Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-04219-98

Combined Assessment Program Review of the VA Illiana Health Care System Danville, Illinois

February 2, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

CAP	Combined Assessment Program
CLC	community living center
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	VA Illiana Health Care System
FY	fiscal year
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
RRTP	residential rehabilitation treatment program
VHA	Veterans Health Administration

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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 November 3, 2014.

Review Results: The review covered eight activities and a follow-up review area from the previous Combined Assessment Program review. The facility's reported accomplishments were the chronic pain care school symposium and the healthy smiles for veterans initiative.

Recommendations: We made recommendations in all eight of the following activities and in the follow-up review area:

Quality Management: Ensure code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

Environment of Care: Ensure patient care areas are clean. Document functionality checks of the community living center's elopement prevention system at least every 24 hours.

Medication Management: Revise the policy for safe use of automated dispensing machines to include employee training and minimum competency requirements for users.

Coordination of Care: Create/designate a committee to oversee consult management. Require that the Medicine, Mental Health, Surgical, and Rehabilitation Services' Automated Data Processing Applications Coordinators provide training in the use of the computerized consult package.

Magnetic Resonance Imaging Safety: Ensure radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan. Require that scanned magnetic resonance imaging documents are accurate and complete.

Acute Ischemic Stroke Care: Develop and implement an acute ischemic stroke policy that addresses all required items. Complete and document National Institutes of Health stroke scales for each stroke patient. Screen patients for difficulty swallowing prior to oral intake.

Emergency Airway Management: Revise the emergency airway management policy to include demonstration of competency by both direct and video laryngoscopy. Ensure clinician reassessment for continued emergency airway management competency includes reviews of clinician-specific emergency airway management data and one of the three required components.

Mental Health Residential Rehabilitation Treatment Program: Ensure the Psychosocial Residential Rehabilitation Treatment Program environment is clean. Replace stained ceiling tiles, repair or replace damaged baseboards and wall tiles, and repair the emergency exit door.

Follow-Up on Medication Management Issue: Document all required vaccination administration elements.

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 28–35, 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
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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 eight activities and a follow-up review area from the previous CAP review:

- QM
- EOC
- Medication Management
- Coordination of Care
- MRI Safety
- Acute Ischemic Stroke Care
- EAM
- MH RRTP
- Follow-Up on Medication Management 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 2014 and FY 2015 through November 7, 2014, 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 VA Illiana Health Care System, Danville, Illinois,* Report No.11-03665-78, February 14, 2012). We made a repeat recommendation in medication management.

During this review, we presented crime awareness briefings for 91 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 389 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

Chronic Pain Care School Symposium

In September 2014, the facility hosted a regional daylong symposium, which highlighted chronic pain care and the Opioid Safety Initiative. The presenters were distinguished pain specialty physicians from VA facilities in Atlanta, GA, and Richmond, VA, and a clinical pain neurologist from Indianapolis, IN. The Tele-Pain symposium was broadcast to more than 49 VA facilities and expanded to community based outpatient clinic locations.

Healthy Smiles for Veterans Initiative

Partnering with Dental, Geriatric, and Nursing Services, the facility rolled out the healthy smiles for veterans initiative in the CLCs and the Green House homes. The focus was to increase staff awareness of oral care, reduce oral care interventions for dependent residents, and promote better oral care for independent residents. Oral care training was provided to 168 CLC staff from May through August 2014 and was accomplished through completion of a 1-hour module and by demonstration of competency in five areas.

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 met selected requirements within its QM program.[a]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, three credentialing and privileging folders, and other relevant documents. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	There was a senior-level committee responsible for key quality, safety, and value functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data. • QM, patient safety, and systems redesign appeared to be integrated.		
NA	Peer reviewed deaths met selected requirements: • Peers completed reviews within specified timeframes. • The Peer Review Committee reviewed cases receiving initial Level 2 or 3 ratings. • Involved providers were invited to provide input prior to the final Peer Review Committee determination.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Credentialing and privileging processes met selected requirements: • Facility managers reviewed privilege forms annually and ensured proper approval of revised forms. • Facility managers ensured appropriate privileges for licensed independent practitioners. • Facility managers removed licensed independent practitioners' access to patients' EHRs upon separation. • Facility managers properly maintained licensed independent practitioners' folders.		
	Observation bed use met selected requirements: • The facility gathered data regarding appropriateness of observation bed usage. • The facility reassessed observation criteria and/or utilization if conversions to acute admissions were consistently 25–30 percent or more.		
X	The process to review resuscitation events met selected requirements: • An interdisciplinary committee reviewed episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • The facility collected data that measured performance in responding to events.	Twelve months of Multidisciplinary Oversight Committee meeting minutes reviewed: • Code review did not include screening for clinical issues prior to code that may have contributed to the occurrence of the code.	**1.** We recommended that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

