Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-01435-210

Combined Assessment Program Review of the New Mexico VA Health Care System Albuquerque, New Mexico

July 27, 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.

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: http://www.va.gov/oig/contacts/hotline.asp)

Table of Contents

Executive Summary

Introduction

During the week of April 19–23, 2010, the OIG conducted a Combined Assessment Program (CAP) review of the New Mexico VA Health Care System (the system), Albuquerque, NM. 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 181 system employees. The system is part of Veterans Integrated Service Network (VISN) 18.

Results of the Review

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

- Institutional Disclosure Process

We made recommendations in six of the activities reviewed; one recommendation was a repeat recommendation from the prior CAP review. For these activities, the system needed to:

- Require that clinicians develop comprehensive safety plans and that patients and/or their families participate in safety plan development.
- Require that peer reviews be completed within the timeframes specified by Veterans Health Administration (VHA) policy.
- Require that managers continuously monitor and evaluate medication reconciliation, as required by Joint Commission (JC) standards.
- Require that designated staff maintain current Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS) certification in accordance with local policy.
- Require that staff identified as at risk for exposure to harmful atmospheres receive annual respirator fit testing and bloodborne pathogens training, as required.
- Require that proper monitoring of dialysate from dialysis machines occurs and is documented, as required by local policy.
- Ensure that all required disciplines attend environment of care (EOC) rounds and that deficiencies found on EOC rounds are properly recorded, tracked, and prioritized.

- Require implementation of system monitoring for the WanderGuard© system, as recommended by the manufacturer.
- Require that engineering correct air flow deficiencies in the clean areas of Supply, Processing, and Distribution (SPD).
- Require that training is provided and documented for all pieces of reusable medical equipment (RME).
- Require that personnel who have access to the magnetic resonance imaging (MRI) area complete appropriate safety training, as required by JC standards.
- Require that the system conduct a comprehensive risk assessment of the MRI area, as required by The JC.
- Require that clinicians consistently take and document appropriate actions when chronic renal disease (CRD) patients' hemoglobin levels exceed 12 grams per deciliter (g/dL).

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

- Coordination of Care
- Physician credentialing and privileging (C&P)

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

Comments

The VISN and System Directors agreed with the CAP review findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 17–24, 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 Level 1 tertiary system located in Albuquerque, NM, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at 11 community based outpatient clinics in Alamogordo, Artesia, Espanola, Farmington, Gallup, Las Vegas, Raton, Santa Fe, Silver City, and Truth or Consequences, NM, and in Durango, CO. The system is part of VISN 18 and serves a veteran population of about 187,000 throughout New Mexico and southern Colorado.

Programs. The system provides medicine, surgery, long-term care, mental health (MH), rehabilitation, and spinal cord injury services. It has 184 hospital beds, 36 community living center (CLC) beds, and 90 MH beds.

Affiliations. The system is affiliated with the University of New Mexico School of Medicine and provides training for 126 residents in 33 clinical training programs.

Resources. In fiscal year (FY) 2009, medical care expenditures totaled $341 million. The FY 2010 medical care budget is $358 million. FY 2009 staffing was 1,942 full-time employee equivalents (FTE), including 154 physician and 404 nursing FTE.

Workload. In FY 2009, the system treated 56,520 unique patients and provided 44,809 inpatient days in the hospital and 8,201 inpatient days in the CLC. The inpatient care workload totaled 6,479 discharges, and the average daily census, including CLC patients, was 193. Outpatient workload totaled 570,118 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
- EOC
- 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 April 19, 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 (*Combined Assessment Program Review of the New Mexico VA Health Care System, Albuquerque, New Mexico*, Report No. 07-02349-29, November 27, 2007). We identified a repeat finding from our prior review in the area of peer review timeliness.

The week prior to the CAP review, we presented fraud and integrity awareness briefings for 181 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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

Organizational Strength

Institutional Disclosure Process

The system improved the institutional disclosure process in order to gain broader input from clinicians, the Chief Ethics Officer, the Office of Regional Counsel, and QM. Before an institutional disclosure is completed, the Chief of Staff conducts a meeting to determine the course of care and whether an institutional disclosure is deemed appropriate. The discussion includes what to disclose, who to disclose it with, and when to disclose. Additionally, because the disclosure itself is so emotional, the system developed a fact sheet so that the veteran has written information regarding how to file a tort claim, seek additional benefits, and obtain assistance. The Chief of Staff or Deputy Chief of Staff participates in and leads every institutional disclosure discussion.

Results

Review Activities With 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.[1]

[1] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.

A previous OIG review of suicide prevention programs in VHA facilities[2] 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 identified the following area that needed improvement.

Inadequate Safety Plans. In 9 (90 percent) of the 10 records, we found that safety plans lacked one or more of the essential elements. Also, in 9 (90 percent) of the 10 records, we could not find evidence to support that the patients and/or their families participated in the development of the plans.

