Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-00465-168

Combined Assessment Program Review of the VA Puget Sound Health Care System Seattle, Washington

June 9, 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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Executive Summary

Introduction

During the week of March 8–12, 2010, the OIG conducted a Combined Assessment Program (CAP) review of the VA Puget Sound Health Care System (the system), Seattle, WA. 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 255 employees. The system is part of Veterans Integrated Service Network (VISN) 20.

Results of the Review

The CAP review covered eight operational activities. We identified the following organizational strengths and reported accomplishments:

- Comprehensive Cancer Care Program
- Under Secretary for Health Customer Service Award

We made recommendations in four of the activities reviewed. For these activities, the system needed to ensure that:

- An effective tracking system to monitor Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS) certification compliance is developed.
- Magnetic resonance imaging (MRI) safety screening questionnaires include all required data and are reviewed and documented, as required.
- Flash sterilization is used in the operating room (OR) only in cases of emergency and that a process for ongoing monitoring is implemented.
- Reusable medical equipment (RME) competencies are documented and evaluated annually.
- Staff complete inter-facility transfer documentation and implement processes to monitor and evaluate transfers.

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

- Environment of Care
- Medication Management
- Physician Credentialing and Privileging (C&P)
- Suicide Prevention Safety Plans

This report was prepared under the direction of Virginia L. Solana, Director, Denver Office of Healthcare Inspections.

Comments

The VISN and Acting System Directors agreed with the CAP review findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 13–18, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Introduction

Profile

Organization. The system is a two division facility located in Seattle and Tacoma, WA. It provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five community based outpatient clinics in Mount Vernon, Bremerton, Bellevue, Federal Way, and Seattle, WA. The system also operates an additional clinic in Port Angeles, WA. The system is one of two primary tertiary care facilities for VISN 20 and serves a veteran population of about 110,500 throughout western Washington.

Programs. The system provides a wide range of medical, surgical, behavioral, geriatric, and rehabilitation services. It has 268 hospital, 131 community living center (CLC), 60 domiciliary, and 30 Psychosocial Residential Rehabilitation Treatment Program beds.

Affiliations and Research. The system is affiliated with the University of Washington, Seattle, and provides training for 638 medical residents and students and for 19 dental residents. It also provides training for students in a variety of allied health discipline programs. In fiscal year (FY) 2009, the system research program had 552 projects and a budget of $35 million. Important areas of research included genetics of Alzheimer's disease, post-traumatic stress disorder and deployment health, prosthetic and amputee care, rehabilitation, mental health, neuro-degenerative diseases, obesity, cancer, and pulmonary diseases.

Resources. In FY 2009, medical care expenditures totaled $520 million. The FY 2010 medical care budget is $545 million. FY 2009 staffing was 2,935 full-time employee equivalents (FTE), including 210 physician and 624 nursing FTE.

Workload. In FY 2009, the system treated 67,670 unique patients and provided 65,835 inpatient days in the hospital and 35,023 inpatient days in the CLC. The inpatient care workload totaled 8,945 discharges, and the average daily census, including CLC patients, was 328. Outpatient workload totaled 788,416 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 eight activities:

- Coordination of Care
- Environment of Care
- Medication Management
- MRI Safety
- Physician C&P
- QM
- RME
- Suicide Prevention Safety Plans

The review covered system operations for FY 2009 and FY 2010 through March 10, 2010, and was done in accordance with OIG standard operating procedures (SOPs) for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the system (*Combined Assessment Program Review of the VA Puget Sound Health Care System, Seattle, Washington,* Report No. 07-03341-73, February 11, 2008). The system had

corrected all findings related to health care from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 255 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the "Review Activities Without Recommendations" section have no reportable findings.

Organizational Strengths

Comprehensive Cancer Care Program

The system has a comprehensive, multidisciplinary cancer care program that serves veterans from the northern region of VISN 20. The program manages complex patients by arranging transportation, housing, and long-term multidisciplinary care and by formulating plans for referral back to the original facilities with appropriate follow-up recommendations. Services include inpatient and outpatient chemotherapy; radiation therapy, including brachytherapy; onsite subspecialty surgical oncology and thoracic surgery; otolaryngology; and social work support. The program also provides pastoral, inpatient, domiciliary, and home hospice care.

