



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 08-03086-192

Combined Assessment Program Review of the Central Alabama Veterans Health Care System Montgomery, Alabama



August 11, 2009

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

During the week of May 4–8, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the Central Alabama Veterans Health Care System (the system), Montgomery, AL. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 112 system employees. The system is part of Veterans Integrated Service Network (VISN) 7.

Results of the Review

The CAP review covered eight operational activities. We made recommendations in four of the activities reviewed; two recommendations were repeat recommendations from our prior CAP review. For these activities, the system needed to ensure that:

- Infection control (IC) staff develop a comprehensive hand hygiene program which includes data collection and analysis for performance improvement and that results are consistently documented in IC Committee (ICC) minutes.
- The action plan and standard operating procedures (SOPs) for the use of panic alarms on the locked mental health (MH) unit (MHU) are implemented and that staff compliance is monitored.
- Strategies for the prevention of Legionnaire's disease (LD) are implemented.
- All designated staff complete life support training and that compliance with certification requirements is monitored.
- Medication reconciliation requirements are met.
- Root cause analysis (RCA) actions are implemented and corresponding outcome measures are evaluated by the designated due date.
- Nurses document the effectiveness of PRN (as needed) pain medications within the timeframe established by local policy.
- Nurses document a patient's understanding of his medication regimen education prior to beginning a self-medication program.
- Inter-facility transfer documentation is completed, as required by Veterans Health Administration (VHA) policy.

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

- Contract/Agency Registered Nurses (RNs).
- Coordination of Care (COC).
- Patient Satisfaction.
- Suicide Prevention Program.

This report was prepared under the direction of Christa Sisterhen, Director, St. Petersburg Office of Healthcare Inspections.

Comments

The VISN and System Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 15–22, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by:)

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

Introduction

Profile

Organization. The system is a two division, comprehensive health care system located in Montgomery and Tuskegee, AL. It provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at three community based outpatient clinics (CBOCs) located in Dothan and Fort Rucker, AL, and in Columbus, GA. The system is part of VISN 7 and serves a veteran population of about 134,000 in a primary service area that includes 43 counties in central and southeastern Alabama and western Georgia.

Programs. The system provides medical, surgical, MH, geriatrics, extended care, rehabilitation, and dental services. It has 31 hospital beds and 100 community living center (CLC)¹ beds.

Affiliations and Research. The system is affiliated with two medical schools—Morehouse School of Medicine and the University of Alabama at Birmingham’s School of Medicine. It is also affiliated with Baptist Health Care and with 14 additional educational institutions. The system provides training for 15 medical residents through a geriatrics training program and also provides training for students in several other disciplines. The system does not participate in research activities.

Resources. In fiscal year (FY) 2008, medical care expenditures totaled \$192.9 million. The FY 2009 medical care budget is \$209.5 million. FY 2008 staffing was 1,416 full-time employee equivalents (FTE), including 66 physician and 175 nursing FTE.

Workload. In FY 2008, the system treated 38,499 unique patients and provided 11,742 inpatient days in the hospital and 16,345 inpatient days in the CLC. The inpatient care workload totaled 888 discharges, and the average daily census, including CLC patients, was 90. Outpatient workload totaled 369,924 visits.

¹ A CLC (formerly called a nursing home care unit) provides compassionate, person-centered care in a safe and homelike environment to eligible veterans who require a nursing home level of care.

Objectives and Scope

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following eight activities:

- COC.
- Contract/Agency RNs.
- Emergency/Urgent Care Operations.
- Environment of Care (EOC).
- Medication Management.
- Patient Satisfaction.
- QM.
- Suicide Prevention Program.

The review covered system operations for FY 2008 and FY 2009 through May 7, 2009, and was done in accordance with OIG SOPs for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the system (*Combined Assessment Program Review of the Central Alabama Veterans Health Care System, Montgomery, Alabama, Report No. 06-02822-45,*

December 15, 2006). The system had not corrected two of the QM findings from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings to 112 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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

Results

Review Activities With Recommendations

Environment of Care

The purpose of this review was to determine if the system maintained a safe and clean health care environment. VHA health care systems are required to establish a comprehensive EOC program that fully meets VHA, National Center for Patient Safety, Occupational Safety and Health Administration, and Joint Commission (JC) standards.

