Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-00048-118

Combined Assessment Program Review of the Overton Brooks VA Medical Center Shreveport, Louisiana

March 29, 2010

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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Table of Contents

Executive Summary

Introduction

During the week of January 25–29, 2010, the OIG conducted a Combined Assessment Program (CAP) review of the Overton Brooks VA Medical Center (the medical center), Shreveport, LA. 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 170 employees. The medical center is part of Veterans Integrated Service Network (VISN) 16.

Results of the Review

The CAP review covered seven operational activities. We made recommendations in six of the activities reviewed; three recommendations were repeat recommendations from the prior CAP review. For these activities, the medical center needed to:

- Implement the corrective action plan to ensure competency of Supply, Processing, and Distribution (SPD) employees and assess and document annual competencies for all employees who reprocess reusable medical equipment (RME).
- Require SPD employees to conduct regular inventories in the SPD storage area to check for outdated items.
- Ensure that standard operating procedures (SOPs) for RME are established in accordance with manufacturers' instructions and that all draft SOPs and the guidelines for low level disinfection are implemented.
- Ensure that safety plans are developed as soon as possible after patients are identified as being at high risk for suicide.
- Require the Peer Review Committee (PRC) to submit quarterly reports to the Medical Executive Committee (MEC).
- Ensure that an adequate mechanism is implemented to track compliance with Advanced Cardiac Life Support (ACLS) and Basic Life Support (BLS) training.
- Require that monitoring of the copy and paste functions in the electronic medical record is fully implemented.
- Require employees to comply with annual tuberculosis (TB) screening.

- Ensure that medication reconciliation monitors are fully implemented.
- Implement a yearly fire drill schedule to ensure compliance with the National Fire Protection Association (NFPA) regulations.
- Ensure the security of medications.
- Require that designated employees receive N95 respirator fit testing and implement an effective tracking system to monitor compliance.
- Require compliance with Veterans Health Administration (VHA) and local policy regarding inter-facility transfer documentation.
- Require that Focused Professional Practice Evaluation (FPPE) plans are implemented for newly hired physicians and that they comply with VHA requirements.

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

- Medication Management.

This report was prepared under the direction of Christa Sisterhen, Director, St. Petersburg 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 17–23, 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 medical center is a Clinical Referral Level 1C facility located in Shreveport, LA, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at three community based outpatient clinics (CBOCs) in Monroe, LA; Longview, TX; and Texarkana, AR. The medical center is part of VISN 16 and serves a veteran population of about 109,000 throughout 12 parishes in Louisiana, 11 counties in southern Arkansas, and 9 counties in east Texas.

Programs. The medical center provides a full range of patient care services. Comprehensive health care is provided through primary and specialty care in the areas of medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, and geriatrics. The medical center has 119 hospital beds.

Affiliations and Research. The medical center currently has active affiliations with 32 educational institutions and trains students from 81 programs. In fiscal year (FY) 2009, the medical center trained 282 medical residents and fellows from 17 specialty programs sponsored by its medical school affiliate—Louisiana State University's Health Sciences Center School of Medicine, Shreveport, LA. The medical center currently supports 63.5 resident training positions.

The medical center is affiliated with seven schools of nursing and trained 327 nursing students in FY 2009. It also trained an additional 286 students from various allied health disciplines, including pharmacy, social work, physical therapy, and nutrition.

In FY 2009, the medical center's research program had 40 projects and a budget of $321,656. Areas of research included cancer, diabetes, and mental health (MH).

Resources. In FY 2009, medical care expenditures totaled $212 million. FY 2009 staffing was 1,397 full-time employee equivalents (FTE), including 134 physician and 418 nursing FTE.

Workload. In FY 2009, the medical center treated 36,262 unique patients and provided 34,500 inpatient days in the hospital. The inpatient care workload totaled

6,044 discharges, and the average daily census was 94.5. Outpatient workload totaled 379,838 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:

- Coordination of Care.
- Environment of Care (EOC).
- Medication Management.
- Physician Credentialing and Privileging (C&P).
- QM.
- RME.
- Suicide Prevention Safety Plans.

The review covered medical center operations for FY 2008, FY 2009, and FY 2010 through January 25, 2010, and was done in accordance with OIG SOPs 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 Overton Brooks VA Medical Center, Shreveport, Louisiana,* Report

No. 06-02822-79, February 8, 2007). The medical center had corrected findings related to breast cancer management, contract community nursing homes, and EOC from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings to 170 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 findings requiring corrective action.

