Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-01611-250

Combined Assessment Program Review of the Jesse Brown VA Medical Center Chicago, Illinois

August 16, 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
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Glossary

C&P	credentialing and privileging
CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CLC	community living center
ED	emergency department
EN	enteral nutrition
EOC	environment of care
facility	Jesse Brown VA Medical Center
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
IC	infection control
MEC	Medical Executive Committee
MM	medication management
OIG	Office of Inspector General
PRC	Peer Review Committee
QM	quality management
RN	registered nurse
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the Jesse Brown VA Medical Center, Chicago, IL

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of June 6, 2011.

Review Results: The review covered eight activities. We made no recommendations in the following activity:

- Management of Workplace Violence

The facility's reported accomplishments were the implementation of an employee recognition program, a safe patient handling program, a home infusion program, and an automated hand hygiene tracking system.

Recommendations: We made recommendations in the following seven activities:

Quality Management: Notify the Peer Review Committee when corrective actions are completed. Ensure Medical Record Committee meeting minutes accurately address the data presented. Monitor the copy and paste functions in the electronic medical record.

Physician Credentialing and Privileging: Report Focused Professional Practice Evaluation results to the Medical Executive Committee.

Environment of Care: Complete N95 respirator fit testing, and monitor compliance. Ensure all laser users complete laser safety training, and monitor compliance.

Enteral Nutrition Safety: Ensure enteral nutrition documentation includes all required elements, and revise facility infection control policy to include enteral nutrition infection control expectations.

Registered Nurse Competencies: Ensure that competencies are validated annually and that competency validation documentation is complete.

Medication Management: Require staff to observe safe work practices when handling hazardous drugs in the pharmacy compounding area. Ensure nursing staff comply with facility chemotherapy medication administration policy.

Coordination of Care: Ensure that all components of written advance directive notification are provided to patients and that notification is documented in the medical record.

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.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

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 crime awareness briefings 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 selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- Coordination of Care
- EN Safety
- EOC
- Management of Workplace Violence
- MM
- Physician C&P
- QM
- RN Competencies

The review covered facility operations for FY 2010 and FY 2011 through June 9, 2011, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the Jesse Brown VA*

Medical Center, Chicago, Illinois, Report No. 08-00003-10, October 17, 2008). The facility had corrected all findings from our previous review. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 342 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.

Reported Accomplishments

Employee Recognition Program

In 2005, only 508 facility employees participated in the VA All Employee Survey. Beginning in 2006, in an effort to improve staff involvement and satisfaction, the facility began investing 2 percent of its annual budget toward employee education, awards, and recognition. In addition to a leadership development program, the facility offered personal and professional development courses. It also hosted an annual employee award and recognition ceremony in the summer and a dinner dance during the holiday season. Transparent leadership became the standard, and employees were informed of decisions affecting the facility. In 2010, more than 1,600 employees completed the All Employee Survey—a response rate of 85 percent. The facility's overall employee scores for 2008, 2009, and 2010 exceeded VISN and national scores. (See Appendix C, Figure 1 for further details.)

Safe Patient Handling Program

In 2008, the facility implemented a safe patient handling program to reduce the risk of injury to employees while enhancing patient safety. Multiple ceiling lifts were installed throughout the facility, including in all inpatient units and in the ED and procedure areas. In areas where ceiling lifts were prohibited, such as psychiatry, staff used auxiliary safe patient equipment. Staff received ongoing training and competency assessments, and 40 inpatient unit leaders provided onsite training and coaching. In FY 2010, the facility reported a lifting/repositioning injury rate that was lower than the national average.

Home Infusion Program

In March 2009, the facility implemented a multi-disciplinary home infusion program designed for patients to receive intravenous antibiotics and total parenteral nutrition at home. Prior to the program's implementation, patients were either admitted to the CLC or placed in community nursing homes to complete their treatment. For the past 25 months, more than 150 patients have been sent home on antimicrobial therapy and total parenteral nutrition. The program has saved the facility nearly 4,000 days of hospitalization, which is equivalent to $4.2 million in cost savings. Additionally, the program has decreased length of stay, increased inpatient bed availability, and improved patient satisfaction.

