complete annual staffing plan reassessments. Require that all members of the unit-based and facility expert panels receive the required training prior to an annual staffing plan reassessment.

Construction Safety: Conduct contractor tuberculosis risk assessments prior to construction project initiation, and ensure all designated employees receive ongoing construction safety training.

Follow-Up on Environment of Care Issue: Ensure all designated employees complete respirator fit testing.

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 21–29, 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

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 and one follow-up review activity from the previous CAP review:

- QM
- EOC
- Medication Management – CS Inspections
- Coordination of Care – HPC
- Pressure Ulcer Prevention and Management
- Nurse Staffing
- Construction Safety
- Follow-Up on EOC Issue

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

The review covered facility operations for FY 2012 and FY 2013 through July 19, 2013, and was done in accordance with OIG SOPs 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 Richard L. Roudebush VA Medical Center, Indianapolis, Indiana,* Report No. 10-03092-129, March 23, 2011). We made a repeat recommendation in EOC.

During this review, we presented crime awareness briefings for 175 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 205 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

GRACE Program

The GRACE Program is an in-home care management program that works in collaboration with the Patient Aligned Care Team to provide ongoing care to complex veterans age 65 and older who are at risk for functional decline and institutionalization due to medical, geriatric, and psychosocial conditions. Since the program's inception in April 2010, the GRACE program has served more than 400 frail veterans and their caregivers and has demonstrated: (1) a 17 percent lower hospitalization rate, (2) 19 percent fewer bed days of care, (3) a 44 percent lower mortality rate, (4) a 46 percent reduction in 30-day readmission rate, and (5) high levels of customer satisfaction.

Mobile Van Project

The Mobile Prosthetic Van Program is the first of its type to be rolled out in the VA health care system and is designed to provide prosthetic specialty care to CBOCs on a rotating basis. The team is comprised of a certified orthotist/prosthetist, an occupational therapist, and a kinesiotherapist and is able to scan, fabricate, and fit a wide array of orthotics, prosthetics, and assistive technology devices. Additionally, if needed, assistive technologists make home visits.

Since its inception in April 2012, the program has increased the number of visits from 198 in FY 2012 to 411 in FY 2013. In addition, the scheduled appointment no-show rate for the Mobile Prosthetic Van Program is less than 3 percent. Veterans have voiced satisfaction with their appointments at the CBOCs since they are no longer required to travel long distances to the facility.

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/PI, 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.	
NA	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 PI over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/PI 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 inpatient units (acute medical/surgical, locked mental health, and medical and surgical intensive care), outpatient clinics (mental health, primary care, and specialty care), the hemodialysis unit, the emergency department, and SPS. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 39 employee training and competency files (19 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
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	Six months of EOC Committee meeting minutes reviewed: • Minutes did not reflect discussion regarding deficiencies identified during EOC rounds.
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	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.	
X	Selected EOC/infection prevention/safety requirements were met.	• We observed one of the six employees not wearing gloves when in contact with patients on the inpatient hemodialysis unit.
	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.	• There was no evidence that any of the seven operating room employees on duty for more than 2 years who performed immediate use sterilization received annual competency assessments.
X	RME SOPs were consistent with manufacturers' instructions, procedures were located where reprocessing occurs, and sterilization was performed as required.	RME SOPs, manufacturers' instructions, and 1 day of sterilization logs for 7 RME items reviewed: • Three of the SOPs were not consistent with manufacturers' instructions. • The sterilization time for three of the items and the reprocessing procedure for one item did not match the SOPs and manufacturers' instructions.
X	Selected infection prevention/environmental safety requirements were met.	Three months of inspection records for three eyewash stations reviewed: • Two weekly checks were missing for each eyewash station.
	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 EOC Committee minutes reflect discussion regarding deficiencies identified during EOC rounds and actions taken in response to those deficiencies.

2. We recommended that processes be strengthened to ensure that employees wear gloves when in contact with patients on the hemodialysis unit and that compliance be monitored.

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

4. We recommended that processes be strengthened to ensure that RME SOPs are consistent with manufacturers' instructions and that RME is reprocessed in accordance with SOPs and manufacturers' instructions and that compliance be monitored.