Results

Review Activities With Recommendations

Reusable Medical Equipment

The purpose of this review was to evaluate whether the medical center had processes in place to ensure effective reprocessing[1] of RME. Improper reprocessing of RME may transmit pathogens to patients and affect the functionality of the equipment. VHA facilities are responsible for minimizing patient risk and maintaining an environment that is safe. The medical center's SPD and satellite reprocessing areas are required to meet VHA, Association for the Advancement of Medical Instrumentation, Occupational Safety and Health Administration (OSHA), and Joint Commission (JC) standards.

We inspected the SPD area, the SPD satellite area, and the gastrointestinal and genitourinary reprocessing areas. We found that all areas were clean and that separation of clean and dirty equipment was maintained to assist in the prevention of cross-contamination.

OSHA requires that employees who work with or around chemicals have access to an emergency eyewash station. We found an uninstalled eyewash station in the SPD satellite area where chemicals were used. The eyewash station was

[1] Reprocessing is the process of cleaning, disinfecting, and/or sterilizing RME.

installed while we were onsite; therefore, we made no recommendation for this finding.

We found a sink in the SPD decontamination area that was not marked to show the correct amounts of water and cleaning solution to be used. In addition, a thermometer was not available for testing water temperatures. Managers corrected these deficiencies while we were onsite; therefore, we made no recommendations for these findings. However, we identified the following conditions that needed improvement.

Competencies and Training. VHA requires[2] that all employees involved in the use and reprocessing of RME have documented initial training and competency validation on the set-up, use, reprocessing, and maintenance of specific equipment. Competencies are to be validated annually thereafter. We did not find documentation of competencies for the four employees working in the SPD decontamination area. In addition, the employee we observed cleaning a laparoscope did not follow the procedural steps dictated by the SOP.

Managers told us that they had been unable to validate the competencies of the four SPD employees working in that area, and for this reason, they were closely supervised by the Assistant Chief of SPD. Although the employees were supervised, lack of competency could lead to errors, which could increase the chances of cross contamination and put patients at risk. Managers assured us that they would take appropriate actions to ensure that RME is only reprocessed by employees with documented competencies. While we were onsite, managers provided us with an acceptable action plan to correct this situation.

We reviewed the competency folders of 10 operating room (OR) employees and found that only 1 (10 percent) of the employees had current documentation of competencies for the Steris prevacuum steam sterilizer. In addition, none of the employees on the dialysis unit had current documentation of competencies on the set-up, use, reprocessing, and maintenance of the dialysis machine.

[2] VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.

Environment. On the shelf in the SPD storage area, we found 25 metal tracheostomy tubes that had expired in September 2009. Managers told us that there was no schedule for conducting inventory on a regular basis. They took immediate action to remove the equipment from the shelves and reprocess it.

SOPs. VHA requires[3] facilities to establish device-specific SOPs for reprocessing RME in accordance with the manufacturers' instructions. We reviewed the SOPs and manufacturers' instructions for 10 pieces of RME. We found that the SOPs for dental instruments, orthopedic instruments, dialysis machines, and laparoscopes were still in draft and that the SOPs for bronchoscopes and colonoscopes were not fully consistent with the manufacturers' instructions. In addition, the SOP for surgical instruments did not include instructions for cleaning instruments with lumens.

Also, we found that there were no guidelines for cleaning items that required low level disinfection.[4] While we were onsite, managers provided a draft copy of the guidelines.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that the corrective action plan to ensure the competency of employees in SPD is implemented and that annual competencies are assessed and documented for all employees who reprocess RME, as required.

The VISN and Medical Center Directors concurred with the findings and recommendation. Initial and annual competencies for employees in SPD will be assessed, documented, and monitored. 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 SPD employees conduct regular inventories in the SPD storage area to check for outdated items.

[3] VHA Directive 2009-004.

[4] Low level disinfection is a process that can kill most bacteria, some viruses, and some fungi, but it cannot be relied on to kill resistant organisms, such as tubercle bacilli or bacterial spores.

The VISN and Medical Center Directors concurred with the finding and recommendation. SPD employees will check for outdated items twice a month, and compliance will be reported quarterly to the MEC. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that SOPs for RME are established in accordance with manufacturers' instructions and that all draft SOPs and the guidelines for low level disinfection are implemented.

The VISN and Medical Center Directors concurred with the findings and recommendation. Nursing Service will review SOPs for compliance with manufacturers' instructions and will implement guidelines for low level disinfection. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Suicide Prevention Safety Plans

The purpose of this review was to determine whether clinicians had developed safety plans that provided strategies to mitigate or avert suicidal crises for patients assessed to be at high risk for suicide. Safety plans should have patient and/or family input, be behaviorally oriented, and identify warning signs preceding crisis and internal coping strategies. They should also identify when patients should seek non-professional support, such as from family and friends, and when patients need to seek professional help. Safety plans must also include information about how patients can access professional help 24 hours a day, 7 days a week.

