Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-02993-70

Combined Assessment Program Review of the John D. Dingell VA Medical Center Detroit, Michigan

January 21, 2011

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 crime awareness briefings 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)

Glossary

C&P	credentialing and privileging
CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CHF	congestive heart failure
CLC	community living center
COC	coordination of care
CPRS	Computerized Patient Record System
ED	emergency department
EOC	environment of care
facility	John D. Dingell VA Medical Center
FTE	full-time employee equivalents
FY	fiscal year
HLC	Healthcare Leadership Committee
ICU	intensive care unit
JC	Joint Commission
MDRO	multidrug-resistant organisms
MICU	medical intensive care unit
OIG	Office of Inspector General
OSHA	Occupational Safety and Health Administration
PET	positron emission tomography
PPE	personal protective equipment
PR	peer review
PRC	Peer Review Committee
PRRTP	Psychosocial Residential Rehabilitation Treatment Program
QLC	Quality Leadership Committee
QM	quality management
RCA	root cause analysis
SOPs	standard operating procedures
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the John D. Dingell VA Medical Center, Detroit, MI

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management. We conducted the review the week of November 15, 2010.

Review Results: The review covered seven activities. The facility's reported accomplishment was its Lung Cancer Collaborative that improved cancer care for patients and received the Excellence Award in January 2010 from the Veterans Health Administration Cancer Care Collaborative Planning Committee.

Recommendations: We made recommendations in the following seven activities:

Environment of Care: Maintain medication security, secure sharp items and cleaning supplies, respond quickly to the emergency call system on the locked behavioral health unit, and secure confidential patient information. Complete and document annual bloodborne pathogens training and N95 respirator fit testing.

Physician Credentialing and Privileging: Ensure that privileges appropriately indicate the setting where they may be practiced.

Quality Management: Document peer review actions and follow-up in Peer Review Committee meeting minutes. Include all required components in moderate sedation documentation.

Management of Test Results: Communicate normal test results to patients within the specified timeframe.

Medication Management: Adhere to American Society of Health-System Pharmacists guidelines for preparation and administration of hazardous drugs. Provide waste containers large enough to accommodate all personal protective equipment.

Management of Multidrug-Resistant Organisms: Provide infection prevention strategies education to patients infected or colonized with multidrug-resistant organisms and their families and document it. Provide annual multidrug-resistant organisms education to employees and document it.

Coordination of Care: Conduct advance directive notification and screening in accordance with Veterans Health Administration policy. Include education for diet restrictions in discharge instructions.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. 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

Objective and Scope

Objective

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 objective of the CAP review is to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.

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 selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities:

- COC
- EOC
- Management of MDRO
- Management of Test Results
- Medication Management
- Physician C&P
- QM

The review covered facility operations for FY 2010 and FY 2011 through November 15, 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 facility (*Combined Assessment Program Review of the John D. Dingell VA Medical Center, Detroit, Michigan,* Report No. 07-03184-77, February 19, 2008). The facility had corrected all findings.

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.

Reported Accomplishment

Lung Cancer Collaborative

The facility's system redesign team identified and focused on improving seven processes that would improve cancer care for patients: (1) surgery timing, (2) timeliness of ordered PET scans, (3) PET scan completion, (4) customer satisfaction, (5) type of surgical resection, (6) lung nodule/cancer suspicion project, and (7) palliative care for advanced stage lung cancer. As a result of the improvements, cancer care is timely, patients have fewer appointments, and patient satisfaction has increased. In January 2010, the facility received the Excellence Award from VHA's Cancer Care Collaborative Planning Committee.

Results

Review Activities With Recommendations

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements.

We inspected the surgery (A4N), MICU/telemetry (A2N), CLC (A6S), medicine (A3N), behavioral health (B2N), and geriatrics/rehabilitation (A5S) units; the Firm D primary care clinic; and the ED. The facility maintained a generally clean and safe environment. However, we identified the following conditions that needed improvement.

Medication Security. JC standards require all medications to be secured from access by unauthorized persons. On the surgery and geriatrics/rehabilitation units, we found the medication room doors open, and no staff were present. On the medicine unit, we found unsecured medications in two occupied patient rooms, in a PPE rack outside of an occupied isolation room, and in the pocket of a rolling computer cart. Additionally, in the primary care clinic, we found unsecured medication in an examination room.

Safety. Sharp items and cleaning products must be secured when not in use. On the medicine unit, we found unsecured syringes and needles in two occupied patient rooms, in the pocket of two rolling computer carts, and in the pocket of a cart that houses the electrocardiogram machine.