The Commission on Cancer of the American College of Surgeons recently approved a 3-year reaccreditation with commendation for the system's program. The distinction of commendation recognizes exceptional performance in outcomes analysis, tumor registry data quality, accrual of patients into research studies, prevention and early detection activities, and quality improvement activities. On March 1, 2010, the commission also awarded the program an Outstanding Achievement Award. This is the only VA facility that achieved this recognition for 2009.

Under Secretary for Health Customer Service Award

The American Lake Urology Team, located in Tacoma, WA, received the 2009 Under Secretary for Health Customer Service Award for a process redesign project. By working with other services, the team eliminated a backlog of consults and reduced urology appointment waiting times from 60 days in 2007 to offering same day urology

appointments and operating room procedures in 2008. Additionally, the Urology Team implemented processes that reduced the rate of patients who fail to show up for scheduled appointments from 6 percent in FY 2007 to 2 percent in FY 2010. As a result of these efforts, staff and patient satisfaction scores have improved.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the system had a comprehensive QM program designed to monitor patient care quality and whether senior managers actively supported the program's activities. We evaluated policies, performance improvement (PI) data, and other relevant documents. We also interviewed appropriate senior managers and the QM Coordinator.

The QM program was generally effective, 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 12 program activities reviewed. However, we identified the following condition that needed improvement.

BLS and ACLS Training. Veterans Health Administration (VHA) policy[1] and local policies define which system employees are required to maintain current BLS and ACLS certification. We found that the system did not have a consistent process in place to monitor staff compliance of required certifications. Tracking of BLS and ACLS training was not standardized or monitored at the organizational level.

Recommendation 1

We recommended that the VISN Director ensure that the Acting System Director requires that an effective process be developed to monitor BLS and ACLS certification.

The VISN and Acting System Directors concurred with the finding and recommendation. The system has revised the local policy to identify BLS and ACLS certification requirements and expectations for clinical staff. Supervisors

[1] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.

will be responsible for monitoring compliance and maintaining documentation of BLS and ACLS certification. In addition, training schedules have been implemented. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Magnetic Resonance Imaging Safety

The purpose of this review was to evaluate whether the system maintained a safe environment and safe practices in the MRI area. Safe MRI procedures minimize risk to patients, visitors, and staff and are essential to quality patient care.

We examined medical and training records, reviewed relevant policies, and interviewed key personnel. We determined that the system had adequate safety policies and had conducted a risk assessment of the environment. (We did not inspect the contracted portable MRI trailer.) We identified one area that needed improvement.

Screening. The American College of Radiology's (ACR's) 2007 guidelines define specific criteria and follow-up for questionnaires related to MRI screening. Staff and patients who have access to Zones 3 and 4 of the MRI area must receive this screening. Screening requires review and signature by a Level II MRI technician, the radiologist when necessary, and the patient or staff. Screening and review must be documented.

We reviewed 10 medical records. None of the records reviewed had all of the ACR's required data documentation. Examples of missing documentation included implants not being addressed and incomplete or missing screening questionnaires. Additionally, non-MRI personnel were not screened, as required.

Recommendation 2 We recommended that the VISN Director ensure that the Acting System Director requires that MRI safety questionnaires include all required data and are reviewed and documented by MRI personnel, as required.

The VISN and Acting System Directors concurred with the findings and recommendation. The system implemented a secondary screening process for patients in which Level II technicians review and collect all MRI safety screening forms. All forms will be scanned into the medical records, copies of forms will be kept on file, and compliance with this process will be tracked. Additionally, Occupational Health

and Diagnostic Imaging are in the process of identifying employees who need to be screened and completing the screening forms. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Reusable Medical Equipment

The purpose of this review was to evaluate whether the system had processes in place to ensure effective reprocessing 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 system's Supply, Processing, and Distribution (SPD) and satellite reprocessing areas are required to meet VHA, Association for the Advancement of Medical Instrumentation, Occupational Safety and Health Administration, and JC standards.

At both divisions, we inspected SPD and the gastrointestinal endoscopy reprocessing areas. We determined that the system had established appropriate guidelines and monitored compliance within those guidelines. In general, we found that SOPs were current and consistent with the manufacturers' instructions. Also, the system had a process in place to track RME should a sterilization failure occur. We identified the following areas that needed improvement.