A previous OIG review of suicide prevention programs in VHA facilities found a 74 percent compliance rate with safety plan development.[5] The safety plan issues identified in that review were that plans were not comprehensive (did not contain the above elements), were not developed timely, or were not developed at all. At the request of VHA, the OIG agreed to follow up on the prior findings. We reviewed the medical records of 10 patients who were assessed to be at high risk for suicide between April and September 2009 and identified the following deficiencies.

[5] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009*, Report No. 09-00326-223, September 22, 2009.

Safety Plans. Only 3 (30 percent) of the 10 patients had a safety plan, as required by VHA.[6] In addition, those three plans were developed between 45 days and 6 months after the patients were identified as being at high risk for suicide. We learned that in November 2009, the medical center provided training to MH staff and providers regarding the safety plan requirement. At the time of our visit, 98 percent of MH staff had received the training. We reviewed the current high risk for suicide list and found that only 51 (68.9 percent) of 74 patients on the list had a safety plan.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that safety plans are developed as soon as possible after patients are identified as being at high risk for suicide.

The VISN and Medical Center Directors concurred with the findings and recommendation. The Suicide Prevention Coordinator will audit patients' records within 10 days of identification as being at high risk for suicide. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

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 Director, the Chief of Staff, and QM personnel. We evaluated policies, performance improvement data, and other relevant documents.

The medical center's QM program was generally effective, and senior managers supported the program through participation in and evaluation of performance improvement initiatives and through allocation of resources to the program. Appropriate review structures were in place for most program activities reviewed; however, we identified the following areas that needed improvement.

Peer Review. PRC reports were not submitted to the MEC quarterly, as required by VHA policy.[7] We found reports for only the 2nd and 4th quarters of FY 2009. Appropriate

[6] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
[7] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.

oversight functions by the MEC can only be fully accomplished with analysis and trending of quarterly data.

Life Support Training. Local policy delineates the individuals required to have ACLS and BLS training. The database tracking system for ACLS and BLS training did not adequately identify these individuals. Therefore, we were unable to determine if all required staff had completed the training. This is a repeat finding from our previous CAP review.

Medical Records. For FY 2009, there was no evidence that the medical center monitored the use of the copy and paste functions in the electronic medical record, as required by VHA policy.[8] Although VHA requirements for monitoring have been in place since 2006, medical center managers did not begin monitoring until FY 2010. Consequently, insufficient data has been collected to allow for identification of issues or trends.

TB Testing. According to the Centers for Disease Control and Prevention (CDC) guidelines, health care workers must be screened for potential exposure to TB. Data provided by Employee Health Service showed that only 524 (49 percent) of 1,064 employees completed the annual screening. This is a repeat finding from our previous CAP review.

Medication Reconciliation. We found that the medical center did not comply with JC standards and local policy for medication reconciliation at admission, transfer, and discharge. The intent of this JC patient safety goal is to ensure that patients and clinicians are aware of medication changes when a patient is admitted, transferred, or discharged from one setting, service, provider, or level of care to another. The medical center did not have ongoing monitors to ensure compliance. We found that only 1 month of data was collected (September 2009), which showed that reconciliation was completed in only 13 (65 percent) of 20 records reviewed. With limited data, the medical center could not monitor for trends.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires that the PRC submits quarterly reports to the MEC.

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

The VISN and Medical Center Directors concurred with the finding and recommendation. The MEC will monitor quarterly submission of reports. 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 an adequate mechanism is implemented to track compliance with ACLS and BLS training.

The VISN and Medical Center Directors concurred with the finding and recommendation. The Chief of Education and Training Service will ensure that a mechanism to track compliance with training is developed. Compliance reports will be submitted quarterly to the MEC. 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 that monitoring of the copy and paste functions in the electronic medical record is fully implemented.

The VISN and Medical Center Directors concurred with the finding and recommendation. Monitoring of the copy and paste functions in the electronic medical record will be implemented, and quarterly compliance reports will be submitted to the Performance Improvement Committee. 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 that employees comply with annual TB screening, as required.

The VISN and Medical Center Directors concurred with the finding and recommendation. The Employee Health Nurse will monitor TB screening compliance. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 9 We recommended that the VISN Director ensure that the Medical Center Director requires that medication reconciliation monitors are fully implemented, as required.

The VISN and Medical Center Directors concurred with the finding and recommendation. The Patient Safety Manager will ensure that a mechanism to track compliance is developed. Quarterly compliance reports will be submitted to the Performance Improvement Committee. 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 maintained a safe and clean health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, National Center for Patient Safety, OSHA, NFPA, and JC standards.

