Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-02604-214

Combined Assessment Program Review of the Iowa City VA Medical Center Iowa City, Iowa

September 16, 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 June 15–19, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the Iowa City VA Medical Center (the medical center), Iowa City, IA. 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 29 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 23.

Results of the Review

The CAP review covered seven operational activities and one follow-up review area. We identified the following organizational strength and reported accomplishment:

- Special programs provide therapeutic benefits.

We made recommendations in six of the activities reviewed and in the follow-up review area. (One environment of care (EOC) recommendation was a repeat recommendation from our prior CAP report.) For these six activities and the follow-up review area, the medical center needed to assure that:

- Clinical privileges granted to contractors do not extend beyond the contract period.
- Credentialing and privileging (C&P) documentation is maintained in accordance with Veterans Health Administration (VHA) policy.
- Supervisors provide written notification of completed peer review (PR) actions to the Peer Review Committee (PRC) and that committee minutes reflect actions taken.
- Clinical disclosure of adverse events is conducted and documented in accordance with VHA policy.
- Identified safety deficiencies are corrected.
- Identified patient privacy deficiencies are corrected.
- Locked mental health (MH) unit staff and Multidisciplinary Safety Inspection Team (MSIT) members receive environmental hazards training, as required by VHA.
- Patient discharge summaries include active outpatient medications.

- Proper medication disposition is initiated for medications brought into the medical center by MH patients.
- Documentation of Suicide Prevention Coordinator (SPC) and MH provider collaboration for patients deemed at high risk for suicide is in compliance with VHA regulations.
- Emergency Department (ED) staff complete all inter-facility transfer documentation in accordance with VHA policy.
- Processes are defined to ensure effective hand-off communications when ED patients are admitted to inpatient units in the medical center.
- ED managers complete competency assessments in accordance with medical center policy.
- Community nursing home (CNH) patients receive follow-up visits and monitoring in accordance with VHA policy.

The medical center complied with selected standards in the following activity:

- 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 Acting VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 17–23 for 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 medical center is located in Iowa City, IA, and provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at a satellite clinic in Coralville, IA, and at five community based outpatient clinics (CBOCs) in Bettendorf, Dubuque, and Waterloo, IA, and in Galesburg and Quincy, IL. The medical center is part of VISN 23 and serves a veteran population of about 184,000 throughout eastern Iowa and western Illinois.

Programs. The medical center provides primary care, specialty care, MH services, extended care and rehabilitation, and social work services. Additional programs focus on Operation Iraqi Freedom/Operation Enduring Freedom and women veterans. The medical center has 93 hospital beds.

Affiliations and Research. The medical center is affiliated with the University of Iowa's Carver College of Medicine and provides training for 97 residents. It also provides training in other health professions, including nursing, pharmacy, dentistry, social work, audiology, clinical laboratory science, and psychology.

In fiscal year (FY) 2008, the medical center research program had 51 VA-funded projects, 200 active research protocols, and a budget of $11 million from the VA and $24.5 million from external sources. Important areas of research included the biology of inflammation, diabetic vascular disease, cancer, immunology, health services, rehabilitation, glaucoma and other visual problems, traumatic brain injury, and post-traumatic stress disorder.

Resources. In FY 2008, medical care expenditures totaled $213.8 million. The FY 2009 medical care budget is $218.7 million. FY 2008 staffing was 1,220 full-time employee equivalents (FTE), including 83 physicians, 13 physician assistants, 16 nurse practitioners, and 229 nurses.

Workload. In FY 2008, the medical center treated 40,541 unique patients and provided 18,803 inpatient days in the hospital. The inpatient care workload totaled 3,380 discharges, and the average daily census was 51. Outpatient workload totaled 238,862 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:

- 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 and one follow-up review area:

- Coordination of Care.
- Emergency/Urgent Care (E/UC) Operations.
- EOC.
- Follow-Up on VA CNH Program.
- Medication Management.
- QM Program.
- SHEP.
- Suicide Prevention Program.

The review covered medical center operations for FY 2008 and FY 2009 through June 12, 2009, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the VA Iowa City Health Care System, Iowa City, Iowa,* Report No. 06-01602-219,

September 25, 2006). We had repeat findings from our prior CAP review in EOC and in the follow-up review area.

During this review, we also presented fraud and integrity awareness briefings for 29 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. The activity in the "Review Activity Without Recommendations" section had no reportable findings.