At the Montgomery division, we inspected the acute inpatient medical/surgical unit, the medical intensive care unit (MICU), the same day clinic, the emergency department (ED), and the primary care clinic (PCC). At the Tuskegee division, we inspected the locked MHU and the CLC. We found that the system was generally clean and well maintained.

At the Montgomery division, we found a lack of patient privacy in the PCC intake area and in the ED. While conducting rounds in the PCC, we heard a patient giving personal information to the clerk behind the desk. The intake area is located in an open space, and information could be overheard by others in the vicinity. The ED also did not afford patients auditory privacy. It was very small, and the cubicles were separated by curtains. Managers provided us with the contracts for a construction project to reconfigure the PCC and the ED. This will correct the privacy deficiencies. Therefore, we made no recommendations for this finding.

We identified the following conditions that needed improvement.

IC. The system monitored staff hand washing compliance by direct observations of hand washing and by recording the volume of alcohol-based hand rub used over a specified period of time. However, we found that the data was not aggregated and analyzed for performance improvement, as required by The JC. We also found that the tool used to collect data for direct observation of hand washing was frequently not completed.

We reviewed April 2009 hand washing observation documentation for the CLC, the MICU, and PCC Team B. There were a total of 40 observations. Twenty-eight (70 percent) of the observations did not specify whether effective hand washing was performed. In addition, there was no documentation of this monitor in the ICC minutes we reviewed.

Also, we found that the data for the use of alcohol-based hand rub was identical in the quarterly ICC minutes for 2 consecutive quarters. Consequently, we could not verify compliance. Therefore, we could not determine whether the actions documented in the ICC minutes for this monitor were appropriate.

Safety on the Locked MHU. We found that not all staff who escorted patients to the laundry area adjacent to the MHU had panic alarms. Although the hallway leading to the laundry room and the laundry area were under 24-hour surveillance, a blind spot was observed on the surveillance monitor. The nurse manager told us that only 50 percent of the staff were issued personal wireless panic alarms, and we found that the system did not have a supply of panic alarms on the unit. While we were onsite, managers provided us with an action plan to ensure that all staff on duty have access to wireless panic alarms and an SOP for use of the alarms.

Also, we found an electrical cord in the day room that exceeded the 12-inch limit. System managers corrected the deficiency while we were onsite. Therefore, we made no recommendation for this finding.

LD. We followed up on recommendations from a prior OIG inspection (*Assessment of Legionnaire's Disease Risk in*

Veterans Health Administration Inpatient Facilities, Report No. 07-00029-151, June 20, 2007). The inspection surveyed inpatient facilities, including the system, for LD prevention strategies. We reviewed the system's policies and found that the system did not have a written plan that addressed the prevention of LD and did not consistently perform annual LD risk assessments, as required by VHA policy.² While we were onsite, system managers developed a draft policy that established guidelines for the annual evaluation of LD risk.

Recommendation 1

We recommended that the VISN Director ensure that the System Director requires that IC staff develop a comprehensive hand hygiene program which includes data collection and analysis for performance improvement and that results are consistently documented in ICC minutes.

The VISN and System Directors agreed with the findings and recommendation and reported that they have developed a comprehensive hand hygiene program that includes monitoring the usage of hand sanitizers and soap in mounted dispensers on all clinical units and in outpatient clinics. The data will be aggregated and analyzed for trends, and any patterns or trends will be compared with the previous quarter. Results will be displayed in graphs and reported in ICC minutes. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 2

We recommended that the VISN Director ensure that the System Director requires that the action plan and SOPs for use of personal panic alarms on the locked MHU are implemented and that staff compliance is monitored.

The VISN and System Directors agreed with the findings and recommendation and reported that the action plan and SOPs have been implemented. Each staff member is required to sign out a panic alarm at the beginning of his or her shift and return it at the end of the shift. Currently, there are 15 panic alarms available on the unit, which is sufficient to provide an alarm to each staff member on duty. Panic alarm use and effectiveness will be monitored daily. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

² VHA Directive 2008-010, *Prevention of Legionella Disease*, February 11, 2008.

Recommendation 3

We recommended that the VISN Director ensure that the System Director implements strategies for the prevention of LD.