Additionally, in the ED, we found unsecured needles in an unlocked cabinet next to an occupied patient bed.

We observed unsecured cleaning supplies underneath the kitchen sink in the CLC dining room and in the unlocked soiled utility room in the ED.

Staff must be prepared to provide quick responses to emergency call systems. We activated the emergency call system in an occupied room on the locked behavioral health unit. Although staff on the unit heard the alarm, there was a delayed response.

Patient Privacy. The Health Insurance Portability and Accountability Act requires confidential patient information to be secured. On the MICU/telemetry and medicine units, in the primary care clinic, and in the ED, we found unsecured documents that displayed patients' full names, social security numbers, and health information. Additionally, on the medicine unit, we found an unattended computer displaying patient information, and in the ED, we found two computers that did not have privacy screens.

Training. OSHA requires that all employees receive initial and annual training on the OSHA Bloodborne Pathogens Rule. We reviewed 15 employee training records and found that only 13 (87 percent) employees had this training documented.

OSHA requires that staff identified to wear an N95 respirator undergo initial and annual fit testing. We requested annual fit testing training records for 25 selected employees. We found that annual fit testing had not been conducted.

Recommendations

1. We recommended that processes be strengthened to ensure that medication security is maintained.

2. We recommended that sharp items and cleaning supplies be secured at all times.

3. We recommended that processes be strengthened to ensure quick responses to the emergency call system on the locked behavioral health unit.

4. We recommended that processes be strengthened to ensure that confidential patient information is secured.

5. We recommended that annual bloodborne pathogens training and N95 respirator fit testing be completed and documented.

Physician C&P

The purpose of this review was to determine whether the facility had consistent processes for physician C&P that complied with applicable requirements.

We reviewed 12 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. However, we identified the following area that needed improvement.

Privileges. VHA requires that when a facility grants a physician privileges to practice, the facility must determine whether the privileges should be restricted to specific care settings (such as the surgery suite, the ICU, or an outpatient clinic) and grant the privileges accordingly.[1] Of the 12 C&P files we reviewed, 8 (67 percent) documented the granting of specialized privileges; however, specific care settings had not been appropriately identified. For example, five providers had been granted specialized privileges to perform invasive procedures, which required certain staffing and equipment support, in several settings, including the outpatient behavioral health clinic.

Recommendation

6. We recommended that privileges appropriately indicate the setting where they may be practiced.

QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program in accordance with applicable requirements and whether senior managers actively supported the program's activities.

We interviewed senior managers and QM personnel, and we evaluated policies, meeting minutes, and other relevant documents. The QM program was generally compliant with requirements, and senior managers supported the program. We identified the following areas that needed improvement.

PR. VHA requires actions/recommendations for Level 3 PRs to be followed to closure.[2] We did not find documentation of actions and follow-up in PRC meeting minutes.

[1] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[2] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.

Moderate Sedation. VHA requires that staff privileged to provide moderate sedation assess and monitor patients undergoing moderate sedation.[3] We reviewed the medical records of 11 patients who had moderate sedation and found that 3 (27 percent) of the records did not include documentation of organ systems, airway assessment, re-evaluation immediately prior to the procedure, and assessment of risk.

Recommendations

7. We recommended that PR actions and follow-up be documented in PRC meeting minutes.

8. We recommended that moderate sedation documentation includes all required components.

Management of Test Results

The purpose of this review was to follow up on a previous review that identified improvement opportunities related to documentation of notification of abnormal test results and follow-up actions taken.[4]

We reviewed the facility's policies and procedures, and we reviewed medical records. We identified the following area that needed improvement.

Communication of Normal Results. VHA requires facilities to communicate normal results to patients no later than 14 calendar days from the date that the results were available to the ordering provider.[5] We reviewed the medical records of 19 patients who had normal results and found that only 11 (58 percent) of the 19 records contained documented evidence that the facility had communicated the results to the patients.

Recommendation

9. We recommended that normal test results be consistently communicated to patients within the specified timeframe.

Medication Management

The purpose of this review was to determine whether the facility employed safe practices in the preparation, transport, and administration of hazardous medications, specifically chemotherapy, in accordance with applicable requirements.

[3] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers,* May 1, 2010.
[4] *Healthcare Inspection Summary Review – Evaluation of Veterans Health Administration Procedures for Communicating Abnormal Test Results,* Report No. 01-01965-24, November 25, 2002.
[5] VHA Directive 2009-019, *Ordering and Reporting Test Results,* March 24, 2009.

We observed the compounding and transportation of chemotherapy medications and the administration of those medications in the oncology clinic, and we interviewed employees. We identified the following areas that needed improvement.

