Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-01189-187

Combined Assessment Program Review of the Central Texas Veterans Health Care System Temple, Texas

July 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 22–26, 2010, the OIG conducted a Combined Assessment Program (CAP) review of the Central Texas Veterans Health Care System (the system), Temple, TX. 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 1,023 system employees. The system is part of Veterans Integrated Service Network (VISN) 17.

Results of the Review

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

- Clinical Nurse Leader (CNL) Program
- Magnetic Resonance Imaging (MRI) Safety Alert and Community Training

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

- Staff wear appropriate personal protective equipment (PPE) in accordance with Veterans Health Administration (VHA) policy.
- Device-specific standard operating procedures (SOPs) and guidelines for low-level disinfection (LLD) are established and consistent with the manufacturers' instructions for all pieces of reusable medical equipment (RME) and that staff comply.
- Corrective action plans implemented ensure competencies of employees in Supply, Processing, and Distribution (SPD) are consistent with manufacturers' instructions and are evaluated annually for all pieces of RME.
- All medication is secured and handled by licensed, approved, and trained personnel.
- Identified environment of care (EOC) rounds deficiencies are addressed.
- Staff identified as at risk for exposure to harmful atmospheres receive respirator fit testing, as required.

- Infection control (IC) staff monitor, track, and provide action plans for all areas where trends are identified.
- Monitoring logs are implemented for negative air flow rooms and the Code Alert® monitoring system, as required.
- Environmental Management Service (EMS) staff annual training is completed, as required.
- The physician privileging process complies with VHA policy.
- Designated staff maintain current Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS) certification in accordance with local policy.
- Monitoring of the copy and paste function in the electronic medical record is fully implemented.
- Staff complete inter-facility transfer documentation in accordance with VHA policy.
- Clinicians consistently document all required influenza vaccine elements.
- Staff complete and follow up with the MRI risk assessment, as required by The Joint Commission (JC).

The system complied with selected standards in the following activity:

- Suicide Prevention Safety Plans

This report was prepared under the direction of Linda DeLong, Director, Dallas Office of Healthcare Inspections.

Comments

The Acting VISN and System Directors agreed with the CAP review findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 23–32, 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
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Introduction

Profile

Organization. The system consists of two divisions located in Temple and Waco, TX, and provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at six community based outpatient clinics located in Austin, Brownwood, College Station, Palestine, Cedar Park, and La Grange, TX. The system serves a veteran population of about 252,000 throughout Texas and is part of VISN 17.

Programs. The system provides medical, surgical, psychiatric, and rehabilitation services. It has 268 hospital beds, 230 community living center (CLC) beds, and 501 mental health (MH) beds.

Affiliations and Research. The system has 72 affiliation agreements, including a major academic program affiliation with Texas A&M Health Science Center College of Medicine. In December 2009, the system had a total of 64 residents and fellows. More than 1,000 trainees receive training in fields such as medicine, nursing, dentistry, pharmacy, laboratory, and dietetics.

In fiscal year (FY) 2009, the system's research program included 67 active projects with total research expenditures of $5.5 million. Researchers included 36 active investigators and 8 affiliated investigators.

Resources. In FY 2009, medical care obligations totaled $506 million. The FY 2010 medical care budget is $524 million. FY 2009 staffing was 3,157 full-time employee equivalents (FTE), including 204 physician and 900 nursing FTE.

Workload. In FY 2009, the system treated 80,821 unique patients and provided 9,395 inpatients days of care in the hospital and 605 inpatient days of care in the CLC. The average daily census was 724. Outpatient workload totaled 961,082 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 system 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
- EOC
- Medication Management
- MRI Safety
- Physician Credentialing and Privileging (C&P)
- QM
- RME
- Suicide Prevention Safety Plans

The review covered system operations for FY 2009 and FY 2010 through March 22, 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 system (*Combined Assessment Program Review of the Central Texas Veterans Health Care System, Temple, Texas,* Report No. 07-01731-28, November 27, 2007). 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 1,023 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 has no reportable findings.

Organizational Strengths

Clinical Nurse Leader Program

The CNL is a nursing role developed by the American Association of Colleges of Nursing designed to impact patient care micro system outcomes through lateral integration and evidence-based practice at the point of care. The CNL functions to coordinate care, measure and manage outcomes, assess risk, and improve quality and communication. Implementation of this role requires clinical agency partnership with an academic nursing program that offers the CNL master's level curriculum and successful completion of a certification exam following graduation. Implementation of the CNL role across all care settings in the VA by the year 2016 is a strategic initiative of the Office of Nursing Services.

The system is supporting this initiative through a structured programmatic approach that includes a locally sponsored traineeship to provide workforce development opportunities to existing staff and program implementation oversight by nursing leadership. The initial traineeship, offered in partnership with the University of Alabama's Capstone College of Nursing, has resulted in five certified CNLs on staff. The system has also established a CNL Advisory Council that currently includes representation from two academic partners offering the CNL curriculum.

Magnetic Resonance Imaging Safety Alert and Community Training

The MRI department has implemented electronic medical record alerts for all patients with known ferromagnetic implants. This alert, much like the drug allergy alert, provides valuable information to providers prior to ordering imaging testing for their patients.

In addition, the MRI department provided training for key community fire personnel and training materials for them to share. The training was well received and provided them

with safety information on how the MRI area can be hazardous to responding fire department personnel.

Results

Review Activities With Recommendations

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 SPD and satellite reprocessing areas are required to meet VHA, Association for the Advancement of Medical Instrumentation, Occupational Safety and Health Administration (OSHA), and JC standards.

We inspected the decontamination area, the cleaning area, and the sterile storage area within SPD. We also inspected the operating room, gastrointestinal (GI), genitourinary, echocardiology, and hemodialysis reprocessing areas. We found that these areas were clean and that separation of clean and dirty equipment was maintained to assist in the prevention of cross-contamination.

VA policy[1] requires that the system maintain a clean and safe environment. We found that: (1) the floor, wall, and sink were visibly dirty in the decontamination area; (2) the self-closing door to the sterile storage receiving area did not latch properly; and (3) EMS staff sign-offs on the SPD cleaning schedules during the month prior to our visit were incomplete. Managers corrected these deficiencies while we were onsite; therefore, we made no recommendations for these findings.

In addition, VA policy[2] requires posting of a written emergency action plan adjacent to the ethylene oxide sterilizer. At the time of our tour, we noted that the plan was not posted. Managers appropriately posted the plan while we were onsite; therefore, we made no recommendation for this finding. However, we identified the following areas that needed improvement.

[1] VA Handbook 7176; *Supply, Processing and Distribution (SPD) Operational Requirements*; August 16, 2002.
[2] VA Handbook 7176.

PPE. VA policy[3] requires staff to wear appropriate PPE at all times while in the decontamination area. The required PPE includes a gown, impervious gloves, shoe covers, and a face mask. We observed staff who did not wear face masks properly and who did not wear appropriate impervious gloves while completing reprocessing of RME.