5. We recommended that processes be strengthened to ensure that SPS eyewash stations are checked weekly and the checks 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 areas 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.	
X	CS inspectors were appointed in writing, completed required certification and training, and were free from conflicts of interest.	Certifications reviewed: • Two CS inspectors did not complete the CS Drug-Diversion Inspection Certification prior to beginning CS inspections.
X	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	Documentation of 10 CS areas inspected during the past 6 months reviewed: • Four required areas were not inspected. • Inspectors were not sufficiently rotated in inspection assignments. • Distinguishable patterns were identified, and most inspections were performed during the last week of the month. • A physical count of 10 line items for all unit and clinic areas during the 2nd and 3rd month of each quarter was not consistently completed.

NC	Areas Reviewed (continued)	Findings
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: • Pharmacy emergency cache inspections did not consistently include monthly verification of the seals. • CS inspectors and the Chief of Pharmacy or designee missed one monthly inspection of the inpatient and outpatient pharmacies.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

6. We recommended that processes be strengthened to ensure that all CS inspectors complete the CS Drug-Diversion Inspection Certification prior to beginning CS inspections.

7. We recommended that processes be strengthened to ensure that all required non-pharmacy areas with CS are inspected, that inspectors are sufficiently rotated in inspection assignments, and that inspections are randomly scheduled with no distinguishable patterns and that compliance be monitored.

8. We recommended that processes be strengthened to ensure that a physical count of 10 line items for all unit and clinic areas during the 2nd and 3rd month of each quarter is consistently completed and that compliance be monitored.

9. We recommended that processes be strengthened to ensure that pharmacy emergency cache inspections include monthly verification of seals and that compliance be monitored.

10. We recommended that processes be strengthened to ensure that CS inspectors and the Chief of Pharmacy or designee consistently complete monthly inspections of the inpatient and outpatient pharmacies and that compliance be monitored.

Coordination of Care – HPC

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

We reviewed relevant documents, 20 EHRs of patients who had PCCT consults, and 23 employee training records (8 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.	
	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, 22 EHRs of patients with pressure ulcers (10 patients with hospital-acquired pressure ulcers, 10 patients with community-acquired pressure ulcers, and 2 patients with pressure ulcers at the time of our onsite visit), and 10 employee training records. Additionally, we inspected two 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
	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.	
X	Skin inspections and risk scales were performed upon transfer, change in condition, and discharge.	• Six of the applicable 20 EHRs did not contain documentation that a skin inspection and risk scale were performed upon transfer, upon change in condition, and/or at discharge.
X	Staff were generally consistent in documenting location, stage, risk scale score, and date acquired.	• In 16 of the 22 EHRs, staff did not consistently document the location, stage, risk scale score, and/or date acquired.
X	Required activities were performed for patients determined to be at risk for pressure ulcers and for patients with pressure ulcers.	• Seven of the applicable 18 EHRs did not contain consistent documentation that staff performed daily skin inspections, daily risk scales, and/or daily monitoring for a change in condition.
X	Required activities were performed for patients determined to not be at risk for pressure ulcers.	• Two of the applicable four EHRs contained no documentation that staff monitored patients daily for change in condition.
	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.	

NC	Areas Reviewed (continued)	Findings
X	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.	• Of the applicable six EHRs, one did not contain evidence of a wound care follow-up plan at discharge, and two did not contain evidence that patients received dressing supplies prior to discharge.
	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.	VHA pressure ulcer staff education requirements reviewed: • The facility had not developed staff pressure ulcer education requirements. • Four employee training records did not contain evidence of how to administer the pressure ulcer risk scale and how to 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.	

Recommendations

11. We recommended that processes be strengthened to ensure that acute care staff perform and document a patient skin inspection and risk scale upon transfer, upon change in condition, and at discharge and that compliance be monitored.

12. We recommended that processes be strengthened to ensure that acute care staff accurately document location, stage, risk scale score, and date pressure ulcer acquired for all patients with pressure ulcers and that compliance be monitored.

13. We recommended that processes be strengthened to ensure that acute care staff perform and document daily skin inspections, daily risk scales, and daily monitoring for a change in condition for patients at risk for or with pressure ulcers and that compliance be monitored.

