Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-03665-78

Combined Assessment Program Review of the VA Illiana Health Care System Danville, Illinois

February 14, 2012

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.

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Glossary

CAP	Combined Assessment Program
CLC	community living center
CRC	colorectal cancer
ED	emergency department
EOC	environment of care
facility	VA Illiana Health Care System
FY	fiscal year
HF	heart failure
MCM	medical center memorandum
MH	mental health
MSDS	Material Safety Data Sheet
OIG	Office of Inspector General
OR	operating room
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the VA Illiana Health Care System, Danville, 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 November 14, 2011.

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

- Colorectal Cancer Screening
- Coordination of Care
- Moderate Sedation
- Quality Management

The facility's reported accomplishments were the implementation of The Green House® model as a new and innovative approach for veterans needing skilled care and the construction of a Healing Garden for community living center residents, which incorporates access to nature in a therapeutic setting.

Recommendations: We made recommendations in the following three activities:

Environment of Care: Ensure that fire exits are identified by visible signage, are not locked, and are clear of obstructions and not blocked. Clean operating room ceiling lights, and repair the walls in the operating room. Develop and implement a policy for the community living center's residential animal program, and ensure that quarterly preventive maintenance is performed on the community living center's elopement prevention system. Review and update Material Safety Data Sheet files annually.

Polytrauma: Ensure interdisciplinary teams develop care plans that contain all required elements. Require monitoring of compliance with staff training requirements.

Medication Management: Ensure that clinicians document all required vaccination administration elements and that compliance is monitored.

Comments

The Veterans Integrated Service Network and Acting 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 seven activities:

- CRC Screening
- Coordination of Care
- EOC
- Medication Management
- Moderate Sedation
- Polytrauma
- QM

We have listed the general information reviewed for each of these activities. Some of the items listed might not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2011 and FY 2012 through November 17, 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 VA*

Illiana Health Care System, Danville, Illinois, Report No. 08-02602-140, June 3, 2009). The facility had corrected all findings. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 101 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.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 258 responded. Survey results were shared with facility managers.

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

The Green House® Model

The facility recently dedicated two homes developed on the Green House® model, which will provide a new and innovative approach for veterans who need to live in a skilled care setting. The facility is the first in the VA system to implement this model. The Green House® model allows individuals to live in a group home designed, equipped, and staffed to deliver personal care and clinical services. Each home will house 10 veterans, who will have their own private bedroom and bathroom. The private rooms are situated around a hearth area with an open kitchen and dining room. Staff will prepare home cooked meals in the kitchen and serve them at a large, single dining table.

Healing Garden

The facility built a "Healing Garden" for CLC residents, which incorporates access to nature in a therapeutic setting. It is an ongoing initiative to provide a physical environment that can enhance healing, health, and well-being. Features include a picnic pavilion, gazebo, benches, recreational game areas, and items such as birdfeeders. A colored concrete path loops continuously throughout the entire garden and is accessible to wheelchairs.

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 inpatient units (medical/surgical, MH, and CLC), the ED, the OR, and outpatient clinics (dental, polytrauma, primary care, and specialty care). Additionally, we reviewed facility policies, meeting minutes, training records, and other relevant documents, and we interviewed employees and managers. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed for EOC
	Patient care areas were clean.
X	Fire safety requirements were properly addressed.
	Environmental safety requirements were met.
X	Infection prevention requirements were met.
	Medications were secured and properly stored, and medication safety practices were in place.
	Sensitive patient information was protected.
X	If the CLC had a resident animal program, facility policy addressed VHA requirements.
	Laser safety requirements in the OR were properly addressed, and users received medical laser safety training.
X	The facility complied with any additional elements required by local policy.
	Areas Reviewed for MH Residential Rehabilitation Treatment Program
	There was a policy that addressed safe medication management, contraband detection, and inspections.
	MH Residential Rehabilitation Treatment Program inspections were conducted, included all required elements, and were documented.
	Actions were initiated when deficiencies were identified in the residential environment.
	Access points had keyless entry and closed circuit television monitoring.
	Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks.
	The facility complied with any additional elements required by local policy.