Automated Hand Hygiene Tracking System

The facility reported to us that it was the first VA facility to implement an automated system to track hand hygiene practices. The system tracks hand-washing practices prior to patient contact using a series of wall-mounted sensors in patient care areas and individualized electronic identification badges. It also sends out an alarm to remind employees who have not washed their hands. IC practitioners are optimistic that information gathered from this system will identify patterns of infection transmission and areas in need of improvement.

Results

Review Activities With Recommendations

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. We identified the following areas that needed improvement.

Peer Review. VHA requires that the PRC receive notification upon completion of corrective actions.[1] In 5 of the 13 cases reviewed, we found that PRC meeting minutes did not indicate that corrective actions had been completed.

Medical Record Review. VHA requires facilities to conduct medical record reviews that include specific areas of review and to monitor the copy and paste functions.[2] We found that

[1] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
[2] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

Medical Record Committee meeting minutes reflected data that appeared to be unrelated to the conclusions and recommendations. For example, the facility reported varying monthly compliance rates for verbal orders. However, the corresponding conclusions and recommendations did not correlate with the data presented for 8 of the 10 months of meeting minutes reviewed. In addition, the facility did not consistently monitor the copy and paste functions in the electronic medical record.

Recommendations

1. We recommended that the PRC be notified when corrective actions are completed.

2. We recommended that Medical Record Committee meeting minutes accurately address the data presented.

3. We recommended that processes be strengthened to ensure consistent monitoring of the copy and paste functions.

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 16 physicians' C&P files and profiles and found that licenses were current and that clinical privileges held elsewhere had been verified. However, we identified the following area that needed improvement.

FPPE. VHA requires reporting of FPPE results to the MEC for consideration in making the recommendation on privileges for newly hired physicians.[3] For three of the six newly hired physicians whose profiles we reviewed, we found that FPPE results had not been reported to the MEC.

Recommendation

4. We recommended that processes be strengthened to ensure that FPPE results are reported to the MEC.

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 selected inpatient (acute medical-surgical, mental health, intensive care, CLC, and telemetry) units, the same day surgery and post-anesthesia care units, primary care and women's health care clinics, and the ED. The

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

facility maintained a generally clean and safe environment. However, we identified the following conditions that needed improvement.

N95 Respirator Fit Testing. If facilities use N95 respirators, the Occupational Safety and Health Administration requires that designated employees are fit tested annually. We reviewed 43 employee training records and determined that 30 (70 percent) designated employees did not have the required annual fit testing.

Laser Safety. Local policy requires that all laser users be trained on the proper and safe use of such equipment. None of the 10 employee training records we reviewed had documented evidence of this training for FY 2010.

Recommendations

5. We recommended that N95 respirator fit testing be completed and that compliance be monitored.

6. We recommended that laser safety training be completed and that compliance be monitored.

EN Safety

The purpose of this review was to evaluate whether the facility established safe and effective EN procedures and practices in accordance with applicable requirements.

We reviewed policies and documents related to EN and patients' medical records. We also inspected areas where EN products were stored while conducting the EOC review, and we interviewed key employees. We identified the following areas that needed improvement.

EN Documentation. VHA requires that staff document specific EN information in patients' medical records.[4] We reviewed the medical records of 10 patients (5 CLC and 5 acute care) receiving EN and determined that 5 records did not contain all required information. For example, none of the five records included documentation of gastric residual checks.

EN IC Policy. VHA requires that facility IC policy address EN.[5] We reviewed facility IC policy and determined that it did not address IC expectations for EN, such as swabbing

[4] VHA Handbook 1109.05, *Specialized Nutritional Support*, May 10, 2007.
[5] VHA Handbook 1109.05

the tops of EN cans with alcohol wipes before pouring contents into feeding bags.

