Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 07-00767-34

Combined Assessment Program Review of the Edward Hines, Jr. VA Hospital Hines, Illinois

December 7, 2007

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 September 17–21, 2007, the OIG conducted a Combined Assessment Program (CAP) review of the Edward Hines, Jr. VA Hospital (the hospital), Hines, IL. 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 254 hospital employees. The hospital is part of Veterans Integrated Service Network (VISN) 12.

Results of the Review

The CAP review covered seven operational activities and assessed compliance with recommendations made regarding the bulk oxygen utility system during the 2004 CAP review.

We identified the following organizational strength and reported accomplishment:

- The hospital established a "Neighborhood Watch" program that improved safety for patients and employees at a clinical care building.

We made recommendations in three of the activities reviewed. For these activities, hospital managers needed to:

- Review Computerized Patient Record System (CPRS) business rules regularly to ensure compliance with Veterans Health Administration (VHA) regulations.
- Ensure that unattended medication carts are locked.
- Correct infection control (IC) deficiencies.
- Continue to address identified safety risks on the Acute Psychiatry Unit.
- Ensure that principal investigators provide scopes of practice for appropriate research employees under their supervision.
- Ensure that the Associate Chief of Staff for Research and Development (ACOS/R&D) reviews and approves all research employees' scopes of practice.

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

- QM Program.
- Surgical Care Improvement Project (SCIP).
- Survey of Healthcare Experiences of Patients (SHEP).
- Tritium Management.

This report was prepared under the direction of Katherine Owens, MSN, Director, Boston Office of Healthcare Inspections.

Comments

The VISN and Hospital Directors agreed with CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 14–18, 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 hospital is a tertiary care facility located 12 miles west of downtown Chicago, IL. It provides a broad range of inpatient and outpatient health care services, including primary care at six community based outpatient clinics located in Manteno, Elgin, Oak Lawn, Aurora, LaSalle, and Joliet, IL. The system is part of VISN 12 and serves a veteran population of more than 370,000 from Cook, DuPage, and Will counties in Illinois.

Programs. The hospital offers acute medicine, surgery, primary care, extended care, and acute and outpatient psychiatry services. Its specialized clinical programs include blind rehabilitation, spinal cord injury, neurosurgery, radiation therapy, and cardiovascular care. The hospital also serves as the level II polytrauma center for VISN 12, and it is the VISN's southern tier hub for pathology, radiology, human resource management, and fiscal services.

Affiliations and Research. The hospital is affiliated with Loyola University's Stritch School of Medicine and also maintains an affiliation with the University of Illinois' College of Medicine at Chicago. Annually, the hospital educates more than 1,000 students, including medical, podiatry, and ophthalmology residents and multiple allied health professionals. The hospital has a diverse research program with approximately 550 projects and 160 investigators. It has an estimated budget of $19.5 million. Major areas of research are neuroscience and infectious diseases.

Resources. In fiscal year (FY) 2006, medical care expenditures totaled over $326 million. The FY 2007 medical care budget was over $389 million. FY 2007 staffing was more than 2,000 full-time employee equivalents (FTE), including 156 physician and 645 nursing FTE.

Workload. During FY 2006, the hospital treated more than 55,000 unique patients. In FY 2006, the hospital had 248 operating hospital beds with an average daily census of 187. It also had 199 operating Nursing Home Care Unit beds with an average daily census of 162. The outpatient workload totaled more than 536,000 visits.

Objectives and Scope

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

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

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

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

- CPRS Business Rules.
- Environment of Care (EOC).
- QM Program.
- Research – Unlicensed Physicians.
- SCIP.
- SHEP.
- Tritium Management.

The review covered hospital operations for FY 2006 and FY 2007 through June 30, 2007, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on recommendations regarding the bulk oxygen utility system from the prior CAP review (*Combined Assessment Program Review of the Edward Hines, Jr. VA Hospital, Hines, Illinois,* Report No. 04-02499-63, January 6, 2005).