Fire Safety. The Joint Commission requires that fire exits are identified by visible signage, are not locked, and are clear of obstructions and not blocked. We found that exit signs in the OR had been removed and not replaced. Additionally, we found a locked exit door on the medical/surgical unit and a blocked exit in the CLC.

Infection Prevention. The Joint Commission requires the facility to maintain a safe environment and reduce the risk of infections. In the OR, we found dead insects in the ceiling lights and gashes and holes in the walls.

VHA requires that the facility develop and implement a local policy if they have a residential animal program.[1] The CLC had a residential animal program; however, the facility had not developed and implemented a policy.

Patient Safety. Local policy requires that preventive maintenance be performed quarterly on the elopement prevention system in the CLC. The required quarterly preventive maintenance was not performed.

MSDS Files. Local policy requires that each service annually review and update their MSDS files. We found outdated MSDS files in seven of the nine clinical areas inspected.

Recommendations

1. We recommended that processes be strengthened to ensure that all fire exits are identified by visible signage, are not locked, and are clear of obstructions and not blocked.

2. We recommended that processes in the OR be strengthened to ensure that ceiling lights are clean and that the walls are repaired and maintained.

3. We recommended that a policy be developed and implemented for the CLC's residential animal program.

4. We recommended that processes be strengthened to ensure that quarterly preventive maintenance is performed on the CLC's elopement prevention system.

5. We recommended that processes be strengthened to ensure that MSDS files are reviewed and updated annually.

[1] Under Secretary for Health, "Non-Research Animals in Health Care Facilities," Information Letter 10-2009-007, June 11, 2009.

Polytrauma

The purpose of this review was to determine whether the facility complied with selected requirements related to screening, evaluation, and coordination of care for patients affected by polytrauma.

We reviewed relevant documents, 10 medical records of patients with positive traumatic brain injury results, and training records, and we interviewed key staff. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	Providers communicated the results of the traumatic brain injury screening to patients and referred patients for comprehensive evaluations within the required timeframe.
	Providers performed timely, comprehensive evaluations of patients with positive screenings.
	Case Managers were appropriately assigned to outpatients and provided frequent, timely communication.
X	Outpatients who needed interdisciplinary care had treatment plans developed that included all required elements.
	Adequate services and staffing were available for the polytrauma care program.
X	Employees involved in polytrauma care were properly trained.
	Case Managers provided frequent, timely communication with hospitalized polytrauma patients.
	The interdisciplinary team coordinated inpatient care planning and discharge planning.
	Patients and their family members received follow-up care instructions at the time of discharge from the inpatient unit.
	Polytrauma-Traumatic Brain Injury System of Care facilities provided an appropriate care environment.
	The facility complied with any additional elements required by local policy.

Outpatient Case Management. VHA requires that a specific interdisciplinary treatment plan be developed.[2] The plan developed by the interdisciplinary team must address specific elements, including the skills needed to maximize independence and the recommended type of vocational rehabilitation. In addition, the plan needs to address family education and the family support needed during the receipt of outpatient services. None of the 10 polytrauma outpatients' interdisciplinary treatment plans contained all the required elements.

[2] VHA Handbook 1172.04, *Physical Medicine and Rehabilitation Individualized Rehabilitation and Community Reintegration Care Plan*, May 3, 2010.

Training. VHA requires staff working with polytrauma patients to have training in age-appropriate interventions, assistive technology, and pain management.[3] None of the 10 training records reviewed contained evidence of all required training.

Recommendations

6. We recommended that processes be strengthened to ensure that interdisciplinary teams develop care plans that contain all required elements.

7. We recommended that the facility monitor compliance with polytrauma training requirements.

[3] VHA Handbook 1172.1, *Polytrauma Rehabilitation Procedures*, September 22, 2005.

Medication Management

The purpose of this review was to determine whether VHA facilities had properly provided selected vaccinations according to Centers for Disease Control and Prevention guidelines and VHA recommendations.

We reviewed a total of 30 medical records for evidence of screening and administration of pneumococcal vaccines to CLC residents and screening and administration of tetanus and shingles vaccines to CLC residents and primary care patients. We also reviewed documentation of selected vaccine administration requirements and interviewed key personnel.