Recommendations

7. We recommended that processes be strengthened to ensure that EN documentation includes all required elements.

8. We recommended that facility IC policy be revised to include EN IC expectations.

RN Competencies

The purpose of this review was to determine whether the facility had an adequate RN competency assessment and validation process.

We reviewed facility policy and processes, interviewed nurse managers, and examined initial and ongoing competency assessment and validation documents for 12 RNs. We identified the following area that needed improvement.

Competency Validation Documentation. The Joint Commission and facility nursing policy require that nursing personnel are competent to function in their assignments. Core competencies, such as use of standard precautions, are skills required for all RNs. Unit/position competencies are specific to a particular area of patient care, such as an intensive care unit. According to facility policy, competencies must be validated annually. Six of the 12 RN competency folders were deficient. Four did not contain evidence that annual core and unit/position-specific competencies had been validated, and three had incomplete or missing validation documentation.

Recommendation

9. We recommended that processes be strengthened to ensure that competencies are validated annually and that competency validation documentation is complete.

MM

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.

We observed the compounding of two chemotherapy medications and the transportation and administration of one chemotherapy medication in the infusion clinic, and we interviewed employees. We identified the following area that needed improvement.

Safe Work Practices. The American Society of Health-System Pharmacists requires safe handling of hazardous drugs to minimize contamination and ensure staff and patient safety. Staff must change gloves whenever they exit and re-enter the biological safety cabinet and must wear clean gloves when handling the final preparation. In the pharmacy compounding area, the supervising pharmacist appropriately used clean gloves when labeling and placing the final preparations into the transport bag. However, we observed a pharmacy technician with unclean gloves holding the final preparations during labeling and exiting the biological safety cabinet and re-entering without changing gloves.

Facility chemotherapy administration policy requires two RNs to verify a chemotherapy medication to ensure that the label is consistent with the order. Additionally, one of the RNs must record the information in the electronic medication administration system prior to administration. We observed an RN and a pharmacist rather than two RNs verify a medication. Also, the RN did not record the information in the medication administration system.

Recommendation

10. We recommended that safe work practices be observed when handling hazardous drugs in the pharmacy compounding area and that processes be strengthened to ensure that nursing staff comply with facility policy when administering chemotherapy medication.

Coordination of Care

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

We reviewed 20 patients' medical records for evidence of advance directive notification, advance directive screening, and documentation of advance care planning discussions. We also reviewed the facility's policy to determine whether it was consistent with VHA policy. We identified the following area that needed improvement.

Advance Directive Notification. VHA requires that patients receive written notification at each admission to a VHA facility regarding their right to accept or refuse medical treatment, to designate a Health Care Agent, and to document their treatment preferences in an advance

directive.[6] As part of notification, patients must be informed that VA does not discriminate based on whether or not they have an advance directive. None of the 20 records reviewed contained evidence of all components of written notification.

Recommendation

11. We recommended that processes be strengthened to ensure that all components of written advance directive notification are provided to patients and that notification is documented in the medical record.

Review Activity Without Recommendations

Management of Workplace Violence

The purpose of this review was to evaluate whether VHA facilities issued and complied with comprehensive policy regarding violent incidents and provided required training.

We reviewed the facility's policy and training plan. Additionally, we selected three assaults that occurred at the facility within the past 2 years, discussed them with managers, and reviewed applicable documents. The facility had a comprehensive workplace violence policy and managed the assaults in accordance with policy. The training plan addressed the required prevention and management of disruptive behavior training. We made no recommendations.

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 15–22 for full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

[6] VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, July 2, 2009.