Flash Sterilization. VA policy[2] requires full sterilization procedures to be used for all surgical instruments. Flash sterilization (a shorter sterilization process) is to be used during a surgical procedure only in cases of emergency, such as a dropped sterilized instrument. We reviewed 3 months of OR flash sterilization log documentation and found that flash sterilization was used in non-emergent situations.

Competencies. VHA policy[3] requires that all employees involved in the use and reprocessing of RME have documented initial competencies and validation of those competencies on an annual basis. We reviewed the competency folders and training records of 12 SPD employees assigned to reprocess RME. We found that 3 (25 percent) of the 12 staff did not have all required,

[2] VA Handbook 7176, *Supply, Processing and Distribution (SPD) Operational Requirements*, August 16, 2002.
[3] VHA Directive 2009-031, *Improving Safety in the Use of Reusable Medical Equipment through Standardization of Organizational Structure and Reprocessing Requirements*, June 26, 2009.

documented competencies. Specifically, a staff person assigned to reprocess the bronchoscope, a staff person assigned to reprocess the dental instruments, and a staff person assigned to reprocess the echocardiography ultrasound scanner did not have documented competencies to reprocess those RME. In addition, we were told that competencies for the transesophageal echocardiography probes had not been completed.

Recommendation 3 We recommended that the VISN Director ensure that the Acting System Director requires that flash sterilization is used in the OR only in cases of emergency and that a process for ongoing monitoring of flash sterilization is implemented.

The VISN and Acting System Directors concurred with the finding and recommendation. A system has been implemented to reduce and monitor the use of flash sterilization in the OR. SPD is reviewing the flash sterilization log each day, and that information is being reported to senior leadership on a daily basis. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 4 We recommended that the VISN Director ensure that the Acting System Director requires that all RME competencies are documented and evaluated annually.

The VISN and Acting System Directors concurred with the finding and recommendation. Employees have now completed the required competencies, and compliance will be monitored. The corrective actions are acceptable, and we consider this recommendation closed.

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 requires that the system have a policy that ensures the safe, appropriate, and timely transfer of patients. We determined that the system had an appropriate transfer policy. VHA policy[4] and JC standards require that providers

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

include information regarding medications, diet, activity level, and follow-up appointments in written patient discharge instructions. We reviewed the medical records of 29 discharged patients and determined that clinicians had generally documented the required elements. We found that follow-up appointments occurred within the timeframes specified. However, we identified the following area that needed improvement.

Inter-Facility Transfers. VHA policy[5] requires specific information (such as the reason for transfer, mode of transportation, and informed consent to transfer) to be recorded in the transfer documentation. VHA also requires inter-facility transfers to be monitored and evaluated as part of the QM program.

We reviewed transfer documentation for 11 patients transferred from the system's acute inpatient unit, emergency department, and urgent care clinic to another facility. We found that providers did not document all required information for 8 (73 percent) of the 11 patients. Missing information included consents for transfer and documentation pertaining to advanced directives. In addition, we did not find evidence that patient transfers were monitored and evaluated as part of the QM program.

Recommendation 5 We recommended that the VISN Director ensure that the Acting System Director requires staff to complete inter-facility transfer documentation and implement processes to monitor and evaluate transfers.

The VISN and Acting System Directors concurred with the findings and recommendation. The system is implementing VA Forms 10-2649A, "Inter-Facility Transfer Form," and 10-2649B, "Physician Certification and Patient Consent for Transfer," to document patient transfers. VISN 20 is developing a monitoring process and a consult template to further ensure compliance with VHA requirements. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

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

Review Activities Without Recommendations

Environment of Care

The purpose of this review was to determine whether VHA facilities maintained a safe and clean health care environment. VHA facilities are required to establish a comprehensive environment of care program that fully meets VHA, National Center for Patient Safety, Occupational Safety and Health Administration, National Fire Protection Association, and JC standards.

At the Seattle division, we inspected the locked inpatient mental health units, medical and surgical inpatient units, medical and cardiac intensive care units, the hemodialysis unit, and the outpatient specialty and primary care clinics. At the American Lakes division, we inspected the dementia unit, the locked inpatient mental health unit, the CLC, the blind rehabilitation center, domiciliary mental health residential rehabilitation areas, the women's clinic, and the outpatient specialty clinics. The system maintained a generally clean and safe environment. The infection control program monitored data and appropriately reported that data to relevant committees. Safety guidelines were generally met, and risk assessments were in compliance with VHA standards. We made no 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 management processes for outpatients and CLC residents.