We inspected the telemetry unit, the medical/surgical unit, the hematology/oncology unit, the dialysis unit, the medical intensive care unit, the emergency department (ED), the locked inpatient MH unit, the day surgery unit, and four primary care clinics. We found that the medical center had an EOC program that included regularly scheduled rounds to identify environmental deficiencies, which were appropriately tracked to completion.

The infection control program monitored exposures and infections appropriately. We found that the hand hygiene program reflected data analysis and appropriate follow-up when trends were identified. The medical center had an appropriate respiratory/cough etiquette program that provided on-the-spot patient and family education, access to personal protective equipment, and hand sanitizer in all high traffic areas and at main entrances.

We found that Environmental Management Service employees received annual training on cleaning and disinfection procedures. The medical center conducted initial and annual training on environmental hazards that represent a threat to suicidal patients for MH employees who worked on the locked inpatient MH unit and for members of the MH safety inspection team. However, we identified the following conditions that needed improvement.

Fire and Life Safety. The NFPA requires fire drills to be conducted once per shift per quarter in each building designated for health care occupancy. We reviewed fire drill records for FY 2009 and for FY 2010 through December 16, 2009, and found that in the 2nd and 4th quarters of FY 2009, no fire drills were conducted on the

evening or night shifts, respectively. We determined that the medical center did not have an adequate fire drill schedule.

Medication Security. JC standards require all medications to be secured from access by unauthorized persons. We found unattended/unlocked medication cabinets on the day surgery unit and in the ED and an unattended/unlocked medication cart on the dialysis unit. We also found a medication left on a bedside table in the ED.

Infection Control. CDC guidelines recommend that all health care personnel entering rooms of patients with confirmed, suspected, or probable H1N1 influenza should wear, at a minimum, a fit tested, disposable N95[9] respirator. In addition, OSHA regulations require designated staff to be medically cleared, fit tested, and trained for respirator use as part of a complete respiratory protection program. We requested documentation of N95 fit testing during the past 12 months for 20 employees from bronchoscopy, radiology, the medical/surgical unit, and the ED. We found that 5 (25 percent) of the 20 employees had not received the required annual N95 fit testing. This is a repeat finding from our previous CAP review.

Recommendation 10 We recommended that the VISN Director ensure that the Medical Center Director requires the implementation of a yearly fire drill schedule to ensure compliance with NFPA regulations**.**

The VISN and Medical Center Directors concurred with the finding and recommendation. The Chief of Engineering Service will ensure that an annual fire drill schedule is developed that includes every shift each quarter. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 11 We recommended that the VISN Director ensure that the Medical Center Director requires that the security of medications is maintained, as required.

The VISN and Medical Center Directors concurred with the findings and recommendation. Nursing Service will conduct weekly rounds in all clinical areas to ensure medication security. Compliance reports will be submitted to the

[9] A disposable particulate respirator that has the ability to filter out 95 percent of particles greater than 0.3 microns in diameter.

Leadership Board. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 12 We recommended that the VISN Director ensure that the Medical Center Director requires that designated employees receive N95 respirator fit testing and that an effective tracking system to monitor compliance is implemented.

The VISN and Medical Center Directors concurred with the finding and recommendation. An electronic tracking system will be developed to monitor N95 fit testing. Compliance data will be reported monthly to the Leadership Board. 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 inter-facility transfers and discharges were coordinated appropriately over the continuum of care and met VHA and JC requirements. Coordinated transfers and discharges are essential to an integrated, ongoing care process and optimal patient outcomes.

VHA policy requires that providers include information regarding medications, diet, activity level, and required follow-up appointments in patient discharge instructions.[10] In addition, the JC requires that clinicians provide patients with written discharge instructions. We reviewed the medical records of 32 discharged patients. Discharge documentation was generally complete. However, in three patients' medical records, we did not find instructions regarding diet or activity level, and in one patient's record, we did not find documentation that the patient received a copy of the discharge instructions.

VHA policy requires medical centers to develop an inter-facility transfer policy that addresses required aspects of transfer documentation.[11] Required aspects include information regarding an advanced directive, mode of transportation, and informed consent to transfer. Additionally, VHA requires inter-facility transfers to be monitored and evaluated as part of the QM program. The medical center had an inter-facility transfer policy and monitored and evaluated transfers as part of the QM

[10] VHA Handbook 1907.01.
[11] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May, 2007.

program, as required. However, we identified the following area that needed improvement.