Recommendation 1 We recommended that the VISN Director ensure that the System Director requires that clinicians develop comprehensive safety plans and that patients and/or their families participate in safety plan development.

The VISN and System Directors concurred with the findings and recommendations. The Chief of Psychiatry and Acting Chief of Psychology initiated the use of an electronic version of the safety plan that includes all required elements. Patient charts are now in compliance, and monitoring is being conducted. The corrective actions are acceptable, and we consider this recommendation closed.

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 the system's Director, Chief of Staff, and QM Chief. We evaluated plans, policies, performance improvement (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

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

resources to the program. However, we identified the following areas that needed improvement.

Peer Review. Once the need for peer review is determined, VHA policy[3] requires final reviews to be completed within 120 days. Any extensions must be granted by the system's Director. During our prior CAP review, we identified peer review cases that had not been completed as required. In FY 2009, 8 (13 percent) of 64 peer reviews had not been completed within the required timeframe. Without timely peer reviews, the system cannot implement required quality and PI activities. Although this is a repeat finding from our previous CAP review, the system has made noticeable improvement in developing the peer review process.

Medication Reconciliation. The JC requires health care organizations to continuously monitor medication reconciliation across the continuum of care. Patients' medications must be reviewed at key points, such as admission, transfer, and discharge, to prevent duplications, omissions, or potentially hazardous combinations. In FY 2009, system managers did not monitor medication reconciliation and did not have ongoing monitors to ensure compliance. Without ongoing collection of data, the system could not monitor for trends. In FY 2010, the system resumed monitoring medication reconciliation.

Life Support Training. VHA policy[4] 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 739 employees who are required to have current BLS certification; however, 245 (33 percent) did not have current certification. Managers identified 207 employees who are required to have ACLS certification; however, 11 (5 percent) did not have current certification. Additionally, there was no action taken for employees who did not maintain current certification.

Recommendation 2 We recommended that the VISN Director ensure that the System Director requires that peer reviews be completed within the timeframes specified by VHA policy.

[3] VHA Directive 2008-004, *Peer Review for Quality Management,* January 28, 2008.
[4] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.

Recommendation 3 We recommended that the VISN Director ensure that the System Director requires that managers continuously monitor and evaluate medication reconciliation, as required by JC standards.

Recommendation 4 We recommended that the VISN Director ensure that the System Director requires that designated staff maintain current BLS and ACLS certification in accordance with local policy.

The VISN and System Directors concurred with the findings and recommendations. The system has implemented changes to the Peer Review Committee agenda to clearly annotate the required completion dates for peer reviews. Services will be required to request written extensions prior to the completion dates. The Continuous Readiness Committee will evaluate medication reconciliation data quarterly to identify opportunities for improvement. The Learning Management System (LMS) will be used to track and monitor BLS and ACLS certification, and status reports will be provided to leadership. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Environment of Care

The purpose of this review was to determine 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, Occupational Safety and Health Administration (OSHA), National Fire Protection Association, and JC standards.

We inspected the spinal cord injury, cardiac care, medical intensive care, surgical intensive care, medical, hemodialysis, locked MH, geriatric/extended care/respite care/palliative care units; the emergency department; and two outpatient clinic areas. The system maintained a generally clean and safe environment. However, we identified the following areas that needed improvement.

Infection Control. Infection control (IC) guidelines require that employees at risk for exposure to bloodborne pathogens receive annual training on the OSHA Bloodborne Pathogens Rule. We reviewed training records for 30 clinical staff and found that 5 (17 percent) did not have the required training.

OSHA policy for respirator fit testing directs that individuals identified to wear an N95 respirator must undergo initial and annual fit testing and training and initial medical evaluation. Respirators will be provided to these employees when it is necessary to protect their health. We requested documentation of N95 fit testing for 20 employees at risk for exposure to harmful atmospheres. We found that 10 (50 percent) of the 20 employees did not receive the required annual N95 fit testing.

Local policy states that dialysate from each dialysis machine is to be cultured monthly. We reviewed 12 months of culture reports for dialysate for each machine and found that documentation of biological testing was inconsistent.

EOC Rounds. The system is required to conduct weekly EOC rounds. They document and track that deficiencies are corrected within 14 days. The system conducted EOC rounds; however, leadership was unable to provide us with documentation that supported tracking and trending of deficiencies until the deficiencies are corrected. The documents provided indicated that 103 (44 percent) of 234 deficiencies were not corrected within 14 days.