NM	Areas Reviewed (continued)	Findings	Recommendations
NA	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement. • The Surgical Work Group reviewed additional data elements.		
	Clinicians appropriately reported critical incidents.		
	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.		
	The process to review the quality of entries in the EHR met selected requirements: • A committee reviewed EHR quality. • A committee analyzed data at least quarterly. • Reviews included data from most services and program areas.		
	The policy for scanning internal forms into EHRs included the following required items: • Quality of the source document and an alternative means of capturing data when the quality of the document is inadequate. • A correction process if scanned items have errors.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	• A complete review of scanned documents to ensure readability and retrievability of the record and quality assurance reviews on a sample of the scanned documents.		
	Overall, if QM reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in performance improvement over the past 12 months.		
	Overall, the facility had a comprehensive, effective QM program over the past 12 months.		
	The facility met 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. We also determined whether the facility met selected requirements in the CLC.[b]

We inspected the CLC, inpatient units (acute medicine and MH), outpatient clinics (physical therapy, primary care, and surgery), the endoscopy suite, and the urgent care clinic. Additionally, we reviewed relevant documents and 24 CLC employee training records and conversed with key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings	Recommendations
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.		
	The facility conducted an infection prevention risk assessment.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.		
	The facility had established a process for cleaning equipment.		
	Selected employees received training on updated requirements regarding chemical labeling and safety data sheets.		
	The facility met fire safety requirements.		
X	The facility met environmental safety requirements.	• Two of seven patient care areas had dirty floors and horizontal surfaces.	**2.** We recommended that facility managers ensure patient care areas are clean and monitor compliance.

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility met infection prevention requirements.		
	The facility met medication safety and security requirements.		
	The facility met privacy requirements.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Critical Care		
NA	Designated critical care employees received bloodborne pathogens training during the past 12 months.		
NA	Alarm-equipped medical devices used in critical care were inspected/checked according to local policy and/or manufacturers' recommendations.		
NA	The facility met fire safety requirements in critical care.		
NA	The facility met environmental safety requirements in critical care.		
NA	The facility met infection prevention requirements in critical care.		
NA	The facility met medication safety and security requirements in critical care.		
NA	The facility met medical equipment requirements in critical care.		
NA	The facility met privacy requirements in critical care.		
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

NM	Areas Reviewed for CLC	Findings	Recommendations
	Designated CLC employees received bloodborne pathogens training during the past 12 months.		
	For CLCs with resident animal programs, the facility conducted infection prevention risk assessments and had policies addressing selected requirements.		
X	For CLCs with elopement prevention systems, the facility documented functionality checks at least every 24 hours and documented complete system checks annually.	• The facility did not consistently document functionality checks of the CLC's elopement prevention system at least every 24 hours.	**3.** We recommended that the facility document functionality checks of the community living center's elopement prevention system at least every 24 hours and that facility managers monitor compliance.
	The facility met fire safety requirements in the CLC.		
X	The facility met environmental safety requirements in the CLC.	• Three occupied rooms had dirty floors, window blinds, and windowsills.	See recommendation 2.
	The facility met infection prevention requirements in the CLC.		
	The facility met medication safety and security requirements in the CLC.		
	The facility met medical equipment requirements in the CLC.		
	The facility met privacy requirements in the CLC.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Construction Safety		
NA	The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter.		

NM	Areas Reviewed for Construction Safety (continued)	Findings	Recommendations
NA	The facility complied with any additional elements required by VHA or local policy, or other regulatory standards.		

Medication Management

The purpose of this review was to determine whether the facility had established safe medication storage practices in accordance with VHA policy and Joint Commission standards.[c]

We reviewed relevant documents, the training records of 20 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected the acute medicine unit, CLC, post-anesthesia care unit, and urgent care clinic and for these areas reviewed documentation of overrides and narcotic wastage from automated dispensing machines and inspected crash carts containing emergency medications. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	Facility policy addressed medication receipt in patient care areas, storage procedures until administration, and staff authorized to have access to medications and areas used to store them.		
	The facility required two signatures on controlled substances partial dose wasting.		
	The facility defined those medications and supplies needed for emergencies and procedures for crash cart checks, checks included all required elements, and the facility conducted checks with the frequency required by local policy.		
	The facility prohibited storage of potassium chloride vials in patient care areas.		
	If the facility stocked heparin in concentrations of more than 5,000 units per milliliter in patient care areas, the Chief of Pharmacy approved it.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility maintained a list of the look-alike and sound-alike medications it stores, dispenses, and administers; reviewed this list annually and ensured it was available for staff reference; and had labeling/storage processes to prevent errors.		
	The facility identified in writing its high-alert and hazardous medications, ensured the high-alert list was available for staff reference, and had processes to manage these medications.		
	The facility conducted and documented inspections of all medication storage areas at least every 30 days, fully implemented corrective actions, and monitored the changes.		
X	The facility/Pharmacy Service had a written policy for safe use of automated dispensing machines that included oversight of overrides and employee training and minimum competency requirements for users, and employees received training or competency assessment in accordance with local policy.	• Facility policy for safe use of automated dispensing machines did not include employee training and minimum competency requirements for users.	**4.** We recommended that the facility revise the policy for safe use of automated dispensing machines to include employee training and minimum competency requirements for users and that facility managers monitor compliance.
	The facility employed practices to prevent wrong-route drug errors.		
	Medications prepared but not immediately administered contained labels with all required elements.		
	The facility removed medications awaiting destruction or stored them separately from medications available for administration.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility met multi-dose insulin pen requirements.		
	The facility complied with any additional elements required by VHA or local policy.		