The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Staff screened patients for pneumococcal and tetanus vaccinations.
	Staff properly administered pneumococcal and tetanus vaccinations.
X	Staff properly documented vaccine administration.
	Vaccines were available for use.
	If applicable, staff provided vaccines as expected by the VISN.
	The facility complied with any additional elements required by local policy.

Vaccination Documentation. Federal law requires that documentation for administered vaccinations include specific elements, such as the vaccine manufacturer and lot number of the vaccine used. Clinicians did not document all required elements in 6 (20 percent) records.

Recommendation

8. We recommended that processes be strengthened to ensure that clinicians document all required vaccination administration elements and that compliance is monitored.

Review Activities Without Recommendations

CRC Screening

The purpose of this review was to follow up on a report, *Healthcare Inspection – Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (Report No. 05-00784-76, February 2, 2006) and to assess the effectiveness of VHA's CRC screening.

We reviewed the medical records of 20 patients who had positive CRC screening tests, and we interviewed key employees involved in CRC management. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Patients were notified of positive screening test results within the required timeframe.
	Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe.
	Patients received a diagnostic test within the required timeframe.
	Patients were notified of the diagnostic test results within the required timeframe.
	Patients who had biopsies were notified within the required timeframe.
	Patients were seen in surgery clinic within the required timeframe.
	The facility complied with any additional elements required by local policy.

Coordination of Care

The purpose of this review was to determine whether patients with a primary discharge diagnosis of HF received adequate discharge planning and care "hand-off" and timely primary care or cardiology follow-up after discharge that included evaluation and documentation of HF management key components.

We reviewed 24 HF patients' medical records and relevant facility policies, and we interviewed employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Medications in discharge instructions matched those ordered at discharge.
	Discharge instructions addressed medications, diet, and the initial follow-up appointment.
	Initial post-discharge follow-up appointments were scheduled within the providers' recommended timeframes.
	The facility complied with any additional elements required by local policy.

Moderate Sedation

The purpose of this review was to determine whether the facility developed safe processes for the provision of moderate sedation that complied with applicable requirements.

We reviewed relevant documents, three medical records, and training/competency records, and we interviewed key individuals. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Staff completed competency-based education/training prior to assisting with or providing moderate sedation.
	Pre-sedation documentation was complete.
	Informed consent was completed appropriately and performed prior to administration of sedation.
	Timeouts were appropriately conducted.
	Monitoring during and after the procedure was appropriate.
	Moderate sedation patients were appropriately discharged.
	The use of reversal agents in moderate sedation was monitored.
	If there were unexpected events/complications from moderate sedation procedures, the numbers were reported to an organization-wide venue.
	If there were complications from moderate sedation, the data was analyzed and benchmarked, and actions taken to address identified problems were implemented and evaluated.
	The facility complied with any additional elements required by local policy.

QM

The purpose of this review was to determine whether VHA facility senior managers actively supported and appropriately responded to QM efforts and whether VHA facilities complied with selected requirements within their QM programs.

We interviewed senior managers and QM personnel, and we evaluated meeting minutes, medical records, and other relevant documents. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	There was a senior-level committee/group responsible for QM/performance improvement, and it included all required members.
	There was evidence that inpatient evaluation data were discussed by senior managers.
	The protected peer review process complied with selected requirements.
	Licensed independent practitioners' clinical privileges from other institutions were properly verified.
	Focused Professional Practice Evaluations for newly hired licensed independent providers complied with selected requirements.
	Staff who performed utilization management reviews met requirements and participated in daily interdisciplinary discussions.
	If cases were referred to a physician utilization management advisor for review, recommendations made were documented and followed.
	There was an integrated ethics policy, and an appropriate annual evaluation and staff survey were completed.
	If ethics consultations were initiated, they were completed and appropriately documented.
	There was a cardiopulmonary resuscitation review policy and process that complied with selected requirements.
	Data regarding resuscitation episodes were collected and analyzed, and actions taken to address identified problems were evaluated for effectiveness.
	If Medical Officers of the Day were responsible for responding to resuscitation codes during non-administrative hours, they had current Advanced Cardiac Life Support certification.
	There was a medical record quality review committee, and the review process complied with selected requirements.
	If the evaluation/management coding compliance report contained failures/negative trends, actions taken to address identified problems were evaluated for effectiveness.
	Copy and paste function monitoring complied with selected requirements.
	The patient safety reporting mechanisms and incident analysis complied with policy.
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.

