Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-02415-151

Combined Assessment Program Review of the Grand Junction VA Medical Center Grand Junction, Colorado

June 25, 2009

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

During the week of April 13–16, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the Grand Junction VA Medical Center (the medical center), Grand Junction, CO. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 133 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 19.

Results of the Review

The CAP review covered seven operational activities. We made recommendations in five of the activities reviewed and had repeat QM findings from our prior CAP review. For these activities, the medical center needed to:

- Require that Peer Review Committee reports to the Clinical Executive Board (CEB) include all Veterans Health Administration (VHA) requirements.
- Require all clinical services to collect relevant practitioner-specific data for use in privileging decisions.
- Appropriately label and store medication.
- Ensure that all designated team members to participate in weekly environment of care (EOC) rounds, as required by local policy.
- Ensure that all required staff receive training on the environmental hazards that represent a threat to suicidal patients.
- Consistently complete emergency cart checks, as required by local policy.
- Monitor nourishment refrigerators, as required by local policy.
- Update the local hand hygiene policy, monitor compliance, and provide feedback to health care workers.
- Complete inpatient consults and intra-facility transfer documentation in accordance with local policy.
- Revise the local policy regarding discharge documentation and consistently complete discharge documentation.

- Consistently document the effectiveness of all pain medications within the required timeframe of the local policy.
- Ensure that emergency department (ED) staff complete inter-facility transfer documentation, as required by VHA and local policy.

The medical center complied with selected standards in the following two activities:

- Suicide Prevention.
- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Dorothy Duncan, Associate Director, and Reba B. Ransom, Healthcare Inspector, Kansas City Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 14–19, for the full text of the Directors' comments). We will follow up on the planned actions until they are completed.

(original signed by Dana Moore, PhD, Deputy Assistant Inspector General for Healthcare Inspections for:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Profile

Organization. The medical center is located in Grand Junction, CO, and provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at a community based outpatient clinic (CBOC) in Montrose, CO; a telehealth outreach clinic in Craig, CO; and a contract outreach clinic in Montezuma Creek, UT. The medical center is part of VISN 19 and serves a veteran population of about 38,000 throughout the western slope of Colorado and in two counties in southeastern Utah.

Programs. The medical center provides primary and secondary care, including acute medical, surgical, and psychiatric inpatient services, as well as a full range of outpatient services. It has 31 hospital beds and 30 community living center (CLC) beds.[1]

Affiliations and Research. The medical center is affiliated with Mesa State College, Colorado Christian University, Colorado Northwestern Community College, New Mexico State University, and the University of Wyoming. It provides training for student nurses and radiology technicians. The medical center has no research programs.

Resources. In fiscal year (FY) 2008, medical care expenditures totaled $78 million. The FY 2009 medical care budget is $79 million. FY 2008 staffing was 428 full-time employee equivalents (FTE), including 36 physician and 126 nursing FTE.

Workload. In FY 2008, the medical center treated 11,102 unique patients and provided 5,748 inpatient days in the hospital and 9,940 inpatient days in the CLC. The inpatient care workload totaled 826 discharges, and the average daily census, including CLC patients, was 46. Outpatient workload totaled 97,794 visits.

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:

[1] A CLC (formerly called a nursing home care unit) provides compassionate, person-centered care in a safe and homelike environment to eligible veterans who require a nursing home level of care.

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following seven activities:

- Coordination of Care.
- Emergency/Urgent Care (E/UC) Operations.
- EOC.
- Medication Management.
- QM.
- SHEP.
- Suicide Prevention.

The review covered medical center operations for FY 2008 and FY 2009 through April 16, 2009, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the Grand Junction VA Medical Center, Grand Junction, Colorado,* Report No. 06-00637-104, March 21, 2007). The medical center had corrected all but two findings related to health care from our prior CAP review. Those findings are discussed in the QM section of this report.

During this review, we also presented fraud and integrity awareness briefings for 133 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.

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. Activities in the "Review Activities Without Recommendations" section have no reportable findings.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the medical center's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the medical center's senior management team and QM personnel. We evaluated plans, policies, and other relevant documents.

The QM program was generally effective in providing oversight of the medical center's quality of care, and senior managers supported the program. Appropriate review structures were in place for 12 of the 14 program activities reviewed. We identified two areas that continued to need improvement. These same two areas had been identified during our prior CAP review.