Facility Profile[7]		
Type of Organization	Tertiary care medical center	
Complexity Level	Clinical referral Level 1-A facility	
VISN	12	
CBOCs	Lakeside CBOC, Chicago, IL Auburn Gresham CBOC, Chicago, IL Chicago Heights CBOC, Chicago Heights, IL Adam Benjamin, Jr. VA Outpatient Clinic, Crown Point, IN	
Veteran Population in Catchment Area	810,000	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	188	
• **CLC/Nursing Home Care Unit**	22	
• **Other**	0	
Medical School Affiliation(s)	Northwestern University, Feinberg School of Medicine University of Illinois at Chicago College of Medicine	
• **Number of Residents**	201	
	Current FY (through March 31, 2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$183.3	$355.0
• **Medical Care Expenditures**	$182.3	$374.5
Total Medical Care Full-Time Employee Equivalents	2,172.9	2,130.7
Workload:		
• **Number of Station Level Unique Patients**	34,940	43,193
• **Inpatient Days of Care:**		
o **Acute Care**	24,094	47,595
o **CLC/Nursing Home Care Unit**	2,517	3,932
Hospital Discharges	4,064	8,930
Total Average Daily Census (including all bed types)	133.94	130.61
Cumulative Occupancy Rate (in percent)	79	76
Outpatient Visits	267,291	560,604

[7] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance**	**Repeat Recommendation? Y/N**
QM			
1. Implement a process for the use of relevant provider-specific performance information to assess competency and to support privileging decisions.	C&P process requirements are documented in Professional Standards Board meeting minutes. Provider-specific information from Ongoing Professional Practice Evaluation and FPPE processes is used to support decisions, and information is documented in Professional Standards Board monthly committee meeting minutes.	Y	N
2. Require that committee minutes document meeting attendance and discussion to support C&P decisions.	Professional Standards Board meeting minutes document attendance and discussion that supports C&P decisions.	Y	N
3. Require that C&P folders and all C&P documentation meet VHA and legal requirements.	C&P folders and documentation comply with VHA and legal requirements.	Y	N
4. Ensure that all peer reviews meet the timeliness requirements and that providers review all cases meeting the criteria specified in local policy.	The PRC meets monthly. Peer reviews are tracked in a database to ensure timeliness and completion as indicated in local policy.	Y	N
MM			
5. Require that nurses consistently document the effectiveness of all pain medications within the required timeframe of the local policy.	Reassessments are conducted and documented within the required timeframe per local policy.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance	Repeat Recommendation? Y/N
ED Operations			
6. Ensure that ED staff complete inter-facility transfer documentation, as required by VHA policy.	ED staff use electronic informed consent to complete inter-facility transfer documentation. Medical record reviews for the past 3 years show good documentation.	Y	N
Coordination of Care			
7. Ensure that staff consistently complete intra-facility transfer documentation, as required by local Nursing Service policy.	Nursing staff use electronic informed consent to complete inter-facility transfer documentation, as required by Nursing Service policy. Documentation shows quality medical record review over a 3-year period.	Y	N
8. Ensure that staff consistently complete discharge documentation, as required by local policy.	Discharge instructions are completed and monitored as required by local policy. The Medical Record Committee reports discharge documentation data to the MEC on an ongoing basis.	Y	N
EOC			
9. Require staff to check emergency carts, as required by local policy.	Emergency carts are checked and monitored as required by local policy.	Y	N
10. Require staff to monitor refrigerators, as required by local policy.	All facility and CBOC refrigerators are tracked electronically using the Temp Trac monitoring system, as required by local policy.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance	Repeat Recommendation? Y/N
11. Ensure that suicide prevention posters and brochures are displayed in highly visible areas throughout the facility.	Suicide Prevention posters and brochures can be seen throughout the facility and are placed in high-risk areas. The Suicide Prevention Coordinator consistently ensures the presence of the posters and brochures.	Y	N
12. Require that staff update the local hand hygiene policy to include the process for monitoring health care workers' adherence to required hand hygiene practices and that staff consistently collect hand hygiene compliance data for all direct patient contact areas.	Hand hygiene policy has been updated. Hand hygiene practices are continuously monitored and reported to the IC Committee, which reports to the Quality Leadership Council quarterly. The annual IC risk assessment includes the required hand hygiene elements.	Y	N
13. Ensure that staff conduct EOC rounds weekly and inspect all facility areas at least semi-annually.	EOC rounds are conducted weekly, and all areas are inspected semi-annually. EOC rounds are tracked, reported, and documented in Safety Committee meeting minutes.	Y	N
14. Require staff to develop action plans for EOC deficiencies.	EOC deficiencies, including action plans, are tracked, reported, and documented in Safety Committee meeting minutes.	Y	N
15. Require that all staff who work on the locked inpatient psychiatric unit receive training on environmental hazards that pose a threat to suicidal patients.	All inpatient psychiatric unit staff receive training on environmental hazards annually. Training compliance is tracked electronically.	Y	N