The VISN and System Directors agreed with the finding and recommendation. The draft policy developed during the OIG visit has been implemented. On May 13, 2009, the water was tested at both divisions, and the results were negative. A risk assessment has been completed, and an oversight team has been appointed to ensure that the water is tested and analyzed in accordance with VHA policy. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

**Quality
Management**

The purposes of this review were to determine whether the system had a comprehensive, effective QM program designed to monitor patient care activities and coordinate improvement efforts and whether senior managers actively supported QM efforts and appropriately responded to QM results. We interviewed the system's senior management team and QM personnel. We reviewed policies and other relevant performance improvement documents.

The QM program was generally effective in providing oversight of the system's quality of care, and senior managers supported the program. Appropriate review structures were in place for 11 of the 15 program activities reviewed. However, we identified four areas that needed improvement.

Life Support Training. The system was not in compliance with local policy, which requires that designated staff remain current in Advanced Cardiac Life Support (ACLS) and/or Basic Life Support (BLS) certification. We reviewed staff training records and found that only 6 (50 percent) of 12 respiratory therapy staff and only 19 (86 percent) of 22 imaging staff had current BLS certification. For designated nursing staff, we found that 62 (90 percent) of 69 had current ACLS certification and that 348 (91 percent) of 382 had current BLS certification. Also, we found that managers did not have a process in place to monitor training to ensure timely completion, as required by local policy.

Medication Reconciliation. We found that the system was not in compliance with JC requirements for medication reconciliation at the time of admission, transfer, and discharge. The complete list of a patient's current

medications must be compared (reconciled) with medications at the next level of care. On average, for the timeframe October 2008 through March 2009, our review indicated 93 percent compliance for admissions and 81 percent compliance for transfers. For the timeframe January through March 2009, we found only 65 percent compliance for discharges. This was a repeat finding from our previous CAP review.

RCA. We found that elements of the RCA process did not comply with VHA guidelines. RCAs are designed to identify and resolve the root cause of system and/or process deficiencies involved in an actual or potential adverse event. VHA policy³ requires that corrective actions be implemented and that outcome measures be evaluated for effectiveness by the designated due date. The system completed a total of eight individual RCAs between March 2008 and February 2009. Four of the eight RCAs had corrective actions and associated outcome measures that were past due (the range was 30 to more than 180 days at the time of our review) and remained pending. This was also a repeat finding from our previous CAP review.

Recommendation 4

We recommended that the VISN Director ensure that the System Director requires that all designated staff complete life support training and that compliance with certification requirements is monitored.

The VISN and System Directors agreed with the findings and recommendation and reported that as of July 27, 2009, 100 percent of imaging, nursing, and respiratory staff have the required certifications. The Risk Manager will conduct quarterly assessments to ensure that certifications are current. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 5

We recommended that the VISN Director ensure that the System Director requires compliance with medication reconciliation requirements.

The VISN and System Directors agreed with the findings and recommendation and reported that the process for medication reconciliation was reviewed with providers during medical staff meetings held in May and June 2009. Additionally, the Chief of Staff (COS) sent a memorandum to

³ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, May 23, 2008.

all providers during the OIG visit. A Healthcare Failure Mode Effect Analysis will be conducted on the medication reconciliation process, and the Patient Safety Committee will monitor medication reconciliation documentation compliance. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 6

We recommended that the VISN Director ensure that the System Director requires RCA actions to be implemented and corresponding outcome measures to be evaluated by the designated due date.

The VISN and System Directors agreed with the finding and recommendation and reported that in May 2009, a new process was implemented to track and complete RCA actions. All action items will be tracked to completion using the Network Action Tracking System. The process and its impact will be monitored monthly by the Patient Safety Committee. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Medication Management

The purpose of this review was to evaluate whether the system had adequate medication management practices. A safe medication management system includes medication ordering, administering, and monitoring.

We reviewed selected medication management processes on the acute inpatient medical/surgical unit and the MICU at the Montgomery division and on the locked MHU, the CLC, and the domiciliary unit at the Tuskegee division. Nurses appropriately scanned patient armbands and used personal identifiers to correctly identify patients prior to medication administration. We found that reconciliation of controlled substance discrepancies at the unit level was adequate. We identified two areas that needed improvement.

PRN Effectiveness. We found that documentation of PRN pain medication effectiveness did not comply with local policy. We reviewed 128 PRN pain medication doses. We found effectiveness documented for only 111 (87 percent) doses. Of those 111 doses, only 83 (75 percent) had effectiveness documented within 2 hours, as required by local policy.