The system had implemented a practice guideline governing the maintenance of chronic renal disease patients who receive erythropoiesis-stimulating agents (ESAs).[6] We found that clinical staff had appropriately identified and addressed elevated hemoglobin levels in the 10 patients whose medical records we reviewed. In general, influenza vaccinations were documented adequately for CLC residents, and clinical staff followed the established protocol when a delay in receipt of vaccines occurred. Also, although the pharmacy is closed in the evening and at night, we found that the system had a qualified pharmacist to answer patients' questions and an adequate retrospective review process. We made no recommendations.

[6] ESAs are drugs that stimulate the bone marrow to make red blood cells and are used to treat anemia.

Physician Credentialing and Privileging

The purpose of this review was to determine whether VHA facilities have consistent processes for physician C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and physician profiles.[7] We also reviewed meeting minutes during which discussions about the physicians took place.

We reviewed 10 C&P files and profiles and found that licenses were current and that primary source verification had been obtained. Focused Professional Practice Evaluation was appropriately implemented for newly hired physicians. Service-specific criteria for Ongoing Professional Practice Evaluation had been developed and approved. We found sufficient performance data to meet current requirements. Meeting minutes consistently documented thorough discussions of the physicians' privileges and performance data prior to recommending renewal of privileges or initial requested privileges. We made no recommendations.

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 behavior 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.[8]

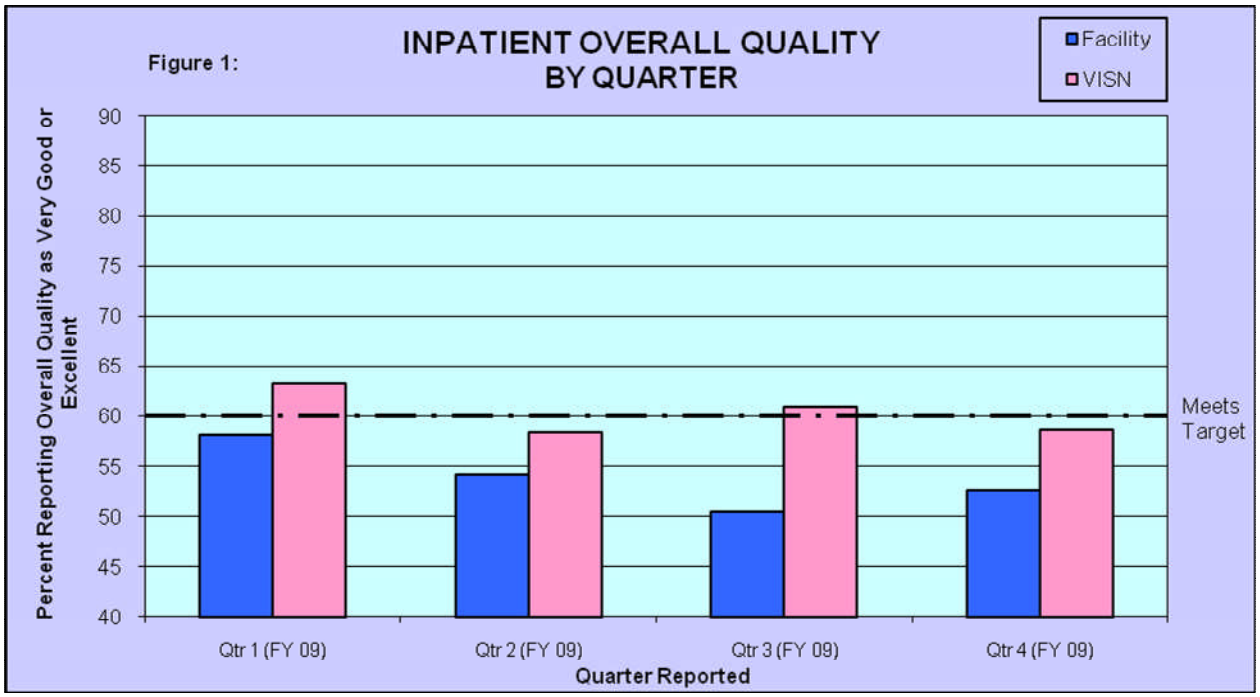
A previous OIG review[9] of suicide prevention programs in VHA facilities found a 74 percent compliance rate with safety plan development. The safety plan issues identified in that review were that plans were not comprehensive (did not contain the above elements), were not developed timely, or were not developed at all. At the request of VHA, the OIG agreed to follow up on the prior findings.