EOC rounds 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[5] requires that EOC rounds be led by either the Director or Associate Director and include managers in nursing, building management, engineering, safety, patient safety, and IC; the Information Security Officer (ISO); and others, as required. There was no documentation that the Director or Associate Director, nursing management, or safety management had participated in any of the EOC rounds. Of the 93 weekly EOC rounds for which attendance sheets were provided, building management participated in 44 (47 percent); engineering in 93 (100 percent); patient safety in 34 (37 percent), IC in 6 (6 percent) and the ISO in 25 (27 percent).

System Monitoring. The system uses the WanderGuard® monitoring system for patients who are confused or have a history of elopement and cannot be safely managed off the

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

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 of a receiver. Receivers are located at each unit exit. The monitoring system code was reset during routine maintenance, and staff were not given the new code. Also, staff reported that the WanderGuard® system had been turned off for more than a week. There were patients on the unit who required the use of the WanderGuard® system during that period of time. Additionally, the system did not have a policy that reflected the manufacturer's requirements for system monitoring.

Recommendation 5 We recommended that the VISN Director ensure that the System Director requires that staff identified as at risk for exposure to harmful atmospheres receive annual respirator fit testing and bloodborne pathogens training, as required.

Recommendation 6 We recommended that the VISN Director ensure that the System Director requires that proper monitoring of dialysate from dialysis machines occurs and is documented, as required by local policy.

Recommendation 7 We recommended that the VISN Director require that the System Director ensures that all required disciplines attend EOC rounds and that deficiencies found on EOC rounds are properly recorded, tracked, and prioritized.

Recommendation 8 We recommended that the VISN Director ensure that the System Director requires implementation of system monitoring for the WanderGuard© system, as recommended by the manufacturer.

The VISN and System Directors concurred with the findings and recommendations. The system will complete fit testing on all appropriate employees by December 31, 2010. New staff requiring annual fit testing will be identified during the pre-employment evaluation. Bloodborne pathogens training will be available in LMS by June 11, 2010. Staff will be expected to complete the training within 120 days.

All indicated dialysis machine testing was completed; however, due to a change in dialysis unit management, testing was not consistently reported to the IC Committee. Local policy will be revised to specify that documentation is to be provided to the IC Committee.

A new local EOC policy was implemented. EOC rounds membership was identified, and participation will be tracked weekly. The Chief of Engineering will track all EOC deficiencies weekly to assure completion or a plan of action to correct within 14 days from the date identified.

Engineering will inspect and test the WanderGuard© system weekly and will provide a monthly report to Nursing Service. Nurses will conduct daily testing in accordance with the manufacturer's requirements. Documentation of testing will be completed. 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 SPD and satellite reprocessing areas are required to meet VHA, Association for the Advancement of Medical Instrumentation, OSHA, and JC standards.

We inspected the SPD reprocessing and sterile supply areas and the satellite reprocessing areas for anesthesiology, cardiac catheterization, gastroenterology, hemodialysis, urology, and the operating room (OR). We determined that the system had established appropriate guidelines and monitored compliance with those guidelines.

For 11 pieces of RME, we reviewed the SOPs for reprocessing. In general, we found that SOPs were current and consistent with manufacturers' instructions. We reviewed 15 months of OR flash sterilization documentation. We noted that the system had successfully reduced its flash sterilization rate from 30 to 7 percent. However, we identified the following areas that needed improvement.

Air Flow. VA policy[6] requires specific air flow and air exchanges in the decontamination (dirty) and sterile (clean) storage areas of SPD to minimize cross-contamination from dirty to clean areas. The clean areas are to be maintained under positive pressure with 10 or more air exchanges per hour. We reviewed documentation of testing conducted by

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

an outside contractor. We determined that the system did not meet the required number of air exchanges in two of the four clean areas.

Training. VHA policy[7] requires that all employees involved in the use and reprocessing of RME have documented training on the set-up, use, reprocessing, and maintenance of specific RME. We reviewed training records for six employees in the satellite areas who reprocess RME. We determined that two did not have current RME training documentation—one for the internal pathways of a hemodialysis machine and the other for a transesophageal endoscope.

Recommendation 9 We recommended that the VISN Director ensure that the System Director requires that engineering correct air flow deficiencies in the clean areas of SPD.

Recommendation 10 We recommended that the VISN Director ensure that the System Director requires that training is provided and documented for all pieces of RME.

The VISN and System Directors concurred with the findings and recommendations. The system conducted air flow testing and balancing, and all clean areas in SPD now have the mandatory 10 air exchanges per hour. All areas that use RME and participate in reprocessing RME will maintain their own documentation for the training and competency of each employee involved in the set-up, use, reprocessing, and maintenance of the specific RME. 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 inspected the MRI area, examined medical and training records, reviewed relevant policies, and interviewed key personnel. The system had appropriate signage and barriers to prevent unauthorized or accidental access to the MRI area. Patients in the magnet rooms are directly

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

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 alarm while in the scanner.