Inter-Facility Transfers. We reviewed the medical records of 10 patients transferred from the medical center's acute inpatient units to another facility. We found that providers did not document all the required information in any of the 10 records. Missing information included documentation of the mode of transportation, acknowledgement of an advanced directive, and the patient's signed consent to transfer. Although local policy dictated that physicians obtain the patient's consent to transfer and included the appropriate form, we were told that no one was aware of this requirement. Additionally, local policy requires the use of VA Form 10-2649A, which contains all the required transfer documentation elements. However, medical center staff treated inter-facility transfers from inpatient units as discharges and documented them in a discharge notes rather than transfer notes.

Recommendation 13 We recommended that the VISN Director ensure that the Medical Center Director requires compliance with VHA and local policy regarding documentation requirements for inter-facility transfers.

The VISN and Medical Center Directors concurred with the findings and recommendation. The Chief of the Business Office will provide training on requirements for inter-facility transfer documentation. A mechanism to track compliance will be developed, and quarterly compliance reports will be submitted to the Performance Improvement Committee. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Physician Credentialing and Privileging

The purpose of this review was to determine whether the medical center had consistent processes for physician C&P. We reviewed C&P files and provider profiles for selected elements required by VHA.[12] We also reviewed meeting minutes during which discussions about the physicians took place.

We reviewed the C&P files and provider profiles for 10 physicians and found that licenses were current and that

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

primary source verification[13] had been obtained. We also found that the clinical privileges for each physician were appropriate for the provider, service, and medical center.

VHA also requires a thorough written plan with specific competency criteria for Ongoing Professional Practice Evaluation (OPPE) for all privileged physicians. The medical center's policies and bylaws contained service-specific criteria to be included in OPPEs, and Executive Committee of the Medical Staff meeting minutes reflected detailed discussion of physicians' performance data prior to reprivileging. We reviewed provider profiles for seven physicians reprivileged in the last 12 months and found that OPPEs were in place for each provider. However, we identified the following area that needed improvement.

FPPE. FPPE is a review process to ensure competence of newly hired physicians and currently privileged physicians requesting new privileges. We reviewed provider profiles for three physicians hired within the last 12 months. Two of the profiles contained an FPPE, but the elements of the FPPE were not service or provider specific and did not support the privileges granted.

Recommendation 14 We recommended that the VISN Director ensure that the Medical Center Director requires that FPPE plans are implemented for newly hired physicians and that they comply with VHA requirements.

The VISN and Medical Center Directors concurred with the finding and recommendation. The C&P Office will implement standardized FPPE processes for newly hired physicians. Monthly compliance reports will be submitted to the Professional Standards Board and the MEC. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activity Without Recommendations

Medication Management The purpose of this review was to evaluate whether VHA facilities had developed effective and safe medication management practices. We reviewed selected medication

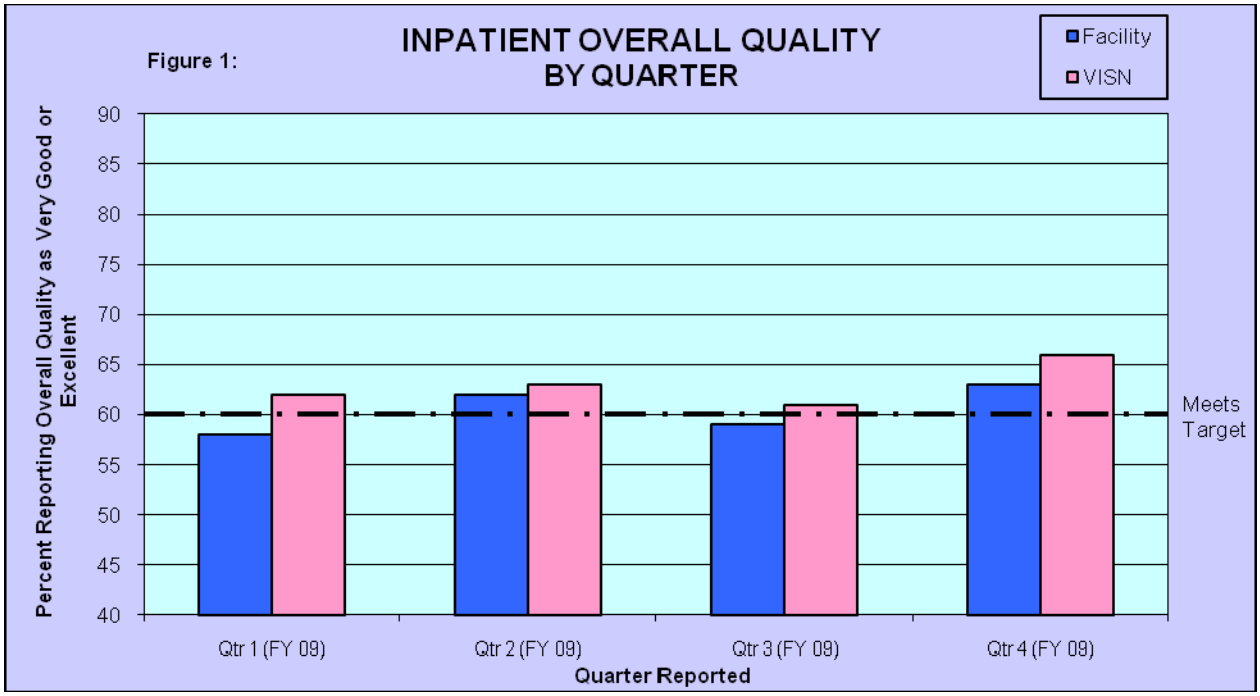
[13] Primary source verification is documentation from the original source of a specific credential that verifies the accuracy of a qualification reported by an individual health care practitioner.