Noncompliant	Areas Reviewed
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.
	The facility complied with any additional elements required by local policy.

Comments

The VISN and Acting Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 18–22 for full text of the Directors' comments.) We consider Recommendations 1 and 2 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[4]		
Type of Organization	Acute medical, acute MH, CLC, and primary care	
Complexity Level	Level 2	
VISN	11	
Community Based Outpatient Clinics	Decatur, IL Mattoon, IL Peoria, IL Springfield, IL West Lafayette, IN	
Veteran Population in Catchment Area	136,009	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	56	
• **CLC/Nursing Home Care Unit**	165	
• **Other**	NA	
Medical School Affiliations	University of Illinois College of Medicine, Urbana, IL, University of Illinois College of Medicine, Peoria, IL,	
• **Number of Residents**	12	
	Current FY (through October 2011)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$217.5	$219.9
• **Medical Care Expenditures**	$14.3	$207.3
Total Medical Care Full-Time Employee Equivalents	1,386	1,379
Workload:		
• **Number of Station Level Unique Patients**	11,048	33,335
• **Inpatient Days of Care:**		
o **Acute Care**	868	11,544
o **CLC/Nursing Home Care Unit**	3,978	52,401
Hospital Discharges	176	2,498
Total Average Daily Census (including all bed types)	161.00	180.51
Cumulative Occupancy Rate (in percent)	63.38	71.06
Outpatient Visits	18,362	324,540

[4] All data provided by facility management.

Follow-Up on Previous Recommendations		
Recommendations	**Current Status of Corrective Actions Taken**	**Repeat Recommendation? Y/N**
QM		
1. Ensure that clinical privileges granted to contractors do not extend beyond the contract period.	The Executive Committee of the Medical Staff reviews all contracted providers' privileges to ensure privileges do not exceed contract length. A process was established that credentialing must have a copy of the contract for privileging.	N
2. Ensure that managers fully implement the mechanism established to track cardiopulmonary resuscitation and Advanced Cardiac Life Support training compliance and that employees complete the training in accordance with facility policy.	The Basic Life Support and Advanced Cardiac Life Support report showing employees certification status, including deficiencies and upcoming renewals, is sent monthly to all service chiefs and supervisors.	N
EOC		
3. Ensure that cleanliness, pest control, infection control, and patient safety issues are corrected.	A schedule was established for the Chief, Environmental Management Service and supervisors to make daily patient care area rounds. The rounds include pest control management. All medication refrigerators are now on an electronic system that is monitored 24 hours a day to ensure temperatures stay in range. All crash carts/defibrillators are monitored at the unit level.	N
4. Ensure that an effective process is established to identify and resolve EOC deficiencies.	A training session to identify cleanliness, pest control, infection control, and patient safety is presented quarterly to employees who participate in EOC rounds. A mechanism was created to report work order status greater than 30 days for evaluation and to improve timeliness of completion.	N

Recommendations	Current Status of Corrective Actions Taken	Repeat Recommendation? Y/N
Coordination of Care		
5. Ensure that consultation responses are received within the timeframe specified by facility policy.	All prior action items were completed. All consults are monitored at the service level for timeliness. Current backlogs with fee and prosthetic consults are monitored.	N
6. Ensure that active outpatient medications are correctly listed in all discharge documentation.	Medication reconciliation is monitored. Data demonstrates continuous improvement.	N
Emergency/Urgent Care Operations		
7. Ensure that ED physicians do not have responsibilities outside the ED.	The facility has full-time contract hospitalist coverage for acute care, MH, and the CLC. ED physicians no longer have responsibilities outside of the ED.	N
8. Ensure that all inter-facility transfer documentation is in compliance with VHA and facility policy.	The use of the forms meeting the requirements set forth in VHA Directive 2007-015 is fully implemented.	N
Suicide Prevention Program		
9. Ensure that medical record documentation for patients deemed at high risk for suicide is in compliance with VHA and facility policy.	The suicide prevention coordinator and case manager monitor veterans at high risk for suicidal behavior daily to ensure they have patient record flags and completed safety plans with subsequent reviews and timely follow-up. Interdisciplinary collaboration and consensus for high-risk cases are ensured through the suicide prevention coordinator's and case manager's attendance at team meetings. The suicide prevention coordinator and case manager assure ongoing interdisciplinary collaboration and communication with outpatient providers through telephone consultation(s) and by adding the providers as additional signers of their progress notes.	N