During this review, we also presented fraud and integrity awareness briefings for 254 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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

Organizational Strength

"Neighborhood Watch" Program

In 2005, front-line employees began bringing safety concerns about a hospital clinical care building to senior managers' attention. Employee concerns centered on people loitering in the building's lobby and smoking in unauthorized areas. There were also concerns about thefts; a lack of police alarm buttons in the triage lobby area; and doors to the building being propped open, allowing anyone to enter unchallenged.

Employees established a committee that included members of the hospital's VA Police, mental health professionals, and Prevention and Management of Disruptive Behavior (PMDB) Program trainers. The committee's goal was to build a culture of safety by proactively addressing potentially unsafe conditions.

Trainers from the PMDB Program trained veterans from the Compensated Work Therapy Program as greeters and stationed them at the information desk in the building's lobby. Greeters ensured that people who entered the building had legitimate reasons for being there. Loitering and unauthorized smoking decreased, and the building's doors were no longer propped open. Additionally, managers placed police alarm buttons in the triage area, and they redesigned foot traffic patterns, which reduced the number of people accessing that area.

Since the inception of the program in this building, reporting of suspicious behavior to police has increased, and thefts have decreased. Employees communicate safety issues through a monthly newsletter. Managers told us that

because of the success of this program, they have plans to expand it to other clinical care buildings on campus.

Results

Review Activities With Recommendations

Computerized Patient Record System Business Rules

The health record, as defined in VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006, includes the electronic medical record and the paper record and is known as the legal health record. It includes items, such as physician orders, chart notes, examinations results, and test reports. Once notes are signed, they must be kept in unaltered form. New information, corrections, or different interpretations may be added as further entries to the record, as addenda to the original notes, or as new notes. New information must accurately reflect the date and time the information was added.

A communication (software informational patch[1] USR*1*26) was sent from the VHA Office of Information (OI) on October 20, 2004, to all medical facilities. The communication provided guidance on a number of issues relating to the editing of electronically signed documents in the electronic medical record system. The OI cautioned that, "…the practice of editing a document that was signed by the author might have a patient safety implication and should not be allowed." On June 7, 2006, VHA issued a memorandum to VISN Directors instructing VA medical facilities to comply with the informational patch sent in October 2004.

Business rules define the functions certain groups or individuals are allowed to perform in the medical record. OI recommended the institution of a VHA-wide software change that limits the ability to edit a signed medical record document to a facility's Privacy Officer.

We reviewed VHA and hospital information and technology policies and interviewed Information Resource Management Service staff. We identified two rules that managers needed to modify or delete. Managers deleted the two rules while we were onsite.

[1] A patch is a piece of code added to computer software in order to fix a problem.

Recommendation 1

We recommended that the VISN Director ensure that the Hospital Director requires that managers regularly review CPRS business rules to ensure compliance with VHA regulations.

The VISN and Hospital Directors agreed with the finding and recommendation. They reported that beginning in quarter 1 of FY 2008, managers implemented a process to have quarterly reviews of CPRS business rules by the CPRS Chart Compliance Committee, the Medical Record Committee, and the Medical Executive Committee (MEC). The first report to MEC is scheduled for its October meeting. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Environment of Care

VHA regulations require that health care facilities provide clean and safe environments in all patient care areas and establish comprehensive EOC programs that fully meet National Center for Patient Safety, Occupational Safety and Health Administration, and Joint Commission[2] standards.

We evaluated the IC program to determine compliance with VHA directives and to determine how managers used data to improve performance. We interviewed IC personnel, and we reviewed IC policies, the IC annual report, and employee illness and injury data. We also reviewed the management of patients with multi-drug resistant organisms. All IC policies and procedures were adequate, and procedures for managing patients with multi-drug resistant organisms were satisfactory.

We reviewed water supply data to ensure compliance with key aspects of VHA Directive 2006−007, *Ensuring the Security and Availability of Potable Water at VHA Facilities*, February 6, 2006. We sought to determine if the hospital maintained proof of contaminant testing of the municipal water supply. The hospital performed monthly contaminant testing, rotating sample sites, and provided our inspectors with test results. Additionally, managers provided documentation of results from municipal water tests.