14. We recommended that processes be strengthened to ensure that acute care staff perform and document daily monitoring for a change in condition for all hospitalized patients identified as not being at risk for pressure ulcers and that compliance be monitored.

15. We recommended that processes be strengthened to ensure that all patients discharged with pressure ulcers have wound care follow-up plans and receive dressing supplies prior to being discharged and that compliance be monitored.

16. We recommended that the facility establish staff pressure ulcer education requirements and that designated employees receive training on how to administer the pressure ulcer risk scale and how to accurately document findings 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 two inpatient units (acute medical/surgical 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 7 North and mental health unit 5 East 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 areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
	The facility completed the required steps to develop a nurse staffing methodology by the deadline.	
X	The unit-based expert panels followed the required processes and included all required members.	• The unit-based expert panels did not complete an annual reassessment.
X	The facility expert panel followed the required processes and included all required members.	• The facility expert panel did not complete an annual reassessment.
X	Members of the expert panels completed the required training.	• Seven of the eight members of the unit-based expert panels had not completed the required training. • Eight of the 17 members of the facility expert panel had not 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.	

Recommendations

17. We recommended that each unit-based expert panel and the facility expert panel complete annual staffing plan reassessments.

18. We recommended that all members of the unit-based and facility expert panels receive the required training prior to an annual staffing plan reassessment.

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 Convert the Pneumatics to Digital Direct Controls 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 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 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 the project's initiation.
	There was documentation of results of contractor tuberculosis skin testing and of follow-up on any positive results.	
	There was a policy addressing Interim Life Safety Measures, and required Interim Life Safety Measures were documented.	
	Site inspections were conducted by the required multidisciplinary team members at the specified frequency and included all required elements.	
	Infection Control Committee minutes documented infection surveillance activities associated with the project and any interventions.	
	Construction Safety Committee minutes documented any unsafe conditions found during inspections and any follow-up actions and tracked actions to completion.	
X	Contractors and designated employees received required training.	Employee and contractor training records reviewed: • Two employee records did not contain evidence of at least 10 hours of construction safety-related training in the past 2 years.

NC	Areas Reviewed (continued)	Findings
	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

19. We recommended that processes be strengthened to ensure that contractor tuberculosis risk assessments are conducted prior to construction project initiation.

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

Review Activity with Previous CAP Recommendations

Follow-Up on EOC Issue

As a follow-up to a recommendation from our prior CAP review, we reassessed facility compliance with respirator fit testing.

Respirator Fit Testing. VHA requires facilities using N95 and other types of respirators to fit test designated employees annually.[8] The respirator fit testing compliance rate for all designated employees at the facility for FY 2013 was 34 percent.

Recommendation

21. We recommended that processes be strengthened to ensure that all designated employees complete respirator fit testing and that compliance be monitored.

Facility Profile (Indianapolis/583) 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	$430
Number (through June 2013) of:	
• **Unique Patients**	53,427
• **Outpatient Visits**	430,080
• **Unique Employees**[b]	3,077
Type and Number of Operating Beds:	
• **Hospital**	159
• **CLC**	NA
• **Mental Health**	50
Average Daily Census:	
• **Hospital**	122
• **CLC**	NA
• **Mental Health**	43
Number of CBOCs	3
Location(s)/Station Number(s)	Terre Haute/583GA Bloomington/583GB Martinsville/583GC
VISN Number	11

[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	67.4	62.7	48.9	54.4	50.8	50.8
VISN	65.0	64.6	53.0	56.7	54.1	54.7
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.

Table 2

	Mortality			Readmission		
	Heart Attack	Heart Failure	Pneumonia	Heart Attack	Heart Failure	Pneumonia
Facility	15.9	10.2	9.6	21.3	26.1	18.3
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.

Appendix C

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 3, 2013

From: Director, Veterans in Partnership (10N11)

Subject: **CAP Review of the Richard L. Roudebush VA Medical Center, Indianapolis, IN**

To: Director, Kansas City Office of Healthcare Inspections (54KC)

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

Per your request, attached is the report from the Richard L. Roudebush VA Medical Center. If you have any questions, please contact Dr. Cynthia Paterson, VISN 11 Acting QMO, at (734) 222-4302.

for Paul D. Bockelman, FACHE

Appendix D

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 3, 2013

From: Director, Richard L. Roudebush VA Medical Center (583/00)

Subject: **CAP Review of the Richard L. Roudebush VA Medical Center, Indianapolis, IN**

To: Director, Veterans in Partnership (10N11)

This memorandum serves as our concurrence with the recommendations found in the draft report of the Inspector General's Combined Assessment Program Review of the Richard L. Roudebush VA Medical Center.