Administration and Preparation. The American Society of Health-System Pharmacists recommends that gloves be sanitized with 70 percent alcohol or other appropriate disinfectant before performing any aseptic compounding activity. This step was omitted during our observation of the compounding phase. Additionally, it is recommended that a plastic-backed absorbent pad be placed under the administration area to absorb leaks and prevent drug contact with patient skin during medication administration. This step was omitted during our observation of the medication administration phase.

Waste Disposal. The American Society of Health-System Pharmacists requires that hazardous waste containers and container openings be large enough to accommodate all PPE without pushing or forcing. We noted that the hazardous waste container in the pharmacy compounding area was utilized for sharps and potentially contaminated materials, such as previously worn gowns and gloves. The waste disposal container in the oncology clinic was utilized for sharps, intravenous administration sets, and potentially contaminated materials, such as previously worn gowns and gloves. The openings of the waste containers were too small, requiring personnel to push PPE through narrow openings.

Recommendations

10. We recommended that personnel adhere to American Society of Health-System Pharmacists guidelines for preparation and administration of hazardous drugs.

11. We recommended that hazardous waste containers be provided that are large enough to accommodate all PPE without pushing or forcing.

Management of MDRO

The purpose of this review was to evaluate whether the facility had developed a safe and effective program to reduce the incidence of MDRO in its patient population in accordance with applicable requirements.

We inspected the medicine (A3N) and surgery (A4N) units and interviewed employees and identified no deficits in either

the inspections or staff interviews. However, we identified the following areas that needed improvement.

Patient/Family Education. The JC requires that patients infected or colonized[6] with MDRO and their families receive education on infection prevention strategies, such as hand washing and the proper use of PPE. We reviewed 10 medical records and found that 7 (70 percent) of the records did not have documented evidence of MDRO education.

Employee Training. The JC requires that facilities conduct a risk assessment to determine the need for staff education. The facility's most recent risk assessment stated that staff education was indicated for all employees annually. We reviewed 12 employee training records to determine whether MDRO education had been provided in accordance with the risk assessment. We found that 6 (50 percent) of the records reviewed did not have documentation of annual MDRO education.

Recommendations

12. We recommended that infection prevention strategies education be provided to patients infected or colonized with MDRO and their families and be documented.

13. We recommended that employees receive annual MDRO education and that the training is consistently documented.

COC

The purpose of this review was to evaluate whether the facility managed advance care planning, advance directives, and discharges in accordance with applicable requirements.

We reviewed patients' medical records for evidence of advance care planning, advance directives, and discharge instructions. We identified the following areas that needed improvement.

Advance Directive Notification Documentation. VHA requires that patients be given written notification stating their right to accept or refuse medical treatment, to designate a health care agent, and to document their treatment preferences in an advance directive.[7] We reviewed 10 patients' medical

[6] Colonization is the presence of bacteria in the body without causing clinical infection.
[7] VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, July 2, 2009.

records and found that only 4 (40 percent) had notification documented.

Advance Directive Screening. VHA requires that patients be asked whether they want more information about advance directives and/or assistance in completing the advance directive forms.[8] We reviewed 10 patients' medical records and found that only 8 (80 percent) patients had been screened.

Discharge Instructions. VHA requires that providers include information regarding medications, diet, activity level, and follow-up appointments in patient discharge instructions.[9] We reviewed the medical records of 10 discharged patients and found deficiencies in 3 (30 percent) of the records. The patients were discharged with diet restrictions; however, we did not find documentation that patients or caregivers received education regarding these restrictions.

Recommendations

14. We recommended that managers ensure that advance directive notification and screening are conducted in accordance with VHA policy.

15. We recommended that processes be strengthened to ensure that discharge instructions include education for diet restrictions.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 17–25, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

[8] VHA Handbook 1004.02.
[9] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

Facility Profile[10]		
Type of Organization	Tertiary care medical center	
Complexity Level	1c	
VISN	11	
CBOCs	Pontiac, MI Yale, MI	
Veteran Population in Catchment Area	295,186	
Type and Number of Total Operating Beds: • **Hospital, including PRRTP**	50	
• **CLC/Nursing Home Care Unit**	102	
Medical School Affiliation	Wayne State University	
• **Number of Residents**	76	
	Current FY (through August 2010)	**Prior FY (2009)**
Resources (in millions):		
• **Total Medical Care Budget**	$272.3	$261.1
• **Medical Care Expenditures**	$271.7	$261.1
Total Medical Care FTE	1,737.2	1,762.5
Workload:		
• **Number of Station Level Unique Patients**	41,806	41,204
• **Inpatient Days of Care:**		
o **Acute Care**	25,313	26,609
o **CLC/Nursing Home Care Unit**	26,053	26,613
Hospital Discharges	4,667	4,648
Total Average Daily Census (including all bed types)	71.5	72.7
Cumulative Occupancy Rate	61.5%	67.3%
Outpatient Visits	391,124	420,148

