



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

Office of Healthcare Inspections

Report No. 07-02946-55

Combined Assessment Program Review of the VA Greater Los Angeles Healthcare System Los Angeles, California



January 9, 2008

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 24–28, 2007, the OIG conducted a Combined Assessment Program (CAP) review of the VA Greater Los Angeles Healthcare System (the VAGLAHS). The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). Within the month following the review, we also provided fraud and integrity awareness training to 355 employees. The VAGLAHS is part of Veterans Integrated Service Network (VISN) 22.

Results of the Review

The CAP review covered six operational activities. We identified the following organizational strengths and reported accomplishments:

- The Patient Safety Assessment Team (PSAT) provided timely identification and assessment of serious patient incidents.
- Evidence-based practice initiatives improved nursing compliance and patient health.
- Ventilator-associated pneumonia (VAP) cases decreased as a result of several clinical initiatives.

We made recommendations in four of the activities reviewed. For these activities, the VAGLAHS needed to:

- Comply with the Veterans Health Administration's (VHA's) peer review directive regarding timeliness, trend analyses, and quarterly reports to the Medical Executive Committee (MEC).
- Comply with VHA's patient safety handbook regarding timeliness of root cause analysis (RCA) completion and corrective action implementation.
- Comply with VHA's utilization management (UM) policy, specifically regarding continued stay reviews.
- Develop plans for continuous review of provider-specific QM/performance improvement (PI) results and maintain provider profiles that demonstrate that the plans are being followed.
- Develop a plan to address identified vulnerabilities in the drinking water system.

- Aggressively monitor and address breeches in maintaining patient privacy and confidentiality.
- Establish a comprehensive strategy to assess, prioritize, and correct environmental deficiencies in patient safety; infection control (IC); storage and security of medications, supplies, and equipment; and general maintenance and repair of equipment.
- Conduct a comprehensive review of electronic health records business rules, delete inappropriate rules, and ensure local policy compliance with VHA policy.
- Meet current requirements regarding education verification for all facility staff engaged in research activities.
- Meet current requirements for scopes of practice of unlicensed physicians.

The VAGLAHS complied with selected standards in the following two activities:

- Surgical Care Improvement Project (SCIP).
- Patient Satisfaction Survey Scores.

This report was prepared under the direction of Julie Watrous, Director, Los Angeles Office of Healthcare Inspections.

Comments

The VISN and VAGLAHS Directors concurred with the findings and recommendations and submitted acceptable action plans. (See Appendixes A and B, pages 16–23, 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 VAGLAHS is a multi-facility organization located in Los Angeles, CA, that provides a broad range of inpatient and outpatient health care services. Patient care is provided at the West Los Angeles (WLA), Sepulveda, and downtown Los Angeles campuses and at 10 community based outpatient clinics in Bakersfield, East Los Angeles, Gardena, Lancaster, Lynwood, Pasadena, Oxnard, San Luis Obispo, Santa Barbara, and Santa Maria, CA. The VAGLAHS is part of VISN 22 and serves a veteran population of about 625,000 throughout Kern, Los Angeles, San Luis Obispo, Santa Barbara, and Ventura counties in California.

Programs. The VAGLAHS provides tertiary, primary, and long-term care services in areas that include medicine, surgery, mental health, and geriatrics. It has 328 hospital beds and 296 nursing home beds.

Affiliations and Research. The VAGLAHS is affiliated with the University of California at Los Angeles' David Geffen School of Medicine and with the University of Southern California's Keck School of Medicine and provides training for 309 residents, as well as other disciplines, including nursing, podiatry, and dentistry. In fiscal year (FY) 2006, the research program had 770 projects and a budget of \$38 million. Important areas of research include Parkinson's disease, cancer, and digestive diseases.

Resources. In FY 2006, VAGLAHS expenditures totaled more than \$589.7 million. The FY 2007 medical care budget was \$507 million. FY 2006 staffing was 3,500 full-time employee equivalents (FTE), including 282 physician and 1,097 nursing FTE.

Workload. In FY 2006, the VAGLAHS treated 78,366 unique patients and provided 77,157 inpatient days in the hospital and 46,067 inpatient days in the Nursing Home Care Unit (NHCU). The inpatient care workload totaled 7,072 discharges, and the average daily census, including nursing home patients, was 338. Outpatient workload totaled 929,554 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 six activities:

- Electronic Health Records Business Rules.
- Environment of Care (EOC).
- Patient Satisfaction Survey Scores.
- QM.
- Scope of Practice – Research Personnel.
- SCIP.

The review covered VAGLAHS operations for FY 2006 and FY 2007 through September 24, 2007, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review (*Combined Assessment Program Review of the VA Greater Los Angeles Healthcare System*, Report No. 03-01948-018, November 10, 2003). In the Community Residential Care (CRC) Program review, we had identified six program areas that needed improvement. We followed up during this review and found sufficient evidence that program managers and staff provided appropriate

administrative and clinical oversight of the 198 patients in the CRC Program. All action plans have been implemented, and we consider the issue closed.

