Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00594-389

Combined Assessment Program Review of the Captain James A. Lovell Federal Health Care Center North Chicago, Illinois

July 2, 2015

Washington, DC 20420

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

Glossary

AD	advance directive
CAP	Combined Assessment Program
CT	computed tomography
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	Captain James A. Lovell Federal Health Care Center
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
SCI	spinal cord injury
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 April 6, 2015.

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

- Computed Tomography Radiation Monitoring
- Advance Directives
- Surgical Complexity

The facility's reported accomplishment was a cross training agreement with the county hospital's trauma unit to allow facility providers to develop new skill sets for managing trauma.

Recommendations: We made recommendations in the following five activities:

Quality Management: Ensure credentialing and privileging folders do not contain information that is not allowed.

Environment of Care: Ensure patient care areas are clean. Require that nurse call systems with portable telephones have alarms that are audible. Ensure the Emergency Operations Plan includes how the facility manages patient scheduling.

Medication Management: Complete monthly medication storage area inspections on the medical/surgical acute care unit. Consistently implement corrective actions for issues identified during monthly medication storage area inspections, and monitor the changes until issues are fully resolved. Ensure designated employees receive initial automated dispensing machine training and competency assessment.

Coordination of Care: Ensure requestors consistently select the proper consult title.

Emergency Airway Management: Ensure initial clinician emergency airway management competency assessment includes documentation of all required elements. Require that clinician reassessment for continued emergency airway management competency is completed at the time of renewal of privileges.

Comments

The Acting Veterans Integrated Service Network Director and Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 24–29, 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 eight activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- Surgical Complexity
- EAM

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 April 9, 2015, and inspectors conducted the review in accordance with OIG standard operating procedures for CAP reviews. We also asked facility managers to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois,* Report No. 13-00376-201, May 31, 2013).

During this review, we presented crime awareness briefings for 23 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. We distributed an electronic survey to all facility employees and received 760 responses. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough for the OIG to monitor until the facility implements corrective actions.

Reported Accomplishment

Cross Training Agreement with County Trauma Unit

In March 2014, the facility entered into a cross training agreement with the trauma unit at the John H. Stroger, Jr. Hospital of Cook County in Chicago, IL. Currently, more than 20 facility providers are developing new skill sets for managing trauma in an urban setting.

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, 10 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.		
	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
X	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.	• Three of the 10 credentialing and privileging folders contained non-allowed information. o One folder contained training information. o One folder contained a certification. o One folder contained licensure registration information.	**1.** We recommended that facility managers ensure that credentialing and privileging folders do not contain information that is not allowed and monitor compliance.
	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.		
	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.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	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 emergency management.[b]

We inspected the medical/surgical acute care unit, intensive care unit, acute MH inpatient unit, community living center, Emergency Department, Green Home community living center, primary care clinic, dental clinic, and orthopedics clinic. Additionally, we reviewed relevant documents 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.		
	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		
	The facility met fire safety requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
X	The facility met environmental safety requirements.	• In four of nine areas inspected, we found dead insects in ceiling light fixtures. • Neither patient care area that had nurse call systems with portable telephones had alarms that were audible.	**2.** We recommended that facility managers ensure patient care areas are clean and monitor compliance. **3.** We recommended that facility managers ensure nurse call systems with portable telephones have alarms that are audible and monitor compliance.
	The facility met infection prevention requirements.		
	The facility met medication safety and security requirements.		
	The facility met patient privacy requirements.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for SCI Center		
NA	The facility completed and documented required inspection checklists of all ceiling mounted patient lifts.		
NA	The facility met fire safety requirements in the SCI Center.		
NA	The facility met environmental safety requirements in the SCI Center.		
NA	The facility met infection prevention requirements in the SCI Center.		
NA	The facility met medication safety and security requirements in the SCI Center.		
NA	The facility met patient privacy requirements in the SCI Center.		
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