Peer Review Analysis Reporting. Although the Peer Review Committee met quarterly and provided reports to the CEB, the quarterly reports did not include all VHA required elements. VHA requires that reports to the medical executive staff include: (a) the number of reviews, (b) the outcome by level, and (c) the number of changes from one level to another during the review process.[2] These aggregate data were not reported.

Credentialing and Privileging. Service chiefs did not consistently collect and utilize appropriate quality data to evaluate physician performance for granting and renewing clinical privileges, as required by VHA.[3] We reviewed 18 physician profiles and found that 11 (61 percent) did not have relevant practitioner-specific data to support renewal of

[2] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.
[3] VHA Handbook 1100.19, *Credentialing and Privileging*, October 2, 2007.

clinical privileges. Also, of the seven services represented in our sample, only two collected data. Local policy requires that clinical service chiefs review performance improvement data to make recommendations to the Professional Standards Board.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that Peer Review Committee reports to the CEB include all VHA requirements.

The VISN and Medical Center Directors concurred with our finding and recommendation. Outcome levels and level changes are now being reported to the CEB on a quarterly basis. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that all clinical services collect relevant practitioner-specific data for use in privileging decisions.

The VISN and Medical Center Directors concurred with our findings and recommendation. The Chief of Staff is working with service chiefs to determine practitioner-specific monitors for each individual service's activities. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Environment of Care

The purpose of this review was to determine whether the medical center complied with selected infection control (IC) standards and maintained a clean and safe health care environment. Medical centers are required to provide a comprehensive EOC program that fully meets VA National Center for Patient Safety, Occupational Safety and Health Administration (OSHA), and Joint Commission (JC) standards.

We conducted onsite inspections of the surgery area, the post-anesthesia care unit, the inpatient medical/surgical unit, the intensive care unit (ICU), the CLC, the locked acute inpatient psychiatric unit, and outpatient clinic areas. The medical center maintained a generally clean and safe environment. Staff and nurse managers expressed satisfaction with the responsiveness of the housekeeping staff on their units.

Medical center managers conducted the required quarterly mental health EOC assessments of the locked acute

inpatient psychiatric unit. While we noted some environmental deficiencies on the unit, they are scheduled to be corrected with the renovation that begins in June 2009. We identified the following areas that needed improvement.

Medication Labeling and Storage. In the surgery area, we found improperly labeled medication syringes, expired prefilled syringes, and one unlocked medication cart. In the outpatient clinic areas, we found four multi-dose vials that either were expired or did not have a date indicating when the vial was opened. During our inspection, the outdated medications were removed.

EOC Rounds. The medical center was not consistently adhering to a weekly schedule when conducting EOC rounds, and attendance by required staff varied. Local policy requires that the inspection team, with representation from all required disciplines, conduct weekly inspections of the medical center. EOC rounds allow managers to identify and correct sanitation discrepancies, unsafe working conditions, and OSHA regulatory violations.

Locked Acute Inpatient Psychiatric Unit Training. We found that 6 (30 percent) of the 20 unit staff and 5 (33 percent) of the 15 Multidisciplinary Safety Inspection Team (MSIT) members did not receive training on identifying and correcting environmental hazards. The Deputy Under Secretary for Health for Operations and Management issued a memorandum on August 27, 2007, which requires that all staff who work on locked inpatient psychiatric units and members of the MSIT receive training on environmental hazards that represent a threat to suicidal patients.

Emergency Cart Checks. Nursing staff had not consistently completed emergency cart checks to ensure that proper equipment was readily available and functioning, as required by local policy. While only one (13 percent) of eight emergency carts had deficiencies, that cart was located on the only inpatient medical/surgical unit, and several checks had not been completed.

Nourishment Refrigerator Monitoring. Monitoring of nourishment refrigerators was not consistently conducted to ensure the safety of food products, as required by local policy. We found the following:

- Outdated juice (24 months past the expiration date) in a nourishment refrigerator on the post-anesthesia care unit.
- Incomplete daily refrigerator temperature checks on two inpatient units.

Hand Hygiene. Local hand hygiene policy did not include the VHA requirements that medical centers have processes for monitoring health care workers' adherence to the required hand hygiene practices and for providing feedback regarding staff performance in order to reduce infection risks for patients and staff.[4] Also, hand hygiene compliance data were not consistently gathered for all direct patient contact areas (the outpatient clinics, the locked acute inpatient psychiatric unit, the radiology department, the CBOC, and the telehealth outpatient clinic).