management processes for outpatients receiving erythropoiesis-stimulating agents (ESAs).[14]

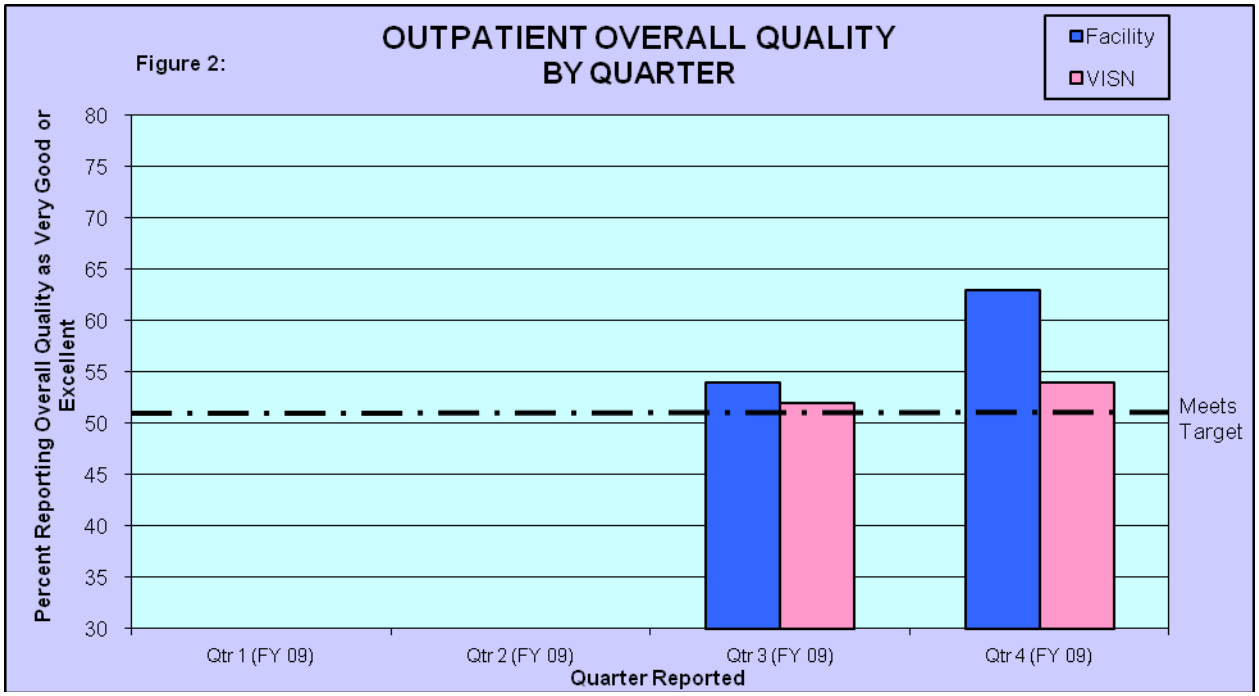
We reviewed the medical records of eight patients and found that clinical staff had appropriately identified and addressed elevated hemoglobin levels in all of the patients. We also found that the medical center's Pharmacy Service had a process to track chronic renal disease patients who receive ESAs. We made no recommendations.