We also followed up on recommendations from a report by VHA's Office of the Medical Inspector (OMI) (*Final Report: Site Visit to the Greater Los Angeles Veterans Affairs Medical Center*, May 10, 2007). In that report, the OMI recommended that the VAGLAHS review a veteran's care: (a) on the inpatient psychiatric unit, (b) in the emergency department, (c) on the medical intensive care unit, and (d) in the domiciliary. In addition, the OMI recommended that the VAGLAHS determine if the veteran's self-medication was properly monitored and revise the Self-Medication Program to conform to VHA regulations. The OMI also recommended policy revisions to ensure that serum toxicology samples are obtained from patients with suspected drug overdoses.

We reviewed documentation of the follow-up items and found evidence that the VAGLAHS responded properly to the self-medication and serum toxicology recommendations. We consider these recommendations closed. The four peer reviews had been initiated but were still in progress at the time of our site visit; therefore, these recommendations will remain open and will require additional follow-up.

Within the month following this review, we also presented fraud and integrity awareness briefings for 355 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 Strengths

Patient Safety Assessment Team

In order to better identify and address potential quality of care issues, VAGLAHS management initiated the PSAT. The PSAT determines the nature and severity of patient incidents and makes a preliminary assessment of the actions needed. As a result, incidents affecting patient care are reviewed by experienced clinicians. When RCAs are

completed, senior managers attend a presentation of the report and discuss the recommendations. The PSAT then tracks the completion of these recommendations.

Evidence-Based Nursing Practice

The VAGLAHS was able to enhance the existing nursing research program by focusing on evidence-based practice through several new strategies, including nursing research mentorship, a journal club, and quarterly fact sheets. Recent efforts in pain management, heart failure, and hypertension have resulted in measurable improvements in both compliance and patient health.

Ventilator-Associated Pneumonia

In 2005, the VAGLAHS initiated a project to reduce VAP cases. Clinicians began performing the following actions for all high-risk patients: (a) elevating the head of the bed, (b) preventing peptic ulcers and deep vein thromboses, and (c) providing “vacations” from daily sedation. As a result of these actions, the number of VAP cases decreased from nine in 2005 to two in 2007.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the VAGLAHS’s QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program’s activities. We interviewed the Director, Chief of Staff, Chief Nurse Executive, Chief of QM, several other service chiefs, and QM personnel. We evaluated plans, policies, and other relevant documents.

The QM program was generally effective in providing oversight of the quality of care. Appropriate review structures were in place for 10 of the 14 program activities reviewed. However, we identified four areas that needed improvement.

Peer Review. A process for performing peer reviews and discussing the results in a committee had been in place for the past 12 months. However, reviews were not accomplished within the required timeframes, results were not fully analyzed for trends, and quarterly reports were not consistently presented to the MEC, as required.

Recommendation 1

We recommended that the VISN Director ensure that the VAGLAHS Director requires compliance with VHA’s peer

review directive, specifically regarding timeliness, trend analyses, and quarterly reports to the MEC.

The VISN and VAGLAHS Directors concurred with the findings and recommendation. The Chair of the Peer Review Committee and the Associate Chief of Staff for Quality and PI (ACOS/QPI) have implemented actions to enhance compliance with the VHA directive, which include developing a tracking system and a timeliness monitor. Target date for completion is April 1, 2008. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Patient Safety. VHA requires that clinicians review serious adverse events and take actions to correct identified problems. In the 15-month period April 2006–June 2007, the VAGLAHS initiated 17 RCAs. However, staff completed only one RCA within the required timeframe of 45 days. In addition, corrective action plans that had been approved by the VAGLAHS Director had not been fully implemented in reasonable timeframes. For example, two tasks (revising a policy and creating a template progress note) assigned more than 12 months earlier were still incomplete. Patient safety reviews and action items needed to be a higher priority for all VAGLAHS managers.

Recommendation 2

We recommended that the VISN Director ensure that the VAGLAHS Director requires compliance with VHA's patient safety handbook, specifically regarding the timeliness of RCA completion and corrective action implementation.

The VISN and VAGLAHS Directors concurred with the findings and recommendation. The ACOS/QPI and the Chief of QM have implemented actions, which include defining milestones for various parts of the RCA process and providing support and direction when timelines are lagging. For RCAs that involve more complex processes, the team will schedule an extended meeting to assure efficient use of team time. The target completion date is April 1, 2008. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Utilization Management. Admission reviews were performed on all acute care units, but continued stay reviews were performed only on acute mental health units. VHA's UM

directive requires that at least 20 percent of continued stay days be reviewed throughout all acute care units.

Recommendation 3

We recommended that the VISN Director ensure that the VAGLAHS Director requires compliance with VHA's UM directive, specifically regarding continued stay reviews.