SOPs and Guidelines. VHA policy[4] requires device-specific SOPs for RME to be established in accordance with manufacturers' instructions. We reviewed the SOPs and manufacturers' instructions for 10 pieces of RME. We found that the SOPs for six pieces of RME were not consistent with the manufacturers' instructions. In addition, managers were unable to provide an SOP for the GI biopsy forceps and were unable to provide the guidelines for LLD of the bladder scanner. While we were onsite, managers provided us with an acceptable interim action plan to correct this situation.

VHA policy[5] requires facilities to follow manufacturers' instructions when reprocessing RME. We observed the following deficiencies:

- Staff did not follow the manufacturer's instructions when cleaning the prostate biopsy probe. The manufacturer's instructions state that the prostate biopsy probe is to soak for 45 minutes in a specified cleaning solution. We observed three prostate biopsy probes soaking in excess of 45 minutes. In addition, there was only one timer used to track the times for all three probes, making it difficult to ensure proper soaking time. According to the manufacturer's instructions, excessive soaking could damage the equipment. While we were onsite, managers obtained additional timers to enable the correct timing for the three separate soaking areas.
- Staff did not ensure that the appropriate water temperature was maintained. The manufacturers' instructions required water temperature between 50 and 104 degrees for a biopsy probe and between 100 and 120 degrees to ensure effective cleaning of a flexible cystoscope. We noted that there were no thermometers in the area to gauge the temperature of the water.

[3] VA Handbook 7176.
[4] VHA Directive 2009-031, *Improving Safety in the Use of Reusable Medical Equipment through Standardization of Organizational Structure and Reprocessing Requirements*, June 26, 2009.
[5] VHA Directive 2009-031.

- Staff did not follow the manufacturers' instructions when reprocessing the bronchoscope, laparoscope, orthopedic set, cystoscope, and prostate biopsy probe. Staff did not: (1) utilize a brush to remove contaminants from the bronchoscope, (2) correctly perform leak testing of a laparoscope (cleaning was done in soapy water versus clear), nor (3) clean orthopedic instruments while submerged.

Competencies. VHA policy[6] requires 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 reviewed the competency folders of 15 SPD employees and found that annual competencies had been completed. However, 8 (67 percent) of 12 RME competencies we reviewed did not correctly reflect the manufacturers' instructions.

Recommendation 1 We recommended that the Acting VISN Director ensure that the System Director requires that staff wear appropriate PPE in accordance with VHA policy.

The Acting VISN and System Directors concurred with the findings and recommendation. The requirement to wear all PPE has been addressed, and all SPD staff have been trained on how to properly wear PPE. The Chief of SPD initiated weekly random monitoring to ensure compliance. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 2 We recommended that the Acting VISN Director ensure that the System Director requires that device-specific SOPs and guidelines for LLD are established and consistent with the manufacturers' instructions for all pieces of RME and that staff comply.

The Acting VISN and System Directors concurred with the findings and recommendation. Additional resources have been allocated to support the SPD program. The system brought in a consultant to complete an organizational assessment of SPD and has implemented several of the recommendations. An RME Committee will be established.

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

Some RME SOPs have been updated to comply with manufacturers' guidelines. Reviews of all critical and semi-critical RME SOPs and staff education and training are scheduled to be completed by the end of June. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 3 We recommended that the Acting VISN Director ensure that the System Director requires that corrective action plans implemented ensure competencies of employees in SPD are consistent with manufacturers' instructions and are evaluated annually for all pieces of RME.

The Acting VISN and System Directors concurred with the findings and recommendation. The Nurse Executive will ensure that the corrective action plans are implemented and that initial and annual competencies for all employees who reprocess RME are assessed and documented. Nursing Service and Human Resources will monitor compliance. SOPs have been rewritten and include staff competencies and personnel position descriptions that are consistent with manufacturers' instructions and VHA requirements. 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 VHA facilities 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, National Fire Protection Association, and JC standards.

At the Temple division, we inspected two medical-surgical, the intensive care, the rehabilitation/CLC, the hospice/CLC, and the dialysis units; the emergency department; and two outpatient clinics. At the Waco division, we inspected the psychiatric intensive care, MH inpatient, and blind rehabilitation units and two outpatient clinics. We identified the following areas that needed improvement.

Medication Security. JC standards require all medications to be secured from access by unlicensed persons. At the Temple division, we found a rolling cart in one of the outpatient clinics that was stocked with medical supplies and vials of medication. An unlicensed staff member was assigned to receive and stock medications in the cart and in a locked cabinet in a clinic room. The unlicensed staff

member had the code to the cart and the key to the cabinet. The cart was moved from room to room in the clinic as needed by various providers.

EOC Rounds. VHA policy[7] requires EOC rounds to be conducted by the system's inspection team to allow each discipline participating to identify and correct discrepancies, unsafe working conditions, and other regulatory violations. Representation from each discipline enables the team to cover the system in depth. VHA policy also requires specific personnel to attend EOC rounds. The system provided 71 weekly EOC rounds attendance sheets. The recorded attendance was: (1) the Director or Associate Director participated in 6 (8 percent) rounds, (2) nursing management participated in 12 (17 percent) rounds, (3) building management participated in 53 (75 percent) rounds, (4) patient safety participated in 38 (54 percent) rounds, (5) IC participated in 41 (58 percent) rounds, and (6) the ISO participated in 15 (21 percent) rounds.

During EOC rounds, the team is to identify cleanliness, pest control, and building maintenance issues and repair requirements. The system is required to track, monitor, and prioritize deficiencies found on EOC rounds until corrective actions are completed. The Temple division's deficiency tracking log generally recorded the date identified and abatement date for each item as the same date. When asked to identify the items that remained open as well as a true closure date for items closed, the EOC team was unable to provide that information. The Waco division's tracking log clearly marked items with the date identified, the abatement date, and a notation that the item was completed. Neither division's log indicated prioritization for the items on the log.

According to OSHA guidelines, oxygen must be stored separately (minimum distance of 20 feet) from combustible materials. Additionally, The JC requires clean and dirty items to be stored separately. On the medical-surgical units at the Temple division, oxygen was stored in the SPD rooms next to the shelves with combustible medical supplies.

During our inspection at the Temple division, we noted that doorways were in need of paint, repair, and proper cleaning. Patient rooms had dirty baseboards and floor tiles that

[7] Deputy Under Secretary for Health for Operations and Management, "Environmental Rounds," memorandum, March 5, 2007.

needed replacement. A closet in the intensive care unit (ICU) had floor tiles with a thick black substance on and between them. Inpatient units had chipped laminated surfaces at the nursing stations. A fire exit door on the first floor would not stay closed. Staff stated that the latch was broken and that a new one was on back order, but they were unable to identify when the door had broken, when the latch was ordered, or when it would arrive. Local policy requires any penetration through fire/smoke barrier walls, floors, or fire doors to be repaired immediately.

Our inspection at the Waco division revealed black stains on the exterior building walls. Pressure cleaning of the exterior walls was scheduled while we were onsite.