NM	Areas Reviewed for Emergency Management	Findings	Recommendations
	The facility had a documented Hazard Vulnerability Assessment and reviewed the assessment annually.		
	The facility maintained a list of resources and assets it may need during an emergency.		
X	The facility had a written Emergency Operations Plan that addressed key components.	• The facility's Emergency Operations Plan did not include how the facility manages patient scheduling.	**4.** We recommended that the facility's Emergency Operations Plan include how the facility manages patient scheduling.
	The facility had a written description of how it will respond to an influx of potentially infectious patients and a plan for managing them over an extended period of time.		
NA	Employees received training and competency assessment on use of emergency evacuation devices.		
NA	Evacuation devices were immediately accessible and in good repair.		
	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.		
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 medical/surgical acute care unit, the intensive care unit, a community living center unit, and the Emergency Department and for these areas reviewed documentation of narcotic wastage from automated dispensing machines and inspected crash carts containing emergency medications. 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
	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.		
NA	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.		
X	The facility conducted and documented inspections of all medication storage areas at least every 30 days, fully implemented corrective actions, and monitored the changes.	• The medical/surgical acute care unit missed four of six monthly medication storage area inspections. • The facility did not consistently implement corrective actions for issues identified during monthly medication storage area inspections.	**5.** We recommended that facility managers ensure monthly medication storage area inspections are completed on the medical/surgical acute care unit and monitor compliance. **6.** We recommended that facility managers consistently implement corrective actions for issues identified during monthly medication storage area inspections and monitor the changes until issues are fully resolved.
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.	• Five nursing employees did not have documentation of initial training and competency assessment for automated dispensing machines.	**7.** We recommended that facility managers ensure designated employees receive initial automated dispensing machine training and competency assessment and monitor compliance.
	The facility employed practices to prevent wrong-route drug errors.		
	Medications prepared but not immediately administered contained labels with all required elements.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility removed medications awaiting destruction or stored them separately from medications available for administration.		
	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 38 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 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
	A committee oversaw the facility's consult management processes.		
	Major bed services had designated employees to: • Provide training in the use of the computerized consult package • Review and manage consults		
X	Consult requests met selected requirements: • Requestors included the reason for the consult. • Requestors selected the proper consult title. • Consultants appropriately changed consult statuses, linked responses to the requests, and completed consults within the specified timeframe.	• Eleven consult requests (29 percent) did not include "inpatient" in the title.	**8.** We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance.
	The facility met any additional elements required by VHA or local policy.		

CT Radiation Monitoring

The purpose of this review was to determine whether the facility complied with selected VHA radiation safety requirements and to follow up on recommendations regarding monitoring and documenting radiation dose from a 2011 report, *Healthcare Inspection – Radiation Safety in Veterans Health Administration Facilities*, Report No. 10-02178-120, March 10, 2011.[e]

We reviewed relevant documents, including qualifications and dosimetry monitoring for nine CT technologists and CT scanner inspection reports, and we conversed with key managers and employees. We also reviewed the EHRs of 50 randomly selected patients who had a CT scan January 1–December 31, 2014. 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.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a designated Radiation Safety Officer responsible for oversight of the radiation safety program.		
	The facility had a CT/imaging/radiation safety policy or procedure that included: • A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance • CT protocol monitoring to ensure doses were as low as reasonably achievable and a method for identifying and reporting excessive CT patient doses to the Radiation Safety Officer • A process for managing/reviewing CT protocols and procedures to follow when revising protocols • Radiologist review of appropriateness of CT orders and specification of protocol prior to scans		

NM	Areas Reviewed (continued)	Findings	Recommendations
	A radiologist, technologist expert in CT, and medical physicist reviewed all CT protocols revised during the past 12 months, and a medical physicist tested a sample of CT protocols at least annually.		
	A medical physicist performed and documented CT scanner annual inspections, an initial inspection after acquisition, and follow-up inspections after repairs or modifications affecting dose or image quality prior to the scanner's return to clinical service.		
NA	If required by local policy, radiologists included patient radiation dose in the CT report available for clinician review, and any summary reports provided by teleradiology included dose information.		
	CT technologists had required certifications or written affirmation of competency if "grandfathered in" prior to January 1987, and technologists hired after July 1, 2014, had CT certification.		
	There was documented evidence that CT technologists had annual radiation safety training and dosimetry monitoring.		
	If required by local policy, CT technologists had documented training on dose reduction/optimization techniques and safe procedures for operating the types of CT equipment they used.		
	The facility complied with any additional elements required by VHA or local policy.		

ADs

The purpose of this review was to determine whether VHA facilities complied with selected requirements for ADs for patients.[f]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 50 randomly selected patients who had an acute care admission January 1–December 31, 2014. 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.