Organizational Strength

Special Programs Provide Therapeutic Benefits

Golf for Veterans Everywhere (GIVE) is a partnership between the Riverside Blue Top Golf Course, the Iowa Section of the Professional Golfers' Association, and the medical center. The program is rehabilitative in nature, providing golf instruction and socialization for veterans who suffer from post-traumatic stress disorder, traumatic brain injury, and other medical or MH conditions. It has educated the public to the challenges faced by veterans in their local communities and has been featured in local and national media. The program is provided at no cost, and class size averages 15–20 veterans. The fifth class will be completed during 2009.

The TEE (training, experience, and exposure) Tournament is an annual event that uses a therapeutic format to provide veterans with an opportunity to develop new skills and strengthen self-esteem through participation in adaptive golf and bowling. The medical center has hosted this event for visually impaired veterans for the past 15 years, and due to the program's success and the efforts of the GIVE partners, the event is now recognized as one of six VA national rehabilitation special events.

Results

Review Activities With Recommendations

Quality Management Program

The purpose of this review was to evaluate whether the medical center 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 senior managers, the Quality and Performance Improvement (PI) Program Manager, and key staff. We evaluated policies, PI data, 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 through participation in and evaluation of PI initiatives and through allocation of resources to the program. Appropriate review structures were in place for 11 of the 14 program activities reviewed. We identified three areas that needed improvement.

C&P. VHA policy[1] 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 C&P folders and corresponding contracts of nine contractors who had been privileged or reprivileged during the past 12 months. All nine contractors had been granted clinical privileges that extended beyond the contract period.

VHA policy also requires that service chiefs review all C&P information and document the review. Requirements include listing the documents reviewed and providing the rationale for conclusions. We reviewed the C&P folders and physician profiles for 14 physicians who had been initially privileged or reprivileged during the past 12 months and found that the documentation did not fully address the information reviewed and the rationale for the conclusions. Additionally, the privileging decision of the medical staff's Executive Committee must be documented, and the minutes must reflect the documents reviewed and the rationale for the stated conclusion. We found that committee minutes reflected the documents reviewed and the rationale for the decision for only 2 (14 percent) of the 14 physicians.

[1] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

PR. When a final Level 2 or 3 is assigned to a PR by the PRC, VHA policy[2] requires that the provider's supervisor communicate with the provider and assure that appropriate non-disciplinary, non-punitive action is implemented. The supervisor is to provide written notification, which contains feedback on the completed action, to the PRC. We found that supervisors had not provided written notification to the PRC.

Adverse Event Disclosure. VHA policy[3] requires that clinical disclosures of significant adverse events be documented in the electronic medical record. We requested documentation of clinical disclosure for adverse events that occurred from June 2008 through May 2009. The medical center did not maintain a log of clinical disclosures and was unable to provide medical record documentation.

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

The Acting VISN and Medical Center Directors agreed with the finding and recommendation. The C&P Coordinator has a list of all sharing agreements and associated expiration dates. As contract physicians' privileges become due for renewal, the privileges granted will not extend beyond the contract period. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 2 We recommended that the Acting VISN Director ensure that the Medical Center Director requires that C&P documentation is maintained in accordance with VHA policy.

The Acting VISN and Medical Center Directors agreed with the findings and recommendation. Since April 2009, the privileging decisions of the Provider Staff Evaluation and Credentialing Subcommittee have been appropriately documented. Minutes reflect that documents have been reviewed and also reflect the rationale for the stated conclusions. The corrective actions are acceptable, and we consider this recommendation closed.

[2] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.
[3] VHA Directive 2008-002, *Disclosure of Adverse Events to Patients*, January 18, 2008.

Recommendation 3 We recommended that the Acting VISN Director ensure that the Medical Center Director requires that supervisors provide written notification of completed PR actions to the PRC and that committee minutes reflect actions taken.

The Acting VISN and Medical Center Directors agreed with the finding and recommendation. The Risk Manager has developed a form for use when the PR Advisory Group (PRAG) has assigned a final Level of 2 or 3 to a case. This form is completed by the service chief, who speaks with the involved provider, provides education/counseling about the issue involved, and documents any other follow-up. The form is noted in the next PRAG meeting minutes as written follow-up for a PR recommendation and is permanently filed in the PR case folder. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 4 We recommended that the Acting VISN Director ensure that the Medical Center Director requires that clinical disclosure of adverse events is conducted and documented in accordance with VHA policy.

