Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-02602-140

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

June 3, 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 March 16–20, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the VA Illiana Health Care System (the system), Danville, IL. 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 403 system employees. The system is part of Veterans Integrated Service Network (VISN) 11.

Results of the Review

The CAP review covered seven operational activities. We identified the following organizational strength and reported accomplishment:

- The system received recognition from the National Center for Patient Safety (NCPS).

We made recommendations in five of the activities reviewed. One environment of care (EOC) finding was a repeat finding from our prior CAP review. For these activities, the system needed to:

- Ensure that clinical privileges granted to contractors do not extend beyond the contract period.
- Ensure that managers fully implement the mechanism established to track cardiopulmonary resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) training compliance and ensure that employees complete the training.
- Correct identified cleanliness, pest control, infection control (IC), and patient safety issues.
- Establish effective processes to ensure that EOC deficiencies are identified and resolved.
- Ensure that consultation responses are received within the timeframe specified by system policy.
- Ensure that active outpatient medications are correctly listed in all discharge documentation.
- Ensure that emergency room (ER) physicians do not have responsibilities outside of the ER, in accordance with Veterans Health Administration (VHA) policy.

- Ensure that all inter-facility transfer documentation is in compliance with VHA and system policy.
- Ensure that medical record documentation for patients deemed at high risk for suicide is in compliance with VHA regulations and system policy.

The system complied with selected standards in the following two activities:

- Medication Management.
- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Verena Briley-Hudson, Director, Chicago and Kansas City Offices of Healthcare Inspections.

Comments

The VISN and System Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 14–18, for the full text of the Directors' comments). We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Profile

Organization. The system is an acute and long-term care facility located in Danville, IL, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at four community based outpatient clinics (CBOCs) in Decatur, Peoria, and Springfield, IL, and in West Lafayette, IN. The system is part of VISN 11 and serves a veteran population of about 147,000 throughout central Illinois and west central Indiana.

Programs. The system provides acute and sub-specialty medicine, surgery, mental health (MH), community living center (CLC),[1] palliative care, women's health, substance abuse, rehabilitation, and ambulatory care services. It has 129 hospital beds and 217 CLC beds.

Affiliations and Research. The system is affiliated with the University of Illinois' Colleges of Medicine at Urbana-Champaign and at Peoria and with Indiana University's School of Optometry and provides training for 45 medical residents. It also provides training for other disciplines, including audiology and speech pathology, dietetics, dental hygiene, music therapy, psychology, radiology, social work, technology, and therapeutic recreation. In fiscal year (FY) 2008, the system's research program had five protocols that were managed within the existing system budget. Important areas of research included diabetes, peripheral vascular disease, glaucoma, and nursing orientation.

Resources. In FY 2008, medical care expenditures totaled approximately $131.7 million. The FY 2009 medical care budget is approximately $181 million. FY 2008 staffing was 1,233 full-time employee equivalents (FTE), including 54 physician and 215 nursing FTE.

Workload. In FY 2008, the system treated 30,976 unique patients and provided 15,988 inpatient days in the hospital and 56,861 inpatient days in the CLC. The inpatient care workload totaled 3,137 discharges, and the average daily census, including CLC patients, was 202. Outpatient workload totaled 253,253 visits.

[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.

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 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 Operations.
- EOC.
- Medication Management.
- QM Program.
- SHEP.
- Suicide Prevention Program.

The review covered system operations for FY 2008 and FY 2009 through March 13, 2009, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on health care recommendations from our prior CAP review of the system (*Combined Assessment Program Review of the VA Illiana Health Care System, Danville, Illinois,* Report No. 05-03220-108, March 22, 2006). We had one repeat EOC finding from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 403 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.

Organizational Strength

National Center for Patient Safety Recognition

In 2008, VA's NCPS initiated a formal recognition program to enhance the root cause analysis (RCA) process and recognize facility-level patient safety efforts. The Cornerstone program measures each VA facility against standard criteria and assesses the volume of RCAs conducted, the timeliness of completion, and the number of strong and intermediate actions developed from the RCAs.