[2] The Joint Commission was formerly the "Joint Commission on Accreditation of Healthcare Organizations," also known as JCAHO.

We assessed compliance with recommendations from the prior CAP review of the bulk oxygen utility system and found that managers had corrected identified deficiencies.

We inspected 16 patient care areas for cleanliness, safety, IC processes, and general maintenance. Nurse managers expressed satisfaction with the housekeeping staff assigned to their units, and the areas we inspected were generally clean and well maintained.

However, we identified conditions that required management attention, such as an unlocked and unattended medication cart; mold in a shower stall used by patients; and a pillow and a footboard with cracked plastic covers, which presented IC risks and needed to be removed from service. We also found cracked and missing tiles in a congregate shower room and a drain in a patient bathroom that was missing a cover and presented a tripping hazard. Managers repaired the drain and replaced the tiles while we were onsite.

Additionally, we identified potential safety hazards on the Acute Psychiatry Unit.

- Patient lockers had protruding eye hasps designed to attach auxiliary locks. The eye hasps were above waist level and could be used as points of attachment, presenting potential risk for suicide.
- Door handles in patient rooms were horizontal, and the handle shafts protruded sufficiently to be used as points of attachment.
- Pipes and plumbing traps under sinks in patient bathrooms were exposed.
- A bulletin board located in the patient day room was not securely attached to the wall.
- Doors to patient rooms and bathrooms were attached with standard hinges. These types of hinges can be used as points of attachment, creating potential risks for suicide. In a risk assessment performed in June 2007, managers identified these hinges as potential risks and were in the process of replacing them.

Recommendation 2 We recommended that the VISN Director ensure that the Hospital Director requires that unattended medication carts on patient units be locked.

The VISN and Hospital Directors agreed with the findings and recommendation. They reported that the clinical nurse manager and nursing staff on the unit with the unlocked medication cart were re-educated regarding the importance of medication security. Periodic checks for compliance will be done during EOC rounds, patient tracer activities, and patient safety rounds. Patient safety rounds are scheduled to begin in November 2007. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 3 We recommended that the VISN Director ensure that the Hospital Director requires that managers correct identified IC risks and ensure that all pillows and footboards are appropriate for patient use.

The VISN and Hospital Directors agreed with the findings and recommendation. They reported that Environmental Management Service (EMS) conducted a 100 percent check of all bed pillows on inpatient units, and nurse managers were instructed to also check their units. Defective pillows and the identified footboard were removed from service. Additionally, the Directors reported that a site survey of Building 217 (Extended Care Center) was conducted on October 4, 2007. Two of the three shower rooms were taken out of service for maintenance and are scheduled for renovation. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 4 We recommended that the VISN Director ensure that the Hospital Director requires that managers continue to address the identified safety concerns on the Acute Psychiatry Unit.

The VISN and Hospital Directors agreed with the findings and recommendation. They reported that locker doors with eye hasps have been removed and that door handles are scheduled for replacement. Additionally, covers for under sink pipes and plumbing traps have been ordered, and the target date for installation is November 16, 2007. The bulletin board in the patient day room was secured to the wall, and hinges on doors to patient rooms were replaced with appropriate hinges. Managers ordered additional hinges for the bathroom doors, and the target for completion of installation is November 2, 2007. The implementation

plans are acceptable, and we will follow up on the planned actions until they are completed.

Research – Unlicensed Physicians

The purpose of this review was to determine whether research activities performed by unlicensed physicians constituted the practice of medicine.

In order to practice medicine in the United States, medical school graduates are required to complete a United States residency program unless they receive an exemption. This requirement exists regardless of the skills, training, or experience of the graduates. Unexempted medical school graduates who do not complete a residency program are not eligible for licensure. If engaged in research activities, these individuals may function in roles such as study coordinators or research assistants, but they cannot practice medicine. Activities traditionally considered to constitute the practice of medicine include performing invasive procedures, conducting physical examinations, and altering medications.