The JC requires patient call light alarms to be audible. At both the Temple and Waco divisions, the alarm volumes were relatively low and could not easily be heard more than one or two rooms away.

At the Temple division, ward secretaries did not answer call lights, and if there were no nursing staff at the desk, call lights went unanswered. When tested, a call light was on for several minutes without being answered.

At the Waco division, the ward secretary answered call lights and alerted nursing staff. Many of the Waco division patients are hard of hearing and had day room television volumes turned up. When asked, staff stated they were in tune to call lights but would prefer them louder. When tested, a call light was answered quickly.

According to The JC, privacy should be maintained when speaking to patients. Auditory privacy was not maintained in one of the Waco outpatient clinics. We observed a clerk on the phone requesting information for a patient with two other patients within hearing distance. Patient auditory privacy is a challenge given the limited space and number of patients served.

Respirator Fit Testing. OSHA requires that fit testing of any negative pressure respirator be completed at least annually. The system utilizes N95 respirators to reduce exposure to harmful atmospheres for staff in high-risk areas. However, 4 (20 percent) of 20 selected direct care staff at risk for exposure did not receive the required fit testing.

IC. The JC requires the system to document hand hygiene practices as a process improvement monitor. The system provided documentation of collection of hand hygiene data. However, the data was grouped into four areas, and individual units were not identified. Of the four groups reviewed for FY 2009, the monitor fell below the system's established threshold of 95 percent for 18 (38 percent) of 48 entries. The acute care group fell below the threshold for 6 (50 percent) of the 12 months recorded, including 5 of the fall/winter months. Our review of IC Committee minutes revealed that the information was presented and closed during committee meetings and that there were no performance improvement (PI) plans.

The system's IC Committee is required to track and trend infections. A plan is to be initiated when a trend is identified. For example, according to IC Committee minutes, a trend every 3rd and 4th quarter for the past 2 fiscal years was identified for *Clostridium difficile*[8] associated diarrhea on two units. There were additional trends identified in the minutes. However, the minutes reflected no action plans, and the items were closed.

The system is required to initiate action plans when performance measures fall below the national target. The system's outpatient influenza immunization rate for FY 2009 for patients 50–64 years of age was 49 percent (VA target rate was 66 percent). The system's rate for patients over 65 years of age was 56 percent (VA target rate was 83 percent). Documentation in IC Committee minutes did not reflect an action plan, and the items were closed.

System Monitoring. Centers for Disease Control and Prevention (CDC) guidelines require daily monitoring of negative air flow rooms with documentation. The system utilizes negative air flow rooms for isolation of patients requiring airborne infection isolation. Although the isolation rooms at the system had monthly biomedical checks recorded, there were no daily monitor logs.

The system uses the Code Alert® monitoring system for patients who are confused or have a history of elopement and cannot be safely managed off the unit without an escort. Patients wear an electronic transmitter around their ankle or wrist that will sound an alert if the patient comes within 5 feet

[8] A bacteria that can cause serious illnesses.

of a receiver. Receivers are located at each exit from the unit. The manufacturer recommends checking the receivers and transmitters at least weekly. Local policy requires documentation of weekly checks of each transmitter; however, there is no requirement for receiver checks. Units we visited that had the monitoring system did not have a log completed in accordance with local policy.

EMS Staff Training. Local policy requires EMS staff to receive annual training on cleaning and disinfection procedures. The training records provided showed that 47 (28 percent) of 168 EMS employees had received annual training in FY 2009. Employees who are at risk for exposure are required to receive training on OSHA's bloodborne pathogens rule annually as part of the exposure control plan. The 10 unit employee records reviewed had the required training. However, the EMS staff training records reviewed showed that 113 (67 percent) of 168 employees had received the required training.

Recommendation 4 We recommended that the Acting VISN Director ensure that the System Director requires that all medication is secured and handled by licensed, approved, and trained personnel.

The Acting VISN and System Directors concurred with the finding and recommendation. During our site visit, the handling and storage of medications by health technicians ceased. The lock system was enhanced, and medications are now secured and handled by licensed, approved, and trained personnel. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 5 We recommended that the Acting VISN Director ensure that the System Director addresses the identified EOC rounds deficiencies.

The Acting VISN and System Directors concurred with the findings and recommendation.

- EOC rounds have been enhanced to comply with VHA policy. The EOC Committee and the Quality Executive Council (QEC) will monitor monthly attendance.
- The system has developed a web-enabled solution to enhance the tracking, monitoring, and reporting of EOC deficiencies. The EOC Committee and the QEC will monitor deficiencies through monthly reports.

- All oxygen tank racks have been relocated. Compliance will be monitored during EOC rounds and reported to the EOC Committee and the QEC monthly.
- A painting schedule was established. A program was implemented to address door jams, floor tiles, and other maintenance needs on a weekly and recurring basis. The floor tile issue in the ICU was addressed, and the chipped laminated surfaces at the nursing stations and the fire exit door on the first floor were repaired.
- Reports of cleanliness will be submitted monthly to the IC Committee and the Medical Staff Executive Council (MSEC). EMS is conducting bi-weekly inspections, and results have demonstrated enhanced improvement. Additional resources were provided to improve cleanliness issues facility wide.
- Exterior building walls at the Waco division were cleaned. A cleaning schedule was developed, and all main building exteriors will be cleaned biannually.
- The volume of the nurse call systems will be increased. If there is still an issue with call system volumes, a formal design and construction project will be initiated.
- Staff were re-educated regarding patient privacy. Weekly monitoring was initiated, and compliance has been 100 percent.

The improvement 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 System Director requires that staff identified as at risk for exposure to harmful atmospheres receive respirator fit testing, as required.

The Acting VISN and System Directors concurred with the finding and recommendation. Staff who require fit testing have been identified, and fit testing is in progress. Compliance will be monitored by the EOC Committee, the QEC, and the Executive Council of the Governing Body (ECGB). The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 7 We recommended that the Acting VISN Director ensure that the System Director requires that IC staff monitor, track, and provide action plans for all areas where trends are identified.

The Acting VISN and System Directors concurred with the findings and recommendation. Aggregate hand hygiene compliance data will be completed monthly and reported to the IC Committee and Patient Safety Council. Data will be compiled and trended quarterly, and anytime the aggregate falls below the threshold, corrective action plans will be executed. A tracking database was implemented to monitor open actions through to resolution. Processes were implemented to ensure that action plans are designed for targets falling below the established thresholds. Open actions and corrective action plans will be monitored by the IC 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 Acting VISN Director ensure that the System Director requires that monitoring logs are implemented for negative air flow rooms and the Code Alert® monitoring system, as required.

The Acting VISN and System Directors concurred with the findings and recommendation. An assessment of the system's operational needs for negative pressure rooms was conducted, and the number of isolation rooms was reduced. Engineering Service is conducting and documenting daily checks, and the EOC Committee and the QEC will monitor compliance. Code Alert® logs were implemented on all units, and a weekly monitoring system was initiated to ensure 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 Acting VISN Director ensure that the System Director requires that EMS staff annual training is completed, as required.