VHA Satisfaction Surveys

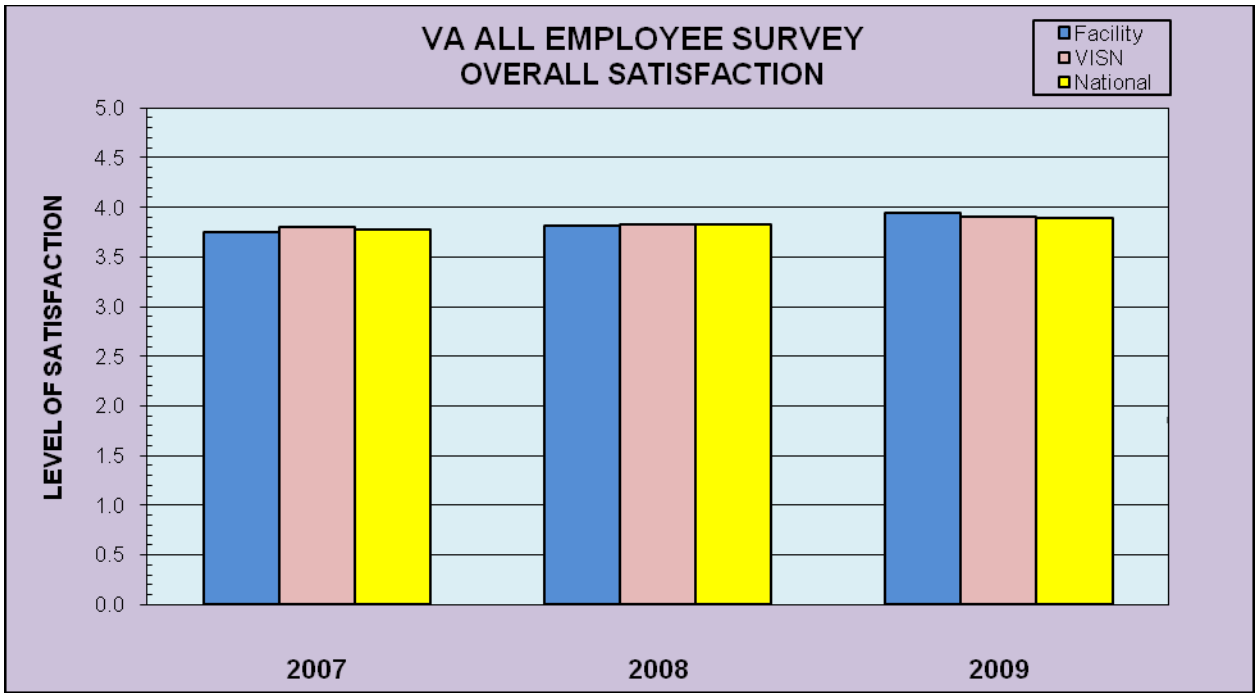
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 below shows the medical center's and VISN's overall inpatient satisfaction scores for quarters 1–4 of FY 2009. Figure 2 on the next page shows the medical center's and VISN's overall outpatient satisfaction scores for quarters 3 and 4 of FY 2009.[15] The target scores are noted on the graphs.



[14] Drugs that stimulate the bone marrow to make red blood cells; used to treat anemia.
[15] Due to technical difficulties with VHA's outpatient survey data, outpatient satisfaction scores for quarters 1 and 2 of FY 2009 are not included for comparison.



Employees are surveyed annually. Figure 3 below shows the medical center's overall employee scores for 2007, 2008, and 2009. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 9, 2010

From: Director, South Central VA Health Care Network (10N16)

Subject: **Combined Assessment Program Review of the Overton Brooks VA Medical Center, Shreveport, LA**

To: Director, St. Petersburg Office of Healthcare Inspections

Director, Management Review Service (10B5)

1. I have reviewed the response of the Overton Brooks VA Medical Center, Shreveport, LA and concur in the response provided.

2. If you have any questions, please contact Mary Jones, HSS, at 601-206-6974.

(original signed by:)

George H. Gray, Jr.

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 1, 2010

From: Director, Overton Brooks VA Medical Center (667/00)

Subject: **Combined Assessment Program Review of the Overton Brooks VA Medical Center, Shreveport, LA**

To: Director, South Central VA Health Care Network (10N16)

1. Medical Center Director concurs with the draft Combined Assessment Program Review Recommendations for Overton Brooks VA Medical Center, Shreveport, Louisiana.

2. Attached are the medical center's Planned Actions to the recommendations.

(original signed by:)

George M. Moore, Jr.

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 the corrective action plan to ensure the competency of employees in SPD is implemented and that annual competencies are assessed and documented for all employees who reprocess RME, as required.

Concur

Planned Action: Nurse Executive will ensure that initial and annual competencies for all employees who reprocess RME will be assessed, implemented, and documented by Nursing Service. Monitoring of competency compliance will be conducted by Human Resources Management Service and reported to Nurse Executive.

Target completion date: March 12, 2010

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that SPD employees conduct regular inventories in the SPD storage area to check for outdated items.

Concur

Planned Action: Nurse Executive will ensure an inventory check list is implemented by SPD employees twice a month to check for outdated items in SPD storage area. Monitoring of compliance will be conducted by Quality Management Team with quarterly reports to MEC.