Coordination of Care

The purpose of this review was to evaluate the consult management process and the completion of inpatient clinical consults.[d]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 27 randomly selected patients who had a consult requested during an acute care admission from January 1 through June 30, 2014. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
X	A committee oversaw the facility's consult management processes.	• The facility did not have a committee to oversee consult management.	**5.** We recommended that the facility create/designate a committee to oversee consult management.
X	Major bed services had designated employees to: • Provide training in the use of the computerized consult package. • Review and manage consults.	• The Medicine, MH, Surgical, and Rehabilitation Services' Automated Data Processing Applications Coordinators did not provide training in the use of the computerized consult package.	**6.** We recommended that the Medicine, Mental Health, Surgical, and Rehabilitation Services' Automated Data Processing Applications Coordinators provide training in the use of the computerized consult package and that facility managers monitor compliance.
	Consult requests met selected requirements: • Requestors included the reason for the consult. • Requestors properly titled the requests. • Consultants appropriately changed consult statuses, linked responses to the requests, and completed consults within the specified timeframe.		
	The facility met any additional elements required by VHA or local policy.		

MRI Safety

The purpose of this review was to determine whether the facility ensured safety in MRI in accordance with VHA policy requirements related to: (1) staff safety training, (2) patient screening, and (3) risk assessment of the MRI environment.[e]

We reviewed relevant documents and the training records of 40 employees (23 Level 1 ancillary staff and 17 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 35 randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted a physical inspection of the MRI area. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility completed an MRI risk assessment, had documented procedures for handling emergencies in MRI, and conducted emergency drills in the MRI area.		
	Patients had two safety screenings conducted prior to MRI; the patient, family member, or caregiver signed the secondary patient safety screening form; and a Level 2 MRI personnel reviewed and signed the secondary patient safety screening form.		
X	Secondary patient safety screening forms contained notations of any MRI contraindications, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.	• Twenty-three of the 25 applicable EHRs did not contain documentation that a Level 2 MRI personnel and/or radiologist addressed all identified contraindications prior to MRI.	**7.** We recommended that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that facility managers monitor compliance.
	The facility designated Level 1 ancillary staff and Level 2 MRI personnel and ensured they received level-specific annual MRI safety training.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility had signage and barriers in place to prevent unauthorized or accidental access to Zones III and IV.		
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the facility regularly tested the two-way communication device.		
	The facility provided patients with MRI-safe hearing protection for use during the scan.		
	The facility had only MRI-safe or compatible equipment in Zones III and IV or appropriately protected the equipment from the magnet.		
X	The facility complied with any additional elements required by VHA or local policy.	VHA policy on health information management and health records reviewed, which requires that patient health records are accurate and complete: • Six EHRs contained inaccurate and incomplete scanned MRI documents.	**8.** We recommended that scanned magnetic resonance imaging documents are accurate and complete and that facility managers monitor compliance.

Acute Ischemic Stroke Care

The purpose of this review was to determine whether the facility complied with selected requirements for the assessment and treatment of patients who had an acute ischemic stroke.[f]

We reviewed relevant documents, the EHRs of 13 patients who experienced stroke symptoms, and 10 employee training records (five urgent care clinic and five acute medicine unit), and we conversed with key employees. We also conducted onsite inspections of the urgent care clinic, the acute medicine unit, three MH units, and seven CLC units. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
X	The facility's stroke policy addressed all required items.	• The facility did not have a policy in place that addressed the management of acute ischemic stroke.	**9.** We recommended that the facility develop and implement an acute ischemic stroke policy that addresses all required items.
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• For two of the eight applicable patients, clinicians did not document evidence of completed stroke scales.	**10.** We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.
NA	Clinicians provided medication (tissue plasminogen activator) timely to halt the stroke and included all required steps, and the facility stocked tissue plasminogen activator in appropriate areas.		
	Facility managers posted stroke guidelines in all areas where patients may present with stroke symptoms.		
X	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	• For three of the nine applicable patients, clinicians did not document in the EHRs that they screened the patients for difficulty swallowing prior to oral intake.	**11.** We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance.
	Clinicians provided printed stroke education to patients upon discharge.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility provided training to employees involved in assessing and treating stroke patients.		
	The facility collected and reported required data related to stroke care.		
	The facility complied with any additional elements required by VHA or local policy.		