VHA Satisfaction Surveys

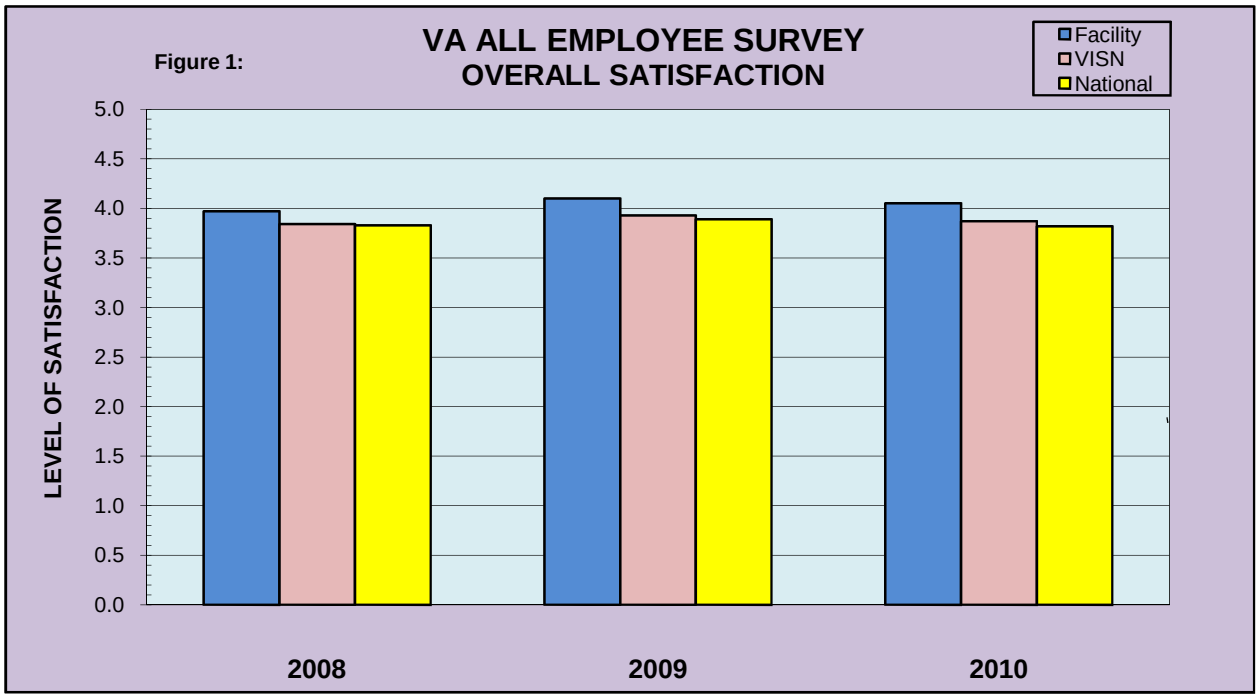
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2010.

Table 1

	FY 2010 (inpatient target = 64, outpatient target = 56)							
	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Inpatient Score Quarter 3	Inpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	60.2	50.3	48.6	66.9	55.6	53.6	49.7	53.0
VISN	62.0	64.9	65.1	68.4	55.5	58.6	54.0	56.9
VHA	63.3	63.9	64.5	63.8	54.7	55.2	54.8	54.4

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.