Target completion date: January 28, 2010

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that SOPs for RME are established in accordance with manufacturer's instructions and that all draft SOPs and the guidelines for low level disinfection are implemented.

Concur

Planned Action: Nurse Executive will ensure that Nursing Service team reviews SOPs for compliance with manufacturer's instructions and include

implementation of SOPs and guidelines for low-level disinfection. Quarterly compliance reports will be submitted to MEC.

Target completion date: March 18, 2010

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that safety plans are developed as soon as possible after patients are identified as being at high risk for suicide.

Concur

Planned Action: Chief, Mental Health Service will ensure that the Suicide Prevention Coordinator (SPC) implements 100 percent audit of the computerized patient record system within 10 days of high risk flag assignment. Quarterly compliance reports will be submitted to MEC.

Target completion date: March 18, 2010

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that the PRC submits quarterly reports to the MEC.

Concur

Planned Action: Chief, Performance Improvement will ensure that Risk Manager submits quarterly PRC reports to MEC. Submission of PRC quarterly reports will be monitored by MEC.

Target completion date: March 18, 2010

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that an adequate mechanism is implemented to track compliance with ACLS and BLS training.

Concur

Planned Action: Chief, Education & Training Service will ensure that a mechanism is developed to track compliance with ACLS and BLS training. Quarterly compliance reports will be submitted to MEC.

Target completion date: March 18, 2010

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that monitoring of the copy and paste functions in the electronic medical record is fully implemented.

Concur

Planned Action: Chief, Business Office will ensure that monitoring of the copy and paste functions in the electronic medical record are added to the quantitative and qualitative reviews performed by Health Information Management staff. Quarterly compliance reports will be submitted to the Performance Improvement Committee.

Target completion date: April 14, 2010

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires that employees comply with annual TB screening, as required.

Concur

Planned Action: Medical Center Director sent a memorandum to all employees to ensure employees complied with regulations to complete TB screening. Nurse Executive will ensure that the Employee Health Nurse monitors annual TB screening compliance and submits reports monthly to Performance Improvement Committee via the Infection Control Committee.

Target completion date: April 14, 2010

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director requires that medication reconciliation monitors are fully implemented, as required.

Concur

Planned Action: Patient Safety Manager will ensure that a mechanism is developed to track compliance with medication reconciliation. Quarterly compliance reports will be submitted to Performance Improvement Committee via the Patient Safety Committee.

Target completion date: April 14, 2010

Recommendation 10. We recommended that the VISN Director ensure that the Medical Center Director requires the implementation of a yearly fire drill schedule to ensure compliance with NFPA regulations.

Concur

Planned Action: Chief, Engineering Service will ensure that an annual fire drill schedule is developed and implemented to ensure fire drills occur at least once per shift per quarter. Quarterly compliance reports will be submitted to the Executive Safety Committee.

Target completion date: March 23, 2010

Recommendation 11. We recommended that the VISN Director ensure that the Medical Center Director requires that the security of medications is maintained, as required.

Concur

Planned Action: Nurse Executive will ensure that medication security is maintained. Weekly rounds in all clinical areas will be conducted by Nursing Service. Compliance reports will be submitted to Leadership Board via Nursing Leadership Council.

Target completion date: April 15, 2010

Recommendation 12. We recommended that the VISN Director ensure that the Medical Center Director requires that designated employees receive N95 respirator fit testing and that an effective tracking system to monitor compliance is implemented.

Concur

Planned Action: Chief, Engineering Service will ensure that an electronic tracking system is developed to monitor N95 respirator fit testing for designated employees. Monthly compliance will be reported to the Leadership Board via the Executive Safety Committee.

Target completion date: March 23, 2010

Recommendation 13. We recommended that the VISN Director ensure that the Medical Center Director requires compliance with VHA and local policy regarding documentation requirements for inter-facility transfers.

Concur

Planned Action: Chief, Business Office will provide training of local policy requirements regarding inter-facility transfer documentation. Evidence of training will be submitted to MEC.

Target completion date: April 15, 2010

Chief, Business Office will ensure that a mechanism is developed to track compliance with inter-facility transfer documentation. Quarterly compliance reports will be submitted by Health Information Management to the Performance Improvement Committee.

Target completion date: May 12, 2010.

Recommendation 14. We recommended that the VISN Director ensure that the Medical Center Director requires that FPPE plans are implemented for newly hired physicians and that they comply with VHA requirements.

Concur

Planned Action: Chief, Performance Improvement will ensure that standardized FPPE processes will be implemented for newly hired physicians by Credentialing & Privileging Office. Compliance reports will be submitted monthly to Professional Standards Board and MEC.

Target completion date: February 18, 2010

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