The VISN and VAGLAHS Directors concurred with the finding and recommendation. The UM Coordinator is in the process of assigning 20 percent of the continued stay reviews. Target date for completion is April 1, 2008. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Provider Profiles. As of January 1, 2007, accreditation standards require that clinical managers continuously review QM and PI data and results for all privileged providers. We did not find any evidence that clinical service chiefs had developed plans that define the provider-specific QM/PI results that will be reviewed or the frequency of review.

Recommendation 4

We recommended that the VISN Director ensure that the VAGLAHS Director requires clinical service chiefs to develop plans for continuous review of provider-specific QM/PI results and to maintain provider profiles that demonstrate that the plans are being followed.

The VISN and VAGLAHS Directors concurred with the findings and recommendation. The MEC will develop and implement plans for continuous review of provider-specific QM/PI results that include designated intervals for documented review and definitions of the QM/PI data to be reviewed. The target completion date is April 1, 2008. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Environment of Care

The purpose of this review was to determine if the VAGLAHS complied with selected standards related to (a) the potable water system, (b) patient privacy and confidentiality, (c) IC and a safe and clean patient care environment, and (d) radiation safety (RS).

We requested a list of all active patient care areas at the three main VAGLAHS campuses and inspected all areas on the list, including inpatient medicine, surgery, and behavioral health units; primary care and specialty care outpatient

clinics; NHCUs; and domiciliary beds. Overall, the VAGLAHS had established a comprehensive EOC program with internal systems and processes in place to identify and address deficiencies and opportunities for improvement. The size and complexity of the VAGLAHS and the age of the buildings contribute to the challenge of sustaining a well-maintained and safe environment. We identified the following areas that needed management attention:

Potable Water Systems. In 2007, managers hired a consulting group to conduct a study of the potential vulnerabilities of the potable water systems, as required by VHA directives. The consultants identified vulnerabilities that needed attention at the WLA campus, the Sepulveda Ambulatory Care Center (SACC), the nursing home on the Sepulveda campus, and the Los Angeles Ambulatory Care Center (LAACC). Several of the vulnerabilities identified in the study required immediate or high priority actions.

Recommendation 5

We recommended that the VISN Director ensure that the VAGLAHS Director develops a plan to address identified vulnerabilities in the potable water systems.

The VISN and VAGLAHCS Directors concurred with the finding and recommendation. A comprehensive water sampling plan derived from the water vulnerability study will be completed by the end of January 2008. The Emergency Management Committee will develop a procedure for water rationing in the event of a disaster; completion is targeted for February 2008. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Patient Privacy and Confidentiality. In the acute, mental health, and outpatient/emergency room patient care areas, we discovered several unattended computer monitors displaying patient information. This information was accessible to other patients and visitors. In addition, we observed a lack of auditory privacy at the SACC pharmacy where patients' full names and partial social security numbers were verified in the presence of others in the waiting area. We also found unsecured radiology films in an unlocked reading room at the WLA campus (Building 500).

Recommendation 6

We recommended that the VISN Director ensure that the VAGLAHS Director requires managers to more aggressively

address breaches to maintain patient privacy and confidentiality.

The VISN and VAGLAHS Directors concurred with the findings and recommendation. The system at the SACC pharmacy has been altered, and patients' partial social security numbers are no longer announced (verification takes place at the pharmacy window). The radiology films were secured, and a storage system for the films is being developed. The target date for completion is January 31, 2008. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Infection Control and Patient Safety. IC practitioners monitored exposures and infections appropriately. Policies and procedures for managing patients with multi-drug resistant organisms were satisfactory. However, we identified several practice issues related to IC and patient safety. The VAGLAHS had implemented several initiatives to improve hand washing compliance. However, in multiple patient care areas, we observed that staff did not wash or disinfect their hands before and/or after patient contact. We noted noncompliance by both physicians and nurses.

In the Urology Clinic at the WLA campus, we found that clean and dirty utility items were not separately confined, as required. In several WLA clinical areas, including the medical intensive care unit, we observed small gnat-like insects in the bathrooms and patient care areas. Managers told us that an on-going pest control program is in place to control flying pests. On one WLA inpatient locked mental health unit (2S), the ceiling in the new patient/visitor room was lower than the ceiling in the rest of the unit. The ceiling needed to be raised to minimize suicide risk and deter contraband concealment. The WLA acute medical/surgical inpatient wards have significantly limited storage space. Consequently, the corridors were obstructed and did not allow for safe egress.

The food preparation area in the Day Treatment Clinic at the LAACC needed significant attention. Patients are provided food preparation training and are supervised by staff. However, we identified multiple concerns related to food storage, kitchen cleanliness, and equipment maintenance.

General Maintenance and Repair. We found multiple inpatient wards with unsecured medication carts, supply

carts (Omnicell), and clean and dirty utility rooms. Generally, the compromised security was related to the improper functioning of the electronic or manual locking mechanisms. In fact, staff were often unaware that the locks were not working properly, as evidenced by their use of access codes or keys.