VHA Handbook 1200.5, *Requirements for the Protection of Human Subjects in Research*, July 15, 2003, requires medical center Directors to ensure that Institutional Review Board members and investigators are appropriately knowledgeable to conduct research in accordance with ethical standards and all applicable regulations. As a result, unlicensed physicians must function under scopes of practice that specifically define the research activities that they may perform.

The hospital identified one unlicensed physician who was assigned to three human subjects research studies. We reviewed the unlicensed physician's scope of practice and 10 patient medical records from each study. We determined that the unlicensed physician's scope of practice was appropriate and that the activities performed by the unlicensed physician were within the scope of practice.

However, we found that the unlicensed physician, employed as a research health assistant since May 1999, did not have a scope of practice prior to July 2007. The 2003 VA guidance on verifying credentials of individuals involved in human subjects research, which is posted on the Office of Research and Development's website,[3] requires that principal investigators provide scopes of practice for

[3] http://www.research.va.gov/programs/pride/credentialing/guidance.cfm.

research staff under their supervision and that the ACOS/R&D approve the scopes of practice.

Recommendation 5 We recommended that the VISN Director ensure that the Hospital Director requires that principal investigators provide scopes of practice for appropriate research employees under their supervision.

The VISN and Hospital Directors agreed with the finding and recommendation. They reported that all individuals who met the requirement of the VA's 2003 guidance on verifying credentials of individuals involved in human subjects research have appropriate scopes of practice. Additionally, the scopes of practice will be reviewed annually to ensure that they are current and have been amended, as necessary. The implementation 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 Hospital Director requires that the ACOS/R&D review and approve research employees' scopes of practice.

The VISN and Hospital Directors agreed with the finding and recommendation. They reported that the principal investigators and the ACOS/R&D approved and signed the scopes of practice. The corrective action is acceptable, and we consider this recommendation closed.

Review Activities Without Recommendations

Quality Management Program

The purpose of this review was to evaluate whether the system had a comprehensive QM program designed to monitor patient care quality and whether senior managers actively supported the program's activities. We interviewed the hospital's Director, Chief of Staff, Nurse Executive, and the Coordinator of Performance Improvement (PI). We evaluated policies, PI data, and other relevant documents.

The hospital had an effective QM program, and senior managers actively supported the program through participation in QM activities and allocation of resources. Managers collected and analyzed data to identify patient care processes that needed improvement or strengthening. Clinical managers collected provider-specific data. However, each clinical service used different methodologies to collect and document data (for example, different forms), and we suggested that managers standardize their processes.

Managers agreed with the suggestion. We made no recommendations.

Surgical Care Improvement Project

The purpose of the review was to determine if clinical managers implemented strategies to prevent or reduce the incidence of surgical infections for patients having major surgical procedures. Surgical infections present significant patient safety risks and contribute to increased post-operative complications, mortality rates, and health care costs.

We reviewed the medical records of 30 patients who had surgery performed during quarter 3 of FY 2007. The review included medical records for each of the following surgical categories: (1) cardiac, (2) colorectal, (3) vascular, and (4) orthopedic (knee and hip replacement).

Inspectors evaluated the following VHA performance measure (PM) indicators:

- Timely administration of prophylactic antibiotics to achieve therapeutic serum and tissue antimicrobial drug levels throughout the operation. Clinicians should administer antibiotics within 1–2 hours prior to the first surgical incision. The time of administration depends on the antibiotics given.
- Timely discontinuation of prophylactic antibiotics to reduce risk of the development of antimicrobial resistant organisms. Clinicians should discontinue antibiotics within 24–48 hours after surgery. The time depends on the surgical procedure performed.
- Controlled blood glucose levels for cardiac surgery, which should be maintained below 200 milligrams/deciliter for the first 2 days post-operative. Elevated levels are associated with impaired bactericidal activity of the immune system.
- Controlled core body temperature for colorectal surgery, which should be maintained at greater than or equal to 36 degrees Centigrade or 96.8 degrees Fahrenheit immediately post-operative. Decreased core body temperature is associated with impaired wound healing.