EAM

The purpose of this review was to determine whether the facility complied with selected VHA out of operating room airway management requirements.[g]

We reviewed relevant documents, including competency assessment documentation of six clinicians applicable for the review period January 1 through June 30, 2014, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a local EAM policy or had a documented exemption.		
NA	If the facility had an exemption, it did not have employees privileged to perform procedures using moderate or deep sedation that might lead to airway compromise.		
	Facility policy designated a clinical subject matter expert, such as the Chief of Staff or Chief of Anesthesia, to oversee EAM.		
X	Facility policy addressed key VHA requirements, including: • Competency assessment and reassessment processes. • Use of equipment to confirm proper placement of breathing tubes. • A plan for managing a difficult airway.	• Facility policy did not address that competency assessment must be demonstrated with both direct and video laryngoscopy.	**12.** We recommended that the facility revise the emergency airway management policy to include demonstration of competency by both direct and video laryngoscopy.
NA	Initial competency assessment for EAM included: • Subject matter content elements and completion of a written test. • Successful demonstration of procedural skills on airway simulators or mannequins. • Successful demonstration of procedural skills on patients.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Reassessments for continued EAM competency were completed at the time of renewal of privileges or scope of practice and included: • Review of clinician-specific EAM data. • Subject matter content elements and completion of a written test. • Successful demonstration of procedural skills on airway simulators or mannequins. • At least one occurrence of successful airway management and intubation in the preceding 2 years, written certification of competency by the supervisor, or successful demonstration of skills to the subject matter expert. • A statement related to EAM if the clinician was not a licensed independent practitioner.	• Neither of the two applicable clinicians had clinician-specific EAM data reviewed. • None of the six clinicians had evidence of successful airway management and intubation of at least one patient in the preceding 2 years, written certification of airway management competency from the evaluating supervisor at the non-VA facility, or successful demonstration of airway management and intubation skills to the facility subject matter expert.	**13.** We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes reviews of clinician-specific emergency airway management data and that facility managers monitor compliance. **14.** We recommended that the facility ensure that clinician reassessment for continued emergency airway management competency includes one of the three required components and that facility managers monitor compliance.
	The facility had a clinician with EAM privileges or scope of practice available during all hours the facility provided patient care.		
	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.		
	The facility complied with any additional elements required by VHA or local policy.		

MH RRTP

The purpose of this review was to determine whether the facility's Psychosocial RRTP complied with selected EOC requirements.[h]

We reviewed relevant documents, inspected the Psychosocial RRTP, and conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
X	The residential environment was clean and in good repair.	• The Psychosocial RRTP had dirty ceiling vents and floor baseboards, and the emergency exit door in the alcove of the women's wing was dirty. • The Psychosocial RRTP had stained ceiling tiles, damaged baseboards, and chipped wall tiles, and the emergency exit door sensor device wiring in the alcove of the women's wing needed repair.	**15.** We recommended that facility managers ensure the Psychosocial Residential Rehabilitation Treatment Program environment is clean and monitor compliance. **16.** We recommended that the facility ensure that Psychosocial Residential Rehabilitation Treatment Program stained ceiling tiles are replaced, damaged baseboards and chipped wall tiles are repaired or replaced, and the emergency exit door is repaired.
NA	Appropriate fire extinguishers were available near grease producing cooking devices.		
	There were policies/procedures that addressed safe medication management and contraband detection.		
	MH RRTP employees conducted and documented monthly MH RRTP self-inspections that included all required elements, submitted work orders for items needing repair, and ensured correction of any identified deficiencies.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	MH RRTP employees conducted and documented contraband inspections, rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications.		
	The MH RRTP had written agreements in place acknowledging resident responsibility for medication security.		
	MH RRTP main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed.		
	The MH RRTP had closed circuit television monitors with recording capability in public areas but not in treatment areas or private spaces and signage alerting veterans and visitors of recording.		
	There was a process for responding to behavioral health and medical emergencies, and MH RRTP employees could articulate the process.		
	In mixed gender MH RRTP units, women veterans' rooms had keyless entry or door locks, and bathrooms had door locks.		
	Residents secured medications in their rooms.		
	The facility complied with any additional elements required by VHA or local policy.		

Review Activity with Previous CAP Recommendations

Follow-Up on Medication Management Issue

As a follow-up to a recommendation from our prior CAP review, we reassessed facility compliance with vaccination documentation. We reviewed documentation of selected vaccine administration requirements and conversed with key personnel.

Vaccination Documentation. Federal law requires that documentation for administered vaccinations include specific elements, such as the vaccine manufacturer and lot number of the vaccine used.[i] The facility reported that their most recent compliance data from January 1 through March 31, 2014, indicated that clinicians did not document all required elements in 33 percent of influenza and 69 percent of tetanus vaccination records.