During FY 2008, the system conducted 25 RCAs. All 25 were completed within the established 45-day timeframe. The system implemented a core RCA "Lead" group, an RCA Timeline Tracking Tool, and a Leadership RCA Review Tool. For these efforts, the system was recognized nationally as one of the four VA medical facilities that received the "gold," which is the highest level of recognition in the Cornerstone program.

Results

Review Activities With Recommendations

Quality Management Program

The purpose of this review was to evaluate whether the system had a comprehensive and effective QM program designed to monitor patient care activities and coordinate improvement efforts and whether senior managers actively supported the program's activities. We interviewed the Director, the Chief of Staff, the Acting Chief of Quality Management, and key staff. We evaluated policies, performance improvement (PI) data, and other documents.

The QM program was generally effective in providing oversight of the system's quality of care, and senior managers supported the program through evaluation of PI

initiatives and through allocation of resources to the program. Appropriate review structures were in place for 12 of the 14 program activities reviewed. We identified two areas that needed improvement.

Credentialing and Privileging. VHA policy[2] requires that clinical privileges be granted for a period not to exceed 2 years and that privileges granted to contractors do not extend beyond the contract period. We reviewed the credentialing and privileging folders and corresponding contracts of seven contractors who had been initially privileged or reprivileged during the past 12 months. We found that five contractors had been granted clinical privileges that extended beyond the contract period.

CPR and ACLS Training. VHA policy[3] requires each medical facility to have a local policy governing CPR and ACLS training and a mechanism for monitoring the maintenance of this training.[4] The system had a policy addressing the requirements for CPR and ACLS training and a plan for monitoring compliance with the policy. We found that the mechanism for tracking CPR training had only been partially implemented, which resulted in an incomplete database. We reviewed the database and found that 61 employees who were required to maintain CPR certification were delinquent at the time of our visit. Because the mechanism was not being used to monitor ACLS training, we were unable to determine the status of ACLS certification for employees required to maintain it.

Recommendation 1 We recommended that the VISN Director ensure that the System Director requires that clinical privileges granted to contractors do not extend beyond the contract period.

The VISN and System Directors concurred with our finding and recommendation. The Professional Standards Board met and privilege end dates were changed to meet contract date requirements. The improvement plan is acceptable, and we will follow up to ensure implementation.

[2] VHA Handbook 1100.19, *Credentialing and Privileging*, October 2, 2007.
[3] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.
[4] After the completion of initial CPR and ACLS training, employees are required to complete review training every 2 years.

Recommendation 2 We recommended that the VISN Director ensure that the System Director requires that managers fully implement the mechanism established to track CPR and ACLS training compliance and that employees complete the training in accordance with system policy.

The VISN and System Directors concurred with our findings and recommendation. The Education Service will set up a Basic Life Support and ACLS class in the Learning Management System, and employees who need to complete training will be assigned to the class. The Education Service will report on employee certification status monthly. 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 system complied with selected IC standards and maintained a safe and clean patient care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VA NCPS, Occupational Safety and Health Administration, and Joint Commission (JC) standards.

We inspected the medical, medical/surgical, and locked MH units and one CLC unit. We also followed up on EOC findings from our prior CAP review. Additionally, we asked for randomly selected preventive maintenance (PM) records for five defibrillators, one ventilator, and one electrocardiogram monitor to determine if PM was accomplished timely. All of these equipment items received PM at the required intervals. We identified the following areas that needed improvement.

Cleaning in Patient Care Areas. We identified the need for greater attention to detail in the cleaning of patient rooms and restrooms, especially along baseboards and in floor corners. Also, managers need to ensure routine cleaning of medication and storage rooms as we noted debris accumulation on floors.

Pest Control. We observed an active pest problem in the dining room of one patient care unit. Managers were uncertain if any actions had been initiated to address the problem. Additionally, we observed dead insects in light banks, between windows, and in patient care areas. Timely actions are necessary when active pest problems are

identified to ensure proper cleaning and the removal of dead insects.

IC. We observed that emergency call system cords—usually located near commodes, sinks, and in shower areas—were made of rope and could not be easily cleaned or disinfected. These cords need to be replaced with a more suitable material, such as plastic. We found furniture, mattresses, and other patient care equipment items with compromised surfaces. Items such as these need to be regularly inspected, and those with compromised surfaces need to be repaired or removed from service. Also, we observed dust accumulation on air ventilation system covers and on internal ducts. This was a repeat finding from our prior CAP review. A routine cleaning schedule of the air ventilation system covers and ducting needs to be established to minimize the potential for the spread of infections.