[7] VHA Handbook 1100.19, *Credentialing and Privileging,* November 14, 2008.
[8] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
[9] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009;* Report No. 09-00326-223; September 22, 2009.

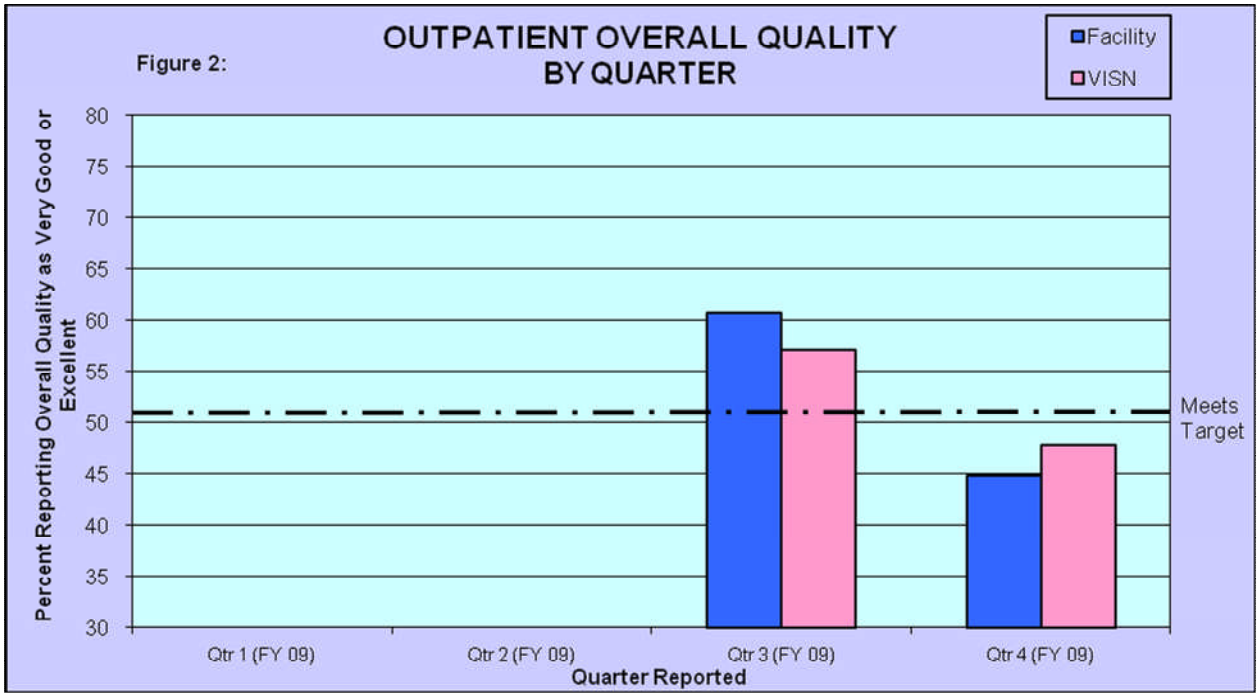
We reviewed the medical records of 10 patients assessed to be at high risk for suicide and found that clinicians had developed timely safety plans that included all required elements. We also found evidence to support that the patients and/or their families participated in the development of the plans. We made no recommendations.