We noted other equipment and environmental maintenance concerns, including broken blood pressure monitoring machines, bar code medication administration scanners with fully discharged batteries, and damaged walls. Most of these concerns had already been reported through facility work orders and internal environmental inspections. Managers assured us that these deficiencies were being corrected as resources and budget permitted.

Recommendation 7

We recommended that the VISN Director ensure that the VAGLAHS Director establishes a comprehensive and systematic strategy to assess, prioritize, and correct environmental deficiencies in patient safety; IC; storage and security of medications, supplies, and equipment; and general maintenance and repair of equipment.

The VISN and VAGLAHS Directors concurred with the findings and recommendation. Actions taken include developing a plan to renovate the Urology Clinic, implementing an aggressive eradication program for the flying insects, instituting regular monitoring rounds at the LAACC Day Treatment Clinic, replacing the lowered ceiling, and ordering new medication carts. Target dates vary, but the longest estimated completion date is June 30, 2008, which is for the Urology Clinic renovation. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Radiation Safety – Tritium Management. RS staff provided sufficient oversight of the RS program. The use, storage, and disposal of tritium (a radioactive material) appeared to comply with VA policy. However, the RS policy needed to be updated to address RS practices for the entire VAGLAHS. Program managers have started developing a comprehensive policy. Therefore, we did not make a recommendation in this area of EOC.

Electronic Health Records Business Rules

The purpose of this review was to determine whether business rules governing the patient health record (electronic and paper) complied with VHA policy. The health record includes entries, such as physician orders, progress notes, and test reports. Once entries are signed, they must be maintained in unaltered form. New information or corrections may be added to the record as addenda to the original notes or as new notes. Business rules define what functions certain groups or individuals are allowed to perform in the health record.

In October 2004, VHA's Office of Information (OI) provided guidance that advised VHA facility managers to review their business rules and delete any rules that allowed editing of signed medical records. OI also recommended that the ability to edit signed records be limited to the facility's Privacy Officer. On June 7, 2006, VHA instructed all facilities to comply with the OI guidance.

We reviewed VHA and local policies and examined more than 450 business rules. The VAGLAHS had no business rules that allowed alteration of a signed note by individuals other than the Health Information Management Service (HIMS) Chief. However, we identified three rules that allowed individuals other than the Chief of HIMS to reassign notes, and the local policy did not delineate reassignment authority to these individuals. Reassignment is an option used when the correct data is entered for the wrong patient. VHA policy requires the Chief of HIMS or the Privacy Officer to approve reassignment of completed documents. In addition, the VAGLAHS had no written procedures for correcting erroneous patient information.

Recommendation 8

We recommended that the VISN Director ensure that the VAGLAHS Director requires responsible program managers to conduct a comprehensive review of business rules, delete inappropriate rules, and ensure local policy compliance with VHA policy.

The VISN and VAGLAHS Directors concurred with the findings and recommendation. A draft policy has been written, and the target date for completion is January 31, 2008. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

**Scope of Practice –
Research
Personnel**

The purpose of this review was to determine whether practices related to unlicensed physicians working in human subjects research were in compliance with applicable regulations.

VHA requires that Institutional Review Board members and investigators conduct research in accordance with ethical standards and all applicable regulations. As a result, unlicensed physicians operate under a scope of practice. “Scope of practice” is a term used to describe activities that may be performed by health care workers, regardless of whether they are licensed independent health care providers.

The Principal Investigator (PI) on a research project must provide a scope of practice for each research staff member under their supervision. The scope of practice is granted and signed by the PI and approved by the Associate Chief of Staff for Research and Development (ACOS/R&D).

In 2003, VHA’s Office of Research and Development provided guidance in regards to verifying the credentials of all individuals involved in human subjects research.¹ Similarly, all education that leads to a degree or certification and any education or training that is relevant to the activities performed by the employee (such as survey methods and interview skills) must be documented and verified.

The VAGLAHS identified seven unlicensed physicians assigned to 16 human subjects research studies. We reviewed the relevant scopes of practice and 141 medical records of patients involved in the 16 studies. We determined that the unlicensed physicians operated within their scopes of practice. However, we found that the education of four of the seven unlicensed physicians was not verified, as required. Also, we identified the following problems related to the scopes of practice:

- The scopes of practice for three unlicensed physicians inappropriately included initiating and administering intravenous (IV) solutions and medications.

¹ <http://www.research.va.gov/programs/pride/credentialing/guidance.cfm>.

- The scopes of practice for two unlicensed physicians included venipuncture; however, they did not have the appropriate training/certification documented.
- Two scopes of practice were not signed by the ACOS/R&D, and one scope of practice was not signed by the unlicensed physician.
- One unlicensed physician did not have a scope of practice. Staff told us that this unlicensed physician was a PI in a study; therefore, a scope of practice was not deemed necessary. However, because this unlicensed physician was also a participant in two other studies, he was required to work within defined scopes of practice for those two studies.