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions[8] 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	Congestive Heart Failure	Pneumonia	Heart Attack	Congestive Heart Failure	Pneumonia
Facility	12.39	8.16	14.32	21.42	22.45	17.73
VHA	13.31	9.73	15.08	20.57	21.71	15.85

[8] Congestive heart failure 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 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: July 25, 2011

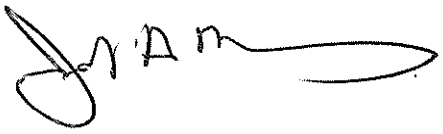
From: Network Director, VISN 12 (10N12)

Subject: **CAP Review of the Jesse Brown VA Medical Center, Chicago, IL**

To: Director, Los Angeles Healthcare Inspections Division (54LA)

Director, Management Review Service (VHA 10A4A4 Management Review)

I have reviewed the CAP report regarding Jesse Brown VAMC and concur with all recommendations and the proposed action plan submitted.



Jeffrey A. Murawsky, M.D.

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: July, 25, 2011

From: Director, Jesse Brown VA Medical Center (537/00)

Subject: **CAP Review of the Jesse Brown VA Medical Center, Chicago, IL**

To: Network Director, VISN 12 (10N12)

Jesse Brown VA Medical Center concurs with the eleven OIG recommendations and provides the attached action plan to address all recommendations. Thank you.

(original signed by:)
Michael Anaya, Director

Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 1. We recommended that the PRC be notified when corrective actions are completed.

Concur

Target date of implementation/completion: August 31, 2011

Planned Action: The Peer Review Committee utilizes the facility's meeting minute format for tracking open items. While the meeting minute format has been utilized for over two years, emphasis has been placed on tracking open items to completion. Tracking open items is accomplished by placing all open items on the follow-up section of the agenda until action plans are completed, reported and documented in the meeting minutes. Prior to April 2011, action plans were being tracked but not until closure: this methodology will ensure this is completed. Another measure put into place is the inclusion of the peer review meeting minutes within the practitioner file when the action is identified and closure of the actions.

Recommendation 2. We recommended that Medical Record Committee meeting minutes accurately address the data presented.

Concur

Target date of implementation/completion: September 30, 2011

Planned Action: The Medical Record Committee reviewed the Medical Record Committee Charter on June 23, 2011. This assessment assisted in review of the Medical Record Committee requirements and the identification of the expected outcomes. In addition, the process of addressing agenda items was revised to ensure documentation in the meeting minutes which include: discussion/conclusion, recommendations/actions, an assignment of responsible parties and when and where follow-up reporting will occur until the closure of the issue. When an issue is identified and then closed, the complete documentation will be recorded in the meeting minutes to notate the compliance or evidence/reasoning for the closure.

Medical Record Committee follow-up items will be reviewed and followed at each meeting with succinct documentation. The meeting minute's agenda will include the methodology of notation under "Follow-Up" of agenda items and all unclosed issues from previous meeting minutes. We have also reinforced the process of ensuring that all recommended agenda items are reported from the Medical Records Committee to the Medical Executive Committee for further discussion and approval/disapproval of

recommendations. This information will be reported back to the Medical Record Committee for implementation and/or further follow-up by the Chairman of the Medical Records Committee post reporting to the Medical Executive Committee. Evidence of these events will be noted in the recording of medical record committee minutes.

Recommendation 3. We recommended that processes be strengthened to ensure consistent monitoring of the copy and paste functions.

Concur

Target date of implementation/completion: September 30, 2011

Planned Action: Copy & paste monitoring is aggregated monthly and reported to the Medical Records Committee. All clinical services continue to participate in a definitive manner by monitoring monthly the copy & paste functions. A clinical report includes the monthly data outcome and trending over time. In addition each service will identify any adverse trends, or concerns on documented action plan format. Copy and paste statistics will be graphed in a cumulative format, based on quarterly reporting and monthly data gathering. Our threshold for compliance with the copy & paste process is 95%. The Copy and Paste Monitor is a standing monthly monitor and is reported by the Chairman of the Medical Records Committee to the Medical Executive Committee.