The Acting VISN and System Directors concurred with the findings and recommendation. All housekeeping employees will receive annual training on cleaning and disinfection procedures, and employees who are at risk will receive training on OSHA's bloodborne pathogens rule. Monthly audits of required training results will be submitted to the IC

Committee and the MSEC. The improvement plan is 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 VHA facilities had consistent processes for physician C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and physician profiles. We also reviewed meeting minutes during which discussions about the physicians took place.

We reviewed 10 C&P records with physician profiles and found that licenses were current and that primary source verification had been obtained. A Focused Professional Practice Evaluation was appropriately implemented for a newly hired physician. Meeting minutes consistently documented thorough discussions of the physicians' privileges and performance data prior to recommending renewal of or initial privileges. However, we identified one area that needed improvement.

Ongoing Professional Practice Evaluation. VHA policy[9] requires specific competency criteria for Ongoing Professional Practice Evaluation (OPPE) for all privileged physicians. We found that for the 2-year period prior to reprivileging, OPPE data for eight of nine physicians were not specific and did not support the privileges granted.

Recommendation 10 We recommended that the Acting VISN Director ensure that the System Director requires that the physician privileging process complies with VHA policy.

The Acting VISN and System Directors concurred with the finding and recommendation. A systematic approach for looking at data regarding performance for all practitioners with privileges has been established. This process includes criteria appropriate for each discipline. Results will be presented to the Practice Standards Board/MSEC. The improvement plan is 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 system had a comprehensive QM program designed to monitor patient care quality and whether senior managers actively supported the program's activities. We interviewed

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

the system's Director, Chief of Staff, and QM Chief. We evaluated plans, policies, PI data, and other relevant documents.

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. However, we identified two areas that needed improvement.

Life Support Training. VHA policy[10] requires the system to monitor BLS and ACLS training and to ensure timely renewal of all certifications. The system has a local policy addressing the requirements for BLS and ACLS certification. Managers identified 1,194 employees requiring BLS certification; however, 26 (2 percent) were not currently certified. Of the 171 employees identified as requiring ACLS certification, 5 (3 percent) were not currently certified. Although the overall compliance for both BLS and ACLS training was noted at 98 and 97 percent, respectively, corrective actions had not been taken in accordance with local policy when employees' certifications expired.

Medical Record Review. VHA policy[11] requires that the system have a process for monitoring the copy and paste function in the electronic medical record. We found that the system's policy defines the rules for copying and pasting text; however, the system had not fully implemented the monitoring of the copy and paste function in the medical record, as required by VHA policy.

Recommendation 11 We recommended that the Acting VISN Director ensure that the System Director requires that designated staff maintain current BLS and ACLS certification in accordance with local policy.

The Acting VISN and System Directors concurred with the findings and recommendation. Education Service has developed a tracking methodology for BLS and ACLS training to ensure that certification is maintained. The MSEC and the QEC will monitor compliance. The improvement plan is acceptable, and we will follow up on the planned actions until they are completed.

[10] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.
[11] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

Recommendation 12 We recommended that the Acting VISN Director ensure that the System Director requires that monitoring of the copy and paste function in the electronic medical record is fully implemented.

The Acting VISN and System Directors concurred with the finding and recommendation. A multidisciplinary team was initiated to implement monitoring of the copy and paste function. An enhanced monitoring tool was designed, and education was provided. QM staff will monitor compliance and submit reports to the Medical Records Committee and the MSEC. The improvement plan is 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[12] requires that systems have a policy that ensures the safe, appropriate, and timely transfer of patients and that transfers are monitored and evaluated as part of the QM program. VHA policy also requires that providers include information regarding medications, diet, activity level, and follow-up appointments in patient discharge instructions. In addition, The JC requires that clinicians provide patients with written discharge instructions.

We determined that the system had an appropriate transfer policy and that transfers were monitored and evaluated as part of the QM program. Both inter-facility transfers and discharges were coordinated appropriately over the continuum of care, and all discharge records reviewed met VHA and JC requirements. However, we identified the following area that needed improvement.

Inter-Facility Transfers. VHA policy[13] requires specific information (such as the reason for transfer, mode of transportation, and informed consent to transfer) to be recorded in the transfer documentation. We reviewed transfer documentation for 10 patients transferred from the system's acute inpatient unit, emergency department, or

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

urgent care clinic to another facility. We found that 4 (40 percent) of the 10 patients had no documentation that advanced directives were addressed and that 3 (30 percent) of the 10 patients had no documentation of informed consent to transfer.

Recommendation 13 We recommended that the Acting VISN Director ensure that the System Director requires staff to complete inter-facility transfer documentation in accordance with VHA policy.

The Acting VISN and System Directors concurred with the findings and recommendation. The system enhanced the transfer note template to include documenting informed consent and advanced directive status. Education on the new template was provided to staff. QM staff will monitor compliance and report monthly to the QEC and the ECGB. The improvement plan is 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 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.[14] We found that clinical staff had appropriately identified and addressed elevated hemoglobin levels in 7 (70 percent) of the 10 patients whose medical records we reviewed. The other three patients were receiving dialysis, follow-up, and treatment from a nephrologist in the community.

Influenza vaccinations were offered and administered to CLC residents, and documentation was adequate for most required elements. However, we identified the following area that needed improvement.

CLC Influenza Vaccinations. For each dose of influenza vaccine, VHA[15] requires the following items to be documented:

[14] Erythropoiesis-stimulating agents are drugs that stimulate the bone marrow to make red blood cells. They are used to treat anemia.
[15] VHA Directive 2009-058, *Seasonal Influenza Vaccine Policy for 2009–2010*, November 12, 2009.

- Date of administration
- Lot number
- Manufacturer
- Route
- Site
- Provider name and title
- Edition and date of the Vaccine Information Statement (VIS) from the CDC

We reviewed the medical records of 10 CLC residents and found that the records did not contain documentation of the VIS edition.

Recommendation 14 We recommended that the Acting VISN Director ensure that the System Director requires that clinicians consistently document all required influenza vaccine elements.

The Acting VISN and System Directors concurred with the finding and recommendation. The electronic nursing note template was modified to include the VIS edition. The corrective action is acceptable, and we consider this recommendation closed.

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 inspected the MRI area, examined medical and training records, reviewed relevant policies, and interviewed key personnel. We determined that the system had adequate safety policies.

The system had appropriate signage and barriers to prevent unauthorized or accidental access to the MRI area. Patients in the magnet room are directly observed at all times. Two-way communication is available between the patient and the MRI technologist, and the patient has access to a push-button call system while in the scanner. Local policy requires that personnel who have access to the MRI area receive appropriate MRI safety training. We reviewed the

training records of 12 personnel and found that all had completed required safety training.