Recommendation 9 We recommended that the VISN Director ensure that the VAGLAHS Director requires that the ACOS/R&D meet current requirements regarding education verification for all staff engaged in research activities.

Recommendation 10 We recommended that the VISN Director ensure that the VAGLAHS Director requires that the ACOS/R&D meet current requirements for scopes of practice of unlicensed physicians and that the scopes of practice for all staff engaged in research activities are properly reviewed and approved.

The VISN and VAGLAHS Directors concurred with the findings and recommendations. The ACOS/R&D has implemented a full review of personnel files to verify documentation of education and training for all research employees and has revised the scope of practice forms to correct the identified problems. Target date for completion is April 1, 2008. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Review Activities Without Recommendations

Surgical Care Improvement Project

The purpose of this review was to determine if clinical managers implemented strategies to prevent or reduce the incidence of 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 evaluated the following VHA performance measures for FY 2006 and the 1st and 2nd quarters of FY 2007:

- Administration of prophylactic antibiotics within 1–2 hours prior to the first surgical incision. The VHA target score was 90 percent.
- Discontinuation of prophylactic antibiotics within 24–48 hours after surgery. The VHA target score was 87 percent.
- Control blood glucose levels for cardiac surgery below 200 milligrams/deciliter for the first 2 days post-operative. The VHA target score was 90 percent.
- Control core body temperature for colorectal surgery at greater than or equal to 96.8 degrees Fahrenheit in the immediate post-operative period. The VHA target score was 70 percent.

The VAGLAHS did not meet the established target score for the discontinuation of prophylactic antibiotics. To improve performance, the Chief of Surgery had initiated an action plan to ensure that antibiotics are discontinued according to established timeframes.

We examined the medical records of 30 patients who had cardiac, colorectal, vascular, or orthopedic surgeries performed during the first 2 quarters of FY 2007. The results of our review are displayed in the table below.

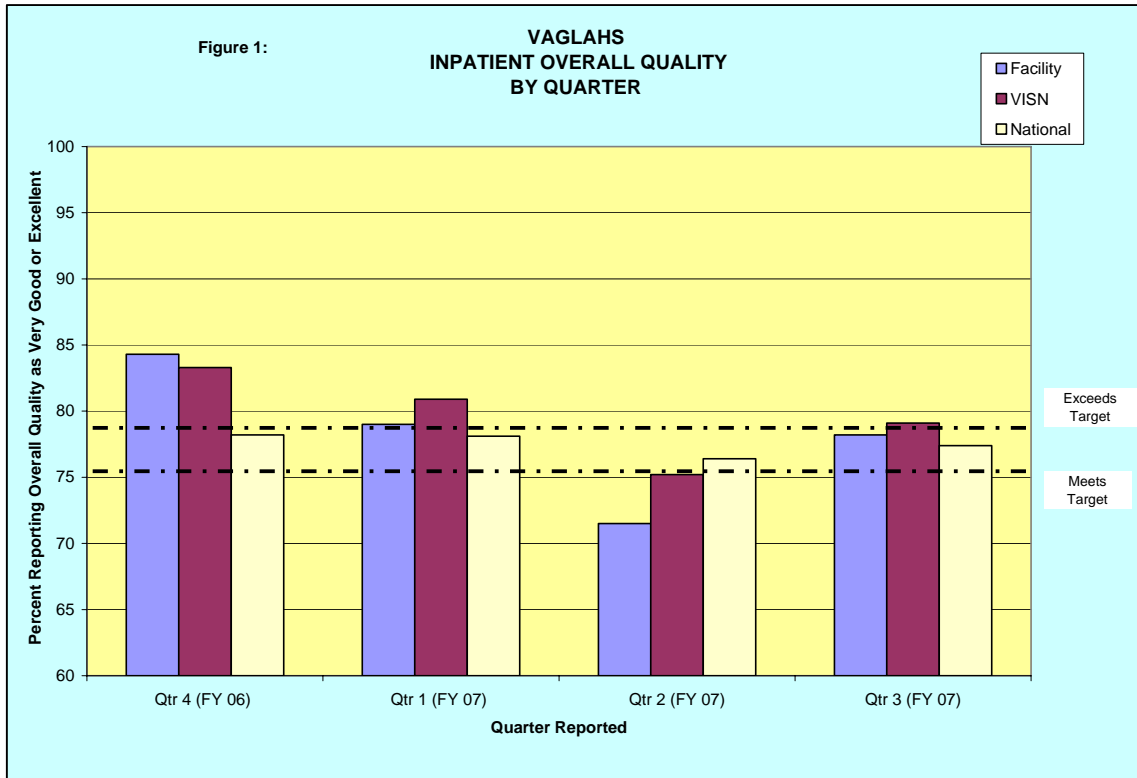
Antibiotic administered timely	Antibiotic stopped timely	Blood glucose monitored (cardiac surgery)	Body temperature controlled (colorectal surgery)
100 percent (30/30)	100 percent (30/30)	100 percent (7/7)	71 percent (5/7)