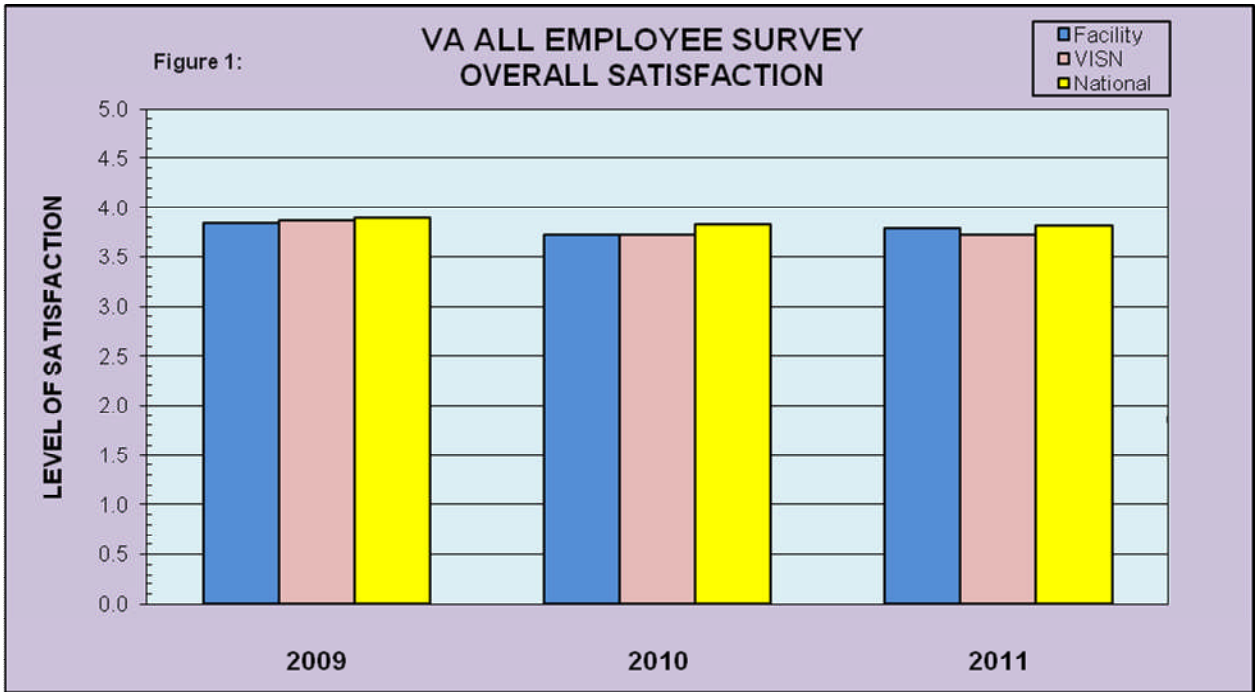
VHA Satisfaction Surveys

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 satisfaction scores and targets for quarters 3–4 of FY 2010 and quarters 1–2 of FY 2011 and overall outpatient satisfaction scores and targets for quarter 4 of FY 2010 and quarters 1–3 of FY 2011.

Table 1

	FY 2010		FY 2011			
	Inpatient Score Quarters 3–4	Outpatient Score Quarter 4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3
Facility	50.1	57.9	52.6	61.0	57.0	51.9
VISN	67.7	55.7	61.1	56.9	54.3	55.0
VHA	64.1	54.4	63.9	55.9	55.3	54.2

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. 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 received hospital care.[5] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2007, and June 30, 2010.[6]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	**	9.6	12.2	**	26.7	20.7
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

** The number of cases is too small (fewer than 25) to reliably tell how well the facility is performing.

[5] A heart attack occurs 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 timely, the heart muscle becomes damaged. Congestive HF is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[6] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 19, 2012

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

Subject: **CAP Review of the VA Illiana Health Care System, Danville, IL**

To: Director, Kansas City Office of Healthcare Inspections (54KC)

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

Per your request, attached is a response to the draft CAP report from VA Illiana Healthcare System. If you have any questions, please contact Kelley Sermak, VISN 11, Acting QMO, at (734) 222-4302.