We reviewed the medical records of 10 patients who received an MRI. In all cases, patients received appropriate screening. We found no patients who had an MRI with contrast media and required informed consents prior to their procedures.

Mock fire and emergency response drills had not been conducted in the MRI area. The current area was very restrictive, but staff verbalized how they would handle a code in the MRI area. There are plans to complete mock training in the new MRI unit, which was scheduled to open in 3 weeks; therefore, we made no recommendations for this finding.

The call button for patients in Zone IV was reported as being tested daily by MRI staff. However, the daily checklist did not include the testing of the call button. While we were onsite, the daily checklist was modified to include checking the call button in Zone IV. Therefore, we did not make a recommendation for this finding. However, we identified the following area that needed improvement.

Risk Assessment. The system did not appropriately conduct a risk assessment of the environment, as required by The JC. When asked, staff stated that they believed all areas had been covered while in the planning phase of the new MRI unit. While we were onsite, the MRI Chief initiated the write-up of the risk assessment based on prior recommendations.

Recommendation 15 We recommended that the Acting VISN Director ensure that the System Director requires that staff complete and follow up with the MRI risk assessment, as required by The JC.

The Acting VISN and System Directors concurred with the finding and recommendation. A formal risk assessment was conducted. The corrective action is acceptable, and we consider this recommendation closed.

Review Activity Without 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.[16]

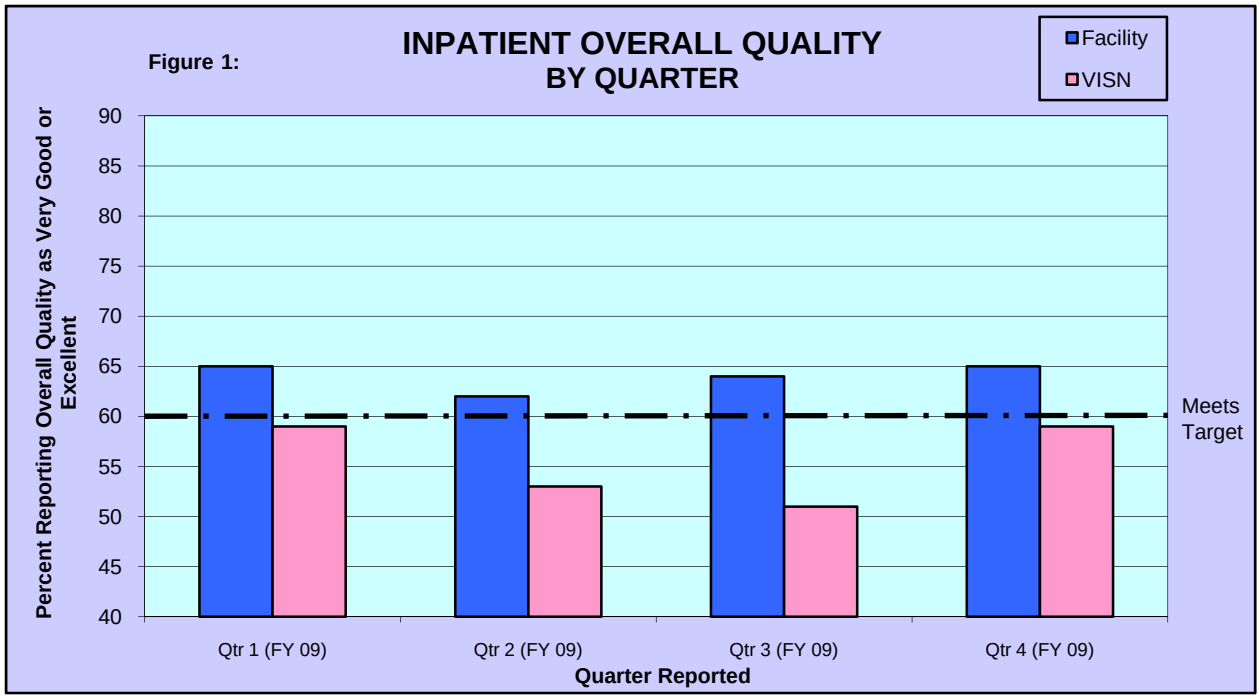
A previous OIG review of suicide prevention programs in VHA facilities[17] found a 74 percent compliance rate with safety plan development. The safety plan issues identified in that review were that plans were not comprehensive (did not contain the above elements), were not developed timely, or were not developed at all. At the request of VHA, the OIG agreed to follow up on the prior findings.

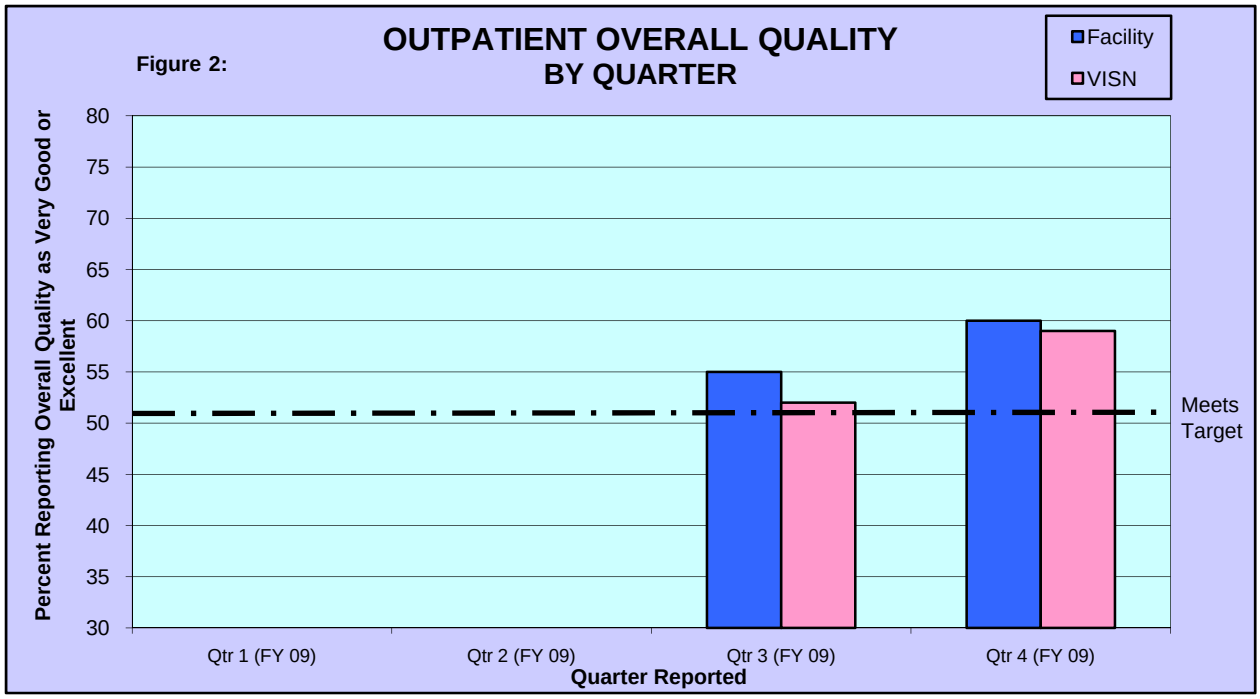
We reviewed the medical records of 10 patients assessed to be at high risk for suicide and found that clinicians had developed timely safety plans that included all required elements. We also found evidence to support that the patients and/or their families participated in the development of the plans. 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 on the next page 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.[18] The target scores are noted on the graphs.