[10] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation? Y/N**
QM			
1. Take actions to meet VHA requirements for PRs.	PRs are completed within the established timeframes, and PRC minutes are submitted monthly to the Clinical Care Committee/Medical Executive Committee and the QLC.	Y	N
2. Ensure the patient advocate conducts critical analyses of patient complaint data, and present results to the HLC for action.	Patient advocates conduct critical analyses of patient complaint data, and results are presented monthly to the Customer Service Steering Committee and quarterly to the QLC for action.	Y	N
3. Conduct an independent review of the 11 patients cited in the review as having adverse outcomes to ensure that VHA policy is followed.	Completed at the time of the previous CAP review site visit.	Y	N
4. Require staff to inform the patients identified by our review and/or their representatives of their rights to file a claim.	Templates for clinical and institutional disclosures were created and are now in use. Completed templates are forwarded to the risk manager to ensure notification of right to file a tort claim and to ensure appropriate follow-up review. All of the patients and/or their families were appropriately contacted. There is documented evidence of facility representatives' communication regarding their rights to file claims.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
5. Immediately initiate and complete the three patient incident reports that were never initiated.	Actions were completed during the previous CAP review. Patient incident reports were completed as required.	Y	N
6. Establish a collaborative disclosure process to ensure that patients are appropriately informed.	A local policy was established and is in congruence with VHA policy.	Y	N
7. Educate managers and staff on the adverse event disclosure requirements and responsibilities outlined in VHA and facility policy.	For FY 2009, a power point was presented to medical staff. In FY 2010, formal training was conducted. Future medical staff orientation will include disclosure training.	Y	N
8. Ensure the quality manager, the risk manager, and other key staff members establish a process to review and monitor the adverse event disclosure process so that improvements can be made.	In addition to risk management screening, disclosures are considered during PRs and patient incident report reviews. Daily communication and monthly QLC meetings ensure all potential cases are considered. Risk management is actively involved and monitors progress of follow-up actions.	Y	N
9. Complete RCAs in accordance with VHA policy.	All RCAs have been completed within the required timeframes.	Y	N
10. Track and trend data on medication reconciliation to identify opportunities for improvement, and present results to the HLC for action.	Medication reconciliation data is tracked and trended to identify opportunities for improvement. Results are submitted monthly to the Patient Safety Committee and the Inpatient and Outpatient System Redesign Subcommittees for action.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
11. Track and trend UM data to identify opportunities for improvement, and present UM data to the HLC for action.	UM data is tracked and trended to identify improvement opportunities. Data is presented monthly to the UM Committee and quarterly to the QLC.	Y	N
12. Assign a physician advisor to the UM program, and ensure proper training.	All physician advisors have been identified and trained for each area, including medicine, the ED, and surgery.	Y	N
13. Conduct inter-rater reliability reviews in accordance with VHA policy.	All UM reviewers complete inter-rater reliability reviews, and all have passed with 80 percent or better.	Y	N
14. Track and trend moderate sedation data to identify opportunities for improvement, and present trended data to the HLC for action.	Moderate sedation tracking and trending is a standing quarterly report for the QLC. It is reviewed monthly at the Invasive Procedures Committee.	Y	N
15. Track and trend code data to identify opportunities for improvement, and present code data to the HLC for action.	Code information is a standing item for the QLC and is reviewed quarterly. It is reviewed monthly by the Cardiopulmonary Resuscitation Committee.	Y	N
CPRS Business Rules			
16. Ensure CPRS business rules comply with VHA policy and Office of Information guidance related to altering signed medical record notes.	Medical record monitors are reviewed monthly at the Health Information Management Committee and quarterly at the QLC. Monitor includes review and report related to altering medical record notes.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
Survey of Healthcare Experiences of Patients			
17. Develop an action plan to improve patient satisfaction and overall scores, and identify specific staff responsibilities.	Committees have been realigned to include a Customer Service Steering Committee and three subcommittees. Action plans are updated monthly. Champions and facilitators are identified for each action plan.	Y	N
EOC			
18. Include nurse managers in EOC rounds in their respective areas.	Nurse managers are required to and actively participate in regularly scheduled EOC rounds.	Y	N
19. Address identified housekeeping issues.	Additional housekeepers have been hired, and housekeeping services are available daily for each shift. An inspection sheet for public areas is completed by the housekeeper and reviewed by the supervisor to ensure proper cleaning.	Y	N
CBOCs			
20. Require the contracting office to ensure that appropriate position risk and sensitivity designations are made.	The contracting officer receives completed VA Form 2280 (used to designate the appropriate position risk and sensitivity) prior to initiating a background check.	Y	N
21. Require the contracting officer to ensure appropriate levels of background screening are monitored and tracked to completion.	The contracting officer maintains an electronic list of all initiated background checks and monitors until completed.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
Breast Cancer Management			
22. Ensure providers document patient notification of abnormal mammogram results in the medical record.	Radiology staff monitor mammography appointments and results daily. Providers are notified of all abnormal mammogram results and contact the patient. Documentation is entered into the medical record. Radiology staff make and track follow-up appointments.	Y	N
23. Require mammography services to be completed by the contract provider within 30 days.	Mammography appointments are completed within 30 days by the contract provider. The average timeframe for communicating test results to the facility is 4 days.	Y	N