VHA set target PM scores for each of the above indicators. To receive fully satisfactory ratings, a facility must achieve the scores summarized in the table on the next page.

Performance Measure	Target Score
Timely antibiotic administration	90 percent
Timely antibiotic discontinuation	87 percent
Controlled blood glucose 2 days post-operative – cardiac surgery	90 percent
Controlled body temperature – colorectal surgery	70 percent

Our review showed that the hospital appropriately administered and discontinued antibiotics or documented clinical reasons why this did not occur. Clinicians monitored blood glucose for the first 2 days post-operative for patients who had cardiac surgery performed. Clinicians controlled immediate post-operative body temperature for patients who had colorectal surgery performed. A summary of the overall findings is displayed in the table below.

Antibiotic given timely	Antibiotic stopped timely	Blood glucose control (cardiac surgery)	Body temperature control (colorectal surgery)
97 percent (29/30)	90 percent (27/30)	100 percent (9/9)	67 percent (2/3)

Additionally, we determined that clinical managers had developed and implemented appropriate action plans for PM scores falling below VHA established targets. These plans were monitored for efficacy, and the results were communicated throughout the organization. We made no recommendations.

Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that VHA medical facilities use quarterly or semi-annual SHEP results to improve patient care and services. The Performance Analysis Center for Excellence of the Office of Quality and Performance within VHA is the analytical, methodological, and reporting staff for SHEP. VHA set performance measure goals for patients reporting overall satisfaction of “very good” or “excellent” at 76 percent for inpatients and 77 percent for outpatients.

We reviewed the inpatient and outpatient survey results for quarters 3 and 4 of FY 2006, and quarters 1 and 2 of FY 2007. The hospital’s scores met or exceeded the target scores except for quarter 2 of FY 2007. A summary is displayed in the graphs on the next page.