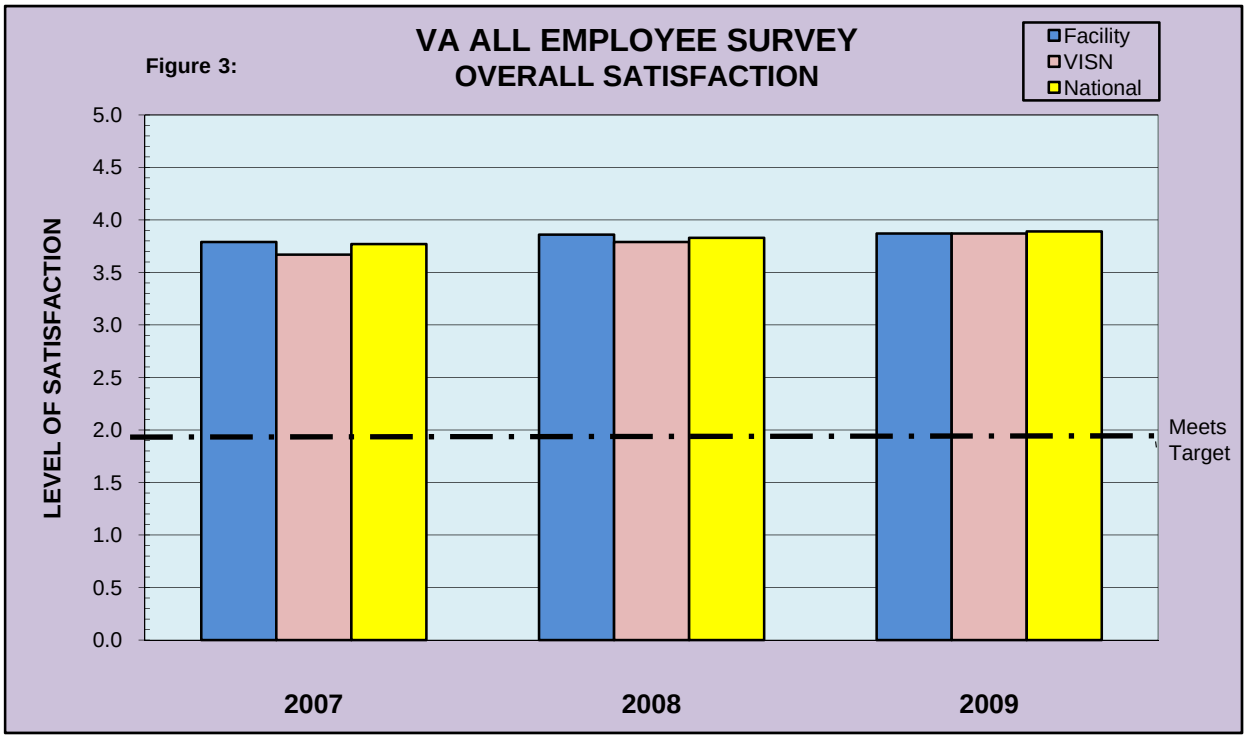
[16] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
[17] Healthcare Inspection – *Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009;* Report No. 09-00326-223; September 22, 2009.
[18] Due to technical difficulties with VHA's outpatient survey data, outpatient satisfaction scores for quarters 1 and 2 FY 2009 are not included for comparison.





Employees are surveyed annually. Figure 3 on the next page 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.

Figure 3:


VA ALL EMPLOYEE SURVEY
OVERALL SATISFACTION
Facility
VISN
National
LEVEL OF SATISFACTION
5.0
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0
Meets Target
2007
2008
2009

Acting VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 3, 2010

From: Acting VISN Director (10N17)

Subject: **Combined Assessment Program Review of the Central Texas Veterans Health Care System, Temple, Texas**

To: Director, Dallas Healthcare Inspections Division (54DA)

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

1. I appreciate the opportunity to review the draft report on the Combined Assessment Program Review of the Central Texas Veterans Health Care System (CTVHCS), conducted March 22-26, 2010. I concur with this report and responses from CTVHCS.

2. If you have additional questions concerning the responses and actions outlined in the implementation plan, please contact Ms. Sylvia Tennent, Chief of Quality Management and Improvement Services at 254-743-0719.

(original signed by:)
Joseph M. Dalpiaz

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 1, 2010

From: Director (674/00), Central Texas Veterans Health Care System (CTVHCS), Temple, TX

Subject: **Combined Assessment Program Review of CTVHCS**

To: VISN Director (10N17)

1. On behalf of CTVHCS, I would like to take this opportunity to express my sincere appreciation to the Office of the Inspector General (OIG), Combined Assessment Program (CAP) review team for their professionalism, consultative approach, and excellent feedback provided to our staff during the review conducted on March 22–26, 2010.

2. The recommendations were reviewed and I concur with the findings. Our comments and implementation plan are delineated below. Corrective action plans have been developed or executed for continuous monitoring. CTVHCS welcomes the external perspective provided, which we will utilize to further strengthen the quality of care we provide to our Veterans.

3. Should you have questions or require additional information, please do not hesitate to contact Sylvia Tennent, Chief of Quality Management and Improvement Service at extension 254-743-0719.

(original signed by:)
Thomas C. Smith, III, FACHE

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 System Director requires that staff wear appropriate PPE in accordance with VHA policy.

Concur: Target Completion Date: Completed

CTVHCS agrees that staff utilize the required PPE while completing reprocessing of Reusable Medical Equipment (RME). The requirement to wear all PPE was addressed and training for Supply, Processing, & Distribution (SPD) staff on proper wear of PPE was completed on April 9, 2010. In addition, the Chief, SPD initiated weekly random monitoring regarding compliance with proper use of PPE. Completed

Recommendation 2. We recommended that the Acting VISN Director ensure that the System Director requires that device-specific SOPs and guidelines for LLD are established and consistent with the manufacturers' instructions for all pieces of RME and that staff comply.

Concur: Target Completion Date: June 25, 2010

CTVHCS leadership has allocated additional resources to support the SPD program to include Nursing Performance Improvement Staff, and an operating room nurse is detailed to assist with SOPs and staff competency reviews. CTVHCS elicited the assistance of a consultant to complete an organizational assessment of the SPD program with recommendations incorporated. To date several of the consultants' recommendations were implemented. In addition, CTVHCS is in the process of establishing an RME Committee. RME was previously followed by the Infection Control (IC) Committee and is now under the direct oversight of the Medical Staff Executive Council (MSEC). SOPs updates (including device-specific) to comply with manufacturers' instructions was completed on May 10, 2010. Additional decontamination SOPs were written in accordance with manufacturers' instructions was completed on May 21, 2010. Completion of the reviews for all SOPs for critical and semi-critical RME is targeted for completion on June 11, 2010. Staff education and training is targeted for the week of June 14, 2010 with expected completion during the week of June 21, 2010.