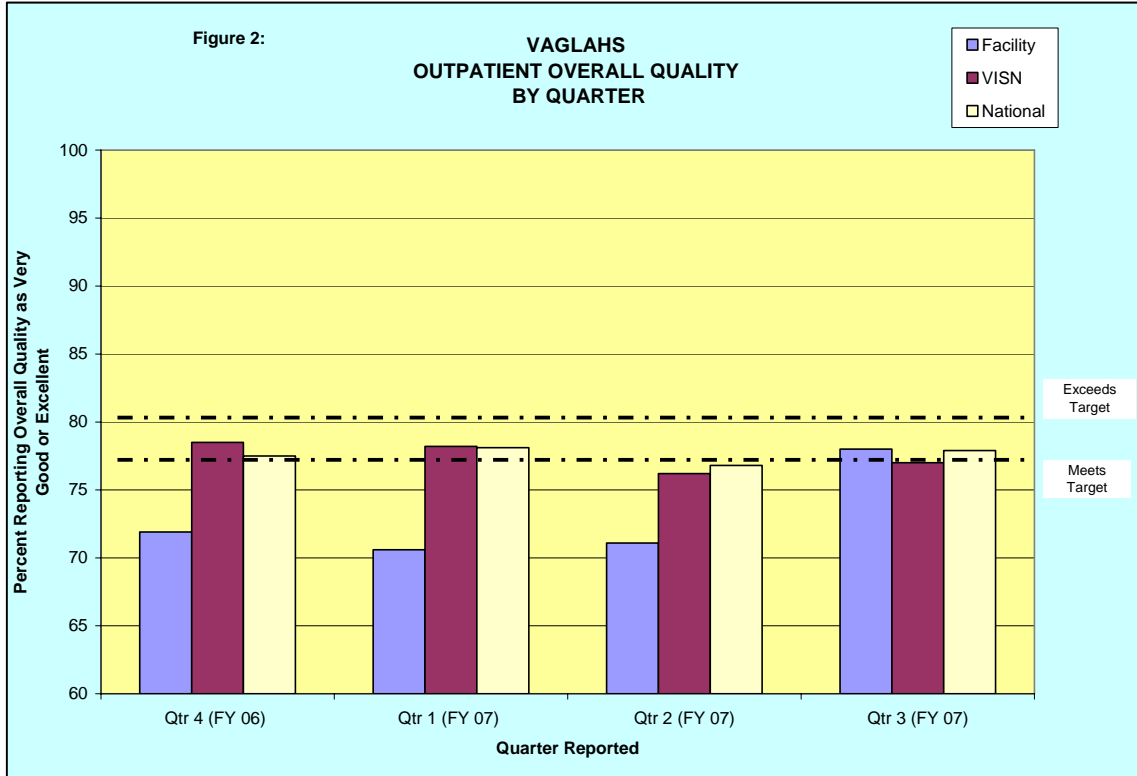
We found that in all 30 cases, clinicians appropriately administered and discontinued antibiotics. Clinicians appropriately monitored blood glucose for the first 2 days post-operative for seven patients who had cardiac surgery. However, we did not find evidence that clinicians controlled immediate post-operative body temperature for two of the seven patients who had colorectal surgery. Program managers provided an acceptable action plan to address this issue. We made no recommendations.

Patient Satisfaction Survey Scores

The purpose of this review was to assess the extent that VHA medical centers use the quarterly survey results of patients’ health care experiences with VHA to improve patient care, treatment, and services. VHA set performance measure results for patients reporting overall satisfaction of “very good” or “excellent” at 76 percent for inpatients and 77 percents for outpatients.

Figure 1 below shows the VAGLAHS’s Survey of Healthcare Experiences of Patients (SHEP) performance measure results for inpatients. Figure 2 on the next page shows the VAGLAHS’s SHEP performance measure results for outpatients.





The VAGLAHS exceeded the established target for inpatient satisfaction in 3 of the past 4 quarters of available data. While the VAGLAHS’s performance in outpatient satisfaction met the target in only 1 of the past 4 quarters, managers had developed an action plan for improvement. We found the action plan to be acceptable and made no recommendations.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: December 7, 2007

From: Director, VA Desert Pacific Healthcare Network (10N/22)

Subject: **Combined Assessment Program Review of the VA
Greater Los Angeles Healthcare System, Los Angeles,
CA**

To: Director Los Angeles Healthcare Inspections Division (54LA)
Director, Management Review Office (10B5)

1. Attached for your review are concurrences and responses to each of the findings from the CAP review of VA Greater Los Angeles Healthcare System performed on September 24 through 28, 2007.
2. Please contact Teresa Osborn, MSN, RN, Network 22, Quality Management Officer, at 562-826-5963 if you have any questions.