Medication Education. We found that nurses documented a patient's understanding of his medication regimen prior to

beginning a self-medication program in the Domiciliary Rehabilitation Treatment Program for only 6 (60 percent) of the 10 medical records reviewed. Medication education was identified as a learning need for each of these patients, and local policy requires documentation of patient understanding of the education provided.

Recommendation 7

We recommended that the VISN Director ensure that the System Director requires that nurses document the effectiveness of PRN pain medications within the timeframe established by local policy.

The VISN and System Directors agreed with the findings and recommendation and reported that in June 2009, SOPs were developed by the services and shared with staff. PRN pain medication effectiveness is monitored daily by nurse managers. Weekly and monthly reports will be generated and shared with staff. Reports will be submitted monthly to the Nursing Quality Council and quarterly to the Health System Council. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 8

We recommended that the VISN Director ensure that the System Director requires that nurses document a patient's understanding of his medication regimen education prior to beginning a self-medication program.

The VISN and System Directors agreed with the finding and recommendation. The nurse manager provided instruction on patient education documentation requirements, and monthly reviews will be conducted to ensure compliance. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Emergency/Urgent Care Operations

The purpose of this review was to evaluate selected aspects of care and operations in the system's ED, including clinical services, consultations, inter-facility transfers, staffing, and staff competencies. We also assessed the ED's physical environment and ED equipment maintenance.

We interviewed program managers and transfer coordinators. We also reviewed competency files, credentialing and privileging (C&P) folders, and medical records of patients who were seen in the ED and

subsequently transferred to other medical facilities, admitted to inpatient units within the system, or discharged home.

The ED is open 24 hours per day, 7 days per week, as required for ED designation. Emergency services provided are within the facility's patient care capabilities.

Our review showed that clinical services, consultations, staffing, and medical record admission and discharge documentation were appropriate. There were no Memorandums of Understanding with other health care entities, but no problems were identified regarding transfer of patients to local hospitals. ED nursing competency assessment tools were well developed, and nursing staff annual competency assessments were completed.

We reviewed three C&P folders of physicians employed in the ED and found that the physicians who had been granted airway management and intubation privileges had documentation of out-of-operating room (OR) airway management training. Also, there was an adequate back-up plan for provision of out-of-OR airway management for situations in which the ED physician was not privileged in this area. We identified one area that needed management attention.

Inter-Facility Transfers. ED staff did not document inter-facility transfer information, as required by VHA policy.⁴ We reviewed the medical records of three patients who were transferred from the ED to another facility. At the time of our review, VA transfer forms "10-2649A" and "10-2649B" were not a part of the electronic medical record (EMR). We were told that the forms were completed and given to the patients to take to the receiving facility and that copies were to be scanned into the medical records. However, none of the three EMRs we reviewed contained scanned transfer forms, and hard copies could not be located.

Recommendation 9

We recommended that the VISN Director ensure that the System Director requires that inter-facility transfer documentation is completed, as required by VHA policy.

The VISN and System Directors agreed with the finding and recommendation and reported that on May 5, 2009, the COS sent a memorandum to all providers and nursing staff

⁴ VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.

emphasizing the requirement to use the electronic inter-facility transfer form. Health Information Management will monitor electronic template usage. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Contract/Agency Registered Nurses

The purpose of this review was to evaluate whether RNs working in VHA facilities through contracts or temporary agencies met the same entry requirements as RNs hired as part of VHA facility staff. We reviewed documents for several required components, including licensure, training, and competencies. We found that system managers had appropriate processes in place and followed them consistently with all contract/agency RNs selected for review. We made no recommendations.

Coordination of Care

The purpose of this review was to evaluate whether inpatient consultations, intra-facility (ward-to-ward) transfers, and discharges were coordinated appropriately over the continuum of care and met VHA and JC requirements. Coordinated consultations, transfers, and discharges are essential to an integrated, ongoing care process and optimal patient outcomes.

We reviewed the medical records of 10 inpatients who had consultations ordered and performed internally. We found that 9 (90 percent) of the 10 consultations were completed within acceptable timeframes.

We determined that clinicians appropriately managed all 12 intra-facility transfers. We found transfer notes from sending to receiving units and documentation that nursing assessments were performed by the receiving units in accordance with established timeframes.

We reviewed the medical records of 12 discharged patients and found that all patients received appropriate written discharge instructions. We also found documentation that the patients understood the instructions. We made no recommendations.