Recommendation 3. We recommended that the Acting VISN Director ensure that the System Director requires that corrective action plans implemented ensure competencies of employees in SPD are consistent with manufacturer's instructions and are evaluated annually for all pieces of RME.

Concur: Target Completion Date: June 11, 2010

The Nurse Executive will ensure that the corrective action plans are implemented, and that initial and annual competencies for all employees who reprocess RME will be assessed, implemented, and documented by the Chief, SPD Service. Nursing Service and Human Resources will conduct monitoring of competency compliance. SOPs were rewritten and included staff competencies and personnel position descriptions (PD) consistent with manufacturers' instructions and VHA requirements.

Recommendation 4. We recommended that the Acting VISN Director ensure that the System Director requires that all medication is secured and handled by licensed, approved, and trained personnel.

Concur: Target Completion Date: Completed

CTVHCS agrees that the current process regarding storage and handling of medication in the clinic requires strengthening. During the OIG CAP site visit, the handling and storage of medications by health technicians ceased. The lock system was enhanced and medications are now secured and handled by licensed, approved and trained personnel.

Recommendation 5. We recommended that the Acting VISN Director ensure that the System Director addresses the identified EOC rounds deficiencies.

Concur: Target Completion Date: June 18, 2010

1. EOC Rounds: The EOC rounds conducted by the system's inspection team have been enhanced to comply with Deputy Under Secretary for Health and Operations Memorandum issued on March 5, 2007. The Health System's Director has established expectations and the membership was changed to mirror the Secretary's expectation. Audit conducted of attendance has demonstrated enhanced improvement. The EOC Committee and the Quality Executive Council (QEC) through resolution will monitor monthly attendance compliance.

2. The system is required to track, monitor, and prioritize deficiencies found on EOC rounds: CTVHCS has recognized this vulnerability and Quality Management has collaborated with Office of Information Technology in designing and executing a web-enabled innovative

solution, which incorporates EOC rounds. This solution was beta-tested in February and March 2010, which is now in the implementation phase throughout CTVHCS for full execution by June 18, 2010. This web-enabled solution will enhance the tracking, monitoring and real-time reporting of EOC deficiencies through resolution. EOC Inspections Memorandum No.004SIH-303-010E was revised on May 5, 2010 to incorporate this process. The EOC Committee and the QEC will monitor monthly reports regarding deficiencies.

3. According to OSHA guidelines, oxygen must be stored separately (minimum distance of 20 feet from combustible materials: We have addressed the oxygen storage tank distance issue and all tank racks have been relocated to comply with NFPA 99 oxygen storage requirements, as well as, The Joint Commission (TJC) Life Safety Standards, 2010 requirements. This was completed on May 7, 2010. Compliance monitoring will be conducted during EOC Rounds and reported to the EOC Committee and QEC monthly.

4. During our inspection at the Temple division, it was noted that doorways were in need of paint, repair, and proper cleaning: An in-house initiative is underway to check all door jams and provide fresh paint to those that are in need. A painting schedule was established. A six week inspection & touch up painting cycle is now monitored through the work order system. The first cycle targeted completion date is June 30, 2010, which is currently 17 percent completed. Additionally, a proactive program was implemented whereby the Maintenance Mechanics assigned to each building will address door jams, floor tiles, and other maintenance needs on a weekly and recurring basis. Target date for initial corrections is June 30, 2010. The floor tiles in the ICU were immediately corrected and this item is now closed. Chip laminated surface at the nursing station was repaired immediately following the OIG CAP Review, and the fire exit doors on first floor was repaired. Completed.

5. A service contract was utilized in cleaning the entire SPD Area; and additional FTEs were assigned to ensure continuity of cleanliness. Ongoing reports of cleanliness will be submitted monthly to the IC Committee and MSEC. EMS continues to conduct bi-weekly inspections using the EOC checklist and results have demonstrated enhanced improvement. Additional resources were provided for both housekeeping aides and supervisors to improve this cleanliness issues facility-wide. Target completion date is June 16, 2010. Reports will be submitted to the IC Committee for monitoring through resolution.

6. Inspection at Waco division revealed black stains on the exterior walls: The substance was pressure-washed, and the exterior of the building cleaned. A cleaning schedule was developed and all main building exteriors will be cleaned on a biannual basis. Completed.

7. Patient call light alarms are required by TJC to be audible (Temple and Waco): An initial assessment was conducted and collaboration with responsible staff is underway. The volume of the nurse call systems will be increased to comply with regulatory requirements. If the system volumes cannot be increased, a formal Design and Construction project will be created and resources pursued. Target Completion date of assessment and identification of project needs is June 25, 2010.

8. According to TJC, privacy should be maintained when speaking to patients: CTVHCS agrees that although patient privacy is a challenge due to space issues (in certain locations), patient privacy must be maintained. Staff re-education was conducted on April 13, 2010 to strengthen this process regarding respecting the rights of patients during encounters and in accordance with local policy. Weekly monitoring was initiated to validate compliance, and results to date revealed 100 percent compliance. Monitoring will continue through resolution. Completed.

Recommendation 6. We recommended that the Acting VISN Director ensure that the System Director requires that staff identified as at risk for exposure to harmful atmospheres receive respirator fit testing, as required.

Concur: Target Completion: June 18, 2010

The Chief, Safety and Industrial Hygiene Service and the Chief, Environmental Health & Safety has established a process for identifying employees at risk for TB exposure who are required to wear N95 Respirator and complete the required training for the fit testing program. Employees identified to wear N95 must be medically cleared by Environmental Health & Safety. A database is utilized for annual notification to employees prior to expiration dates, as well as monitoring and reporting.

On May 6, 2010, the groups were identified, and the positions required to wear the N95 respirators have been identified. As of May 25, 2010, ninety-six percent of the staff has been fit tested, and the remaining staff will be fit tested by June 18, 2010. Ongoing monthly compliance will be monitored through EOC Committee, QEC, and Executive Council of the Governing Body (ECGB).

Recommendation 7. We recommended that the Acting VISN Director ensure that the System Director requires that IC staff monitor, track, and provide action plans for all areas where trends are identified.

Concur: Target Completion Date: Completed April 30, 2010

1. Aggregate hand hygiene Compliance data will be completed monthly and reported to the IC Committee and Patient Safety Council in accordance with regulatory requirements. Detailed data will be complied and trended quarterly and anytime the aggregate falls below the threshold, corrective action plans will be executed for monitoring through resolution. Corrective action plan and data specifics were presented to the Patient Safety Council on April 5, 2010. This process has been strengthened, and corrective action plans will be addressed by the respective committee/council through resolution. Action plan and data specifics were presented to the Patient Safety Council on April 5, 2010.