Local policy requires that an MRI screening form be completed for each patient prior to an MRI scan and that the form be initialed by the MRI technician. We reviewed the medical records of 10 patients who received an MRI prior to our visit and found that 2 (20 percent) of the records did not contain the MRI technician's initials. Additionally, all questions answered "yes" by the patient are to be reviewed and initialed prior to scanning. We found that 2 (20 percent) of the 10 records did not have initials indicating review of "yes" answers. MRI leadership reported they were in the process of moving to all electronic screening forms within the medical record. Therefore, we made no recommendations for these findings.

Fire drills had been conducted in the MRI area. Emergency response drills had not been conducted in the MRI area. However, leadership provided a draft MRI policy that included specific training and a process for medical, behavioral, and system emergencies within the MRI area. When asked, staff verbalized appropriate responses for handling all types of emergencies in the MRI area. During our interview with MRI leadership, they reported that they were in the process of implementing the American College of Radiology safety guidelines in the MRI area. Therefore, we made no recommendation for this finding. However, we identified the following area that needed improvement.

Safety Education. The JC recommends that initial and annual MRI safety education be provided to all staff who may enter the MRI area, including housekeepers and police officers. Managers told us that the required annual Level 1 MRI safety education had not been provided to MRI or non-MRI staff members. We reviewed training records for 12 staff who enter the MRI area and found that 2 (17 percent) had received initial safety training. During our site visit, the manager conducted safety training for staff to meet the annual training requirement. However, only 3 (25 percent) of the 12 employees whose training records we reviewed had received the required annual training prior to our visit.

Risk Assessment. In February 2008, The JC issued a sentinel event alert for facilities with MRI machines advising them of recently reported adverse events and setting the standard for conducting a risk assessment. We determined that Radiology Service had not conducted a risk assessment of the environment, as required by The JC.

Recommendation 11 We recommended that the VISN Director ensure that the System Director requires that personnel who have access to the MRI area complete appropriate safety training, as required by JC standards.

Recommendation 12 We recommended that the VISN Director ensure that the System Director requires that the system conduct a comprehensive risk assessment of the MRI area, as required by The JC.

The VISN and System Directors concurred with the findings and recommendations. All new employees assigned to Imaging Service will receive initial MRI safety training as part of new employee orientation and will receive training annually thereafter. Other system staff who may have access to the MRI area will complete the appropriate level of annual MRI safety training. A comprehensive risk assessment of the MRI area has been scheduled. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had developed effective and safe medication management practices. We reviewed selected medication management processes for outpatients and CLC residents.

Influenza vaccinations were documented adequately for CLC residents. However, we identified the following area that needed improvement.

Management of Erythropoiesis-Stimulating Agents. In November 2007, the U.S. Food and Drug Administration issued a safety alert stating that for CRD patients, erythropoiesis-stimulating agents (ESAs)[8] should be used to maintain hemoglobin levels between 10 and 12g/dL. Hemoglobin levels greater than 12g/dL increase the risk of serious conditions and death. We reviewed the medical records of 10 outpatients with CRD who had hemoglobin

[8] Drugs that stimulate the bone marrow to make red blood cells; used to treat anemia.

levels greater than 12g/dL. Clinicians documented an action to address the hemoglobin level in only 6 (60 percent) of the 10 cases.

Recommendation 13 We recommended that the VISN Director ensure that the System Director requires that clinicians consistently take and document appropriate actions when CRD patients' hemoglobin levels exceed 12g/dL.

A multidisciplinary policy will be developed and implemented by September 30, 2010. Pharmacy staff, laboratory staff, and ESA prescribers will develop an electronic process to identify and track patients receiving these drugs. Monthly reports will be provided to prescribers. The implementation plan is acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

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[9] that the system 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. We determined that the system had an appropriate transfer policy and that acceptable monitoring was in place.

VHA requires specific information (such as the reason for transfer and services required) to be recorded in the transfer documentation. We reviewed documentation for 10 patients who transferred from the system's acute inpatient unit, emergency department, or urgent care clinic to another facility. We determined that clinicians consistently documented the required information for the patient transfers reviewed.

VHA policy[10] and JC standards require that providers include information regarding medications, diet, activity

[9] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.
[10] VHA Handbook 1907.01, *Health Information Management and Heath Records*, August 25, 2006.

level, and follow-up appointments in written patient discharge instructions. We reviewed the medical records of 10 discharged patients and determined that clinicians had generally documented the required elements. Also, we found that follow-up appointments occurred within the timeframes specified. We made no recommendations.

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.[11] We also reviewed meeting minutes during which discussions about the physicians took place.