(original signed by:)

Kenneth J. Clark, FACHE

VAGLAHS Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: December 3, 2007

From: VA Greater Los Angeles Healthcare System Director
(691/00)

Subject: **Combined Assessment Program Review of the VA
Greater Los Angeles Healthcare System, Los Angeles,
CA**

To: Director, Desert Pacific Network (10N22)

Attached for your review are concurrences and responses to each of the findings from the CAP review of VA Greater Los Angeles Healthcare System performed during the week of September 24 through 28, 2007.

(original signed by:)

Charles M. Dorman, FACHE
Director

Attachment

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 VAGLAHS Director requires compliance with VHA's peer review directive, specifically regarding timeliness, trend analyses, and quarterly reports to the MEC.

Concur with recommendation. Target Date for Completion: April 1, 2008

Planned Actions:

A tracking system has been developed and is in place. Key processes will be monitored for timeliness. Reminders are being developed to deploy for the key process time lines to participants in the peer review process to enhance compliance with the national directive. The Chair of the Peer Review Committee and the ACOS/Quality and Performance Improvement will be monitoring and responsible for assuring compliance with timelines.

Recommendation 2. We recommended that the VISN Director ensure that the VAGLAHS Director requires compliance with VHA's patient safety handbook, specifically regarding the timeliness of RCA completion and corrective action implementation.

Concur with recommendation. Target Date for Completion: April 1, 2008

Planned Actions:

An algorithm has been developed with milestones for various parts of the process (e.g., identification and confirmation of members, sign off on charter, team meetings, report completion). With each new RCA, the algorithm will be monitored by the ACOS/Quality and Performance Improvement and the Chief of Quality Management to provide support and direction when time lines are falling behind recommendations. In addition, for RCA's that involve more complex processes, the recommendation to the team is to schedule an extended period of time (a minimum of 1 full

day and more depending upon complexity and number of people to be interviewed) to further assure efficient use of team time.

Recommendation 3. We recommended that the VISN Director ensure that the VAGLAHS Director requires compliance with VHA's UM policy, specifically regarding continued stay reviews.

Concur with recommendation. Target Date for Completion: April 1, 2008

Planned Actions:

Within the staffing limitations, the current Utilization Management Coordinator is in the process of assigning 20 percent of the continued stay reviews partially to the staff Utilization Management person as well as the Case Managers. The Coordinator will maintain oversight and provide coverage to assure compliance until the full complement of Utilization Management Staff is provided and properly oriented.

Recommendation 4. We recommended that the VISN Director ensure that the VAGLAHS Director requires clinical service chiefs to develop plans for continuous review of provider-specific QM/PI results and to maintain provider profiles that demonstrate that the plans are being followed.

Concur with recommendation. Target Date for Completion: April 1, 2008

Planned Actions:

The Medical Executive Committee, working closely with the Professional Standards Board, will develop plans for continuous review of provider specific QM/PI results with designated intervals for documented review. The plans will also include the definitions for sections/services of the QM/PI data to be reviewed. Upon completion of the plans, the Medical Executive Committee and the Professional Standards Board will initiate implementation of the plans, working closely with the affected clinical services.

Recommendation 5. We recommended that the VISN Director ensure that the VAGLAHS Director develops a plan to address identified vulnerabilities in the potable water systems.

Concur with recommendation. Target Date for Completion: February 28, 2008

Planned Actions:

Emergency management is developing an SOP for water rationing at all sites in the event of a disaster. The Emergency Management Committee, as well as the Environment of Care Committee, will review for approval with the expected completion date of February 2008. A comprehensive water sampling plan derived from the water vulnerability (consultants) study will be completed by the end of January 2008. This plan will also go to the EOC Committee for approval of priorities and actions.

Recommendation 6. We recommended that the VISN Director ensure that the VAGLAHS Director requires managers to more aggressively address breaches to maintain patient privacy and confidentiality.

Concur with recommendation. Target Date for Completion: January 31, 2007

Planned Actions:

The system at SACC Pharmacy has been altered and the patient's social security number is no longer announced (it is verified at the window with the patient). The unsecured radiology films that were observed in Bldg. 500 served as "educational films" for house staff. These films were secured, are in the process of being stored, and a conversion to a digital system is being planned.

Recommendation 7. We recommended that the VISN Director ensure that the VAGLAHS Director establishes a comprehensive and systematic strategy to assess, prioritize, and correct environmental deficiencies in patient safety; IC; storage and security of medications, supplies, and equipment; and general maintenance and repair of equipment.

Concur with recommendation. Target Date for Completion: See specifics below.