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires staff to appropriately label and store medication.

The VISN and Medical Center Directors concurred with our findings and recommendation. Anesthesia and ambulatory care staff have been re-educated regarding the appropriate labeling and storage of medication, and the medication cart storage room has been secured. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that all designated EOC team members participate in weekly EOC rounds, as required by local policy.

The VISN and Medical Center Directors concurred with our findings and recommendation. The local policy will be revised to ensure designated team member participation, and attendance will be tracked. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 5 We recommended that the VISN Director require that the Medical Center Director ensures that all required staff

[4] VHA Directive 2005-002, *Required Hand Hygiene Practices*, January 13, 2005.

receive training on the environmental hazards that represent a threat to suicidal patients.

The VISN and Medical Center Directors concurred with our findings and recommendation. Training was provided to all required staff and will be repeated annually. Training will be provided to other staff as needed and will be documented electronically. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires that staff consistently complete emergency cart checks, as required by local policy.

The VISN and Medical Center Directors concurred with our finding and recommendation. Staff have been re-educated on local policy requirements. Unannounced inspections will be conducted to evaluate compliance. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires staff to monitor nourishment refrigerators, as required by local policy.

The VISN and Medical Center Directors concurred with our findings and recommendation. The Nurse Executive has initiated weekly rounds to evaluate compliance with refrigerator monitoring. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires staff to update the local hand hygiene policy, monitor compliance, and provide feedback to health care workers.

The VISN and Medical Center Directors concurred with our findings and recommendation. The local policy will be revised, and the IC nurse will monitor and report staff compliance. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Coordination of Care

The purpose of this review was to evaluate whether inpatient consultations, intra-facility (ward-to-ward) transfers, and discharges were coordinated appropriately over the continuum of care and met VHA and JC requirements. Coordinated consultations, transfers, and discharges are essential to an integrated, ongoing care process resulting in optimal patient outcomes.

We identified the following areas that needed improvement.

Inpatient Consult Response. One (8 percent) of 12 inpatient consults was not performed within 24 hours of being ordered, as required by local policy.

Intra-Facility Transfer Documentation. Seven (58 percent) of 12 intra-facility transfers did not have the required medical record documentation specified by local Nursing Service policy. Local policy requires that both the sending and receiving units' nursing staff document a patient transfer note.

Discharge Documentation. The local policy for medical record documentation did not incorporate all VHA required discharge information. Therefore, 9 (75 percent) of 12 discharges did not have the required documentation specified by VHA regulations.[5] VHA requires that specific information, such as medications, be included in both discharge summaries and patient discharge instructions.

Recommendation 9 We recommended that the VISN Director ensure that the Medical Center Director requires that staff complete inpatient consults and intra-facility transfer documentation in accordance with local policy.

The VISN and Medical Center Directors concurred with our findings and recommendation. A process has been implemented to ensure timely consult completion for inpatients. The existing patient transfer template will be revised, and the new template will be available electronically. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 10 We recommended that the VISN Director ensure that the Medical Center Director requires that staff revise the local

[5] VHA Handbook 1907.01, *Health Information Management and Health Records,* August 25, 2006.

policy regarding discharge documentation and consistently complete discharge documentation.

The VISN and Medical Center Directors concurred with our findings and recommendation. The medical center has revised its discharge policy. All required components of the discharge process will be completed and documented. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Medication Management

The purpose of this review was to evaluate whether the medical center had adequate medication management practices. A safe medication management system includes medication ordering, administering, and monitoring.

We reviewed selected medication management processes in the inpatient medical/surgical unit, the ICU, and the CLC. We found adequate management of medications brought into the facility by patients or their families. Nurses appropriately scanned patient armbands and used personal identifiers prior to medication administration. We identified the following area that needed improvement.

Documentation of Pain Medication Effectiveness. Nurses did not consistently document the effectiveness of pain medications in accordance with local policy requirements. We reviewed the Bar Code Medication Administration (BCMA) records of 15 patients who were hospitalized in selected units at the time of our visit. For each patient, we reviewed documentation for several doses of pain medication. Nurses documented pain medication effectiveness within the locally required timeframe of 1 hour for 38 (54 percent) of the 70 doses of pain medication.