The Health Information Management Department has begun random audits on copy & paste process for all clinical services. These audits will be correlated with the monthly clinical services reports provided to the Medical Record Committee. If the results identify opportunities for improvement, the clinical service will identify actions through an action plan to improve compliance. This will be documented in the Medical Record Committee meeting minutes from the initiation of the action plan until compliance is achieved.

The Medical Record Committee and Health Information Management department will continue to work toward a collaborative effort of educating our providers on guidelines of copy and paste according to local and VHA Health Information Management policy. Supplemental educational material will be provided and reviewed at the Medical Record Committee assist the clinical representatives address provider education.

Recommendation 4. We recommended that processes be strengthened to ensure that FPPE results are reported to the MEC.

Concur

Target date of implementation/completion: August 31, 2011.

Planned Action: The Professional Standards Board/Medical Executive Committee has implemented an extensive process for full compliance with documentation of the committee's review of the FPPE/OPPE prior to OIG review. Although it was noted that 3 of the 6 newly hired physicians were not reported to MEC, these discrepancies were prior to the implementation of the new format of review, discussion and documentation

of the FPPE. The Chief of Staff is confident that this process will mandate the review of the FPPE results with documentation in the meeting. The COS also reviews all information prior to the PSB/MEC. In addition, the Associate Chief of Staff for Clinical Affairs conducts quarterly reviews of the individual services OPPE after the initial FPPE. Recommend that this recommendation be closed based on the current practice and compliance review.

Recommendation 5. We recommended that N95 respirator fit testing be completed and that compliance be monitored.

Concur

Target date of implementation/completion: September 30, 2011

Planned Action: It was noted during the review that our tracking system for Respirator fit testing did not retain historical data for tracking of Respirator fit testing. In May 2011, a contractor conducted a mass fit test operation to bring the program to full compliance. During the OIG review, when the request was made to provide the proof of 2010 fit test dates, the results weren't fully available due to the new fit test records superseding the old records in the Microsoft Access Database. The action plan to resolve this discrepancy is as follows. In conjunction with Employee Health and Infection Control, the Industrial Hygiene/GEMS Coordinator is working to create a new system and obtain quantitative fit test (QNFT) equipment that retains the historical data. Additionally, a risk assessment was completed to identify the number of personnel requiring fit tests and determined that the number of personnel requiring fit testing was dramatically reduced. The plan is to train personnel at Jesse Brown and the Community Based Outpatient Clinic's using the new equipment and designate once a week fit testing days to accommodate all shifts. Employee data will be tracked via an excel spreadsheet exported from QNFT equipment and Service Chiefs will be notified in advance, of their employees coming due in their upcoming birth month. Service Chiefs will also be notified ahead of time from a monthly report identifying who was delinquent, due to any unforeseen circumstances. Employees shall be notified and scheduled for next fit test day to ensure no future delinquencies in the program. The current policy lists Engineering Services as the tracker for the Respiratory Protection Program, however, the program status and compliance reports will be tracked in the Green Environmental Systems and Environment of Care Committee, monthly. The projected program implementation date is August 24, 2011 and all delinquencies, if any, made current by September 16, 2011.

Recommendation 6. We recommended that laser safety training be completed and that compliance be monitored.

Concur

Target date of implementation/completion: September 30, 2011

Planned Action: The Laser Safety Program memorandum was approved May 20, 2011 which outlines the laser safety training requirements. The Laser Safety

Committee has been chartered May 20, 2011 and will be responsible for monitoring the laser safety training compliance for Jesse Brown Medical Center. All Laser Safety training will be submitted and included in the TMS training files for database tracking. The Laser Safety Committee will report to the Medical Executive Committee quarterly the current level of compliance with the laser safety training and any action plans for noncompliance with this directive.

Recommendation 7. We recommended that processes be strengthened to ensure that EN documentation includes all required elements.