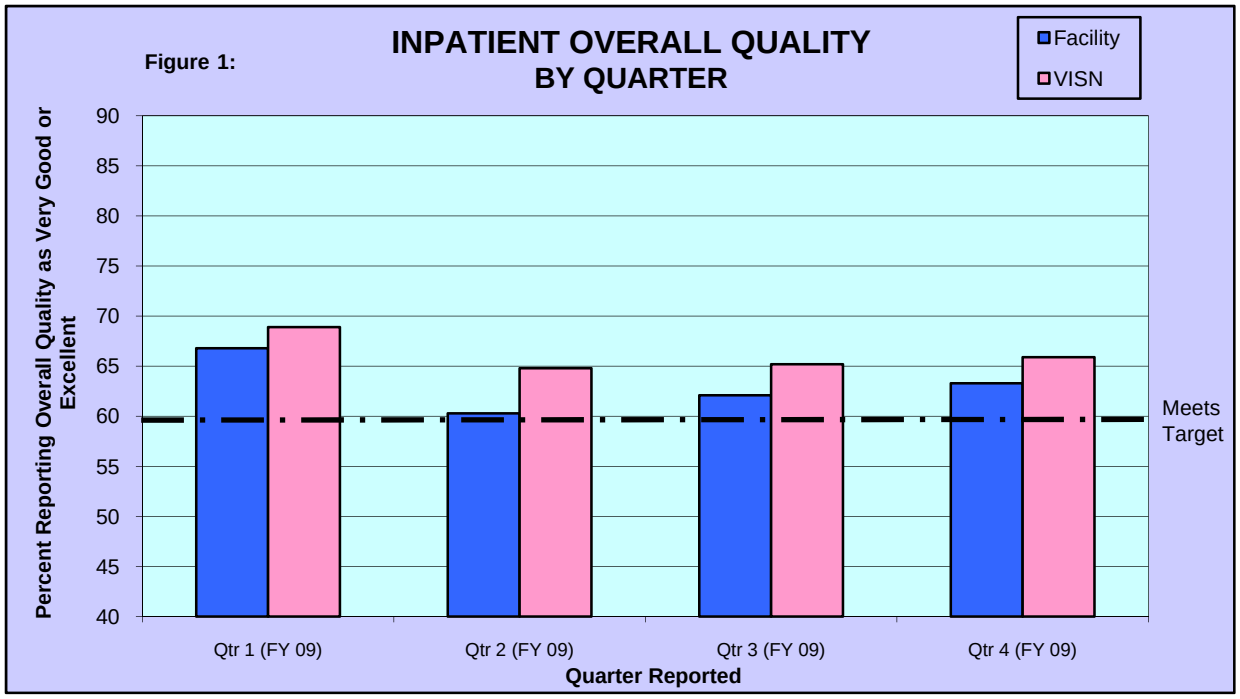
We reviewed 10 C&P files and profiles and found that licenses were current and that primary source verification had been obtained. Focused Professional Practice Evaluation was appropriately implemented for newly hired physicians. Service-specific criteria for Ongoing Professional Practice Evaluation had been developed and approved.

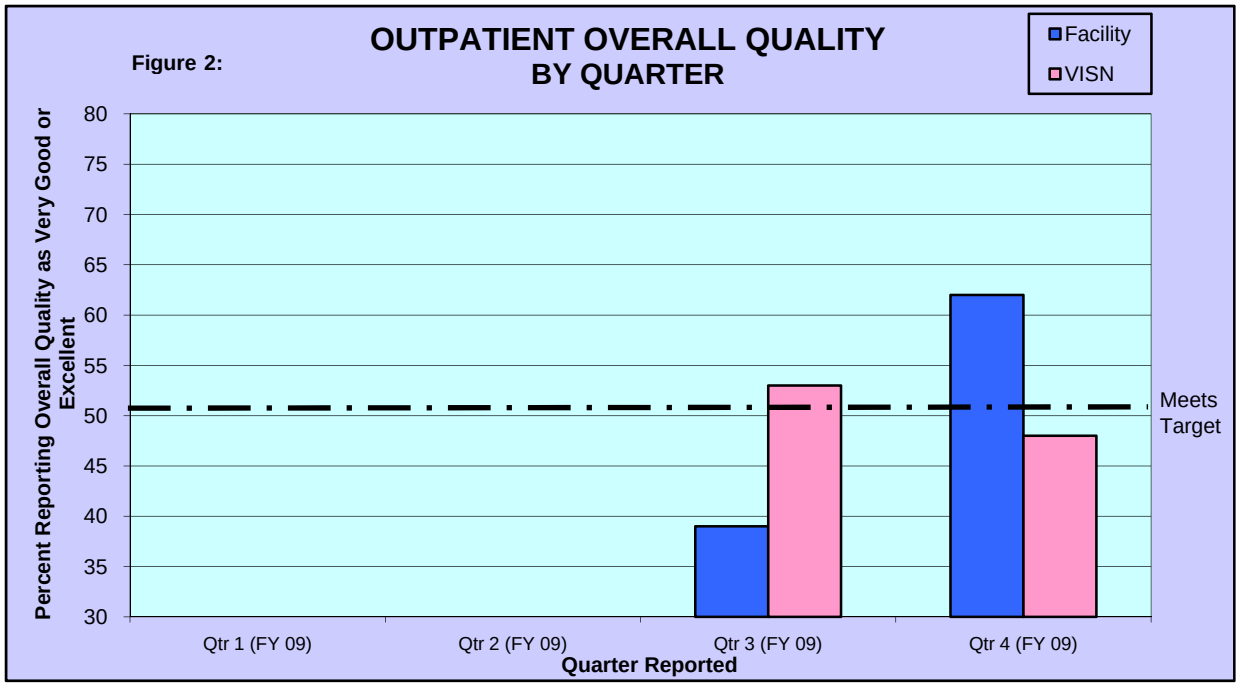
We found sufficient performance data to meet current requirements. Meeting minutes consistently documented thorough discussions of the physicians' privileges and performance data prior to recommending renewal of or initial requested privileges. We found one record where the provider was credentialed beyond the clinical practice setting. The physician worked in a highly specialized area. While we were onsite, the Chief of Staff agreed to modify the privileges to match the actual practice. 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 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.[12] The target scores are noted on the graphs.