I appreciate the opportunity for this review as a continuous process to improve the care to our Veterans.

Thank You

Thomas Mattice, FACHE
Richard L. Roudebush VA Medical Center Director

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 EOC Committee minutes reflect discussion regarding deficiencies identified during EOC rounds and actions taken in response to those deficiencies.

Concur: Yes

Target date for completion: September 30, 2013

EOC deficiency reports, corrective actions, and follow-up reports will be presented monthly to the EOC Board.

Recommendation 2. We recommended that processes be strengthened to ensure that employees wear gloves when in contact with patients on the hemodialysis unit and that compliance be monitored.

Concur: Yes

Target date for completion: October 15, 2013

Dialysis staff were re-educated on required hand hygiene practices by the Dialysis Unit Manager on July 22, 2013. The Unit Manager will provide on the spot education with staff found not adhering to the facility policy. An educational blitz to include hand hygiene, aseptic technique versus sterile technique and Center for Disease Control recommendations for dialysis will be held on September 24, 2013, for all dialysis staff. Patient education will be provided quarterly via the monthly patient newsletter encouraging patients to remind staff to wear gloves and/or wash their hands. Hand hygiene compliance will be monitored and reported monthly to Nursing PI Committee.

Recommendation 3. We recommended that processes be strengthened to ensure that operating room employees who perform immediate use sterilization receive annual competency assessments.

Concur: Yes

Target date for completion: July 16, 2013

Immediate use sterilization annual competency assessments were completed on July 16, 2013. An annual competency fair for the Operating Room staff will be held each December.

Recommendation 4. We recommended that processes be strengthened to ensure that RME SOPs are consistent with manufacturers' instructions and that RME is reprocessed in accordance with SOPs and manufacturers' instructions and that compliance be monitored.

Concur: Yes

Target date for completion: September 30, 2013

SOPs identified were updated to reflect the manufacturers' recommendation on July 19, 2013. A rotating schedule has been developed to review/compare all facility RME SOPs with manufacturer's instructions. The Assistant Chief and Evening Supervisor for SPS will ensure staff demonstrate/verbalize competency as SOPs and sterilization parameters are updated and the sterilization parameters will be added to the Count sheets as a visual cue to staff. The RME committee will be updated monthly on new and/or updated SOPs and staff competency related to the new and /or updated SOPs to ensure sustainability/compliance.

Recommendation 5. We recommended that processes be strengthened to ensure that SPS eyewash stations are checked weekly and the checks documented and that compliance be monitored.

Concur: Yes

Target date for completion: September 15, 2013

August 5, 2013, began the process of testing eye wash stations weekly and the shower testing monthly with documentation on a standard form to include the location of each eye wash station. The record of documentation will be maintained in the SPS area. The Chief and Assistant Chief of SPS will review the eyewash inspection form weekly for compliance with weekly and monthly testing of equipment.

Recommendation 6. We recommended that processes be strengthened to ensure that all CS inspectors complete the CS Drug-Diversion Inspection Certification prior to beginning CS inspections.

Concur: Yes

Target date for completion: October 1, 2013

All CS inspectors will have TMS module and annual classroom training assigned. Until confirmation by the CS Coordinator for each CS inspector via receipt of certification of completion from TMS and documentation of class participation, the CS inspector will not be allowed to perform inspections.

Recommendation 7. We recommended that processes be strengthened to ensure that all required non-pharmacy areas with CS are inspected, that inspectors are sufficiently

rotated in inspection assignments, and that inspections are randomly scheduled with no distinguishable patterns and that compliance be monitored.

Concur: Yes

Target date for completion: September 30, 2013

Controlled Substance coordinator will assign four independent CS inspectors to inspect MedSelect areas on a rotating basis. A schedule will be maintained by the CS Coordinator of areas inspected by each CS inspector to ensure compliance with assignments.