NM	Areas Reviewed	Findings	Recommendations
	The facility had an AD policy that addressed: • AD notification, screening, and discussions • Proper use of AD note titles		
	Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening.		
	When patients provided copies of their current ADs, employees had scanned them into the EHR. • Employees correctly posted patients' AD status.		
	When inpatients requested a discussion about ADs (create, change, and/or revoke), employees: • Documented the discussion • Used the required AD note titles		
	The facility met any additional elements required by VHA or local policy.		

Surgical Complexity

The purpose of this review was to determine whether the facility provided selected support services appropriate to the assigned surgical complexity designation.[g]

We reviewed relevant documents and the training records of 20 employees, and we conversed with key managers and 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.

NM	Areas Reviewed	Findings	Recommendations
	Facility policy defined appropriate availability for all support services required by VHA for the facility's surgical designation.		
	Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation.		
	The facility properly reported surgical procedures performed that were beyond the facility's surgical complexity designation. • The facility reviewed and implemented recommendations made by the Veterans Integrated Service Network Chief Surgical Consultant.		
	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.[h]

We reviewed relevant documents, including competency assessment documentation of 11 clinicians applicable for the review period January 1–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.

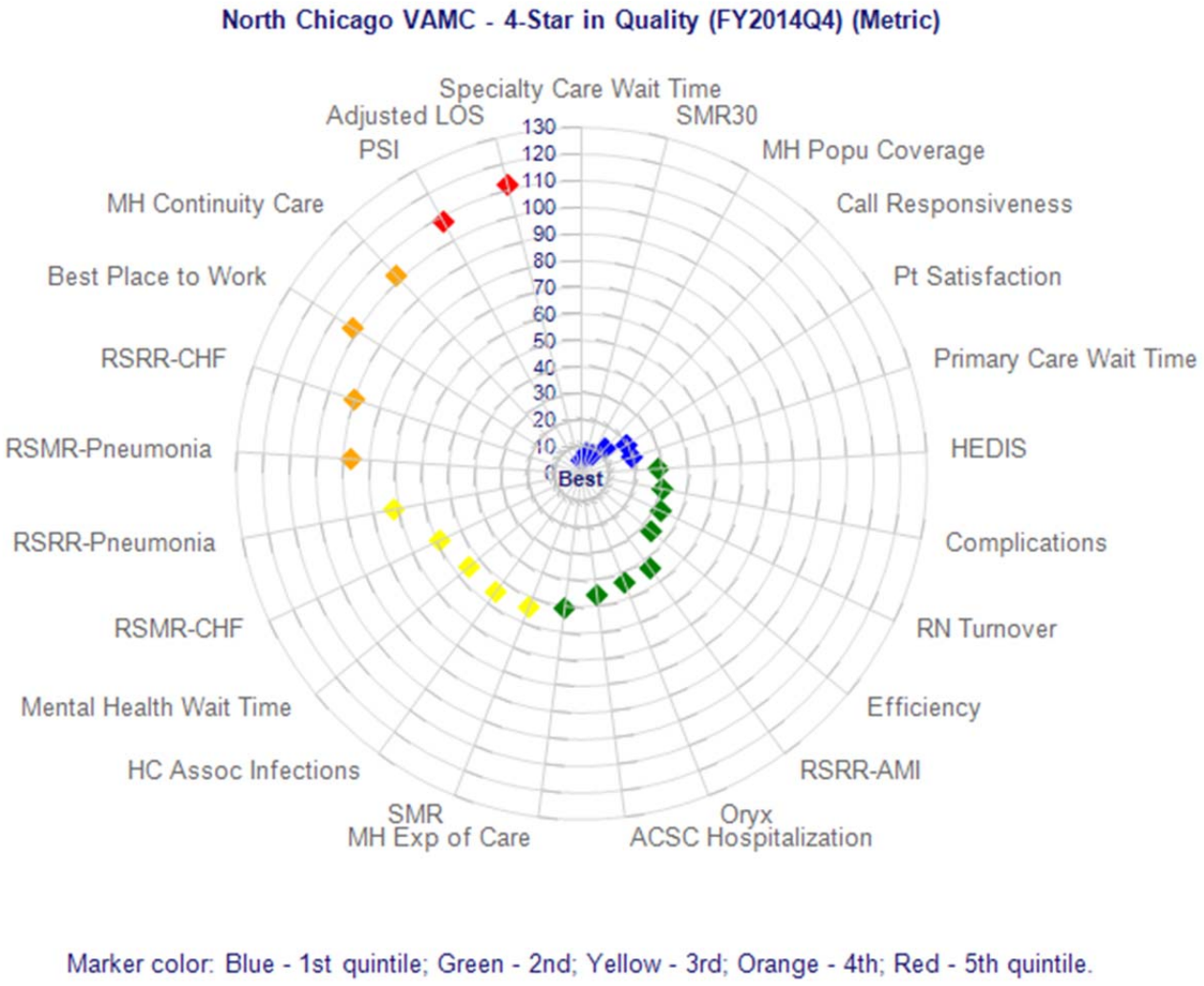
NM	Areas Reviewed	Findings	Recommendations
	The facility had a local EAM policy or had a documented exemption.		
NA	If the facility had an exemption, it did not have employees privileged to perform procedures using moderate or deep sedation that might lead to airway compromise.		
	Facility policy designated a clinical subject matter expert, such as the Chief of Staff or Chief of Anesthesia, to oversee EAM.		
	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		
X	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	• Neither of the two clinicians with initial EAM competency assessment had documentation of any of the required elements.	**9.** We recommended that facility managers ensure initial clinician emergency airway management competency assessment includes documentation of all required elements.