Patient Safety. We observed damaged laminate counter surfaces in patient restrooms, broken cabinetry, and damaged ceramic tiles. Employees need to identify and initiate work orders for the repair of items that may cause patient injury. We determined that managers had not ensured that required crash cart and defibrillator checks and medication and nourishment refrigerator temperature monitoring were accomplished in accordance with local policy. Also, we observed unsecured cleaning products and other patient care items, such as hydrogen peroxide, sodium chloride, and betadine. These items need to be secured to prevent accidental or purposeful ingestion. Additionally, we observed that multi-use vials of medications were not always dated when first used. As a result, staff might not recognize when the medications expire.

EOC Rounds. We reviewed findings from the system's most recent EOC rounds inspection of one patient care area and compared the findings with those from our inspection of the area. We identified a number of deficiencies that were not included in the system's findings; however, some of these deficiencies had existed for several months. Managers need to ensure that members of the EOC rounds team are properly trained to identify cleanliness, pest control, IC, and patient safety issues.

Recommendation 3 We recommended that the VISN Director ensure that the System Director takes action to correct identified cleanliness, pest control, IC, and patient safety issues.

The VISN and System Directors concurred with our findings and recommendation. A schedule for cleaning patient care areas has been established, and the pest control program has been enhanced. All pull cords have been replaced with cords that can be cleaned and disinfected. Nursing Service is conducting daily environmental rounds to monitor patient safety issues. 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 System Director establishes effective processes to ensure that EOC deficiencies are identified and resolved.

The VISN and System Directors concurred with our findings and recommendation. A training session on identifying cleanliness, pest control, IC, and patient safety issues will be held for service chiefs, supervisors, and all employees who participate in EOC rounds. A workgroup has been tasked to establish a mechanism to report the status of delinquent work orders. 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 consultations, intra-facility 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 optimal patient outcomes.

We determined that clinicians appropriately managed all 12 intra-facility transfers reviewed. We found appropriate hand-off communication between providers and between nursing staff. Sending and receiving unit documentation was completed timely and in accordance with system policy. We identified two areas that needed improvement.

Consultations. We reviewed the medical records of 12 inpatients who had consultations ordered and performed internally. Two (17 percent) of the 12 consultation requests did not receive responses within the timeframe specified by system policy. Also, system policy requires that when a

STAT[5] consultation is requested, the provider must contact the consulted department to discuss the patient's needs. There was no evidence of communication between the provider and the consulted department for the one STAT consultation in our sample.

Discharges. We reviewed the medical records of 12 discharged patients. We found that 3 (25 percent) of the records contained inconsistencies between active outpatient medications listed in the provider's discharge summary, those listed in the discharge instructions, and/or those listed in the medication reconciliation note.

Recommendation 5 We recommended that the VISN Director ensure that the System Director takes action to ensure that consultation responses are received within the timeframe specified by system policy.

The VISN and System Directors concurred with our findings and recommendation. The Chief of Staff has established a workgroup to review and revise system policy. Staff will be educated regarding the policy revision. 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 System Director requires that active outpatient medications are correctly listed in all discharge documentation.

The VISN and System Directors concurred with our findings and recommendation. The Patient Safety Committee (PSC) will develop a medication reconciliation tool. Each service will conduct monitoring. Results will be assessed by the PSC. 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 the system's ER complied with VHA guidelines related to hours of operation, clinical capability, staffing adequacy, and nursing staff competency. In addition, we inspected the ER environment for cleanliness and safety.

The ER is located in Building 98 and is open 24 hours per day, 7 days per week, as required for ER designation. The emergency services provided are within the system's patient

[5] Derived from the Latin word "statim," which means immediately.

care capabilities. In addition, the system has a procedure in place for the management of patients whose care may exceed the system's capability.