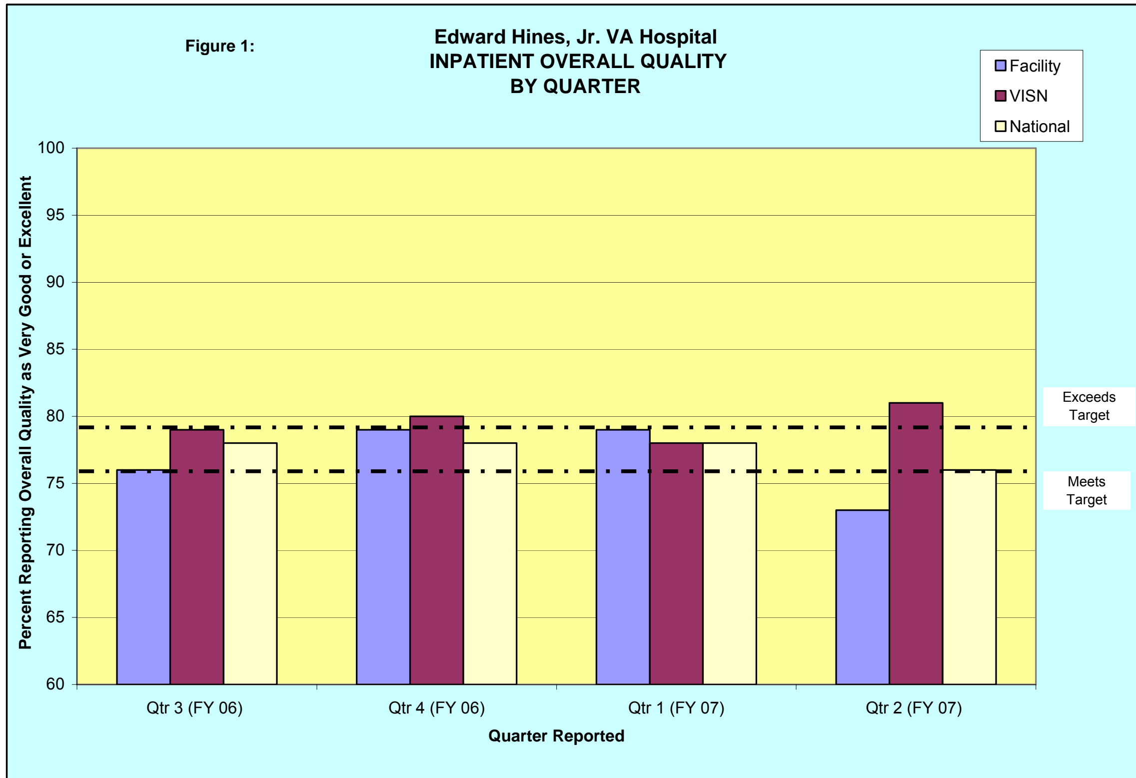


Figure 1:
Edward Hines, Jr. VA Hospital
INPATIENT OVERALL QUALITY
BY QUARTER
Facility
VISN
National
Percent Reporting Overall Quality as Very Good or Excellent
100
95
90
85
80
75
70
65
60
Exceeds Target
Meets Target
Qtr 3 (FY 06)
Qtr 4 (FY 06)
Qtr 1 (FY 07)
Qtr 2 (FY 07)
Quarter Reported