VHA Satisfaction Surveys

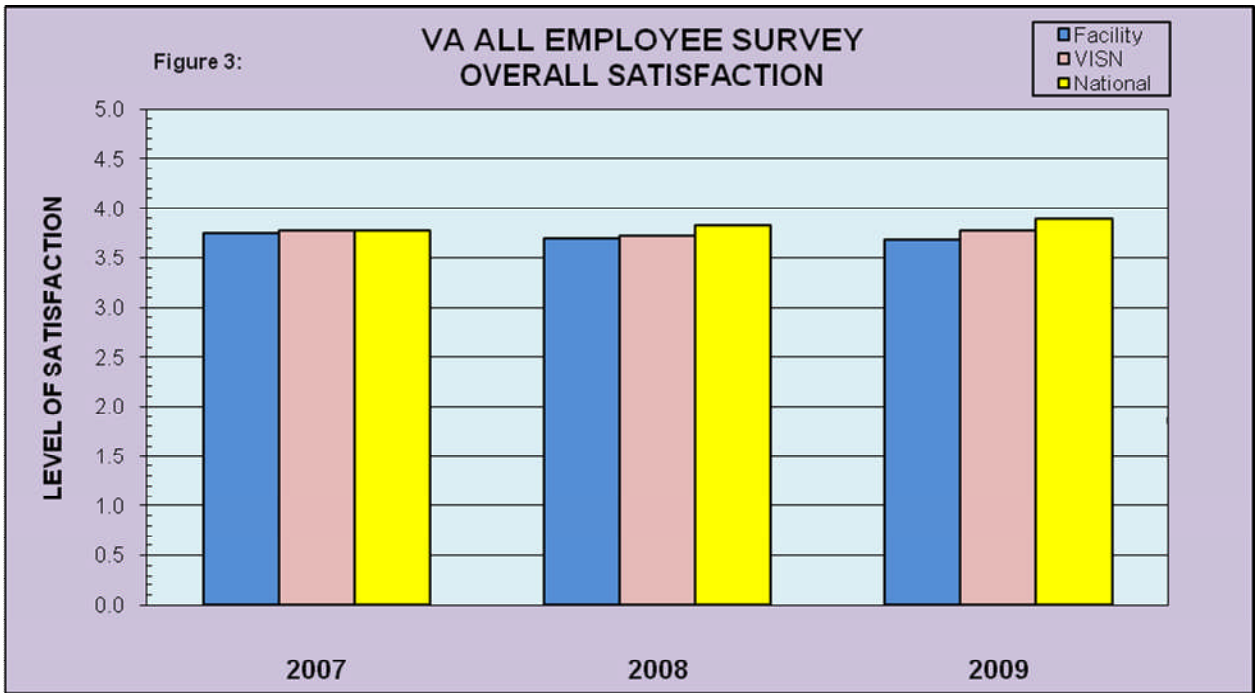
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 (below) shows the system's and VISN's overall inpatient satisfaction scores for quarters 1–4 of FY 2009. Figure 2 (on the next page) shows the system's and VISN's overall outpatient satisfaction scores for quarters 3 and 4 of FY 2009.[10] The target scores are noted on the graphs.



[10] 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 system'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: May 28, 2010

From: Director, Northwest Network (10N20)

Subject: **Combined Assessment Program Review of the VA Puget Sound Health Care System, Seattle, Washington**

To: Director, Denver Office of Healthcare Inspections (54DV)

Director, Management Review Service (VHA CO 10B5 Staff)

1. Thank you for the opportunity to provide a status report on the follow-up to the findings from the Combined Assessment Program Review of the VA Puget Sound Health Care System, Seattle, Washington.

2. Attached please find the facility concurrences and responses to each of the findings from the review.

3. If you have additional questions or need further information, please contact Nancy Benton, Quality Management Officer, VISN 20 at (360) 619-5949.

(original signed by:)
Susan Pendergrass, DrPH

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 3, 2010

From: Acting Director, VA Puget Sound Health Care System (663/00)

Subject: **Combined Assessment Program Review of the VA Puget Sound Health Care System, Seattle, Washington**

To: Director, Northwest Network (10N20)

1. The status report on the follow-up to the findings from the Combined Assessment Program Review of the VA Puget Sound Health Care System is attached. It includes the facility concurrences and responses to each of the findings from the review.

2. If you have additional questions or need further information, please contact Dave Tostenrude, Health Systems Specialist, at (206) 768-5381.

(original signed by:)
DeAnn Lestenkof

Attachment

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 Acting System Director requires that an effective process be developed to monitor BLS and ACLS certification.

Concur

VA Puget Sound Health Care System has implemented a revised facility memorandum PF-06, "Basic Life Support (BLS), Automated External Defibrillator (AED), and Advanced Cardiac Life Support (ACLS) Training for Staff," dated April 2010, that mandates BLS and ACLS certification for clinical staff. This memorandum specifically identifies BLS or ACLS certification requirements for specific clinical staff. Employees are not eligible for clinical duties if their BLS or ACLS certification expires.