We toured the ER and found the environment to be safe for the delivery of patient care. We determined that nurse staffing plans met local requirements and that nursing competencies were appropriately documented. We examined three medical equipment items and found that PM was completed, as required. We reviewed the medical records of five patients who presented to the ER with acute MH conditions and found that all five patients were managed appropriately. We identified two conditions that needed improvement.

ER Physician Coverage. The ER utilizes 1 full-time physician for regular tours of duty and 18 contracted physicians for off-tour, weekend, and holiday coverage. We found that physicians left the ER without coverage when they were requested to pronounce a patient's death in the inpatient and CLC units. We reviewed the medical records of three deceased patients and found that their deaths were pronounced by ER physicians. VHA policy[6] requires that ER physicians have no responsibilities outside of the ER.

Inter-Facility Transfers. We reviewed the medical records of two patients who were transferred out of the ER to local private hospitals and found that they did not contain one or more of the following: (a) documented evidence of date and time of the transfer, (b) an informed consent, (c) designation of the level of care required during transportation, or (d) documentation of the patient's advanced directive status prior to transfer. VHA[7] and system policy require completion of an inter-facility transfer form, which is to be sent to the receiving facility at the time of transfer. ER staff confirmed that they were not using the mandated "VISN 11 Medical Center Inter-Facility Transfer Form."

Recommendation 7 We recommended that the VISN Director ensure that the System Director requires that ER physicians do not have responsibilities outside of the ER, in accordance with VHA policy.

[6] Deputy Under Secretary for Health for Operations and Management, "Clarification of Provider Staffing Requirements for Emergency Departments and Urgent Care Clinics in VHA," memorandum, April 18, 2008.
[7] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.

The VISN and System Directors concurred with our findings and recommendation. The system has developed a contract statement of work for hospitalist coverage for evenings, weekends, and holidays. Once contract staff are on board, ER physicians will no longer have responsibilities outside of the ER. 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 System Director requires that all inter-facility transfer documentation is in compliance with VHA and system policy.

The VISN and System Directors concurred with our findings and recommendation. The system is now using forms that meet VHA requirements. The improvement plan is acceptable, and we will follow up to ensure implementation.

Suicide Prevention Program

The purpose of this review was to determine whether VHA health care facilities had implemented a suicide prevention program that was in compliance with VHA regulations. We assessed whether senior managers had appointed Suicide Prevention Coordinators (SPCs) at facilities and very large CBOCs,[8] and we evaluated whether SPCs fulfilled all required functions. Also, we verified whether medical records of patients determined to be at high risk for suicide contained Category II Patient Record Flags (PRFs),[9] documented safety plans that addressed suicidality, and documented collaboration between MH providers and SPCs.

We interviewed the system's SPC, and we reviewed pertinent policies and the medical records of five system patients and five CBOC patients determined to be at risk for suicide. We found that the suicide prevention program was generally effective. However, we identified the following area that needed improvement.

Medical Record Review. We reviewed 10 medical records and found that all had the required PRFs. However, 2 (20 percent) of the 10 records did not contain evidence of safety plans, and 1 of these 2 records did not have evidence of a 90-day review for continued placement, as required by system policy. Additionally, we identified that 1 (10 percent) of the 10 records had a current PRF and a safety plan but did not have documented evidence of collaboration between

[8] Very large CBOCs are defined as clinics with more than 10,000 unique patients enrolled.
[9] A Category II PRF is an alert mechanism that is displayed prominently in medical records.

the SPC and MH providers. VHA regulations[10] require that all medical records of patients at high risk for suicide have a Category II PRF and a safety plan and show evidence of collaboration.

Recommendation 9 We recommended that the VISN Director ensure that the System Director requires that medical record documentation for patients deemed at high risk for suicide is in compliance with VHA regulations and system policy.

The VISN and System Directors concurred with our findings and recommendation. The SPC and the case manager will monitor high-risk patients daily to ensure that they have PRFs and completed safety plans. Also, the SPC and the case manager will assure ongoing, interdisciplinary collaboration. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Medication Management

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

We reviewed selected medication management processes in the locked MH, intensive care, and medical/surgical units and in two CLC units. We found adequate management of medications brought into the system by patients or their families. Nurses appropriately scanned patient armbands and used personal identifiers to correctly identify patients prior to medication administration. Also, we found that reconciliation of controlled substances discrepancies at the unit level was adequate.