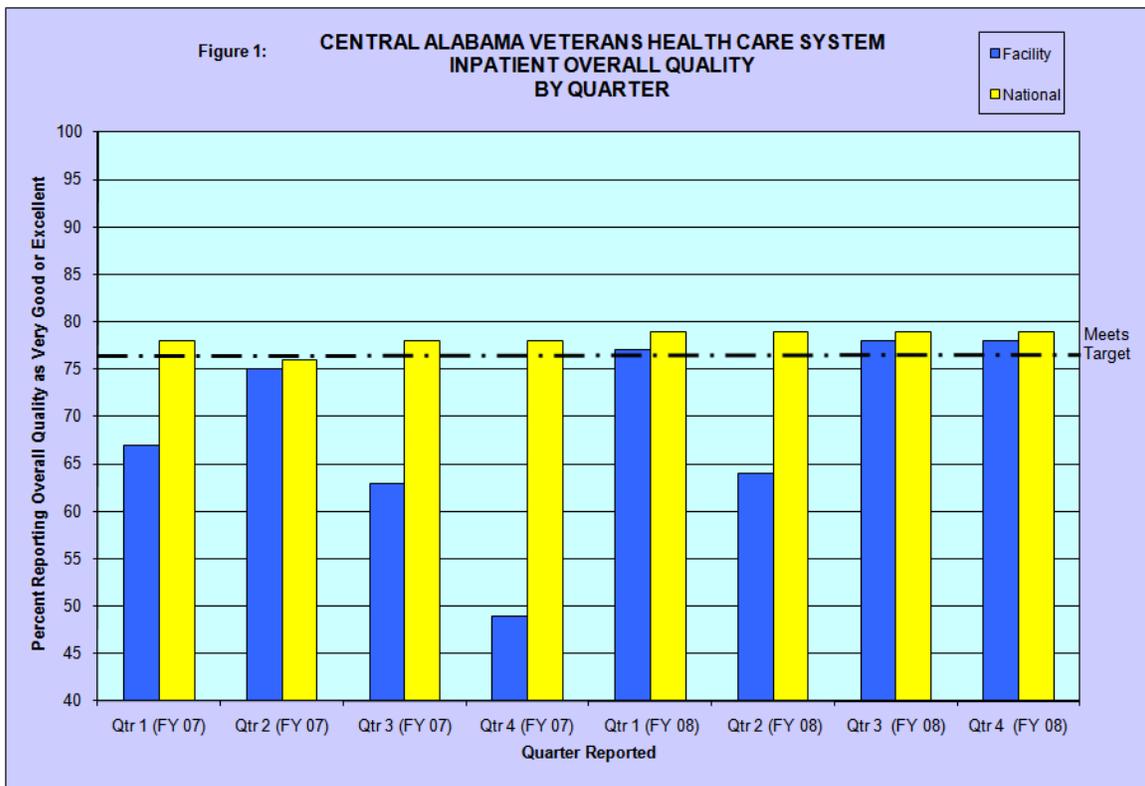
Patient Satisfaction

The Survey of Healthcare Experiences of Patients (SHEP) is aimed at capturing patient perceptions of care in 12 service areas, including access to care, coordination of care, and courtesy. VHA relies on the Office of Quality and