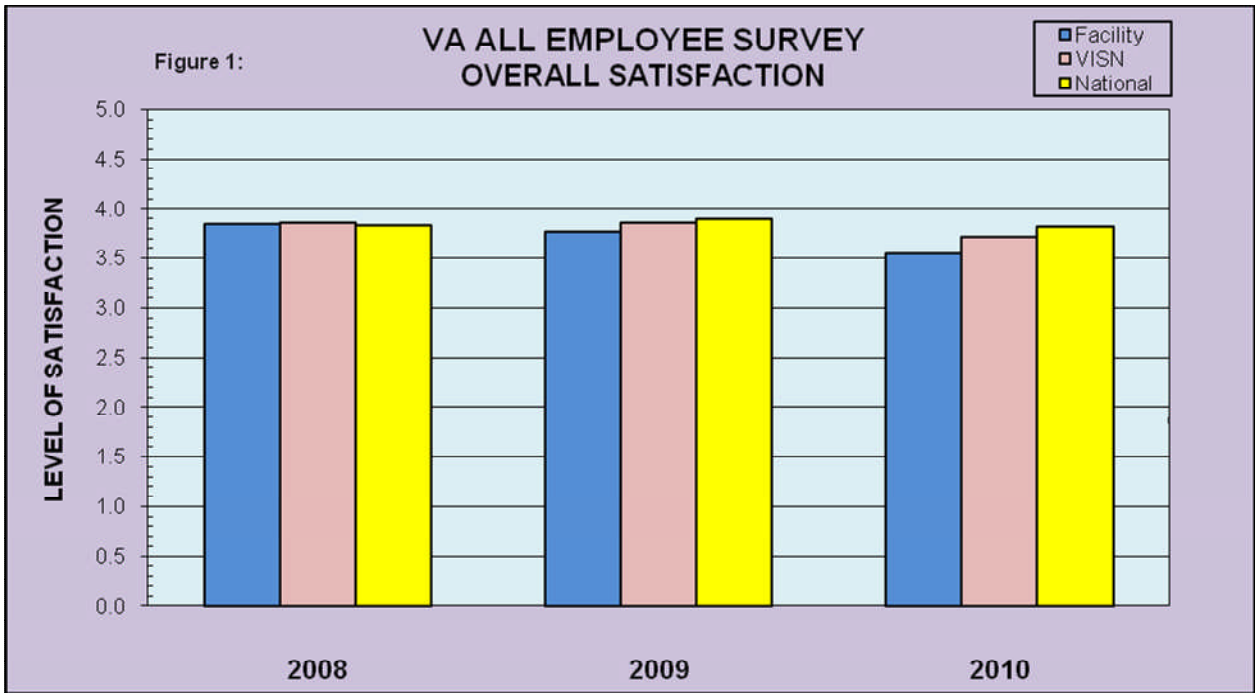
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for quarters 1–3 of FY 2010.

Table 1

	FY 2010 (inpatient target = 64, outpatient target = 56)					
	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Inpatient Score Quarter 3	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3
Facility	53.9	57.1	52.2	47.3	44.6	51.1
VISN	67.4	66.1	65.6	53.4	54.5	56.3
VHA	63.3	63.9	64.5	54.7	55.2	54.8

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2008, 2009, and 2010. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions[11] received hospital care. The mortality (or death) rates focus on whether patients died within 30 days of their hospitalization. The rates of readmission focus on whether patients were hospitalized again within 30 days. Mortality rates and rates of readmission show whether a hospital is doing its best to prevent complications, teach patients at discharge, and ensure patients make a smooth transition to their home or another setting. The hospital mortality rates and rates of readmission are based on people who are 65 and older. These comparisons are "adjusted" to take into account their age and how sick patients were before they were admitted to the VA facility. Table 2 below shows the facility's Hospital Outcome of Care Measures for FYs 2006–2009.