Concur

Target date of implementation/completion: September 30, 2011

Planned Action: An interdisciplinary group composed of Nursing, Food & Nutrition Service, Pharmacy, Computerized Patient Record System (CPRS), and Performance Improvement determined the most effective and efficient method to comply with this requirements of this program. It was determined that a CPRS template was the appropriate and practical action to implement. The template includes the nutritional appetite, nothing by mouth (NPO), a section on tube feeding with route, formula (type/rate/amount), type of administration (pump/gravity), section for gastric residual volume and with general parameters of when to notify MD, and other nutritional support (central/peripheral line). Final approval and education of staff on the usage is planned for July 30, 2011.

To ensure sustainability, and continued compliance, five (5) medical records, or 100%, per month will be monitored for 3 months to ensure appropriate documentation is recorded in the medical record. Any deficiencies noted will require immediate notification of the appropriate clinical service and follow-up action plans. The Medical Record Review will be reported to the Nutrition Committee. The Nutrition Committee reports to the Medical Executive Committee quarterly.

Recommendation 8. We recommended that facility IC policy be revised to include EN IC expectations.

Concur

Target date of implementation/completion: August 31, 2011

Planned Action: The JBVAMC Infection Control Plan is being revised to include the prevention of healthcare associated infections (HAI), related to EN and parental nutrition. In addition, a memorandum, "Enteral and Parental Nutrition: Special Infection Prevention Measures," was developed and reflects the current expectations regarding EN and parental nutrition. This memorandum will be referenced in the Infection Control Plan and available on the JBVA web-site, by July 30, 2011.

The Infection Control and Prevention Committee will monitor surveillance monthly of healthcare associated infections related to enteral and parental nutrition. This review

will be a standing agenda item for the Infection Control and Prevention Committee to address, update, and follow-up any issues identified in Enteral and Parental Nutrition Safety.

Recommendation 9. We recommended that processes be strengthened to ensure that competencies are validated annually and that competency validation documentation is complete.

Concur

Target date of implementation/completion: August 31, 2011

Planned Action: Employee folders will be reviewed monthly by the Nursing Competency Review Team for completeness and accuracy. A total of 30 employee folders from all nursing units/departments will be reviewed monthly for a compliance rate of 90%. The nursing competency review will be presented to the Human Resources Committee monthly.

Recommendation 10. We recommended that safe work practices be observed when handling hazardous drugs in the pharmacy compounding area and that processes be strengthened to ensure that nursing staff comply with facility policy when administering chemotherapy medication.

Concur

Target date of implementation/completion: August 31, 2011

Planned Action: After a comprehensive risk assessment using accepted industry regulations including the Unites States Pharmacopeia 797 (USP 797), American Health Systems Pharmacists (ASHP) and National Institute for Occupational Safety and Health (NIOSH) standards, the pharmacy service has developed a program to accomplish the safe handling of chemotherapeutic agents. This risk assessment included a thorough evaluation of preparation, labeling and transportation of chemotherapeutic agents. In order to meet and exceed the standards, pharmacy technicians change gloves when exiting the biological cabinet prior to re-entry. Additionally, the verifying pharmacist affixes the labels and places tamper evident buttons for all chemotherapeutic preparations. This process will be randomly validated on a monthly basis via direct observation. These monthly audits are maintained and will be used for validation of performance for each pharmacy personnel compounding chemotherapy.

Two nurses check the chemotherapy prior to administration and document this double check in CPRS. The primary nurse will sign the note and the co-signer will be the second nurse. Random monitoring will be completed by Nursing Service and reported to the Quality Leadership Council for three months.

Recommendation 11. We recommended that processes be strengthened to ensure that all components of written advance directive notification are provided to patients and that notification is documented in the medical record.

Concur

Target date of implementation/completion: August 31, 2011

Planned Action: The current inpatient advance directive template is being amended to include the following statement to meet full compliance of components of the written advance directive notification: "the patient was informed that the VA does not discriminate based on whether or not they have an advance directive."

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