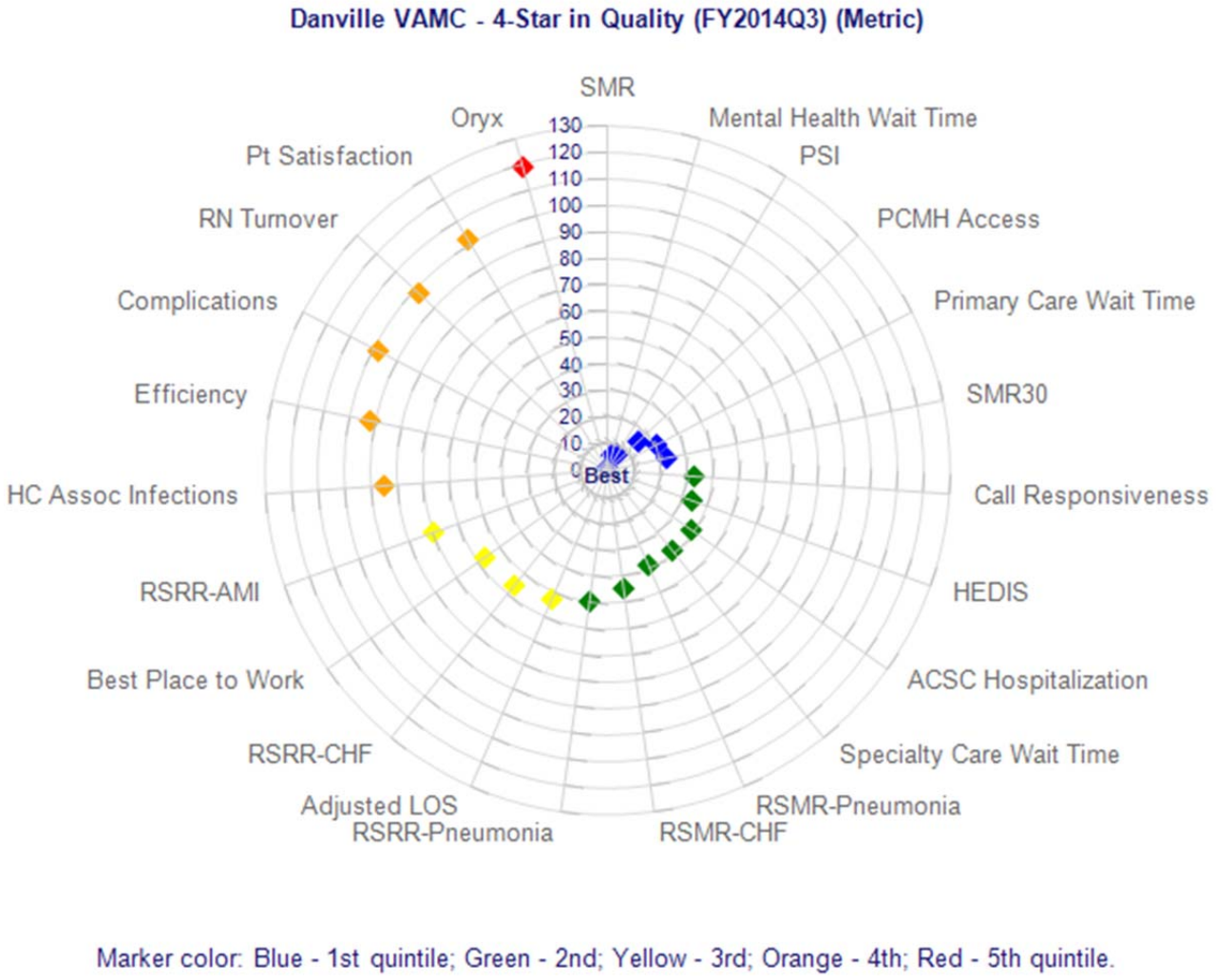
Recommendation

17. We recommended that clinicians document all required vaccination administration elements and that facility managers monitor compliance.

Facility Profile (Danville/550) FY 2015 through November 2014[1]	
Type of Organization	Secondary
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$181.3
Number of:	
• **Unique Patients**	18,674
• **Outpatient Visits**	49,933
• **Unique Employees**[2]	1,192
Type and Number of Operating Beds (as of October):	
• **Hospital**	79
• **CLC**	217
• **MH**	35
Average Daily Census (as of October):	
• **Hospital**	25
• **CLC**	91
• **MH**	34
Number of Community Based Outpatient Clinics	5
Location(s)/Station Number(s)	Peoria/550BY Decatur/550GA West Lafayette/550GC Springfield/550GD Mattoon/550GF
Veterans Integrated Service Network Number	11