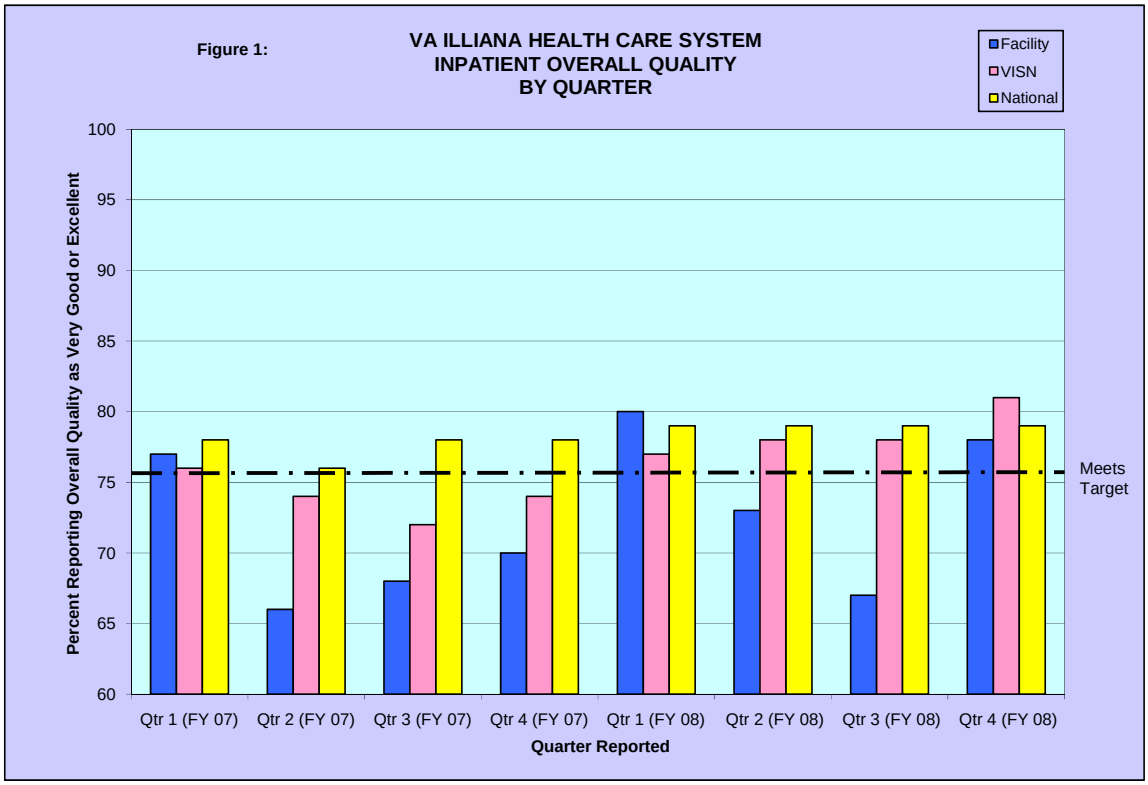
We reviewed 44 randomly selected doses of PRN (as needed) pain medication to determine if clinicians documented effectiveness within 4 hours of administration, as required by system policy. Clinicians met this requirement in 41 (93 percent) of the doses. We made no recommendations.