The Acting VISN and Medical Center Directors agreed with the finding and recommendation. A Computerized Patient Record System (CPRS) template is being developed for clinical disclosure of adverse events. All clinical disclosures will be documented using this template and will be tracked by Patient Safety and Quality Improvement. The implementation 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 if the medical center complied with selected infection control (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 National Center for Patient Safety, Occupational Safety and Health Administration, and Joint Commission (JC) standards.

We inspected the inpatient medical unit (5E), the surgical unit (5W), the locked MH unit (9E), the telemetry unit (7E), the intensive care unit (ICU), the dialysis unit, the eye clinic, and primary care clinics.

We evaluated the IC program to determine compliance with VHA directives. IC staff appropriately collected, trended, and analyzed data related to infections, and they involved

clinicians in improvement initiatives to reduce infection risks for patients and staff. IC staff also provided in-service education as new health concerns were identified.

We also followed up on recommendations from our prior CAP review and identified unsecured sharp items and unsecured cleaning products as repeat findings. (See below.)

The medical center was generally clean and effectively maintained. Nurse managers and unit staff expressed satisfaction with the responsiveness of the housekeeping staff on their units. We identified the following areas that needed improvement.

Safety. Medications and cleaning products must be secured when not in use. Bags of intravenous fluids were stored in an unlocked room and under the kitchenette sink on the surgical unit. We found an unlocked medication cart in the hallway on the medical unit. Unsecured medications were also found in the ICU men's staff locker room and on a desktop in the eye clinic. Unsecured cleaning products were found in a men's restroom on the surgical unit, in the soiled utility rooms on the medical unit and in the ED, and in the eye clinic.

Sharp items must be secured from public access. We found unsecured sharp items in the medical unit's soiled utility room, in the dialysis unit's clean utility room and isolation room, and in an unlocked cart located in the center of the dialysis unit. In the ICU, we found scissors and knives in the unlocked staff break room and sharp items in the unlocked anteroom and in unlocked treatment carts. On the surgical unit, we noted unsecured respiratory supplies that included sharp items. We also found unsecured sharp items in the primary care clinics.

Patient Privacy. Federal law requires the protection of sensitive patient information. A computer with an active screen was left unattended in the ICU, leaving the patient's name, social security number, date of birth, and health information accessible. In the eye clinic, an unsecured computer with digital camera imaging capability was not properly logged off.

Environmental Hazards Training. VHA requires that all staff who work on locked MH units and members of the MSIT

receive training on the environmental hazards that represent a threat to suicidal patients.[4] We reviewed position-specific competency assessment checklists for 26 locked MH unit employees and noted that 23 (88 percent) had not received this training. Additionally, MSIT members were also lacking this training.

Recommendation 5 We recommended that the Acting VISN Director ensure that the Medical Center Director requires that identified safety deficiencies are corrected.

The Acting VISN and Medical Center Directors agreed with the findings and recommendation. A section has been added to JC Readiness Rounds regarding security of medications, sharps, respiratory supplies, and cleaning products. New supply carts have been ordered for the ICU unit. Managers are currently reviewing all clinical areas to ensure compliance. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 6 We recommended that the Acting VISN Director ensure that the Medical Center Director requires that identified patient privacy deficiencies are corrected.

The Acting VISN and Medical Center Directors agreed with the findings and recommendation. The Privacy Officer and Information Security Officer conduct weekly EOC rounds to check for privacy and information security violations. They have increased awareness by educating staff on privacy and information security policies. All employees, volunteers, and contractors are required to complete privacy and information security training annually and to comply with medical center policy. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 7 We recommended that the Acting VISN Director ensure that the Medical Center Director requires that locked MH unit staff and MSIT members receive environmental hazards training, as required by VHA.

The Acting VISN and Medical Center Directors agreed with the findings and recommendation. All locked MH unit staff and MSIT members will complete training. Training will be

[4] Deputy Under Secretary for Health for Operations and Management, "Mental Health Environment of Care Checklist," memorandum to Network Directors, August 27, 2007.

reflected on annual competency assessments. The implementation 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 reviewed consultations, discharges, and intra-facility transfer documentation for three patients per bed service (medicine, surgery, and MH). We determined that clinicians appropriately managed patient consultations and intra-facility transfers in accordance with medical center policy. We identified one area that needed improvement.

Discharges. VHA policy[5] requires the provider to document in the discharge summary those medications that the patient should take after being discharged from the facility. For the three surgical unit patients whose records we reviewed, we identified that providers did not include all active outpatient medications in the patients' discharge summaries.