Recommendation 11 We recommended that the VISN Director ensure that the Medical Center Director requires that nurses consistently document the effectiveness of all pain medications within the required timeframe of the local policy.

The VISN and Medical Center Directors concurred with our finding and recommendation. A report to monitor pain medication effectiveness will be run weekly. The BCMA Coordinator and nurse managers will monitor to ensure that appropriate documentation has been completed. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Emergency/Urgent Care Operations

The purpose of this review was to evaluate whether VHA facility E/UC operations complied with VHA guidelines related to hours of operation, clinical capability (including management of patients with acute mental health conditions and patients transferred to other facilities), staffing adequacy, and staff competency. In addition, we inspected the medical center's ED for cleanliness and safety.

The ED is located within the main hospital building and is open 24 hours per day, 7 days per week. The emergency services provided are within the medical center's patient care capabilities.

We reviewed medical records of patients who presented in the ED with acute mental health conditions, and in all cases, staff managed the patients' care appropriately. We reviewed the ED nurse staffing plan and time schedules and determined that managers had consistently followed their established staffing guidelines for allocating nursing resources. Also, we found that managers had appropriately documented nurse competencies.

We determined that the ED complied with VHA operational standards, including staffing guidelines, cleanliness, and competency. However, we identified one area that needed improvement.

Inter-Facility Transfers. ED staff did not document specific inter-facility transfer data, as required by VHA and local policy.[6] None of the medical records we reviewed contained all the required documentation elements. During onsite interviews, ED staff identified their local inter-facility transfer policy, and they provided paper forms that contained all required documentation elements. However, staff did not consistently complete the forms. Staff reported that they plan to develop an electronic inter-facility transfer template.

Recommendation 12 We recommended that the VISN Director ensure that the Medical Center Director requires ED staff to complete inter-facility transfer documentation, as required by VHA and local policy.

The VISN and Medical Center Directors concurred with our findings and recommendation. The Clinical Applications Coordinator and the clinical team will revise the existing

[6] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.

patient transfer template. The new template will be available electronically. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Suicide Prevention

The purpose of this review was to determine whether the medical center had implemented a suicide prevention program that was in compliance with VHA regulations. We assessed whether senior managers had appointed a Suicide Prevention Coordinator (SPC) at the medical center and at any very large CBOCs, and we evaluated whether the SPC fulfilled all required functions.[7] We also verified whether medical records of patients determined to be at high risk for suicide contained Category II Patient Record Flags (PRFs), documented safety plans that addressed suicidality, and documented collaboration between mental health providers and the SPC.[8]

We interviewed the SPC, and we reviewed pertinent policies and the medical records of nine medical center patients and one CBOC patient determined to be at risk for suicide. All 10 medical records had Category II PRFs. We found that senior managers had appropriately appointed the SPC and that the SPC fulfilled the required functions.[9] Nine (90 percent) of the 10 medical records reviewed had documented safety plans that addressed suicidality and documented collaboration between mental health providers and the SPC. The one record that did not have a documented safety plan or a note from the SPC did include a suicide consult from a social worker. Because the program was generally effective and the SPC had implemented community outreach initiatives related to suicide prevention, we made no recommendations.