Table 2

	Mortality			Readmission		
	Heart Attack	CHF	Pneumonia	Heart Attack	CHF	Pneumonia
Facility	13.22	9.42	16.24	19.98	22	15.42
VHA	13.31	9.73	15.08	20.57	21.71	15.85

[11] CHF is a weakening of the heart's pumping power. With heart failure, your body does not get enough oxygen and nutrients to meet its needs. A heart attack (also called acute myocardial infarction) happens when blood flow to a section of the heart muscle becomes blocked and the blood supply is slowed or stopped. If the blood flow is not restored in a timely manner, the sedition of the heart muscle becomes damaged from lack of oxygen. Pneumonia is a serious lung infection that fills your lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 30, 2010

From: Director, Veterans in Partnership Network (10N11)

Subject: **CAP Review of the John D. Dingell VA Medical Center, Detroit, MI**

To: Director, Chicago Office of Healthcare Inspections (54CH)

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

Per your request, attached is the response to the draft report from Detroit VAMC. If you have any questions, please contact Jim Rice, VISN 11 QMO, at (734) 222-4314.

MICHAEL S. FINEGAN

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 27, 2010

From: Director, John D. Dingell VA Medical Center (553/00)

Subject: **CAP Review of the John D. Dingell VA Medical Center, Detroit, MI**

To: Director, Veterans in Partnership Network (10N11)

1. I would like to take this opportunity to express my gratitude for the helpful insight provided by this OIG team during the CAP review. The opportunities for improvement have been embraced by all of us and will serve as the way forward for continuous improvement as we strive to meet the needs of our Veterans.

2. We have reviewed each recommendation and developed a plan of action that will meet the intent of the associated recommendation. Each plan will be implemented expeditiously and thoroughly monitored to satisfactory completion.

3. Thank you again for your assistance during this visit.

//es// on file
Pamela Reeves, M.D.

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 processes be strengthened to ensure that medication security is maintained.

Concur

Target date for completion: March 31, 2011

1. Self closing door hinges and electronic keyless locks will be installed on all medication room doors. (3/31/2011)

2. Immediately following the OIG recommendations, staff was educated to close and lock the medication room door as they are exiting the medication room. Beginning 1/3 through 3/31/2011, all nursing staff will be in-serviced regarding medication safety and security. Staff will be counseled if they are seen leaving the medication room unsecured.

3. Beginning the week of 12/27/10, in the acute care areas, the charge nurses will perform daily spot checks to monitor the safety and security of medication rooms. The Clinical Nurse Managers will conduct weekly monitors to check for unsecured medications within outpatient examination rooms and acute care areas. The CNM rounding checklist will be revised to include areas for medication security.

4. Nursing monitors will be reported monthly to nursing leadership and the Patient Safety Committee. Reporting will include aggregated and trended data. The first report to Patient Safety Committee is scheduled for February 2011.

Recommendation 2. We recommended that sharp items and cleaning supplies be secured at all times.

Concur

Target date for completion: March 31, 2011

1. By 2/1/2011, in-service education will be provided to all nursing and EMS staff regarding the proper storage and disposal of sharps items and cleaning supplies.

2. Effective immediately, clinical nurse managers will begin weekly unit checks/monitors for sharps and cleaning supplies. The CNM rounding checklist will be revised to include areas for proper storage and disposal of sharps items and

cleaning supplies. Monitors will be reported on a regular basis to nursing leadership and the Patient Safety Committee beginning February 2011.

3. Effective immediately, System Redesign team will begin review of the facility wide process for storage and disposal of sharps and cleaning supplies to determine a standardized process or 5S approach for each practice. (Target date for completion 3/31/2011)

Recommendation 3. We recommended that processes be strengthened to ensure quick responses to the emergency call system on the locked behavioral health unit.

Concur

Target date for completion: February 28, 2011

1. By January 10, 2011, in-service education will be provided to all behavioral health unit patient care staff regarding the protocols and expectations for responding to emergency call lights.

2. By January 15, 2011, the Clinical Nurse Managers for each unit will initiate weekly monitors for all inpatient units, to test that a timely response to emergency call lights is occurring. The CNM rounding checklist will be revised to include the emergency call light test.