Recommendation 8. We recommended that processes be strengthened to ensure that a physical count of 10 line items for all unit and clinic areas during the 2nd and 3rd month of each quarter is consistently completed and that compliance be monitored.

Concur: Yes

Target date for completion: September 30, 2013

The audit tool will be located on the CS Inspector SharePoint site for use. As part of the education, the CS Inspectors will be instructed to place "n/a" in unused spaces on the inspection form to demonstrate all items reviewed and documented if applicable. The CS Coordinator will monitor to ensure the physical count of 10 line items is completed.

Recommendation 9. We recommended that processes be strengthened to ensure that pharmacy emergency cache inspections include monthly verification of seals and that compliance be monitored.

Concur: Yes

Target date for completion: September 30, 2013

Documentation form is being updated and will require CS inspector to submit a copy of the Inventory Sheet for Disaster Vault where cache tote tags are recorded. The CS Coordinator will monitor for compliance.

Recommendation 10. We recommended that processes be strengthened to ensure that CS inspectors and the Chief of Pharmacy or designee consistently complete monthly inspections of the inpatient and outpatient pharmacies and that compliance be monitored.

Concur: Yes

Target date for completion: September 30, 2013

Pharmacy documentation of monthly inspections will be reviewed by CS Coordinator at time of submission to ensure all required documentation is accounted for.

Recommendation 11. We recommended that processes be strengthened to ensure that acute care staff perform and document a patient skin inspection and risk scale upon transfer, upon change in condition, and at discharge and that compliance be monitored.

Concur: Yes

Target date for completion: October 1, 2013

The most recent electronic nursing skin assessment note will automatically populate the accepting RN's transfer note and RN discharge note. Daily and monthly feedback of compliance is provided to the Unit Managers. For patients with change in condition, the unit charge nurse will receive daily reports of unit specific reassessments. Summary compliance will be reported to Nursing PI monthly.

Recommendation 12. We recommended that processes be strengthened to ensure that acute care staff accurately document location, stage, risk scale score, and date pressure ulcer acquired for all patients with pressure ulcers and that compliance be monitored.

Concur: Yes

Target date for completion: October 1, 2013

The nursing skin assessment template is being revised to include forced functions to ensure that patients with hospital acquired pressure ulcers will have the location, stage, risk scale score and date pressure ulcer acquired consistently and accurately documented. Daily monitoring by the wound/ostomy RNs and feedback to the Unit Manager on inconsistent or inaccurate documentation will be done and monthly unit-specific reports will be monitored and reported to the Nursing PI committee. Monthly review of the VA Nursing Outcomes Database Skin Risk Reassessment report by the Wound/Ostomy RNs with compliance included on the unit-specific report cards.

Recommendation 13. We recommended that processes be strengthened to ensure that acute care staff perform and document daily skin inspections, daily risk scales, and daily monitoring for a change in condition for patients at risk for or with pressure ulcers and that compliance be monitored.

Concur: Yes

Target date for completion: October 1, 2013

Unit-specific skin reassessment reports are printed daily for review by the unit Charge Nurse. The Charge Nurse reviews the report and ensures the reassessment is completed and records the information on a monitor. Immediate feedback will be provided and a monthly report of compliance will be discussed at the Nursing PI meeting.

Recommendation 14. We recommended that processes be strengthened to ensure that acute care staff perform and document daily monitoring for a change in condition for all hospitalized patients identified as not being at risk for pressure ulcers and that compliance be monitored.

Concur: Yes

Target date for completion: September 30, 2013

Unit-specific skin reassessment reports are printed daily for review by the unit Charge Nurse. The Charge Nurse reviews the report and ensures the reassessment is completed and records the information on a monitor. Immediate feedback will be provided and a monthly report of compliance will be discussed at the Nursing PI meeting.

Recommendation 15. We recommended that processes be strengthened to ensure that all patients discharged with pressure ulcers have wound care follow-up plans and receive dressing supplies prior to being discharged and that compliance be monitored.

Concur: Yes

Target date for completion: September 30, 2013

The physician and RN discharge templates are being revised to ensure that patients discharged with pressure ulcers have wound care follow-up plans and dressing supplies ordered. Monthly reports will be generated to monitor patients discharged with pressure ulcers who have wound care follow-up plans and dressing supplies ordered. Unit-specific compliance reports will be distributed to Nursing Unit Managers and Medical Staff.