Survey of Healthcare Experiences of Patients

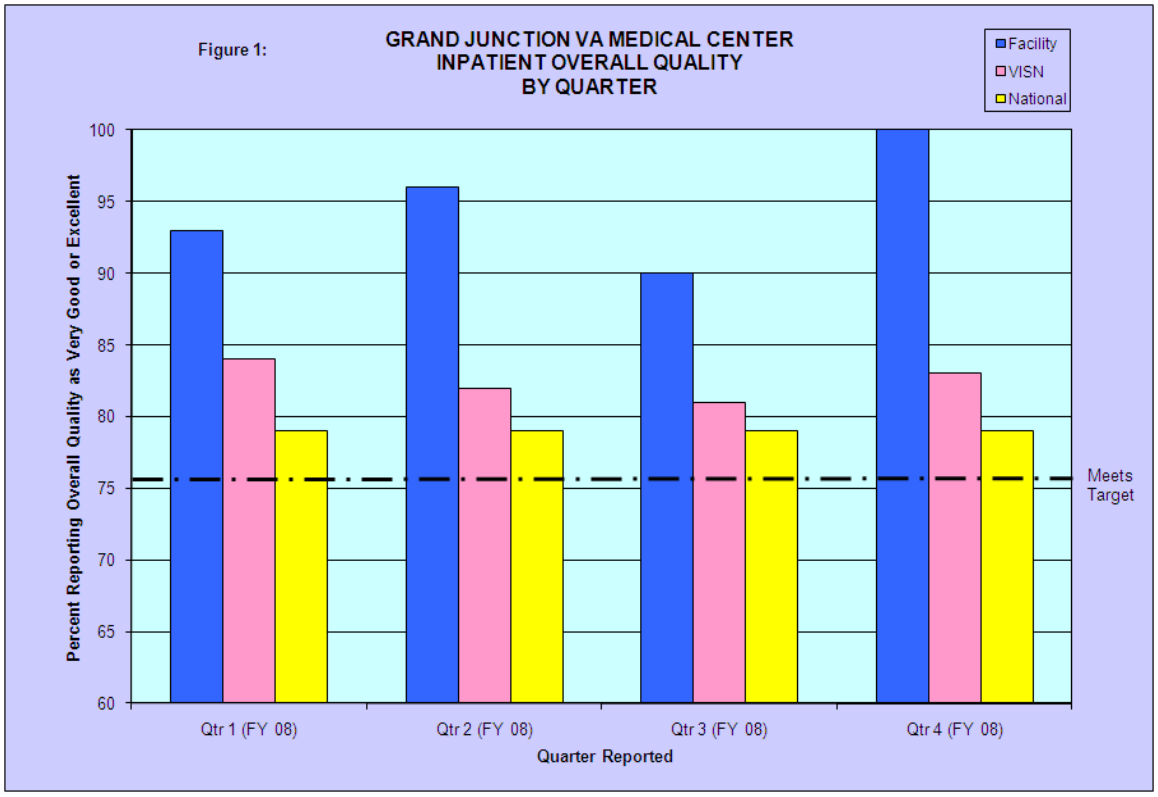
The purpose of this review was to assess the extent that VHA medical centers use quarterly survey results of patients' health care experiences with the VHA system to improve patient care, treatment, and services. The Performance Analysis Center for Excellence of the Office of Quality and Performance (OQP) within VHA is the analytical,

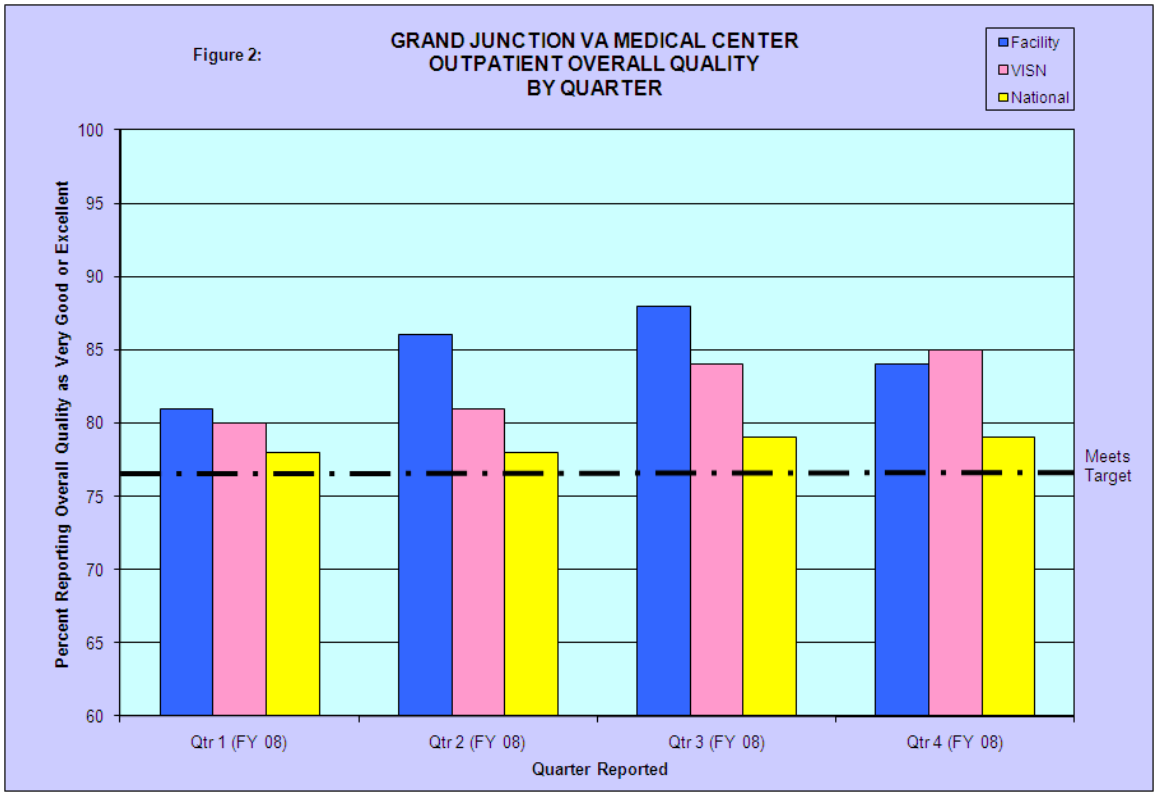
[7] Very large CBOCs are defined as clinics with more than 10,000 unique patients enrolled.
[8] A Category II PRF is an alert mechanism that is displayed prominently in medical records.
[9] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.