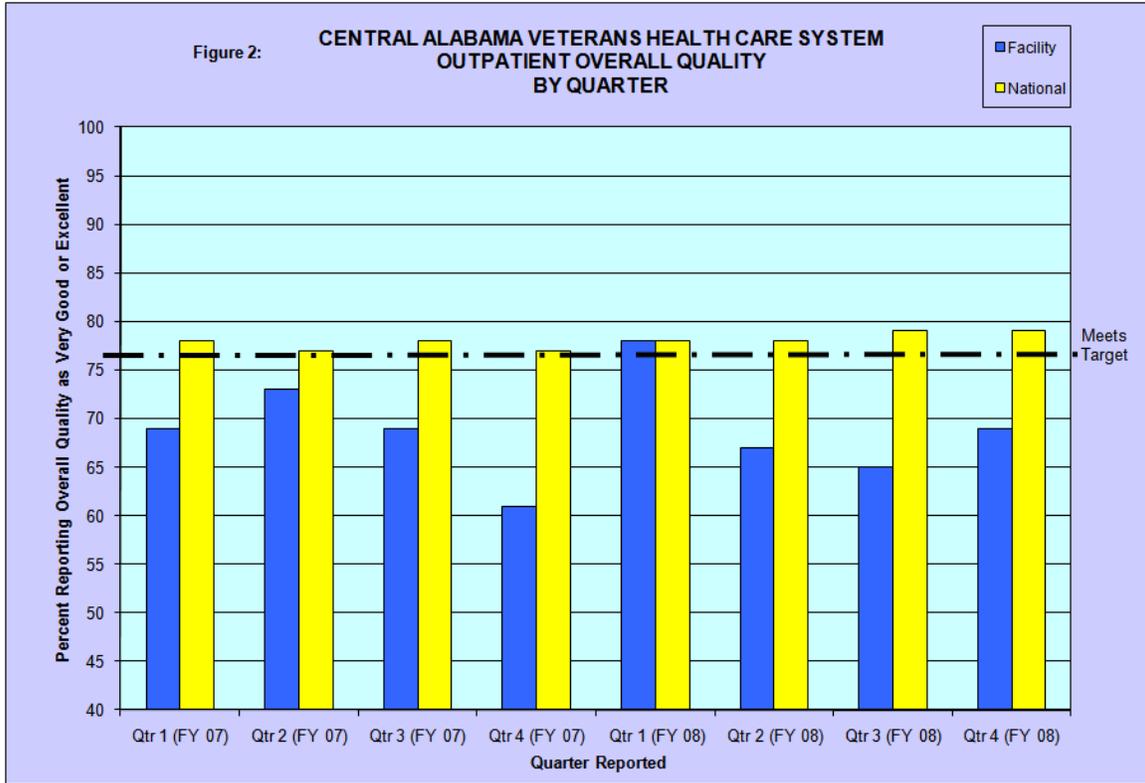
Performance’s analysis of the survey data to improve the quality of care delivered to patients.

The purpose of this review was to assess the extent that the system used SHEP data to improve patient care, treatment, and services. VHA’s Executive Career Field Performance Plan states that at least 76 percent of inpatients discharged during a specified date range and 77 percent of outpatients treated will report the overall quality of their experiences as “very good” or “excellent.” Facilities are expected to address areas in which they are underperforming.

The graphs below and on the next page show the system’s performance for FYs 2007 and 2008 in relation to national performance.⁵ Figure 1 shows the system’s SHEP performance measure (PM) results for inpatients. Figure 2 shows the system’s SHEP PM results for outpatients.



⁵ No VISN data was available for this time period.



The system did not meet the target for inpatient overall quality for 5 of the last 8 quarters of available data and did not meet the target for outpatient overall quality for 7 of the last 8 quarters of available data. While the overall scores are significantly below target, the system’s scores have steadily improved since FY 2003. Senior management is actively involved in oversight of customer service initiatives. The system is currently implementing a patient/family-centered care model that emphasizes partnerships and collaboration between health care providers, patients, and families. We made no recommendations.

Suicide Prevention Program

The purpose of this review was to determine whether the system had implemented a suicide prevention program that was in compliance with VHA regulations.⁶ We assessed whether senior managers had appointed Suicide Prevention Coordinators (SPCs) at the system and at any very large CBOCs,⁷ and we evaluated whether SPCs fulfilled all required functions. Also, we verified whether medical

⁶ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.

⁷ Very large CBOCs are defined as clinics with more than 10,000 unique patients enrolled.

records of patients determined to be at high risk for suicide contained Category II Patient Record Flags (PRFs),⁸ documented safety plans that addressed suicidality, and documented collaboration between MH providers and SPCs.

The system had appointed two SPCs to cover the two divisions but had no large CBOCs requiring an additional SPC. We interviewed both SPCs, and we reviewed pertinent policies and the medical records of 10 patients determined to be at risk for suicide. We found that senior managers had appropriately appointed the SPCs and that the SPCs fulfilled the required functions. We also found that all 10 records we reviewed contained PRFs and that 9 (90 percent) of the 10 contained suicide safety plans and documentation of collaboration between SPCs and MH providers. We made no recommendations.

⁸ A Category II PRF is an alert mechanism that is displayed prominently in medical records.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: July 31, 2009

From: Director, VA Southeast Network, (10N7)

Subject: **Combined Assessment Program Review of the Central Alabama Veterans Health Care System, Montgomery, Alabama**

To: Director, St. Petersburg Regional Office of Healthcare Inspections (54SP)
Director, Management Review Service (10B5)

I have reviewed and concur with the recommendations and responses from Central Alabama Veterans Health Care System (CAVHCS).