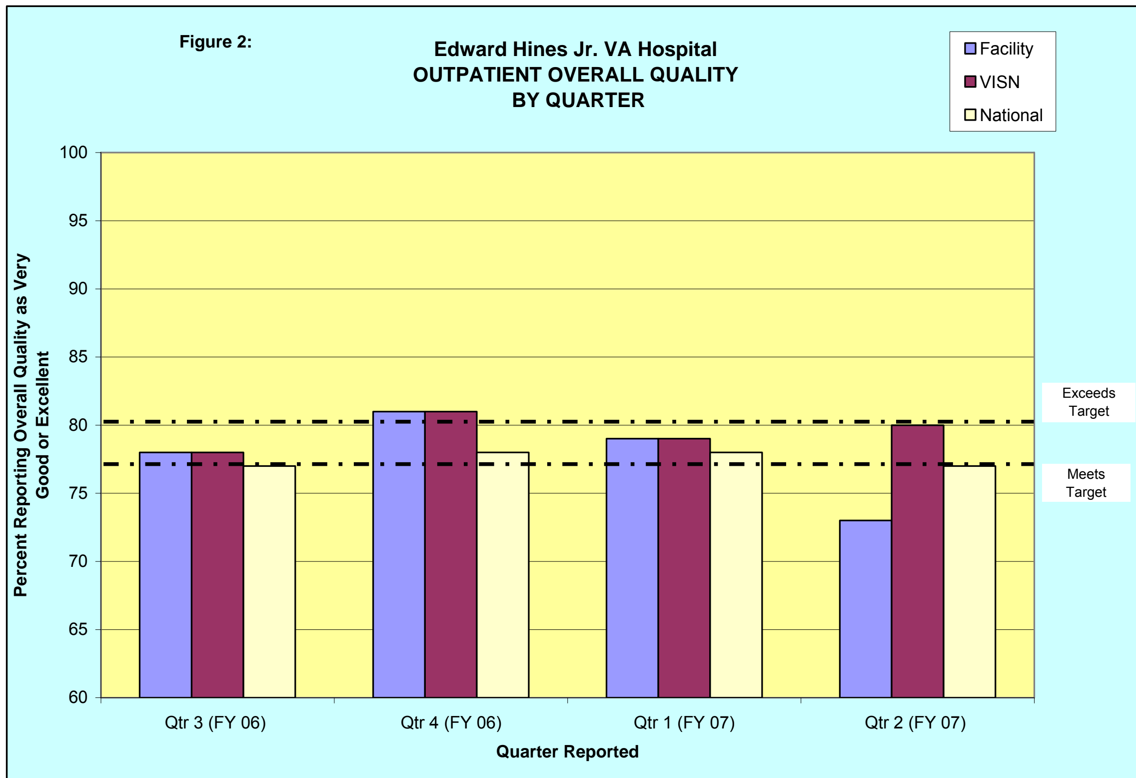


Figure 2:
Edward Hines Jr. VA Hospital
OUTPATIENT OVERALL QUALITY
BY QUARTER
Facility
VISN
National
Percent Reporting Overall Quality as Very Good or Excellent
100
95
90
85
80
75
70
65
60
Exceeds Target
Meets Target
Qtr 3 (FY 06)
Qtr 4 (FY 06)
Qtr 1 (FY 07)
Qtr 2 (FY 07)
Quarter Reported

Managers analyzed the scores, developed improvement strategies, and monitored the results of the strategies. We found the action plans acceptable, and we made no recommendations.

Tritium Management

The purpose of this review was to ensure that the hospital safely managed tritium, a radioactive compound used in research protocols. We reviewed radiation safety policies and practices to ensure that managers controlled the storage, use, and disposal of tritium in compliance with Nuclear Regulatory Commission Master Materials License No. 03-23853-01VA, VA's National Radiation Safety Committee guidance, and VHA Directive 1105.1, *Management of Radioactive Materials*, September 22, 2004.

We interviewed the Radiation Safety Officer and visited areas where tritium was located, such as laboratories and waste storage areas. We found that the management of tritium during procurement, storage, and waste was adequate. We made no recommendations.

Appendix A

VISN Director Comments

Department of
Veterans Affairs **Memorandum**

Date: October 15, 2007

From: Network Director, VA Great Lakes Health Care System (10N12)

Subject: Combined Assessment Program Review of the Edward Hines, Jr. VA Hospital, Hines, Illinois

To: Director Boston Healthcare Inspections Division (54BN)

Thru: Director, Management Review Office (10B5)

1. Please find the Hines VA Hospital's response to the attached CAP report.

2. I have reviewed and concur with the Facility Director's responses.

for
James W. Roseborough

Appendix B

Hospital Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 12, 2007

From: Director, Edward Hines, Jr. VA Hospital (578/00)

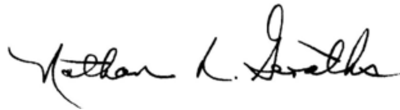
Subject: Combined Assessment Program Review of the Edward Hines, Jr. VA Hospital, Hines Illinois

To: Director Boston Healthcare Inspections Division (54BN)

Director, Management Review Office (10B5)

1. This is to acknowledge receipt and thorough review of the findings and recommendations of the Office of the Inspector General Combined Assessment Program review conducted September 17–20, 2007. Hines VAH concurs with the IG findings and the recommendations and appreciates the opportunity to review the draft report. Actions taken are included in our response, and we request that these items be closed.

2. We want to thank all of the people involved in the CAP review. The team members required us to take a critical look at our systems and processes, and we do appreciate the very thorough review and the opportunity to further improve the quality care we provide for our veterans.



Nathan L. Geraths
Director

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 Hospital Director requires that managers regularly review CPRS business rules to ensure compliance with VHA regulations.

Concur

A process has been implemented to have a quarterly review of the CPRS business rules by the CPRS Chart Compliance Committee, the Medical Record Committee to whom it reports, and the Medical Executive Committee (MEC) that provides oversight for the Medical Records Committee. This has been implemented for FY 08-Q1, with the first report scheduled for the October MEC meeting.

Recommendation 2. We recommended that the VISN Director ensure that the Hospital Director requires that unattended medication carts on patient units be locked.

Concur

The clinical nurse manager and the staff on the unit with the unlocked medication cart were counseled, and staff have been re-educated regarding the importance of medication security and the need to ensure that medication carts remain locked when not in use. Periodic checks will continue to be done during Environment of Care Rounds, ongoing patient tracer activities, and unannounced Patient Safety Rounds that are being implemented in November 2007.