Recommendation 16. We recommended that the facility establish staff pressure ulcer education requirements and that designated employees receive training on how to administer the pressure ulcer risk scale and how to accurately document findings and that compliance be monitored.

Concur: Yes

Target date for completion: March 31, 2014

By October 30, 2013, a computerized training module (TMS Competency for Pressure Ulcers) including how to administer the pressure ulcer risk scale and how to accurately document findings is being revised and will be mandatory for all inpatient RNs. A computerized training module is being revised (Pressure Ulcer Prevention) for all inpatient Licensed Practical Nurses, Nursing Assistants and Health Technicians and will be completed by October 30, 2013. Compliance with training completion will be tracked monthly and reported to Unit Managers and Nurse Executive Team. All designated current employees and new staff will complete the training modules by March 31, 2014.

Recommendation 17. We recommended that each unit-based expert panel and the facility expert panel complete annual staffing plan reassessments.

Concur: Yes

Target date for completion: October 15, 2013

The unit-based expert panels are collecting and reviewing trended data. The implementation date for completing the annual staffing plan reassessments is September 27, 2013. The Associate Director for Patient Care Services will ensure the staffing plan reassessments are completed by the unit-based expert panels on an annual basis.

The implementation date for the facility expert panel to conduct the annual staffing plan reassessment is October 2, 2013. The Associate Director for Patient Care Services will ensure the staffing plan reassessment is completed by the facility expert panel on an annual basis.

Recommendation 18. We recommended that all members of the unit-based and facility expert panels receive the required training prior to an annual staffing plan reassessment.

Concur: Yes

Target date for completion: July 19, 2013

All required training for members of unit-based panels and the facility expert panel was completed (100%) on July 19, 2013. New members of the unit-based panels and the facility expert panel will complete training within 30 days of joining the panel. A compliance report will be run quarterly with feedback to the appropriate unit managers, supervisors and service chiefs.

Recommendation 19. We recommended that processes be strengthened to ensure that contractor tuberculosis risk assessments are conducted prior to construction project initiation.

Concur: Yes

Target date for completion: October 1, 2013

A Pre-construction Risk Assessment (PCRA) checklist has been developed to be completed by the Project Engineer on which the infection prevention coordinator will sign and date for verification of the assessment of risk for Tuberculosis transmission to contractors has been completed during the design and planning stage of the project/renovation. The Project Engineer will track all PCRAs and if not completed in its entirety, the bidding for the proposed project will not proceed. Compliance will be reported monthly to EOC Board indicating the number of projects or that there are no new projects requiring the PCRA.

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

Concur: Yes

Target date for completion: September 30, 2013

A list of employees identified as requiring ongoing safety training will be maintained electronically and reviewed monthly for compliance. Notification of non-compliance will be sent to the employee and Service Chief. Compliance will be monitored monthly and reported to the EOC Board.

Recommendation 21. We recommended that processes be strengthened to ensure that all designated employees complete respirator fit testing and that compliance be monitored.

Concur: Yes

Target date for completion: September 15, 2013

Medical Center wide annual fit test bonanza began on August 12, 2013, for designated employees requiring N95 fit testing. Safety Service will monitor compliance and ensure new employees identified as needing N95 training will receive it within 30 days of hire. A N95 fit test bonanza will be scheduled annually.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Onsite Contributors	Larry Selzler, MSPT, Team Leader John Brooks Cindy Niemack-Brown, CMSW, LMHP James Seitz, RN, MBA Laura Snow, LMSW, MHCL Ann Ver Linden, RN, MBA
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Paula Chapman, CTRS Lin Clegg, PhD Marnette Dhooghe, MS Matt Frazier, MPH Jeff Joppie, BS Victor Rhee, MHS Julie Watrous, RN, MS Jennifer Whitehead Jarvis Yu, MS

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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, and the International Association of Healthcare Central Service Materiel Management, 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.

[8] The reference used for this topic was:
- Under Secretary for Health, "Respiratory Protection Used for Infectious Disease and Annual Fit-Testing," Information Letter 10-2012-012, August 2, 2012.