Michael S. Finegan

Attachment

Acting Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 17, 2012

From: Acting Director, VA Illiana Health Care System (550/00)

Subject: **CAP Review of the VA Illiana Health Care System, Danville, IL**

To: VISN Director (10N11)

Please see attached responses to report.

(original signed by:)
Thomas Mattice
Acting Medical Center Director

Comments to OIG's Report

The following Acting Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that all fire exits are identified by visible signage, are not locked, and are clear of obstructions and not blocked.

Concur

Target date for completion: 12/9/2011

Exit signs in the OR that had been removed during construction have now been reinstalled by Engineering staff.

Staff has been educated on the importance of maintaining clear egress to all exits. Unit managers are conducting rounds daily to ensure all egresses are clear. Assessment of equipment needs on the units was conducted and excess equipment was removed.

The facility requests to close this recommendation.

Recommendation 2. We recommended that processes in the OR be strengthened to ensure that ceiling lights are clean and that the walls are repaired and maintained.

Concur

Target date for completion: 12/20/2011

The wall in the OR has been repaired by Engineering staff.

Ceiling lights in the OR have been cleaned. To assure that ceiling lights in the OR are clean, this task has been added to the newly developed checklist for cleaning of surgical suites to assure cleanliness is achieved and maintained daily. The nightly cleaning schedule and cleanliness of lights in the OR will be monitored weekly by Environmental Management Supervisors.

The facility requests to close this recommendation.

Recommendation 3. We recommended that a policy be developed and implemented for the CLC's residential animal program.

Concur

Target date for completion: 1/31/2012

Chief Recreation is currently revising MCM 11K-15 Service/Guide/Pet Therapy Policy. Revisions will include and reference programmatic responsibilities for CLC's residential animal program. Cleaning and maintaining the environment properly will be based on specifics listed in the MCM.

Recommendation 4. We recommended that processes be strengthened to ensure that quarterly preventive maintenance is performed on the CLC's elopement prevention system.

Concur

Target date for completion: 1/31/2012

In accordance with the manufacturers' recommendations there are no preventative maintenance requirements for the WanderGuard elopement prevention system; however, it is recommended to test the system monthly. The system was tested in December to assure proper function. The MCM has been updated to reflect monthly testing on the elopement system and is currently in the review process. Once the MCM has been approved, a monitor will be established to track monthly testing.

Recommendation 5. We recommended that processes be strengthened to ensure that MSDS files are reviewed and updated annually.

Concur

Target date for completion: 2/17/2012

All services are in the process of updating MSDS books. Once completed, the facility's Industrial Hygienist will conduct a facility wide audit to ensure 100% compliance. An annual review schedule will be developed to assure all MSDS books remain current. A quick link has been added to the employee web page for easy access to the electronic MSDS and service chiefs were instructed to share the location of the link with staff.

Recommendation 6. We recommended that processes be strengthened to ensure that interdisciplinary teams develop care plans that contain all required elements.

Concur

Target date for completion: 12/30/2011

The family education template was revised and approved for use. Providers are documenting on the TBI Evaluation or Polytrauma Support Clinic Team Consult note as to whether family was present and if education was provided to the family.

The facility requests to close this recommendation.

Recommendation 7. We recommended that the facility monitor compliance with polytrauma training requirements.

Concur

Target date for completion: 12/30/2011

TMS education modules have been identified and assigned to Polytrauma staff for completion, which will satisfy polytrauma training requirements. All assigned modules have been completed by all Polytrauma staff.

The facility requests to close this recommendation.

Recommendation 8. We recommended that processes be strengthened to ensure that clinicians document all required vaccination administration elements and that compliance is monitored.

Concur

Target date for completion: 2/17/2012

All required elements for vaccination administration have been incorporated into the order entry package for in patients and clinical reminders for outpatients. A monitor has been developed to ensure that all required elements are documented.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720
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