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	• None of the nine applicable clinicians had reassessments for continued EAM competency completed at the time of renewal of privileges.	**10.** We recommended that facility managers ensure clinician reassessment for continued emergency airway management competency is completed at the time of renewal of privileges and monitor compliance.
	The facility had a clinician with EAM privileges or scope of practice or an anesthesiology staff member 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.		

Facility Profile (North Chicago/556) FY 2015 through April 2015[1]	
Type of Organization	Tertiary
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$380.4
Number (as of March) of:	
• **Unique Patients**	35,418
• **Outpatient Visits**	177,914
• **Unique Employees**[2]	2,250
Type and Number of Operating Beds:	
• **Hospital**	88
• **Community Living Center**	134
• **MH**	125
Average Daily Census:	
• **Hospital**	44
• **Community Living Center**	115
• **MH**	93
Number of Community Based Outpatient Clinics	3
Location(s)/Station Number(s)	Evanston/556GA McHenry/556GC Kenosha/556GD
Veterans Integrated Service Network Number	12

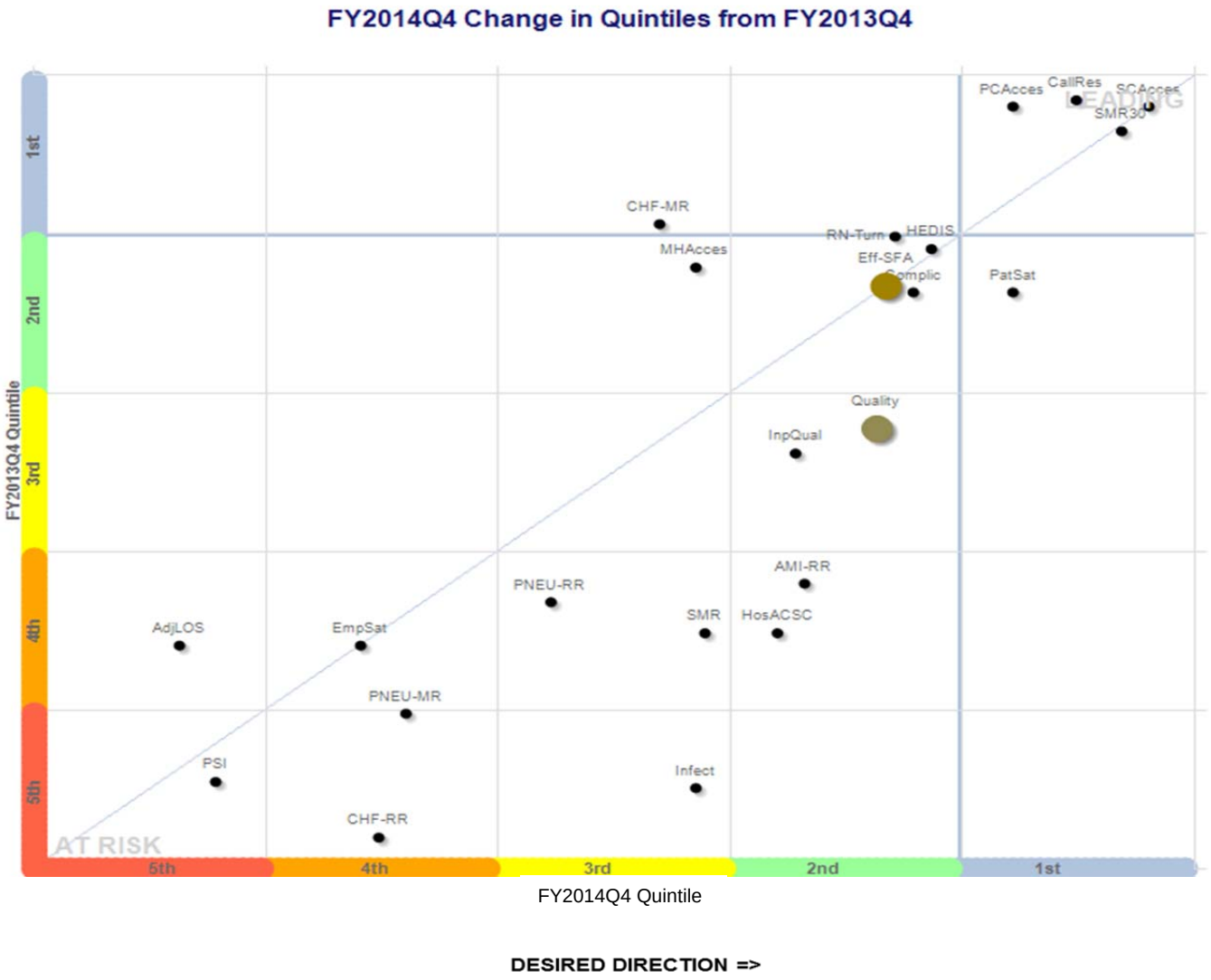
[1] All data is for FY 2015 through April 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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 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
MH Continuity Care	MH continuity of care (FY14Q3 and later)	MH Continuity Care
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 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
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