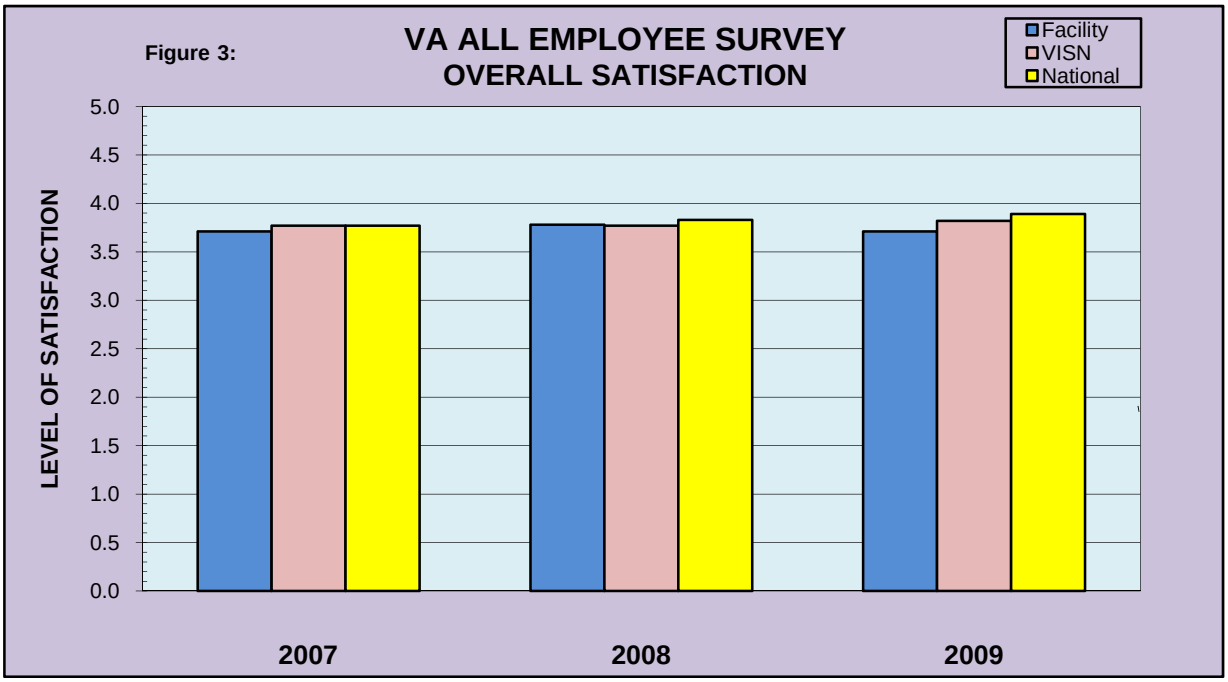
[11] VHA Handbook 1100.19, *Credentialing and Privileging,* November 14, 2008.
[12] Due to technical difficulties with VHA's outpatient survey data, outpatient satisfaction scores for quarters 1 and 2 of FY 2009 are not included for comparison.





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.

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
2007
2008
2009

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 15, 2010

From: Director, VA Southwest Health Care Network (10N18/494)

Subject: **Combined Assessment Program Review of the New Mexico VA Health Care System, Albuquerque, NM**

To: Director, Dallas Office of Healthcare Inspections (54DA)

Thru: Director, Management Review Office (10B5)

I concur with the findings from the OIG CAP visit conducted April 19–23, 2010, and with the actions plans developed by the New Mexico VAHCS. If you have any questions, please contact Sally Compton, Executive Assistant to Network Director, VISN 18 at 602.222.2699.