BLS requirement: All new employees will have 6 months to become BLS certified. Current employees who do not have BLS certification will have until September 30, 2010 to become certified. **ACLS requirement**: New, full-time VA employees that are required to have ACLS must become ACLS certified before becoming eligible for clinical duties. Current employees who have ACLS "equivalent" must become ACLS certified before their "equivalent" certification expires or before their medical privileges are renewed, whichever occurs first.

Part-time (less than five-eighths) and/or contract staff are expected to obtain training through their primary employer, or at their own expense, before becoming eligible for clinical duties. Essential part-time employees, as designated by the Chief of Staff, can obtain BLS and/or ACLS by the same mechanism as full-time VA employees.

The Center for Education and Development (CED) service line will provide the BLS and ACLS education for full-time VA employees. Supervisors are responsible for monitoring compliance and maintaining documentation of BLS and ACLS certification records in employee competency folders or provider files. Training schedules have been implemented:

Target Completion Date: September 30, 2010, for all current staff to be BLS certified.

Recommendation 2. We recommended that the VISN Director ensure that the Acting System Director requires that MRI safety questionnaires include all required data and are reviewed and documented by MRI personnel, as required.

Concur

Secondary screening with patients is accomplished prior to the MRI scan. The process began on March 17, 2010, with the patient filling out the form and the MRI Level II technician reviews and collects all forms. A copy is maintained in MRI and the original is sent to medical records to be scanned and uploaded into CPRS. Tracking for compliance will occur for 90 days.

The following process for employee screening is in practice for MRI safety screening. Occupational Health, together with Diagnostic Imaging and Safety is identifying those sections/service lines where staff routinely enters the inner core of the MRI in the course of their work. At present, those sections have been identified as Housekeeping (EMS), Escort (Nursing), Biomed (FMS), MRI Staff (Diagnostic Imaging Service) and Safety (EMS). Employees required to work in the MRI inner core must have an MRI Screening Form for Employees completed. At this time, affected staff are being identified and the screening form is being completed.

Target Completion Date: July 1, 2010

Recommendation 3. We recommended that the VISN Director ensure that the Acting System Director requires that flash sterilization is used in the OR only in cases of emergency and that a process for ongoing monitoring of flash sterilization is implemented.

Concur

A system has been implemented to reduce and monitor the use of flash sterilization in the OR. SPD is reviewing the flash sterilization daily and the data is uploaded to a system SharePoint site. That information is then reported the next day to senior leadership at morning report through the Nurse of the Day report.

Furthermore, the SPD Chief meets weekly with the OR manager to review the items and reasons that flash sterilization was required for the week. A monthly report is developed and submitted to the Quality Executive Board for review.

Target Completion Date: Completed, monitoring will continue.

Recommendation 4. We recommended that the VISN Director ensure that the Acting System Director requires that all RME competencies are documented and evaluated annually.

Concur

The competencies for the three identified employees have been completed.

SPD employees had competencies for surgical instrument trays, which included dental instruments. Separate competencies for dental instrument trays were developed in February 2010, when it was discovered that there was a requirement to separate the dental instrument trays from the surgical instrument trays, and documentation had begun. At the time of the OIG visit, four SPD employees had their dental competencies completed. Employees were initially selected based on experience, ability, and shift coverage. They were the only employees charged with sterilizing dental instrument trays at that time. Sixteen SPD employees now have documented general dental competencies.

At the time of the OIG survey, one cardiology employee did not have completed competency documentation for non-critical RME or for the transesophageal echocardiography probe. Those competencies have been completed and verified as of March 10, 2010 and March 15, 2010. Competency documentation has also been reviewed for the other two individuals in the Cardiology department who perform echocardiograms.

Target Completion Date: Completed, monitoring will continue.

Recommendation 5. We recommended that the VISN Director ensure that the Acting System Director requires staff to complete inter-facility transfer documentation and implement processes to monitor and evaluate transfers.

Concur

VA Form 10-2649-A, Inter-Facility Transfer Form and VA Form 10-2649-B, Physician Certification and Patient Consent for Transfer, are being implemented to document patient transfers. VISN 20 has charged a group to develop a VISN 20-wide monitoring process and a consult template to further ensure compliance with the requirements in VHA Directive 2007-015, Inter-Facility Transfer Policy, dated May 7, 2007. The consult template and monitoring process is to be implemented by July 1, 2010.

Target Completion Date: July 1, 2010

OIG Contact and Staff Acknowledgments

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