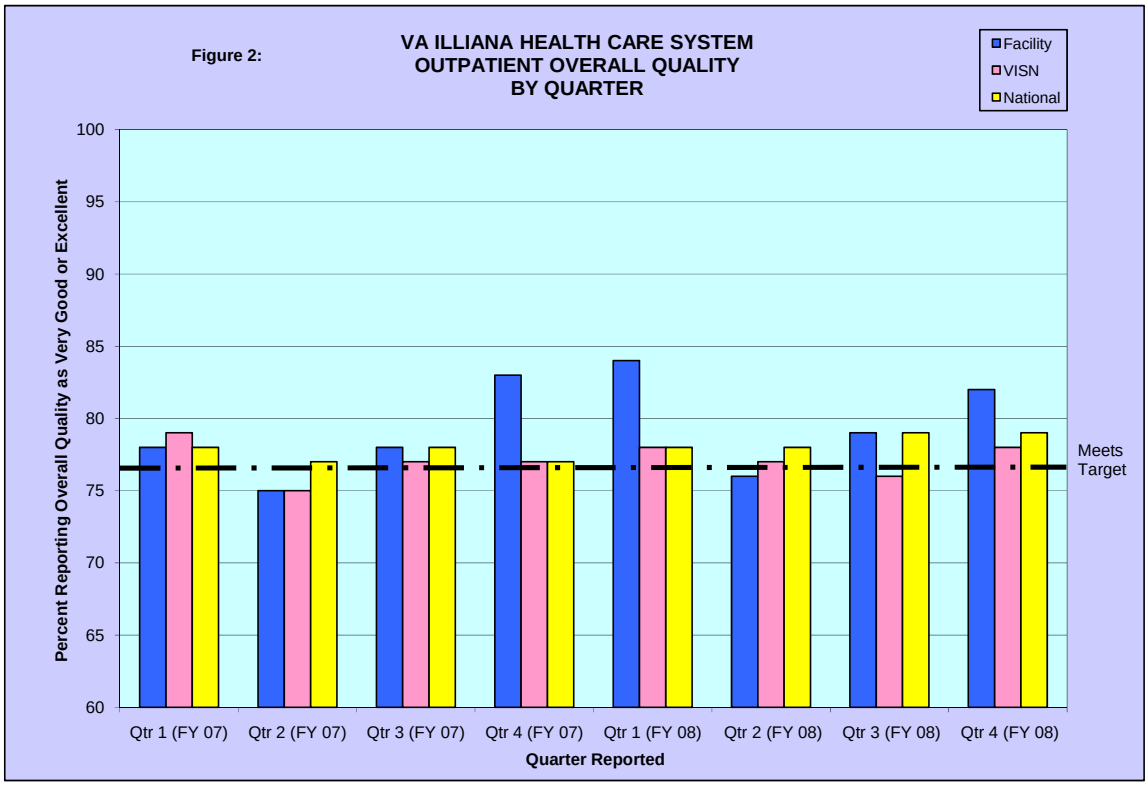
[10] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008.

Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that the system used quarterly SHEP results to improve patient care, treatment, and services. The Performance Analysis Center for Excellence of the Office of Quality and Performance within VHA is the analytical, methodological, and reporting staff for SHEP. VHA set performance measure results for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients.

Figures 1 and 2 (below and on the next page) show the system's SHEP performance measure results for inpatients and outpatients, respectively.





We reviewed survey results for FYs 2007 and 2008. The system's inpatient results exceeded the target in 3 of the 8 quarters reviewed. The system's outpatient results exceeded the target in 6 of the 8 quarters reviewed. Managers had analyzed survey results, identified opportunities for improvement, initiated an action plan, and evaluated the plan for effectiveness. Therefore, we made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 22, 2009

From: Director, Veterans In Partnership Network (10N11)

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

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

Director, Management Review Service (10B5)

Per your request, attached is the response to the draft report from VA Illiana HCS.

If you have any questions, please contact Jim Rice, VISN 11 QMO, at (734) 222-4314.

MICHAEL S. FINEGAN

Attachment

System Director Comments

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 System Director requires that clinical privileges granted to contractors do not extend beyond the contract period.

Concur **Target Date of Completion: April 2, 2009**

Plan of action: The Professional Standards Board met and privilege end dates were changed to meet contract date requirements.

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires that managers fully implement the mechanism established to track CPR and ACLS training compliance and that employees complete the training in accordance with system policy.

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

Plan of action: The Education Service will set up a class in LMS of everyone that needs to complete BLS and ACLS and an assignment will be made utilizing assignment profile. Reports can than be run against the LMS item for BLS and ACLS showing employees certification status, including deficiencies and upcoming renewals. The Education Service will run this report and send to service chiefs and report through the Education and Training Committee monthly.

Recommendation 3. We recommended that the VISN Director ensure that the System Director takes action to correct identified cleanliness, pest control, IC, and patient safety issues.