(original signed by:)

Susan P. Bowers

System Director Comments

Department of Veterans Affairs **Memorandum**

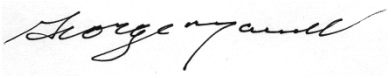
Date: June 15, 2010

From: Director, New Mexico VA Health Care System (501/00)

Subject: **Combined Assessment Program Review of the New Mexico VA Health Care System, Albuquerque, NM**

To: Director, VA Southwest Health Care Network (10N18/494)

I concur with the findings from the OIG CAP visit conducted April 19–23, 2010. Attached are responses with action plans as appropriate for each recommendation.



George Marnell

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1: We recommended that the VISN Director ensure that the System Director requires that clinicians develop comprehensive safety plans and that patients and/or their families participate in safety plan development.

Concur

Target Completion Date: April 20, 2010

Patient charts reviewed at the time of the visit did not contain appropriate documentation of safety plans. Further investigation revealed that paper documents were being generated but not copied into patient charts. The Chief of Psychiatry and Acting Chief of Psychology initiated the immediate use of an electronic version of the safety plan. Patient charts are now in compliance and being monitored through nursing chart audits.

Recommendation 2: We recommended that the VISN Director ensure that the System Director requires that peer reviews be completed within the timeframes specified by VHA policy.

Concur

Target Completion Date: May 1, 2010

The facility has implemented changes to the Peer Review Committee agenda to clearly annotate the date required for completion of the peer review and has enforced the regulation that prior to the completion date the service will request an extension by written letter from the System Director if indicated. In addition, peer review members are now required to send a proxy to the Peer Review Committee if they cannot attend regular meetings to ensure cases from their service will be presented and completed within the timeframe outlined in VHA policy.

Recommendation 3: We recommended that the VISN Director ensure that the System Director requires that managers continuously monitor and evaluate medication reconciliation, as required by JC Standards.

Concur

The facility consistently monitored Medication Reconciliation in 2008 and has resumed monitoring in 2010. The facility's Continuous Readiness Committee is the oversight body for medication reconciliation monitoring and reporting. Membership of this committee includes all facility PENTAD members. Evaluation of data will occur quarterly to identify opportunities for improvement.

Recommendation 4: We recommended that the VISN Director ensure that the System Director requires that designated staff maintain current BLS and ACLS certification in accordance with local policy.

The Learning Management System (LMS) is the newly designated tracking tool for electronic documentation, notification and monitoring of BLS and ACLS certification.

Concur

Target Completion Date: July 1, 2010

Employees will receive notices through LMS when their certification is due within 90, 60, 30 days and then weekly prior to expiration and once expired. Supervisors will also receive reminder notices through LMS regarding staff certification status at the same intervals. Monthly tracking status reports will be extracted from LMS and provided to Leadership. The local policy will be changed to reflect consequences for non-compliant staff.

Recommendation 5: We recommended that the VISN Director ensure that the System Director requires that staff identified as at risk for exposure to harmful atmospheres receive annual respirator fit testing and blood borne pathogens training, as required.

Concur

Respirator Fit-testing

Target Completion Date: December 31, 2010

The respiratory protection program medical center memorandum will be completed by August 1, 2010. The facility will complete fit testing on all appropriate employees by either qualitative or quantitative means by December 31, 2010. New staff requiring annual fit-testing will be identified by Employee Health Services during the pre-employment evaluation. The existing list of employees requiring annual fit-testing (created in response to the DUSHOM Item – Facility Exposure Risk Assessment Aug 2009) will be reviewed by Employee Health and the Department Manager for accuracy. New and existing employees requiring annual fit-testing will be identified in the Clinical Information Support System – Occupational

Health Record Keeping System (CISS-OHRS) and automatic reminders to Employee Health Service, the employee, and the supervisor will be established. All resources required to complete fit-testing on at risk employees will be identified by August 1, 2010. The facility will complete fit testing on all appropriate employees by either qualitative or quantitative means by December 31, 2010.

Bloodborne Pathogen Training

Target Completion Date: October 20, 2010

NMVAHCS Infection Control Module was restored April 22, 2010. The updated module will be completed and loaded to LMS by June 11, 2010. All staff will complete the updated module within 120 days. Tracking compliance with Infection Control training has been added to the 2010 Risk Assessment and Plan. Data will be reported starting in July to the Infection Control Committee. The Infection Control Committee will recommend actions based on percent of compliance reported in the October meeting.

Recommendation 6: We recommended that the VISN Director ensure that the System Director requires that proper monitoring of dialysate from dialysis machines occurs and is documented, as required by local policy.