Recommendation 8 We recommended that the Acting VISN Director ensure that the Medical Center Director requires that patient discharge summaries include active outpatient medications.

The Acting VISN and Medical Center Directors agreed with the finding and recommendation. The Chief of Staff has requested that the Surgical Specialty Service Line ensure that all active outpatient medications are included in surgery discharge summaries. Monthly medical record audits will be completed by the service line to ensure compliance. The implementation 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 for three inpatient units. We found appropriate use of patient

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

armbands to correctly identify patients prior to medication administration. We identified one area that needed improvement.

Medication Disposition Upon Admission. Medical center policy requires that medications brought into the facility by a patient be identified by the physician and, whenever possible, returned to family members or mailed back to the patient's residence. During our inspection of the locked MH unit, we found patient medications brought from patients' homes stored in the medication room. We also found medications belonging to a discharged patient stored in this area. Additionally, we found controlled substances stored in a locked cabinet in the medication room with other patient personal belongings. This storage of patient medications is contrary to medical center policy. Staff expressed concerns regarding medication disposition challenges for the MH patient population.

Recommendation 9 We recommended that the Acting VISN Director ensure that the Medical Center Director requires the proper disposition of medications brought into the medical center by MH patients.

The Acting VISN and Medical Center Directors agreed with the findings and recommendation. All patient medications brought into the medical center are being sent home with family members or mailed to the patients' homes. Medications for homeless patients are being stored in the outpatient pharmacy until the patients are discharged. Daily checks are performed to ensure that no patient medications are kept on the unit. The corrective actions are acceptable, and we consider this recommendation closed.

Suicide Prevention Program

The purpose of this review was to determine whether VHA health care facilities had implemented suicide prevention programs that were in compliance with VHA regulations.[6] We assessed whether senior managers had appointed SPCs at facilities and very large CBOCs,[7] 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),[8] documented safety plans that

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

addressed suicidality, and documented collaboration between MH providers and SPCs.

We interviewed the medical center's SPCs and a MH provider, and we reviewed pertinent policies. We reviewed the medical records of seven medical center patients and three CBOC patients determined to be at high risk for suicide. All 10 records contained the required PRFs and safety plans. We identified one area that needed improvement.

Collaboration Between SPCs and MH Providers. Three (30 percent) of the 10 medical records did not show clear evidence of collaboration between the SPCs and MH providers.

Recommendation 10 We recommended that the Acting VISN Director ensure that the Medical Center Director requires compliance with VHA regulations regarding documentation of SPC and MH provider collaboration for patients deemed at high risk for suicide.

The Acting VISN and Medical Center Directors agreed with the finding and recommendation. Patients at high risk for suicide are identified by the treatment team, and a note is entered in CPRS by the SPC. Members of the treatment team have been added as additional signers of this progress note, and concurrence is noted by their electronic signature. An audit of patients flagged in the past 6 months shows 100 percent compliance with treatment team documentation. The corrective actions are acceptable, and we consider this recommendation closed.

Emergency/Urgent Care Operations

The purpose of this review was to evaluate whether the medical center's ED complied with VHA guidelines related to hours of operation, clinical services, consultations, transfers, staffing, and staff competencies. In addition, we inspected the ED physical environment for cleanliness and safety.

The ED is located in the main hospital and operates 24 hours a day, 7 days a week, as required for ED designation. Emergency services provided are within the medical center's patient care capabilities, and a policy is in place for managing patients whose care exceeds the medical center's capability. We identified three areas that needed improvement.

Inter-Facility Transfers. We reviewed the medical records of three patients transferred from the ED to other facilities. ED staff did not comply with VHA regulations[9] and local policy for inter-facility transfers, which require completion of all necessary documentation prior to patient transfer. In all three records reviewed, staff failed to document patient eligibility information, reason for transfer, type and level of services required, consent, and condition on transfer.

Admissions. We reviewed five medical records of ED patients who were admitted to an inpatient unit within the medical center. None of these records showed evidence of registered nurse (RN) hand-off communication. Two weeks prior to our site visit, ED managers created a process for nursing hand-off; however, the records we reviewed lacked sufficient documentation.

Competency Assessment. Medical center policy requires that competency assessments be conducted annually. We reviewed three ED RN competency folders, and all lacked current assessments. For two RNs, managers were delinquent with the previous year of competency assessments; the third RN lacked 2 years of assessments.

Recommendation 11 We recommended that the Acting VISN Director ensure that the Medical Center Director requires that ED staff complete all inter-facility transfer documentation in accordance with VHA policy.