Planned Actions:

In order to eliminate the infection control vulnerability, Engineering has already started working with Urology on a \$1.3 million NRM project (#691-08-165WL) for the expansion/redesign of Urology's work area. **Target Date: Construction award for project is June 30, 2008.** The pest control contractor (EcoLab) has implemented an aggressive eradication program for the flying insects. Environmental Management has secured more covered trash containers for eating areas. In addition, Environmental Management has embarked on an education program, stressing the importance of appropriate storage and disposal of food

through the building. Staff has also been reminded to contact pest control immediately upon any sighting of pests. The Day Treatment Clinic located at LAACC is in the process of renovation with installation of new appliances and repairs, as needed. Environmental rounds at the site will identify any cleanliness or storage items that may need follow-up post remodel. The Day Treatment Center staff have re-educated patients, and the Coordinator has a plan for monitoring food handling, cleanliness, and food storage when the kitchen is open for use again. **Target Date: Completion of work December 31, 2007.** The ceiling on an inpatient locked mental health unit (2S) is undergoing a station level project to replace the suspended ceiling with a hard ceiling. **Target Date: Completion of ceiling installation November 30, 2007.** To eliminate obstructions in the corridors, GLA Executive Management is working with the GLA Space Committee in identifying functions that would relocate some services to other buildings to create additional temporary storage space. The Omnicells were probably deactivated following a power outage. A&MM has assured that this equipment is now functional and will be checking following a power outage to assure continuous security. New medication carts are being ordered. **Target Date: Delivery of medication carts February 28, 2008.** All reported equipment has been repaired. EOC is developing a comprehensive list of deficiencies and findings that will be prioritized and approved at the EOC meetings and reviewed by the Resources Board when decisions are being made to allocate resources to accomplish these priorities. **Target Date: Priorities List review by EOC April 1, 2008.**

Recommendation 8. We recommended that the VISN Director ensure that the VAGLAHS Director requires responsible program managers to conduct a comprehensive review of business rules, delete inappropriate rules, and ensure local policy compliance with VHA policy.

Concur with recommendation. Target Date for Completion: January 31, 2008

Planned Actions:

A draft policy has been written to comply with the CPRS business rules, specifically to correct erroneous patient information and designate individuals with authority to correct or reassign notes appropriately. Upon review by the Medical Executive Committee, this policy will be accepted and signed off for the organization.

Recommendation 9. We recommended that the VISN Director ensure that the VAGLAHS Director requires that the ACOS/R&D meet current requirements regarding education verification for all staff engaged in research activities.

Concur with recommendation. Target Date for Completion: April 1, 2008, for re-verification with intermediate target date of February 1, 2008, for education, certification, and licensure verification.

Planned Actions:

1) The unlicensed physicians that were reviewed by the OIG who did not have documentation that education was verified will have their education verified **immediately**.

2) Review personnel files for verification of documentation of education and training for all research employees.

In compliance with recently published Standard Operating Procedures: Research Personnel Credentialing Procedures (approved by Research and Development, July 23, 2007, revised, November 15, 2007) a review of the remaining files for verification of education, certifications, and licenses will take place and be completed by **February 1, 2008**. All documentation relating to education will be reviewed in the research competency folders. Consistent with the newly published procedures, files will be reviewed for the following as described in 3) and 4).

3) On an ongoing basis, all new employees, VA paid and WOC, engaged in research will have their educational degrees, certifications, and licensure verified by this process. Finally, all research personnel must be reviewed for compliance with relevant credentialing, training, and personnel requirements, including those for WOC's, on an annual basis by the R&D Committee.

4) Written documentation: Acceptable written documentation includes the following:

- Document search – primary source verification from institution. If after a minimum of two requests documents are not received, a Report of Contact will be placed in the credentialing folder in lieu of documents sought, signed by the requester for primary source verification.
- Upon presentation of certificates, originals are copied and authenticated by the person's signature who reviews the certificates.
- Verification can also be considered by a reference letter from a reputable source verifying participation in a program or training. This information should be placed in the individual's file and dated.

Final review documentation: All files will be reviewed for completeness by ACOS/R&D with dated signature on the Scope of Practice as verification of the complete process. If no confirmations for licenses, education, or certifications can be obtained, candidate must be disqualified. (The PI has the option of assigning candidate to duties other than human subjects research.)

Recommendation 10. We recommended that the VISN Director ensure that the VAGLAHS Director requires that the ACOS/R&D meet current requirements for scopes of practice of unlicensed physicians and that the scopes of practice for all staff engaged in research activities are properly reviewed and approved.

Concur with recommendation. Target Date for Completion: April 1, 2008

Planned Actions:

Current Scope of Practice form was revised November 20, 2007, as follows:

- Remove IV infusion and venipuncture and place under a new heading entitled, "other duties requiring certification."
- Provide space for verification of training for "other duties" not requiring certification with PI signature.
- Add statement that employee does not require certification or training, signed by PI.

All personnel eligible for licensure or certification will be processed through VetPro to be completed by **March 1, 2008**.

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