Recommendation 3. We recommended that the VISN Director ensure that the Hospital Director requires that managers correct identified IC risks and ensure that all pillows and footboards are appropriate for patient use.

Concur

Environmental Management Service (EMS) conducted a 100 percent sweep review of patient bed pillows on all inpatient units. In addition, a message was sent to the clinical nurse managers to check the units for any instances that might have been missed by EMS staff when a patient was sitting or sleeping at the time of the review, and all pillows with

cracked plastic coverings have been removed from service. The foam footboard with a cracked plastic cover was removed, and no additional instances were identified.

A site survey of Building 217 was conducted October 4, 2007. Two of the three shower areas within the larger shower room have been taken out of service. The Environmental Management Service staff has thoroughly cleaned the shower rooms and the Facilities Management Service (FMS) staff have completed chalking/grouting of tile joints to address the immediate concerns. In order to address the root cause of the problems and provide long term resolution, Project 578-07-002 to remodel Bldg 217, Floor 1C, which has already been awarded, has been modified to include 2C. The A/E Design is not expected to take more than 6 weeks, and projected construction is 90–120 days. Prior to the start of the project, the larger tub area will be converted to a shower area so phasing can occur and patients and staff will not be inconvenienced during the remodeling. Once this renovation has been completed, the floors will undergo a Sani-glaze treatment to improve the overall appearance and make ongoing maintenance easier.

Recommendation 4. We recommended that the VISN Director ensure that the Hospital Director requires that managers continue to address the identified safety concerns on the Acute Psychiatry Unit.

Concur

Three of the five items identified during the June risk assessment referenced during the OIG visit have either been completed or resolved. The remaining items are the door hinges and the furniture. The furniture is classified as high risk; however, it is still pending completion of the evaluation. The Interior Designer has been actively researching available options, and we have been in contact with the National Center for Patient Safety regarding potential sources. As soon as a vendor is identified, a purchase order will be generated as funding has been set aside for this purpose. The target date for entry of the purchase order is November 30, 2007. The hinges on the doors to the patient rooms have been replaced with appropriate hinges. With the recent decision not to remove the doors to the bathrooms, additional hinges have been ordered so that the hinges on the bathroom doors can also be replaced. The target date for completion of the installation of the remaining hinges is November 2, 2007

Each of the potential safety hazards identified on the Acute Psych Unit has been addressed. The doors (with the protruding eye hasps) on the patient lockers have been removed. The Interior Designer is actively working with staff to assess future needs as part of the overall furniture replacement project. The door handles are scheduled for replacement;

however, guidance has been sought from the National Center for Patient Safety to identify a product that would be acceptable that takes into consideration the usability in an older patient population. The VISN will make funding available for acquisition as soon as a product is identified. Covers for the under sink pipes and plumbing traps have been ordered and will be installed upon receipt. The target date for completion of the installation is November 16, 2007. The bulletin board in the patient day room has been secured to the wall.

Reassessments will be conducted on a quarterly basis and updates submitted to the VISN Safety Officer.

Recommendation 5. We recommended that the VISN Director ensure that the Hospital Director requires that principal investigators provide scopes of practice for appropriate research employees under their supervision.

Concur

The 2003 guidance on verifying the credentials of all Individuals involved in human subjects research, available on the VA Research & Development website, has been reviewed. All individuals have scopes of practice that meet the requirements, i.e., including signatures of the principal investigators and the ACOS for Research. These will be reviewed on an annual basis to ensure that all are current and have been amended, as necessary, to reflect any changes in the research coordinator's duties/responsibilities, utilization guidelines, and/or hospital policies. Certification of this review will be included in the Annual Evaluation submitted to Senior Leadership by November 30 of each year.

Recommendation 6. We recommended that the VISN Director ensure that the Hospital Director requires that the ACOS/R&D review and approve research employees' scopes of practice.

Concur

See response to Recommendation 5.

OIG Contact and Staff Acknowledgments

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House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
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Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
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U.S. House of Representatives: Danny K. Davis

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