The Acting VISN and Medical Center Directors agreed with the findings and recommendation. A multidisciplinary workgroup has reviewed VHA policy and is completing an electronic progress note template that will meet requirements. ED staff will complete all inter-facility transfer documentation in accordance with VHA policy, and monthly audits will be conducted to ensure compliance. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 12 We recommended that the Acting VISN Director ensure that the Medical Center Director defines processes to ensure effective hand-off communications when ED patients are admitted to inpatient units in the medical center.

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

The Acting VISN and Medical Center Directors agreed with the finding and recommendation. A template was developed and has been implemented. The medical center's policy on hand-off communications will be updated to reflect changes to the process. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 13 We recommended that the Acting VISN Director ensure that the Medical Center Director requires that ED managers complete competency assessments in accordance with medical center policy.

The Acting VISN and Medical Center Directors agreed with the findings and recommendation. ED staff have been educated, and competencies have been completed in accordance with the annual review requirement. The corrective actions are acceptable, and we consider this recommendation closed.

Follow-Up on VA Community Nursing Home Program

As a follow-up to a recommendation from our prior CAP review, we reassessed the medical center's compliance with selected requirements in VHA policy[10] regarding monitoring of and follow-up visits for patients placed in VA contract CNHs. In addition, we reexamined CNH oversight committee membership and the reporting process to clinical leadership to assess compliance with VHA policy.

The medical center had completed one of the corrective actions from the previous CAP review by appointing a medical staff representative to the CNH/Adult Day Health Care Committee. This committee reports CNH oversight activities to the Clinical Executive Board. We identified one area that continued to require management attention.

Follow-Up Visits. We reviewed the medical records of 12 CNH patients. Eight (67 percent) of these patients did not have documentation in their medical records of follow-up visits and/or monthly monitoring by an RN. The medical center's action plan in response to our prior CAP review was to add a 0.5 FTE RN to the CNH program. We found that this action had not been completed. The CNH Program had no RN FTE assigned. Rather, the Community Health RN was instructed to perform CNH patient visits and monitoring as a collateral duty. As a result, documentation of follow-up

[10] VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.

visits and monitoring were not being accomplished in accordance with VHA policy.

Recommendation 14 We recommended that the Acting VISN Director ensure that the Medical Center Director requires that CNH patients receive follow-up visits and monitoring in accordance with VHA policy.

The Acting VISN and Medical Center Directors agreed with the findings and recommendation. The Community Health RN assigned to do follow-up visits and monitoring is assigned to the CNH program as a 0.5 FTE. The organizational chart has been changed to reflect this. The Community Health RN will be instructed to complete review notes in a more accurate and timely manner; other duties have been reduced to allow time to complete visits and documentation. Compliance with completion of documentation will be monitored monthly. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activity Without Recommendations

Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that the medical center 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 on the next page show the medical center's SHEP performance measure results for inpatients and outpatients, respectively.

Figure 1:

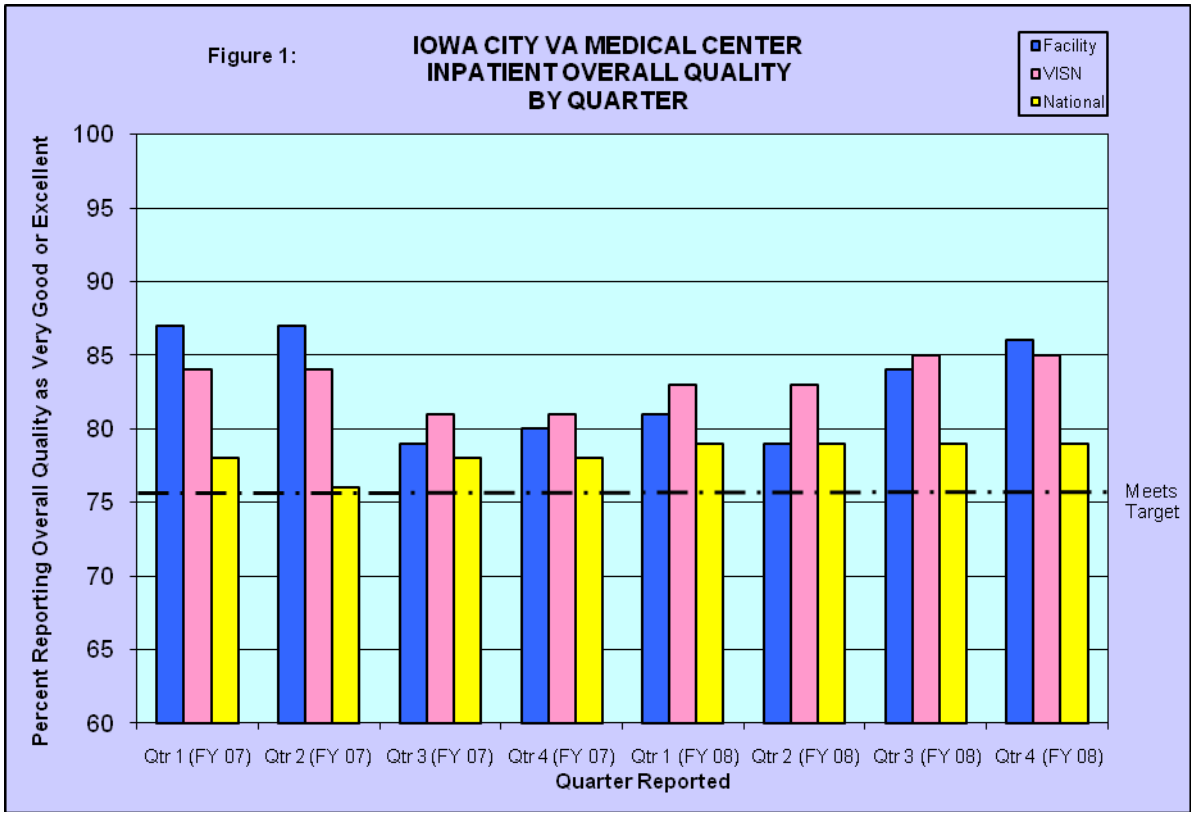
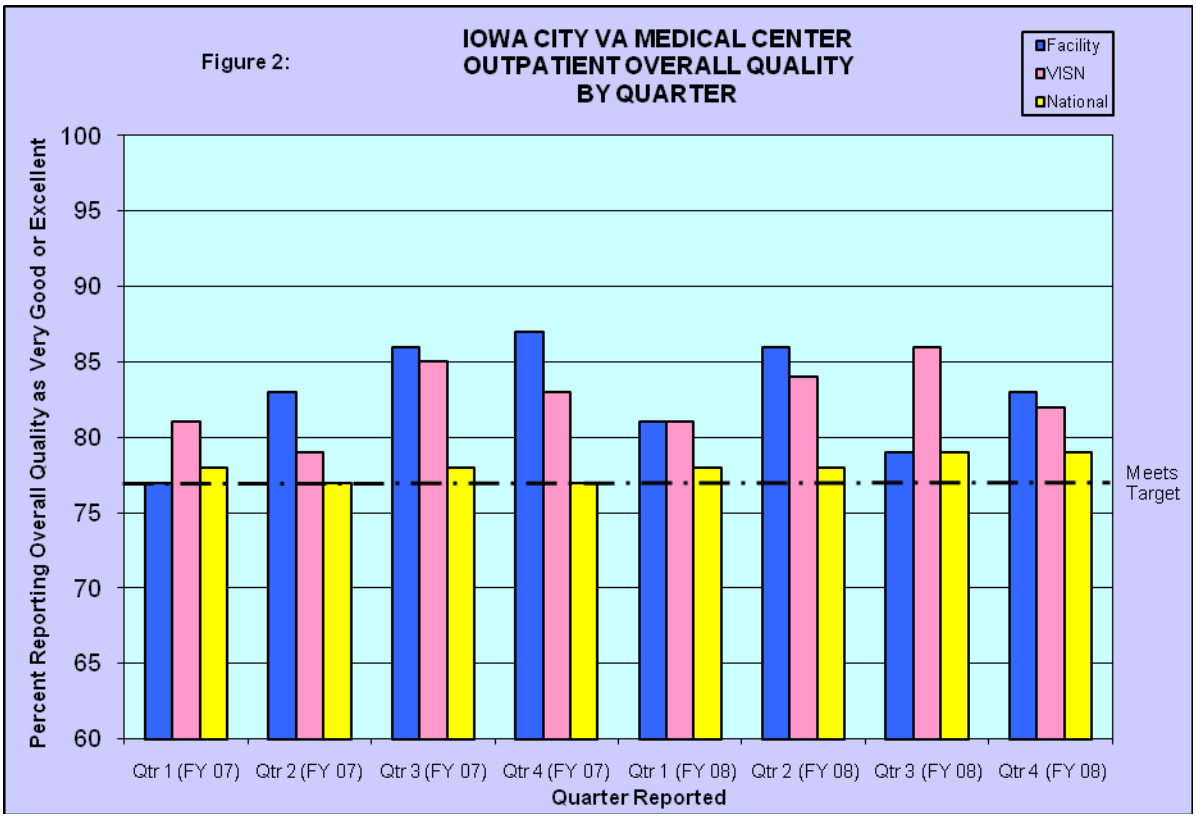