Acting Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: May 26, 2015

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

Subject: **CAP Review of the Captain James A. Lovell Federal Health Care Center, North Chicago, IL**

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

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

Attached please find the Combined Assessment Program (CAP) response to the draft report from the Captain James A. Lovell Federal Health Care Center review.

I have reviewed the completed response.

I appreciate the Office of Inspector General's efforts to ensure high quality of care to veterans, active duty patients and families at FHCC.

Renee Oshinski

Renee Oshinski

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: May 26, 2015

From: Director, Captain James A. Lovell Federal Health Care Center (556/00)

Subject: **CAP Review of the Captain James A. Lovell Federal Health Care Center, North Chicago, IL**

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

I am forwarding the Captain James A. Lovell Federal Health Care Center's response to the Office of Inspector General's (OIG) Combined Assessment Program (CAP) draft report. I want to express my appreciation to the OIG survey team for their professional and comprehensive CAP review.

I appreciate the opportunity for this review as a continuing process to improve the care to our veterans, active duty patients and families.

Stephen R. Holt, MD, MPH, MSNRS

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 facility managers ensure that credentialing and privileging folders do not contain information that is not allowed and monitor compliance.

Concur

Target date for completion: November 30, 2015

Facility response: 100% audit of credentialing and privileging folders to remove non-allowed documents is in progress and will be completed on May 29, 2015. Quarterly audits beginning June 2015 of 5% of credentialing and privileging folders will be done to monitor ongoing compliance.

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

Concur

Target date for completion: November 30, 2015

Facility response: The facility has a "daily/weekly/monthly/quarterly/annual" list of cleaning duties. Facility Management staff will ensure patient care areas are clean and monitor compliance. The compliance will be added to the bi-weekly Environment of Care (EOC) round checklist. Cleaning compliance will be reported up to the monthly Safety Committee for additional oversight. Six months of data will be audited for 90% compliance.

Recommendation 3. We recommended that facility managers ensure nurse call systems with portable telephones have alarms that are audible and monitor compliance.

Concur

Target date for completion: November 30, 2015

Facility response: The facility biomedical engineering and Facilities Management staff corrected the nurse call system and tested the system and portable telephones to ensure full functioning during the week of April 6, 2015.

The Medical Surgical Unit Manager or designee will begin conducting monthly rounds June 2015 to ensure that the audible alarms remain audible on the unit. Results of the

rounds will be reported up to the monthly Nursing Practice Council. Six months of data will be audited for 90% compliance.

Recommendation 4. We recommended that the facility's Emergency Operations Plan include how the facility manages patient scheduling.