2. A tracking database solution was designed and executed on March 4, 2010 to strengthen this process and effectively monitor open actions through resolution, in accordance with CTVHCS Station Memorandum 00-029-10. CTVHCS recognizes this vulnerability and processes were implemented to strengthen and ensure action plans are also designed for targets falling below the established thresholds. Clostridium difficile rates decreased in the second quarter of 2010, which is an improvement. Open actions and corrective action plans are now monitored by the IC Committee through resolution. Completed.

Recommendation 8. We recommended that the Acting VISN Director ensure that the System Director requires that monitoring logs are implemented for negative air flow rooms and the Code Alert® monitoring system, as required.

Concur: Target Completion Date: June 1, 2010

1. Ensure monitoring logs are implemented for negative airflow rooms: CTVHCS agrees that monitoring logs should be used for negative airflow rooms. Although this process was in place at the time of the review, opportunities were identified. As a result, CTVHCS has conducted a thorough assessment of Healthcare System operational needs. The number of isolation rooms were reduced to the actual number required through this needs assessment. These isolation rooms are equipped with an audible alarm capability activated on the room monitors. Engineering Service is conducting and documenting daily checks utilizing these monitors to enhance documentation and

compliance, which will be monitored monthly by the EOC Committee and the QEC.

2. Ensure Code Alert Monitoring system is implemented: CTVHCS has reviewed the Nursing Procedure Code alert monitoring System, processes were enhanced, staff was educated, and logs were implemented on all units in accordance with local policy on May 1, 2010. A weekly monitoring system was initiated to ensure compliance. Completed.

Recommendation 9. We recommended that the Acting VISN Director ensure that the System Director requires that EMS staff annual training is completed, as required.

Concur: Target Completion Date: June 30, 2010

All housekeeping employees will receive annual training on cleaning and disinfection procedures. Employees who are at risk for exposure will also receive annual training for the OSHA Bloodborne pathogens to comply with these requirements established by CTVHCS local policy. The mandatory training will be completed no later than June 30, 2010. CTVHCS leadership has allocated additional resources to strengthen this process with an EMS trainer. Monthly audits of required training results will be submitted to the IC Committee and MSEC monthly for monitoring through resolution.

Recommendation 10. We recommended that the Acting VISN Director ensure that the System Director requires that the physician privileging process complies with VHA policy.

Concur: Target Completion Date: June 30, 2010

CTVHCS has designed a systematic approach for looking at data regarding performance for all practitioners with privileges on an ongoing basis to facilitate compliance with VHA Handbook 1100.19, Credentialing and Privileging (November 12, 2008) and 2010 TJC requirements. This process includes criteria appropriate for each discipline and will be populated quarterly, reviewed by each Service Chief and results presented to the Practice Standards Board/MSEC (process which is currently in place). This will serve to validate compliance with the standards specific for each service and identify outliers who may require a focused review. This is scheduled for final approval by the Professional Standards Board on June 1, 2010 and the ECGB no later than June 30, 2010.

Recommendation 11. We recommended that the Acting VISN Director ensure that the System Director requires that designated staff maintain current BLS and ACLS certification in accordance with local policy.

Concur: Target Completion Date: June 30, 2010

1. Education Service was tasked to develop a tracking methodology for both BLS and ACLS to ensure certification is maintained in accordance with VHA Directive 2008-008 and facilitate compliance monitoring. Education Service designed the capability in the LMS and instructed all service chiefs with staff members mandated to complete ACLS and BCLS certification are entered by their LMS administrator by April 30, 2010. As a curriculum assignment on the individuals Learning Plan, 90, 60, and 30-day notification reminders will be sent to the supervisor prior to expiration dates. The MSEC and the QEC will conduct monitoring through resolution.

2. The CTVHCS policy for BLS and ACLS was revised to incorporate the process changes. The Quality Management Staff hired for the Credentialing and Privileging Service will work collaboratively with the services to provide additional oversight of this process.

Recommendation 12. We recommended that the Acting VISN Director ensure that the System Director requires that monitoring of the copy and paste function in the electronic medical record is fully implemented.

Concur: Target Completion Date: Completed

CTVHCS agrees that staff monitors the copy and paste function of the medical record in accordance with VHA Handbook 1907.01 and local Memorandum No: 04-019-08. Although a process for monitoring copy and paste function in the electronic medical record was in place at the time of the review, this process was not fully implemented. A multidisciplinary team was initiated immediately following the OIG review to improve and strengthen this process. Enhanced monitoring tool was designed; education was conducted to the medical staff and other providers. The Quality Management Clinicians initiated monthly monitoring of copy and paste function in April 2010 that yielded substantial improvements. This process is now fully executed system-wide with monthly reports submitted to the Medical Records Committee and the MSEC for compliance monitoring.

Recommendation 13. We recommended that the Acting VISN Director ensure that the System Director requires staff to complete inter-facility transfer documentation in accordance with VHA policy.

Concur: Target Completion Date: Completed

CTVHCS agrees that staff complete Inter-Facility transfer documentation in accordance with VHA Directive 2007-015. CTVHCS had a process in place for monitoring compliance with completion of the inter-facility transfer at the time of the review. A subsequent review of the process identified opportunities for improvement and a team approach was utilized to enhance the CPRS note template to include documenting informed consent, advanced directive status and streamline the data collection tool. Education was conducted to the responsible individuals, local policy was developed with enhance note template which was approved by the MSEC on May 14, 2010. Audits conducted revealed improvement with compliance. Monitoring conducted by the Quality Management staff for all patient transfers are reported monthly to the QEC and the ECGB.

Recommendation 14. We recommended that the Acting VISN Director ensure that the System Director requires that clinicians consistently document all required influenza vaccine elements.

Concur: Target Completion Date: Completed

Electronic note template was designed to modify the Nursing note to include the edition of the Vaccine Information Sheet. Information Technology request was submitted on April 5, 2010 to identify all immunization notes to make the changes and to ensure that mandatory field requiring the CDC VIS edition is linked to the templates for both inpatient and outpatient system-wide. This was approved by the ACNS Nursing and Chief, Employee Health on April 5, 2010. Completed.

Recommendation 15. We recommended that the Acting VISN Director ensure that the System Director requires that staff complete and follow up with the MRI risk assessment, as required by The JC.

Concur: Target Completion Date: Completed

A risk assessment was previously performed based on recommendations from TJC Sentinel Event Alert Number 38, but was not available in written format during the survey. An additional formal risk assessment based on TJC Sentinel Event Alert Number 38 was conducted during the OIG CAP review on March 23, 2010 and provided to the reviewer. Daily checks of the patient panic alarm are conducted, which is included in the MRI Infection Control and QA Checklist. On April 5, 2010 a “ring down” phone has been installed in the MRI control room and connects with the CTVHCS Police Service. Completed.

OIG Contact and Staff Acknowledgments

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