Figure 2:



We reviewed survey results for FYs 2007 and 2008. The medical center's inpatient results exceeded the target in all 8 quarters. The medical center's outpatient results met or exceeded the target in all 8 quarters reviewed. Managers had analyzed survey results, identified opportunities for improvement, and initiated actions when appropriate.

Effective October 1, 2008, VHA changed to a new survey process. The medical center's 1st quarter FY 2009 inpatient data exceeded the targets. We made no recommendations.

Acting VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 25, 2009

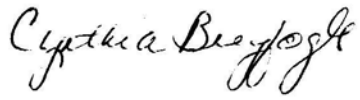
From: Acting Director, VA Midwest Health Care Network (10N23)

Subject: **Combined Assessment Program Review of the Iowa City VA Medical Center, Iowa City, Iowa**

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

Director, Management Review Service (10B5)

Concur with the action plans regarding the findings and recommendations in this report.



CYNTHIA BREYFOGLE, FACHE

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 25, 2009

From: Director, Iowa City VA Medical Center (636A8/00)

Subject: **Combined Assessment Program Review of the Iowa City VA Medical Center, Iowa City, Iowa**

To: Acting Director, VA Midwest Health Care Network (10N23)

The purpose of this memorandum is to forward our comments to the Combined Assessment Program review conducted at this facility on June 15-19, 2009. If you have any questions, please contact me directly at 319-339-7100.

(original signed by:)

BARRY D. SHARP

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 Acting VISN Director ensure that the Medical Center Director requires that clinical privileges granted to contractors do not extend beyond the contract period.

Concur **Target Completion Date: Completed**

Action Plan: The Credentialing and Privileging Coordinator has a listing of all sharing agreements and associated expiration dates. Effective immediately, as contract physicians' privileges become due for renewal, their privileges will be granted to not extend beyond the contract period.

Recommendation 2. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that C&P documentation is maintained in accordance with VHA policy.

Concur **Target Completion Date: Completed**

Action Plan: Chief of Staff acknowledges that the Medical Staff's Executive Committee minutes did not reflect the documents reviewed and rationale for the stated conclusions for a 12-month period prior to the OIG CAP visit. Since April of 2009, the privileging decisions of the Provider Staff Evaluation and Credentialing Subcommittee have been appropriately documented, and the minutes reflect that documents were reviewed and reflect the rationale for the stated conclusions.

Recommendation 3. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that supervisors provide written notification of completed PR actions to the PRC and that committee minutes reflect actions taken.

Concur **Target Completion Date: Completed**

Action Plan: The Risk Manager has developed a form, "Service Chief Meeting with Involved Practitioner Form," which is initiated by the Risk Manager after the Peer Review Advisory Group (PRAG) has given a final level of 2 or 3 to any case presented at the committee meeting. The form is delivered to the service chief for completion. Completion of this form constitutes the service chief speaking with the involved provider, providing

education/counseling about the issue involved, and documenting any other follow up. The form is then returned to the Risk Manager where it is noted in the next PRAG meeting minutes as a written follow up for a PR recommendation. The form is permanently filed in the PR case folder.

Recommendation 4. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that clinical disclosure of adverse events is conducted and documented in accordance with VHA policy.

Concur **Target Completion Date: October 1, 2009**

Action Plan: A CPRS template is in the process of being developed for clinical disclosure of adverse events. All clinical disclosures will be documented using this template in the future. The VA Medical Center has been using a CPRS template for formal disclosures of adverse events. Both the formal and clinical disclosures will be tracked by Patient Safety and Quality Improvement.

Recommendation 5. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that identified safety deficiencies are corrected.

Concur **Target Completion Date: October 30, 2009**

Action Plan: A section has been added to the JC Readiness Rounds for security of medications, sharps, respiratory supplies, and cleaning products. Secured supplies carts have been order for the ICU unit. Managers are currently reviewing all clinical areas to ensure compliance.