Concur

All indicated testing was completed in 2009 and 2010 year to date. Due to a change in dialysis unit management, testing was not consistently reported to the Infection Control Committee. Testing results for September–December 2009 were not reported. The results for January and February 2010 were reported verbally at the February Infection Control Committee meeting and results for March–April 2010 were verbally reported in the May 2010 meeting. Data for January–April 2010 was not reported in the table format that facilitated analysis of the data. Data for September 2009–April 2010 has been provided to the Infection Control Committee and will continue to be submitted for attachment to their minutes. Local policy will be corrected to indicate that documentation will be provided to the Infection Control Committee to document compliance.

Recommendation 7: We recommended that the VISN Director require that the System Director ensures that all required disciplines attend EOC rounds and that deficiencies found on EOC rounds are properly recorded, tracked, and prioritized.

Concur

Target Completion Date: May 1, 2010

A new facility policy was implemented. Membership was identified and participation is tracked weekly. All EOC deficiencies are tracked weekly by the Chief of Engineering to assure completion or a plan of action to correct within 14 days from the date identified and documented. A new web-based program/tool was identified for purchase which will enable all EOC disciplines to record, track, prioritize and trend deficiencies.

Recommendation 8: We recommended that the VISN Director ensure that the System Director requires implementation of system monitoring for the WanderGuard© system, as recommended by the manufacturer.

Concur

Target Completion Date: June 1, 2010

Engineering shall inspect and test the WanderGuard© system weekly. A monthly report shall be prepared by Engineering for Nursing Service's monthly review. The Registered Nurse (RN) will follow the manufacturer's requirements for daily testing and securing the device. This will ensure proper battery function and receiver and transmitter operation using the "Watchlet Tester Instrument." Documentation will be completed per nursing Memorandum 118-43.

Recommendation 9: We recommended that the VISN Director ensure that the System Director requires that engineering correct air flow deficiencies in the clean areas of SPD.

Concur

Target Completion Date: May 26, 2010

Air flow testing and balancing was conducted and all clean areas in SPD now have the mandatory ten air changes per hour and dirty decontamination areas have six air changes per hour as required.

Recommendation 10: We recommended that the VISN Director ensure that the System Director requires that training is provided and documented for all pieces of RME.

Concur

Target Completion Date: July 7, 2010

The facility agrees that all employees involved in the use and reprocessing of RME have documented training on the set up, use, reprocessing, and maintenance of specific RME. Effective July 7, 2010, system-wide areas that participate in these activities will have separate documentation for

training and competency of all employees involved in the set up, use, reprocessing, and maintenance of specific RME.

Recommendation 11: We recommended that the VISN Director ensure that the System Director requires that personnel who have access to the MRI area complete appropriate safety training, as required by JC standards.

Concur

Target Completion Date: September 30, 2010

All new employees assigned to Imaging Service will receive initial MRI safety training (Level I and/or Level II as appropriate) as part of their new employee service orientation and annually thereafter.

Additionally, all other medical center staff that may have access to the MRI areas, including personnel from services such as, but not limited to, Nursing, Environmental Management, Police, and Engineering will complete the appropriate (Level I and/or Level II) annual MRI safety training.

Recommendation 12: We recommended that the VISN Director ensure that the System Director requires that the system conduct a comprehensive risk assessment of the MRI area, as required by The JC.

Concur

Target Completion Date: June 22, 2010

A comprehensive risk assessment of the MRI area is scheduled for June 22, 2010. This assessment will review access, appropriate training, patient safety, equipment, management of critically ill patients, and processes for code events.

Recommendation 13: We recommended that the VISN Director ensures that the System Director requires that clinicians consistently take and document appropriate actions when CRD patients' hemoglobin levels exceed 12g/dL.

Concur

Target Completion Date: September 30, 2010

A multi-disciplinary policy will be developed and implemented by September 30, 2010. Pharmacy staff, laboratory staff, and all erythropoietin stimulating agent prescribers will develop an electronic process that will identify and track patients receiving these drugs

specifically. Monthly reports will be provided to the prescribers and their direct supervisors. Situations where Hbg is not addressed in the first month by their prescriber will be referred to the Chief of Staff for review.

OIG Contact and Staff Acknowledgments

Contact	Linda DeLong, Director Dallas Office of Healthcare Inspections (214) 253-3331
Contributors	Cathleen King, Associate Director, Team Leader Wilma Reyes Kathleen Shimoda Marilyn Walls Misti Kincaid, Program Support Assistant Richard Cady, Office of Investigations

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Southwest Health Care Network (10N18)
Director, New Mexico VA Health Care System (501/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Michael F. Bennet, Jeff Bingaman, Mark Udall, Tom Udall,
U.S. House of Representatives: Martin T. Heinrich, Ben R. Lujan, John T. Salazar, Harry Teague

This report is available at http://www.va.gov/oig/publications/reports-list.asp.