3. This information will be reported on a monthly basis to nursing leadership and the Patient Safety Committee beginning February 2011 meeting.

Recommendation 4. We recommended that processes be strengthened to ensure that confidential patient information is secured.

Concur

Target date for completion: January 31, 2011

1. By January 31, 2011, all areas identified in the OIG recommendations will complete an in-service training regarding information security. In addition, each employee in these areas will be required to retake the Information Security and Privacy awareness training prior to January 31, 2011.

2. By January 31, 2011, electronic keyless locks will be installed on the printer room doors in the emergency department and in the Firm D area to prevent patient access. The EoC rounding checklist will be revised to include on-going assessment of information security needs.

3. By January 31, 2011, all computer screens in areas with patient access will be checked to ensure privacy screens are in place and “Do Not Remove” warning labels will be placed on the privacy screens. In addition, The EoC rounding checklist

will be revised to include inspection for privacy screen monitors. Information from the EoC rounds is reported to the EoC Committee on a monthly basis.

Recommendation 5. We recommended that annual bloodborne pathogens training and N95 respirator fit testing be completed and documented.

Concur

Target date for completion: January 31, 2011

Respiratory Protection Fit Testing Action Plan

In October 2010, fit testing was conducted for the core groups, additional fit testers were trained, and core T&Ls were added to LMS as requiring respirator fit testing with VA course VA 2323. This will allow for better tracking and provide automated yearly reminders to employees. Additional fit testing kits were purchased.

1. By 1/15/2011, the Safety Office will have updated the respirator policy to reflect the current program.

2. The Safety office will continue to track fit testing compliance in LMS and report quarterly progress to the EoC Committee (standing agenda item).

3. Maintaining compliance with LMS requirements is a performance measure for all service chiefs and employees.

Bloodborne Pathogens Training

1. This training is currently tracked using LMS; Infection Control will now maintain oversight for compliance and will report quarterly to the Infection Control Committee – Completed.

Recommendation 6. We recommended that privileges appropriately indicate the setting where they may be practiced.

Concur

Target date for completion: January 31, 2011

On all privilege forms, option 13 under Medical Center Settings, “all of the above” has been eliminated. Each Service Chief will now be required to specify exactly where each provider will be allowed to practice each privilege. Effective immediately, all new applicants and re-privilege requests will use the newly approved “Delineation of Privileges” form for their respective Service.

Recommendation 7. We recommended that PR actions and follow-up be documented in PRC meeting minutes.

Concur

Target date for completion: November 19, 2010

At the time of review, a column was added on the Peer Review tracking log sheet to indicate the date that the issue was officially closed. The tracking log is reviewed for open issues at each Clinical Care Committee (Medical Executive Committee).

Recommendation 8. We recommended that moderate sedation documentation includes all required components.

Concur

Target date for completion: March 31, 2011

1. By 1/31/2011, create a standardized process for all moderate sedation areas/procedures. The Endoscopy Moderate Sedation Pre-procedure Assessment note will be changed to a generic title; i.e. remove "ENDOSCOPY" in the title, and all fields within template will be changed to mandatory. The fields may be answered by a negative response if indicated. The use of the paper "tri-fold" in the Radiology area will be eliminated and CPRS will be utilized for all moderate sedation procedure notes throughout the facility. Training for the new template will be completed by each provider prior to implementation on 1/31/2011.

2. An on-going monitor will begin 2/1/2011 to confirm and maintain hospital-wide compliance. The monitor will be based on Joint Commission standards and sample size requirements. The Moderate Sedation Committee will be responsible for aggregating and analyzing the information and reporting on a regular basis to the Clinical Care Committee as well as the Quality Management Leadership Committee. The first report is scheduled for 3/2011.

Recommendation 9. We recommended that normal test results be consistently communicated to patients within the specified timeframe.

Concur

Target date for completion: January 31, 2011

1. In November 2010, the "Tests Notification" policy was completed and the "Tests Notification" letter template was approved by the Medical/Dental staff and the ISO and privacy officers.

2. In December 2010, a standard operating procedure (SOP) was established for all areas. This SOP will be implemented in all areas by 1/31/2011. The SOP summary is listed below.

    i. Provider enters a test notification note in CPRS and prints the letter.

    ii. Notification letters will be automatically printed and ward administration staff will mail the letters.

    iii. Training of the providers on the utilization of tests notification template will be completed by 1/31/2011.

3. The medical record review will include a monitor of compliance for patient notification of normal test results. The monitor/analysis will be reviewed monthly at the Medical Records Committee and quarterly at the Clinical Care Committee.