Recommendation 6. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that identified patient privacy deficiencies are corrected.

Concur **Target Completion Date: Completed**

Action Plan: The Privacy Officer and Information Security Officer conduct weekly environment of care rounds to check for privacy and information security violations, which include unlocked computers, patient health information lying out in the open, identification badges, and physical privacy around the facility and community based outpatient clinics (CBOCs). The Privacy Officer and Information Security Officer have increased awareness throughout the facility by involving other staff to complete checks on environment of care rounds or when walking throughout the facility and educating staff on privacy and information security policies. When a privacy incident occurs, the Privacy Officer discusses the incident with the individual immediately and/or notifies the supervisor for corrective action/education. All VA employees, volunteers,

and contractors are required to complete privacy and information security training annually and comply with the medical center's privacy and information security policies.

Recommendation 7. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that locked MH unit staff and MSIT members receive environmental hazards training, as required by VHA.

Concur **Target Completion Date: October 1, 2009**

Action Plan: All locked Mental Health Unit staff and MSIT members will have completed EOC/MSIT training by August 24, 2009. The training will be reflected on the annual competency assessments, coupled with documentation from the staff in-services.

Recommendation 8. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that patient discharge summaries include active outpatient medications.

Concur **Target Completion Date: October 30, 2009**

Action Plan: Chief of Staff has requested that the Surgical Specialty Service Line ensure that all active outpatient medications are included in surgery discharge summaries no later than October 1, 2009. Monthly medical records audits will be completed by the Surgery Service Line.

Recommendation 9. We recommended that the Acting VISN Director ensure that the Medical Center Director requires the proper disposition of medications brought into the medical center by MH patients.

Concur **Target Completion Date: Completed**

Action Plan: All patient medications brought into the medical center are being sent home with family members or mailed to the patient's home, according to policy. Homeless patient medications are stored in the Outpatient Pharmacy until the patient is discharged from the hospital. Staff has been provided a copy of the policy, and daily checks are performed by the nursing administrator to ensure that no patient medications are kept on the unit.

Recommendation 10. We recommended that the Acting VISN Director ensure that the Medical Center Director requires compliance with VHA regulations regarding documentation of SPC and MH provider collaboration for patients deemed at high risk for suicide.

Concur **Target Completion Date: Completed**

Action Plan: Patients at high risk for suicide are identified by the treatment team, and a note is entered in CPRS by the SPC. Members of the treatment team have been added as additional signers of this progress note. Concurrence is noted by their electronic signature. An audit of patients flagged in the past 6 months shows 100% compliance with treatment team documentation.

Recommendation 11. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that ED staff complete all inter-facility transfer documentation in accordance with VHA policy.

Concur **Target Completion Date: October 30, 2009**

Action Plan: A multidisciplinary workgroup has reviewed VHA policy and is completing an electronic progress note template that will meet VHA policy requirements. ED staff will complete all inter-facility transfer documentation in accordance with VHA policy no later than October 1, 2009. Monthly audits will be completed by CPRS.

Recommendation 12. We recommended that the Acting VISN Director ensure that the Medical Center Director defines processes to ensure effective hand-off communications when ED patients are admitted to inpatient units in the medical center.

Concur **Target Completion Date: October 1, 2009**

Action Plan: A template was developed for patient transfer between units including ED. The template has been implemented. The Medical Center Memorandum (MCM) on Handoff will be updated to reflect changes to the process**.**

Recommendation 13. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that ED managers complete competency assessments in accordance with medical center policy.

Concur **Target Completion Date: Completed**

Action Plan: ED staff has been educated, and competencies have been completed in accordance with the annual review requirement.

Recommendation 14. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that CNH patients receive follow-up visits and monitoring in accordance with VHA policy.

Concur **Target Completion Date: October 30, 2009**

Action Plan: The Community Health Nurse assigned to do follow-up visits and monitoring is assigned to the program on a 0.5 FTE basis, not as a collateral duty as was stated by the CNH Social Worker. This was not reflected in the Extended Care and Rehabilitation organizational chart at the time of the CAP review. The organizational chart has been changed to reflect the 0.5 assignment to CNH review. The Community Health Nurse will be instructed to complete her review notes in a more accurate and timely manner, and she will be provided with additional training in this process. In addition, her duties as a Community Health Nurse Coordinator have been further reduced in order to accommodate time for her to complete her nursing home visits and notes. Compliance with completion of nursing home notes will be monitored monthly as part of medical record review.

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