(original signed by)
Lawrence A. Biro

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: July 31, 2009

From: Central Alabama Veterans Health Care System Director
(619/00)

Subject: **Combined Assessment Program Review of the Central
Alabama Veterans Health Care System, Montgomery,
Alabama**

To: Director, VA Southeast Network, (10N7)

I concur with the findings/recommendations presented in the Central Alabama Veterans Health Care System (CAVHCS) OIG CAP review. Actions taken as a result of these findings are attached.

(original signed by)
Glen E. Struchtemeyer

Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the System Director requires that IC staff develop a comprehensive hand hygiene program which includes data collection and analysis for performance improvement and that results are consistently documented in ICC minutes.

Concur

A comprehensive hand hygiene program has been developed. Performance Improvement assisted the Infection Control Coordinator in developing a data collection tool. Our data process includes monitoring the usage of hand sanitizers (Purell) and soap mounted in dispensers for all clinical units. Purell is not monitored in Mental Health. Environmental Management Staff (EMS) monitors the volume of hand hygiene products being used in the facility (e.g., alcohol hand rubs and/or antimicrobial soap containers). This information is provided to the Infection Control Practitioner.

Health care workers adherence with the recommended hand hygiene practices is monitored on a monthly basis. Each service area records the number of Purell and soap units used per day per month on a standardized document. All services provide these documents to Infection Control as well. The information is entered and stored in an Excel spreadsheet. The Infection Control Practitioner tabulates these totals monthly for each unit. The usage of product for inpatient clinical areas is calculated by total grams (TG) divided by bed days of care (BDOC) times one thousand (TG/BDOC*1000). The outpatient areas are calculated based on the sum of total grams used. The spread sheet contains pre-calculated formulas to compute relevant statistics and generate graphs.

Trends and patterns noted are compared to the previous quarter. Since there was no baseline information, data collected from 2008 was compared against first and second quarter of 2009 as an initial step. Data has been collected for the first three quarters of Fiscal Year (FY) 09. The information resulting from the analyses is integrated into the Infection Control minutes. The errors noted in the January 2009 Infection Control minutes were corrected.

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires that the action plan and SOPs for use of personal panic alarms on the locked MHU are implemented and that staff compliance is monitored.

Concur

An action plan and Standard Operating Procedures (SOP) were developed during the OIG visit (May 6, 2009). On May 11, 2009, the SOP was implemented. To date, one hundred percent of staff have custody of a panic alarm while on duty. At the beginning of each shift, supervisors/charge nurses validate that each staff member has a panic alarm. Staff members are required to sign out the panic alarms at the beginning of each shift and return them at the end of the shift. Currently there are 15 panic alarms available on the unit which is sufficient to provide alarms to each staff member on duty. The Associate Chief Nurse and Nurse Manager monitor the use and effectiveness of the alarms daily. They evaluate panic debriefing documents and daily sign-out logs. Compliance is 100%.

Recommendation 3. We recommend that the VISN Director ensure that the System Director implements strategies for the prevention of LD.

Concur

A draft system policy was developed during the OIG visit. The policy has been implemented. On May 13, 2009, the water was tested at both sites with negative results. A risk assessment has been completed and forwarded to the Infection Control Committee. An oversight team consisting of the Risk Manager and Infection Control Coordinator has been appointed to ensure that the water is tested and analyzed in accordance with the local policy and VHA Directive.

Recommendation 4. We recommended that the VISN Director ensure that the System Director requires that all designated staff complete life support training and that compliance with certification requirements is monitored.

Concur

As of July 27, 2009, one hundred percent of Imaging, Nursing, and Respiratory staff have the required certifications. Each service has a system for monitoring compliance on an ongoing basis. CAVHCS' Risk Manager will conduct quarterly assessments to ensure certifications are current. Documentation is on file to support 100% compliance.

Recommendation 5. We recommended that the VISN Director ensure that the System Director requires compliance with medication reconciliation requirements.

Concur

CAVHCS has an existing policy that delineates the medication reconciliation process in detail for admissions, discharges, and transfers. In brief, our process is as follows: In the inpatient setting, the admitting provider reviews the CPRS medication list with the patient and/or caregiver as part of the admission evaluation document. Non-VA medications are documented in CPRS, and a record of these actions is placed in the admission note. Upon discharge, the provider will ensure that the outpatient medication profile reflects any changes made to the expected outpatient regimen.