methodological, and reporting staff for SHEP. VHA set performance measure goals for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients. Medical centers are expected to address areas that fall below target scores.

We reviewed the inpatient and outpatient survey results for each quarter in FY 2008. Data for FY 2007 was not available on the OQP website. Figures 1 and 2 below and on the next page show the medical center's SHEP performance measure results for inpatients and outpatients, respectively.

Figure 1:





The medical center exceeded inpatient and outpatient targets for all 4 quarters reported. The SHEP coordinator provided a comprehensive plan that facilitates successful results for high patient satisfaction scores. In collaboration with the Patient Advocate, the committee that addresses patient satisfaction proactively addresses potential issues and seeks appropriate staff involvement. We made no recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 5, 2009

From: Director, VA Rocky Mountain Network (10N19)

Subject: **Combined Assessment Program Review of the Grand Junction VA Medical Center, Grand Junction, Colorado**

To: Director, Chicago and Kansas City Healthcare Inspections Division (54CH/KC)

Director, Management Review Service (10B5)

I have reviewed the OIG Combined Assessment Program Review of the Grand Junction VAMC and concur on the responses as provided by the Medical Center Director. If you have any questions, please contact Ms. Anita Urdiales, HSS, at (303) 756-9279.

(original signed by:)
Glen W. Grippen, FACHE

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 1, 2009

From: Director, Grand Junction VA Medical Center (575/00)

Subject: **Combined Assessment Program Review of the Grand Junction VA Medical Center, Grand Junction, Colorado**

To: Director, VA Rocky Mountain Network (10N19)

1. We have reviewed the OIG draft report and appreciate the opportunity to provide comments. After careful review, we have concurred with the recommendations and have provided the following implementation plan.

2. If you have any questions or need additional information, please contact Charlotte Haislip, Quality Manager, at (970) 242-0731 extension 2234.

(original signed by:)
Terry S. Atienza

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires that Peer Review Committee reports to the CEB include all VHA requirements.

Concur **Target Date of Completion: Completed**

Plan: Peer Review Committee outcome levels continue to be determined within the Peer Review Committee and reported to the CEB. As of 4/29/09, outcome levels and level changes are reported on a quarterly basis, as specified per VHA Directive.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that all clinical services collect relevant practitioner-specific data for use in privileging decisions.

Concur **Target Date of Completion: September 30, 2009**

Plan: The Medical and Surgical Services developed and implemented provider-specific and comparative data prior to the OIG CAP Review. The Chief of Staff continues to work with other Service Chiefs to determine similar practitioner-specific monitors based on their individual service activities.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires staff to appropriately label and store medication.

Concur **Target Date of Completion: Completed**

Plan:

a) Improperly labeled prefilled syringes were immediately removed during the OIG CAP Review. Anesthesia and Ambulatory Care staff were re-educated regarding the appropriate labeling and storage of medication.

b) The Anesthesia Cart Storage Room has been secured through the installation of a keyless entry lock.

c) Weekly "Clean Sweep" Rounds were initiated by the Nurse Executive on May 15, 2009. Various nursing units will be reviewed on an unannounced basis. The purpose of the Clean Sweep Rounds will be to evaluate unit compliance with medication labeling/storage, refrigeration temperatures, etc.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that all designated EOC team members participate in weekly EOC rounds, as required by local policy.