Concur

Target date for completion: November 30, 2015

Facility response: The Emergency Operations Plan (EOP) has been revised to include how facility managers will manage the activities required as part of patient scheduling. Patient Administration and Home Health staff will receive education on the EOP revision. The Emergency After-Action reports for emergency responses will be amended to incorporate scheduling issues. After-Action Reports will be monitored for 6 months to ensure any scheduling issues have been addressed.

Recommendation 5. We recommended that facility managers ensure monthly medication storage area inspections are completed on the medical/surgical acute care unit and monitor compliance.

Concur

Target date for completion: November 30, 2015

Facility response: Pharmacy procedures were updated to ensure 100% completion of ward inspections every month. The pharmacy supervisor will physically review the documentation for each ward inspection and verify on a checklist that every unit is completed each month. Pharmacy staff conducting audits must obtain signatures from ward staff. A matrix checklist is utilized for monitoring 100% compliance. Pharmacy staff will monitor compliance monthly and report compliance to the Medication Management Sub-Committee. Six months of data will be audited for 90% compliance.

Recommendation 6. We recommended that facility managers consistently implement corrective actions for issues identified during monthly medication storage area inspections and monitor the changes until issues are fully resolved.

Concur

Target date for completion: November 30, 2015

Facility response: Pharmacy procedures were updated to ensure on-going tracking and assurance that issues identified during audits are addressed until corrected. The pharmacy has created a monthly inspection tracker to monitor issues and trends. Findings will be immediately corrected by the pharmacy staff member conducting the audit and trends will be reported at staff meetings by the pharmacy supervisor. Monthly reports will be reviewed to ensure identified process changes are regularly implemented when indicated.

Recommendation 7. We recommended that facility managers ensure designated employees receive initial automated dispensing machine training and competency assessment and monitor compliance.

Concur

Target date for completion: November 30, 2015

Facility response: The Medical Surgical Nurse Manager or designee will ensure that all designated employees receive initial automated dispensing machine training. Access will not be granted unless the training certificate is provided to the pharmacy. As of May 22, 2015, all Medical-Surgical Unit designated employees have a certificate on file enabling them access to the Medication Pyxis system within the Captain James A. Lovell Federal Health Care Center (FHCC). This is part of phase 3 orientation provided by the department/unit. The Medical Surgical Nurse Manager or designee will ensure ongoing compliance by performing quarterly audits to ensure that the new staff will receive automated dispensing machine training prior to receiving Medication Pyxis access.

Recommendation 8. We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance.

Concur

Target date for completion: November 30, 2015

Facility response: All the consults which did not include the inpatient title were corrected on May 22, 2015. All of our Clinicians who utilize the electronic health record consults will complete a Talent Management System (TMS) course on consult which includes the proper selection of consult titles prior to August 1, 2015. Consult Oversight Committee will monitor the compliance with requestors consistently selecting the proper consult title by audits to ensure consults are requested appropriately.

Recommendation 9. We recommended that facility managers ensure initial clinician emergency airway management competency assessment includes documentation of all required elements.

Concur

Target date for completion: May 29, 2015

Facility response: Facility credentialing staff created an Out of Operating Room Airway Management (OORAM) specific Focused Performance Peer Evaluation (FPPE) tool on April 28, 2015, and reviewed all provider files to ensure emergency airway management competency has been completed. All active staff are compliant with the emergency management competency. This FPPE tool includes Talent Management System (TMS) training, Simulation, and Live Patient Procedure.

Recommendation 10. We recommended that facility managers ensure clinician reassessment for continued emergency airway management competency is completed at the time of renewal of privileges and monitor compliance.

Concur

Target date for completion: May 29, 2015

Facility response: Facility credentialing staff created an Out of Operating Room Airway Management (OORAM) specific Ongoing Professional Peer Evaluation (OPPE) tool on April 28, 2015, and reviewed all provider files to ensure emergency airway management competency has been completed. All active staff are compliant with the emergency management competency. This OPPE tool includes TMS training, Simulation, and Live Patient Procedure.

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

Endnotes

[a] References used for this topic included:
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- VHA Handbook 1102.01, *National Surgery Office*, January 30, 2013.
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[b] References used for this topic included:
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[c] References used for this topic included:
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[d] The reference used for this topic was:
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[e] References used for this topic included:
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[g] References used for this topic included:
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- VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010.

[h] References used for this topic included:
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- VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010.