Recommendation 10. We recommended that personnel adhere to American Society of Health-System Pharmacists guidelines for preparation and administration of hazardous drugs.

Concur

Target date for completion: January 15, 2011

1. Nursing staff responsible for the administration of chemotherapeutic agents have been educated on the proper use of the absorbent pad during administration (week of 12/27/2010).

2. A standard operating procedure/check list will be created and posted in the work areas to include the use of the absorbent pad (1/15/2011).

3. Beginning 1/3/2011, the Clinical Nurse Manager will conduct weekly spot checks to monitor the use of the absorbent pad. This information will be reported to nursing leadership and the Patient Safety Committee.

Recommendation 11. We recommended that hazardous waste containers be provided that are large enough to accommodate all PPE without pushing or forcing.

Concur

Target date for completion: January 15, 2011

1. During the site visit, pharmacy service obtained a separate hazardous waste container to be used only for worn gowns and gloves. There are currently two large containers, one for sharps items and one for hazardous waste.

2. To ensure on-going and facility wide compliance, review of adequate and appropriate hazardous waste containers will be added to the EoC Rounding checklist as well as the daily EMS checklist (1/15/2011).

3. Staff will be in-serviced on the proper methods for disposal of sharps and hazardous waste materials as well as when it is appropriate to request removal or replacement of disposal containers.

Recommendation 12. We recommended that infection prevention strategies education be provided to patients infected or colonized with MDRO and their families and be documented.

Concur

Target date for completion: January 31, 2011

1. All educational materials and CPRS documentation templates are currently in place. Clinical Nurse Managers will begin monitoring nursing compliance with this requirement on 1/3/2011.

2. Monitor outcomes/analysis will be reported monthly to the Infection Control Committee and quarterly to the Clinical Care Committee beginning January 2011.

Recommendation 13. We recommended that employees receive annual MDRO education and that the training is consistently documented.

Concur

Target date for completion: March 15, 2011

1. Education Service to assign “MDRO-Infection Control Principles in Health Care” in LMS to designated staff – target date 1/15/2010.

2. Education Service and Infection Control to develop MDRO LMS module for EMS staff – target date 2/15/2011.

3. Beginning 1/15/2011, Infection Control Service will run LMS compliance reports and will notify all Service Chiefs/Managers of required follow-up. In addition, monthly automated emails are generated by LMS for required training. These automated e-mails are sent to the employee and his/her supervisor. Maintaining LMS compliance is included in all service chiefs and employee performance evaluations.

4. To ensure on-going facility wide compliance, MDRO training compliance will be reviewed quarterly (standing agenda item) via the EoC Committee.

Recommendation 14. We recommended that managers ensure that advance directive notification and screening are conducted in accordance with VHA policy.

Concur

Target date for completion: February 28, 2011

1. The local policy will be revised to include all requirements by 1/31/2011.

2. The admission process will be revised to ensure the advance directive information is included in the admission packet for all types of admissions (including direct admits), and that the information is reviewed during the nursing admission process (2/15/2011).

3. In order to account for inpatient admissions, informatics has added a required field in the advance directives section on the nursing admission data base. The nurse cannot exit the admission data base until the required field/screen is complete (see below). A positive screen will result in a social work referral for advance directives.

    a. Did the patient want more information about advance directives? Y or N

    b. Is assistance needed to complete the advance directives? Y or N

4. For the outpatient area, a one-time clinical reminder will be developed to address advance directives. A positive screen will result in a social work referral for advance directives (1/31/2011).

5. Monthly medical records review will include review of compliance with advance directive documentation requirements (2/1/2011). Analysis and reporting of the monitor will occur monthly at the Medical Records Committee and quarterly at the Clinical Care Committee (3/2011).

Recommendation 15. We recommended that processes be strengthened to ensure that discharge instructions include education for diet restrictions.

Concur

Target date for completion: January 31, 2011

1. The nursing discharge summary note will be revised to include a required field for diet instructions. The nurse cannot exit the note until this section is addressed. If the screen is positive for a specially ordered diet, the specific diet instructions will be automatically printed and included in the nursing discharge instructions.

OIG Contact and Staff Acknowledgments

Contact	Wachita Haywood, BSN, RN, Associate Director Chicago Office of Healthcare Inspections
Contributors	Roberta Thompson, MSW, Team Leader Lisa Barnes, MSW Jody Marquez, BSN, RN Jennifer Reed, RN-BC Ann Ver Linden, BSN, RN Judy Brown, Program Support Assistant
Report Preparation	Produced under the direction of Verena Briley-Hudson, MN, RN Director, Chicago Office of Healthcare Inspections

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