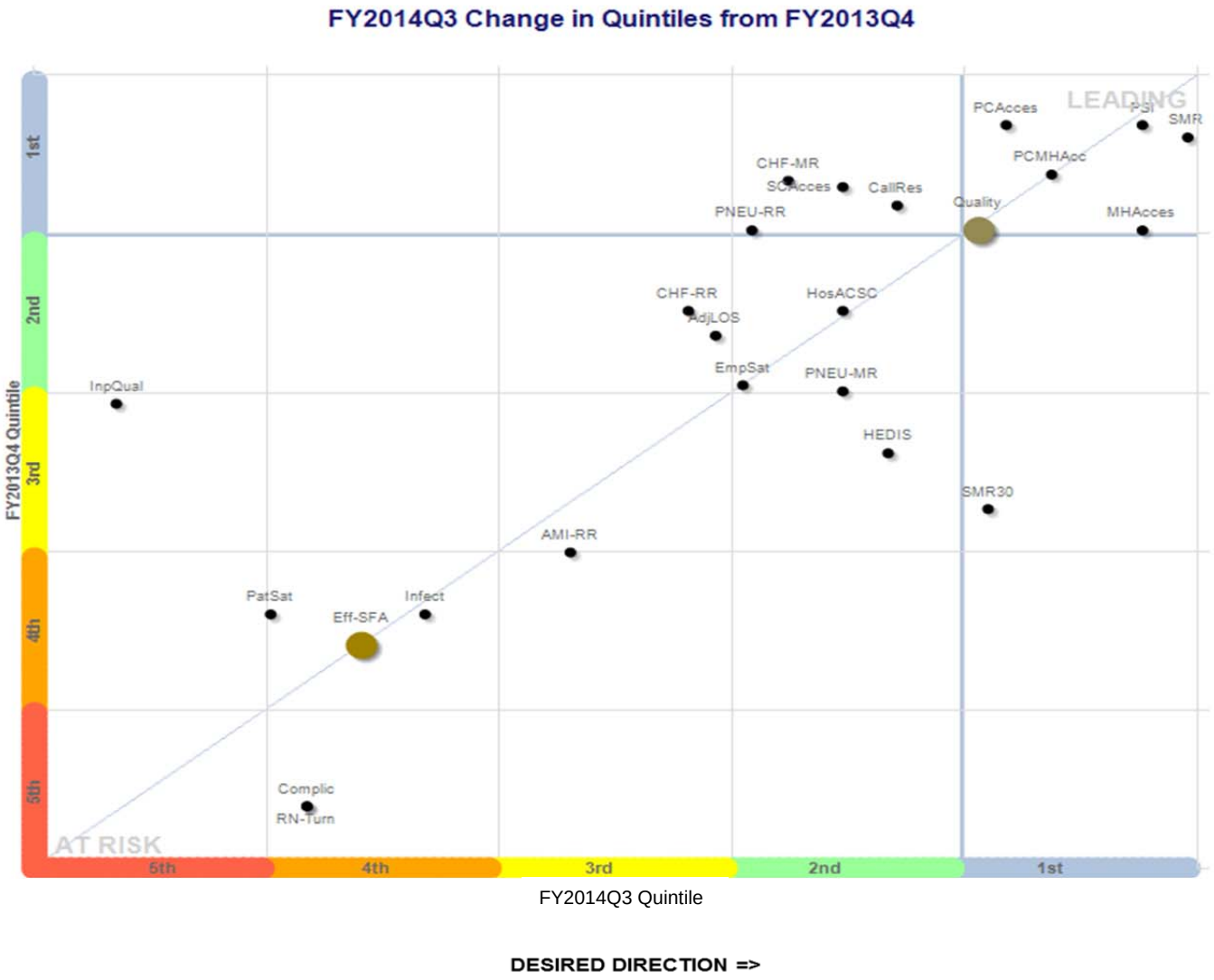
[1] All data is for FY 2015 through November 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

Strategic Analytics for Improvement and Learning (SAIL)[3]



[3] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Status	MH status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value

Appendix C

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: January 8. 2015

From: Director, Veterans in Partnership (10N11)

Subject: **CAP Review of the VA Illiana Health Care System, Danville, IL**

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

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

Per your request, attached is a response to the draft CAP report from VA Illiana Healthcare System. If you have any questions, please contact Carol Jones, VISN 11, Quality Management Officer at (734) 222-4302.

for Tony Zapata

Paul Bockelman

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: January 2, 2015

From: Director, VA Illiana Health Care System (550/00)

Subject: **CAP Review of the VA Illiana Health Care System, Danville, IL**

To: Director, Veterans in Partnership (10N11)

Attached is a response to the draft CAP report from VA Illiana Healthcare System. If you have any questions, please contact Alissa Broderick, Chief, Quality Management at (217) 554-5083.

(original signed by:)
Japhet C. Rivera

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 code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

Concur

Target date for completion: January 31, 2015

Facility response: Following a code event, Quality Management staff will conduct a review of the episode, inclusive of screening for clinical issues that may have been present prior to the code. Each review of a code event will be presented to the Multidisciplinary Oversight Committee for review and approval.

Recommendation 2. We recommended that facility managers ensure patient care areas are clean and monitor compliance.