A CPRS discharge note contains a list of pertinent changes made, and this information is sent as an alert to the patient's primary provider. The medication list is reviewed with the patient as well. The patient's medications are updated prior to being transferred, and a hard copy of this list is sent with the patient for the gaining physician or health care provider. In the outpatient setting, the nurse interviews the patient and determines the patient's medication regimen. All medications are documented in CPRS, and the clinician is informed of any changes from previous listed medications. The Patient Safety Manager is monitoring compliance on a quarterly basis.

The Chief of Staff continues to emphasize the requirement to conduct medication reconciliation in accordance with the policy with all providers. The process for medication reconciliation was reviewed with providers during medical staff meetings in May–June 2009. Additionally, the Chief of Staff sent a memorandum to all providers during the OIG visit. A Health Failure Mode Effect Analysis (HFMEA) will be conducted on the medication reconciliation process.

The HFMEA team will consist of a Pharmacist, Clinical informatics Coordinator, Inpatient Provider, Outpatient Provider, Inpatient Nurse, Outpatient Nurse, and a Performance Improvement Coordinator. The HFMEA report is anticipated to be completed prior to September 30, 2009. The Patient Safety Committee will monitor the compliance with medication reconciliation documentation.

Recommendation 6. We recommended that the VISN Director ensure that the System Director requires RCA actions to be implemented and corresponding outcome measures to be evaluated by the designated due date.

Concur

In May 2009, a new process was implemented to track and complete RCA actions. Individuals responsible for completing the actions are personally contacted concerning action items or desired outcome measures before and assignment is made. The intent of this strategy is to improve identification of realistic timeframes for completion of RCA actions and outcome measures. Their consultation has also assisted Patient Safety in assigning action appropriately.

Additionally, an Excel spreadsheet containing actionable items is sent to the responsible officials electronically. All action items are tracked to completion using the Network Action Tracking System (NATS). The process as well as its impact will be monitored monthly by the Patient Safety Committee. Since the initiation of this process, 36 actions and outcomes have been tracked for individual RCAs. Sixty-four percent (23/36) have been completed by the due date. Prior to this process, completion of actions and outcomes were exceeding the due date by as much as 180 days.

Recommendation 7. We recommended that the VISN Director ensure that the System Director requires that nurses document the effectiveness of PRN pain medications within the timeframe established by local policy.

Concur

In June 2009, Standard Operation Procedures were developed by the services and shared with staff. PRN effectiveness is monitored daily by the Nurse Managers. A PRN report is generated weekly by the Nurse Manager and monthly by the Bar Coding Medication Administration (BCMA) Coordinator and also shared with staff. Reports are submitted monthly to the Nursing Quality Council and quarterly to the Health System Council. Other methods to enhance the accuracy of administering pain medication have been implemented. They include the use of time clocks and hanging door signs.

Recommendation 8. We recommended that the VISN Director ensure that the System Director requires that nurses document a patient's understanding of his medication regimen education prior to beginning a self-medication program.

Concur

After an initial review, it was noted that the four records identified as not in compliance were completed by a Registered Nurse recently detailed to the Domiciliary. The nurse received education by the Nurse Manager on the need to ensure completeness of documentation. Results of the medical record review were shared with all staff at the May staff meeting. Monthly

reviews are conducted to ensure compliance with documentation of patient education. The compliance level for July 2009 is 100% based on a random review of 10 records (10/10).

Recommendation 9. We recommended that the VISN Director ensure that the System Director requires that inter-facility transfer documentation is completed, as required by VHA policy.

Concur

On May 5, 2009, the Chief of Staff sent a memorandum to all providers and nursing staff emphasizing the requirement to use the electronic interfacility transfer form. The Deputy Associate Director for Primary Care personally delivered the memorandum to the Emergency Room providers. The Health Information Management Section is monitoring the usage of the electronic template. The compliance level for July 2009 is 100% based on a random review of 32 records (32/32).

OIG Contact and Staff Acknowledgments

Contact	Christa Sisterhen, Director St. Petersburg Office of Healthcare Inspections (727) 395-2419
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Contributors	Deborah Howard, Team Leader David Griffith Alice Morales-Rullan Carol Torczon Susan Zarter Carl Scott, Office of Investigations
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