Concur **Target Date of Completion: Listed below.**

Plan of action:

- **Cleaning Patient Care Areas:** A schedule has been established for the Chief of EMS and supervisors to make weekly rounds utilizing a checklist in the patient care areas. The cleaning schedule for all units includes weekly and as needed cleaning of medication and storage rooms. (Completed: April 24, 2009)

- **Pest Control:** The pest control program has been enhanced to increase frequency and surveillance. Part of the weekly rounds being conducted by EMS includes quality control of pest control contract and making enhancements. (Completed: April 1, 2009)

- **Infection Control:** All pull cords have been replaced by cords that can be cleaned and disinfected after use (Completed: April 13, 2009). EOC rounds include inspection of furniture, equipment, etc., along with staff education to identify deficiencies more timely. (Completed: May 1, 2009)

- **Patient Safety:** Nurse Managers met with staff regarding importance of completion of monitors for crash cart/defibrillator and refrigerator temperature. On going surveillance of these monitors, along with unsecured cleaning products and medications are part of regular environmental rounds conducted by Nursing Service daily and will be reemphasized with staff during rounds. (Completed: April 30, 2009)

Recommendation 4. We recommended that the VISN Director ensure that the System Director establishes effective processes to ensure that EOC deficiencies are identified and resolved.

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

Plan of action:

- A training session to identify cleanliness, pest control, IC, and patient safety issues will be held for all employees who participate in the facility EOC rounds, service chiefs, and supervisors.

- EOC checklist and deficiency list are sent to the area of inspection two weeks prior so staff can perform EOC rounds proactively.

- A workgroup has been established to identify and develop an administrative system redesign to establish a mechanism to report status of work orders greater than 30 days for evaluation and improve timeliness of completion.

Recommendation 5. We recommended that the VISN Director ensure that the System Director takes action to ensure that consultation responses are received within the timeframe specified by system policy.

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

Plan of action: The Chief of Staff has established a workgroup to review and revise the MCM to address the OIG findings. Staff education will be provided in conjunction with finalization of the policy revision.

Recommendation 6. We recommended that the VISN Director ensure that the System Director requires that active outpatient medications are correctly listed in all discharge documentation.

Concur **Target Date of Completion: January 1, 2010**

Plan of action:

- The PSC will evaluate development of a medication reconciliation tool to be shared with staff. (Completion: September 1, 2009)
- Each service will monitor and review at least 10 records per provider (if less than 10 then 100% of records) each month to check for consistency/accuracy for a period of one quarter. (Completion: September 1, 2009 to November 30, 2009)
- Results will be assessed by PSC for further compliance analysis. (Completion: December 12, 2009)
- Add this monitor to service chiefs ECF performance plans and will be updated with this monitor in their mission critical element.

Recommendation 7. We recommended that the VISN Director ensure that the System Director requires that ER physicians do not have responsibilities outside of the ER, in accordance with VHA policy.

Concur **Target Date of Completion: December 15, 2009**

Plan of action: In order to address compliance with VHA policy, VA Illiana Health Care System has developed a contract statement of work for Hospitalist coverage for evenings, weekends, and holidays. Once the contract has been announced and contract staff on board, Emergency Department physicians will not have responsibilities outside of the Emergency Department.

Recommendation 8. We recommended that the VISN Director ensure that the System Director requires that all inter-facility transfer documentation is in compliance with VHA and system policy.

Concur **Target Date of Completion: May 2009**

Plan of action: The use of the forms meeting the requirements as set forth in VHA Directive 2007-015 was implemented shortly before the OIG visit and is fully implemented at this time.

Recommendation 9. We recommended that the VISN Director ensure that the System Director requires that medical record documentation for

patients deemed at high risk for suicide is in compliance with VHA regulations and system policy.

Concur **Target Date of Completion: May 7, 2009**

Plan of action: The SPC and new Case Manager provide additional daily monitoring of veterans at high risk for suicidal behavior to ensure they have a patient record flag and a completed safety plan with subsequent reviews and timely follow-up. Interdisciplinary collaboration and consensus regarding high risk cases is ensured through SPC and case manager attendance at inpatient treatment team meetings. SPC and case manager assure ongoing interdisciplinary collaboration and communication with outpatient providers through telephone consultation(s) and adding the providers as additional signers of their progress notes.

OIG Contact and Staff Acknowledgments

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