Concur

Target date for completion: June 1, 2015

Facility response: The current process of weekly inspections of work assignments by Housekeeping Supervisors will continue with the results being documented on an excel spreadsheet for monitoring purposes and communicated to the managers of these areas. Follow up communication with the managers of these areas will occur once deficiencies have been completed. This process will be implemented and monitored thru June 1, 2015.

Recommendation 3. We recommended that the facility document functionality checks of the community living center's elopement prevention system at least every 24 hours and that facility managers monitor compliance.

Concur

Target date for completion: March 31, 2015

Facility response: The wanderguard functionality check has been added to the face check sheet for ward CLC-8 and is to be checked and initialed by staff once daily. The wanderguard functionality checks are monitored daily per the Nurse Manager by reviewing the rounding sheets. Monitoring will be conducted thru March 31, 2015 to ensure daily sustained compliance is achieved.

Recommendation 4. We recommended that the facility revise the policy for safe use of automated dispensing machines to include employee training and minimum competency requirements for users and that facility managers monitor compliance.

Concur

Target date for completion: April 30, 2015

Facility response: The facility policy for automated dispensing machines will be revised to include 100 percent pharmacy ownership of all Automated Dispensing Machine account creation and access. Additionally, the current policy will be updated to specify that access will only be granted upon confirmation statement that minimum competency standards for the Automated Dispensing Machine have been completed. Monitoring will be conducted thru April 30, 2015 to ensure sustained compliance is achieved with the revised process.

Recommendation 5. We recommended that the facility create/designate a committee to oversee consult management.

Concur

Target date for completion: March 31, 2015

Facility response: A Consult Management Committee has been chartered and is designated to receive, monitor, analyze and address all aspects of consult management to meet the facility's mission and commitment to timeliness of care, provide support to enhance communication of Veteran needs and outcome of treatment. This committee will meet monthly and report to Access Committee.

Recommendation 6. We recommended that the Medicine, Mental Health, Surgical, and Rehabilitation Services' Automated Data Processing Applications Coordinators provide training in the use of the computerized consult package and that facility managers monitor compliance.

Concur

Target date for completion: March 31, 2015

Facility response: The staff in the role of Automated Data Processing Application Coordinators (ADPAC) in the services identified above will provide training in the use of the computerized consult package and provide evidence of this training in their staff meeting minutes at a minimum of annually. The identified services will be required to provide evidence of training to the Consult Management Committee annually to ensure there is sustained improvement and that training is completed. Compliance will be monitored by all the above listed services providing documentation that required education has been completed and will be submitted to Consult Management Committee by March 31, 2015.

Recommendation 7. We recommended that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that facility managers monitor compliance.

Concur

Target date for completion: March 31, 2015

Facility response: Education has been provided to the Magnetic Resonance Imaging Technologists on accurate and proper documentation concerning contraindications for Magnetic Resonance Imaging exams by the Imaging Supervisor. Monitoring will be conducted by the Imaging Supervisor thru March 31, 2015 to ensure sustained improvement is achieved.

Recommendation 8. We recommended that scanned magnetic resonance imaging documents are accurate and complete and that facility managers monitor compliance.

Concur

Target date for completion: March 31, 2015

Facility response: Education to staff was provided by the Medical Records staff on accurate and proper documentation that is required to be included on scanned records. Imaging Picture Archiving Communication Systems Manager and/or designee will review every Magnetic Resonance Imaging safety screening form to ensure proper documentation has been completed prior to scanning. Imaging staff that scan documents into the patient's record will thoroughly double check that each scanned document matches that patient's record. Monitoring will be conducted by Imaging Supervisor thru March 31, 2015 to ensure sustained compliance is achieved.

Recommendation 9. We recommended that the facility develop and implement an acute ischemic stroke policy that addresses all required items.

Concur

Target date for completion: March 31, 2015

Facility response: An Acute Ischemic Stroke Management policy has been developed and is currently in the approval process. The policy establishes a protocol to implement a standardized approach to provide efficient, expedient, quality care for the patients developing signs and symptoms of acute stroke.

Recommendation 10. We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.

Concur

Target date for completion: April 30, 2015

Facility response: A monitor is being developed to ensure that clinicians complete and document National Institute for Health stroke scales for each stroke patient within the expected timeframe. Monitor results will be provided to Quality Management by Nursing Service for review to ensure sustained compliance is achieved. Monitoring will be reported at the Multidisciplinary Committee thru April 30, 2015 to ensure sustained compliance is achieved.

Recommendation 11. We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance.

Concur

Target date for completion: April 30, 2015

Facility response: The dysphagia screen is currently included in the National Institutes of Health stroke assessment. Completion of this screening tool and monitor results will be provided to the Multidisciplinary Oversight Committee by Nursing Service monthly for review to ensure sustained compliance is achieved.