Concur **Target Date of Completion: Completed**

Plan: Local policy will be revised to ensure team members (or designee) attend weekly environmental rounds. Attendance will be tracked through use of a sign-in form.

Recommendation 5. We recommended that the VISN Director require that the Medical Center Director ensures that all required staff receive training on the environmental hazards that represent a threat to suicidal patients.

Concur **Target Date of Completion: Completed**

Plan: Training was provided to all required staff who provide care on the Behavioral Health Unit and will be repeated on an annual basis. Training will also be provided to other staff as the need is identified. Training will be recorded via Tempo for verification purposes.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that staff consistently complete emergency cart checks, as required by local policy.

Concur **Target Date of Completion: Completed**

Plan:

a) Staff were re-educated to the requirements of our local policy.

b) Weekly "Clean Sweep" Rounds were initiated by the Nurse Executive on May 15, 2009. Various nursing units will be reviewed on an unannounced basis. The purpose of the Clean Sweep Rounds will be to evaluate unit compliance with emergency cart checks, medication labeling/storage, Joint Commission requirements, etc.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires staff to monitor nourishment refrigerators, as required by local policy.

Concur **Target Date of Completion: Completed**

Plan:

a) Weekly "Clean Sweep" Rounds were initiated by the Nurse Executive on May 15, 2009. Various nursing units will be reviewed on an unannounced basis. The purpose of the Clean Sweep Rounds will be to evaluate unit compliance with refrigeration temperatures, medication labeling/storage, etc.

b) All nourishment refrigerators/freezers in patient care areas are monitored through the Temp/Trak System (Cooper-Adkins). As additional refrigerator/freezer units are ordered, the Temp/Trak System will be expanded to keep up with growing demand.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires staff to update the local hand hygiene policy, monitor compliance, and provide feedback to health care workers.

Concur **Target Date of Completion: August 1, 2009**

Plan: Local policy will be revised based on requirements within VHA Directive 2005-002 (*Required Hand Hygiene Practices*). The Infection Control Nurse will initiate monitoring and reporting of staff compliance to the revised hand hygiene policy.

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director requires that staff complete inpatient consults and intra-facility transfer documentation in accordance with local policy.

Concur **Target Date of Completion: July 1, 2009**

Plan:

a) A process to ensure timely consult completion for inpatients has been implemented.

b) The Clinical Applications Coordinator and clinical team will revise the existing patient transfer template. The new template will be available through CPRS and utilized by all units, including the previously excluded OR, PACU, and CLC.

Recommendation 10. We recommended that the VISN Director ensure that the Medical Center Director requires that staff revise the local policy regarding discharge documentation and consistently complete discharge documentation.

Concur **Target Date of Completion: Completed**

Plan: Requests by Veterans to be discharged while "on pass" are no longer be honored. All necessary components of the discharge process must be completed and documented within the facility and prior to discharge.

Recommendation 11. We recommended that the VISN Director ensure that the Medical Center Director requires that nurses consistently document the effectiveness of all pain medications within the required timeframe of the local policy.

Concur **Target Date of Completion: Completed**

Plan: A report to monitor PRN pain effectiveness will be run on a weekly basis as of June 1, 2009. The BCMA Coordinator and Nurse Managers will monitor the report and ensure appropriate documentation of PRN medication effectiveness has been completed. Corrective action(s) will be taken as necessary.

Recommendation 12. We recommended that the VISN Director ensure that the Medical Center Director requires ED staff to complete inter-facility transfer documentation, as required by VHA and local policy.

Concur **Target Date of Completion: August 1, 2009**

Plan: The Clinical Applications Coordinator and clinical team will revise the existing patient transfer template. The new template will be available through CPRS and utilized by all units.

OIG Contact and Staff Acknowledgments

Contact	Verena Briley-Hudson, MN, RN Director, Chicago and Kansas City Offices of Healthcare Inspections
Contributors	Reba B. Ransom, MSN, RN, Team Leader Judy Brown Dorothy Duncan, BSN, MHA, RN, CPHQ James Seitz, BSN, MBA, RN Randy Rupp, Office of Investigations

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