Recommendation 12. We recommended that the facility revise the emergency airway management policy to include demonstration of competency by both direct and video laryngoscopy.

Concur

Target date for completion: March 31, 2015

Facility response: Facility policy 112-03, Out of Operating Room Airway Management has been revised to include demonstration of competency by both direct and video laryngoscopy. The policy is currently beginning the facility approval process.

Recommendation 13. We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes reviews of clinician-specific emergency airway management data and that facility managers monitor compliance.

Concur

Target date for completion: April 30, 2015

Facility response: The clinician assessment for continued emergency airway management competency has been revised and will include reviews of clinician specific emergency airway management data. Compliance will be monitored by Surgery Service thru April 30, 2015 to ensure adherence to approved revisions and requirements.

Recommendation 14. We recommended that the facility ensure that clinician reassessment for continued emergency airway management competency includes one of the three required components and that facility managers monitor compliance.

Concur

Target date for completion: April 30, 2015

Facility response: The clinician reassessment for continued emergency airway management competency includes one of the three required components. Compliance will be monitored by Surgery Service thru April 30, 2015 to ensure adherence to approved revisions and requirements.

Recommendation 15. We recommended that facility managers ensure the Psychosocial Residential Rehabilitation Treatment Program environment is clean and monitor compliance.

Concur

Target date for completion: June 1, 2015

Facility response: The Chief, Environmental Management Service will coordinate weekly inspections of this area and ensure results are documented on an excel spreadsheet and communicated with the Coordinator of the Psychosocial Residential Rehabilitation Treatment Program. This weekly inspection of this area will continue and be monitored thru June 1, 2015.

Recommendation 16. We recommended that the facility ensure that Psychosocial Residential Rehabilitation Treatment Program stained ceiling tiles are replaced, damaged baseboards and chipped wall tiles are repaired or replaced, and the emergency exit door is repaired.

Concur

Target date for completion: February 28, 2015.

Facility response: A walk through of the Psychosocial Residential Rehabilitation Treatment Program has been conducted by Engineering staff to review and monitor work that has been completed to date. All remaining identified issues will be resolved by Engineering staff by February 28, 2015.

Recommendation 17. We recommended that clinicians document all required vaccination administration elements and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2015

Facility response: A progress note is being developed that will capture all required vaccination administration elements. Once approved, education will be provided to all clinicians who will be responsible for entering the required information, prior to implementation of the progress note. Monitoring by Nursing Service is being established to ensure all required vaccination administration elements are documented consistently for all vaccinations and will be conducted thru June 30, 2015.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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This report is available at www.va.gov/oig.

Endnotes

[a] References used for this topic included:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 1036, *Standards for Observation in VA Medical Facilities*, February 6, 2014.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Handbook 1102.01, *National Surgery Office*, January 30, 2013.
- 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*, July 22, 2014.

[b] References used for this topic included:
- VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- Under Secretary for Health, "Non- Research Animals in Health Care Facilities," Information Letter 10-2009-007, June 11, 2009.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the National Fire Protection Association, the Health Insurance Portability and Accountability Act, Underwriters Laboratories.

[c] References used for this topic included:
- VHA Directive 2008-027, *The Availability of Potassium Chloride for Injection Concentrate USP*, May 13, 2008.
- VHA Directive 2010-020, *Anticoagulation Therapy Management*, May 14, 2010.
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of The Joint Commission.

[d] The reference used for this topic was:
- Under Secretary for Health, "Consult Business Rule Implementation," memorandum, May 23, 2013.

[e] References used for this topic included:
- VHA Handbook 1105.05, *Magnetic Resonance Imaging Safety*, July 19, 2012.
- VHA Handbook 1907.01.
- Emanuel Kanal, MD, et al., "ACR Guidance Document on MR Safe Practices: 2013," *Journal of Magnetic Resonance Imaging*, Vol. 37, No. 3, January 23, 2013, pp. 501–530.
- The Joint Commission, "Preventing accidents and injuries in the MRI suite," Sentinel Event Alert, Issue 38, February 14, 2008.
- VA National Center for Patient Safety, "MR Hazard Summary," http://www.patientsafety.va.gov/professionals/hazards/mr.asp.
- VA Radiology, "Online Guide," http://vaww1.va.gov/RADIOLOGY/OnLine_Guide.asp, updated October 4, 2011.

[f] The references used for this topic were:
- VHA Directive 2011-038, Treatment of Acute Ischemic Stroke, November 2, 2011.
- Guidelines for the Early Management of Patients with Acute Ischemic Stroke (AHA/ASA Guidelines), January 31, 2013.

[g] References used for this topic included:
- VHA Directive 2012-032, *Out of Operating Room Airway Management*, October 26, 2012.
- VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010.

[h] References used for this topic were:
- VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- Requirements of the VHA Center for Engineering and Occupational Safety and Health and the National Fire Protection Association.

[i] The reference used for this topic was:
- *National Childhood Vaccine Injury Act of 1986*, sub part C.