Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 07-03185-82

Combined Assessment Program Review of the VA Northern Indiana Health Care System Fort Wayne and Marion, Indiana

February 25, 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.

Table of Contents

Executive Summary

Introduction

During the week of November 26–30, 2007, the OIG conducted a Combined Assessment Program (CAP) review of the VA Northern Indiana Health Care System (the system), Fort Wayne and Marion, IN. 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 274 system employees. The system is part of Veterans Integrated Service Network (VISN) 11.

Results of the Review

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

- Expedited Extended Care Placement Process.
- Reduced Acute Mental Health Bed Days of Care.

We made recommendations in four of the activities reviewed; four were repeat recommendations (two in QM, one in environment of care (EOC), and one in moderate sedation practices) from the prior CAP review of the system. For these activities, the system needed to:

- Ensure that assault data is critically analyzed when presented to the Performance Improvement (PI) Committee.
- Meet Veterans Health Administration (VHA) requirements for peer reviews (PRs).
- Analyze patient complaint data, compare data to results from the Survey of Healthcare Experiences of Patients (SHEP) survey, and report findings to the PI Committee for corrective action.
- Meet VHA and system requirements for cardiopulmonary resuscitation (CPR) training for all clinically active staff.
- Meet VHA requirements for background investigations of contract employees.
- Critically analyze blood usage data.
- Establish a collaborative disclosure process to ensure that patients are informed of their right to file claims.
- Meet VHA requirements for root cause analysis (RCA).

- Address safety vulnerabilities in the locked acute mental health unit.
- Monitor refrigerator temperatures and document corrective actions when temperatures are outside the acceptable range, inspect shower curtains and ensure that they are properly cleaned and disinfected, and clean air system vents.
- Complete emergency crash cart checks in accordance with system policy and secure sharp items.
- Ensure that computerized patient record system (CPRS) business rules comply with VHA policy and Office of Information (OI) guidance.
- Ensure that contract physicians who administer moderate sedation receive moderate sedation and CPR training in accordance with VHA policy.

The system complied with selected standards in the following activity:

- SHEP.

This report was prepared under the direction of Verena Briley-Hudson, Director, Chicago Office of Healthcare Inspections.

Comments

The VISN and System Directors agreed with all findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 16–22 for the full text of the Directors' comments.) We will follow up on all 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 consists of two facilities located in Fort Wayne and Marion, IN, and provides a broad range of inpatient, outpatient, and long-term care services. Outpatient care is also provided at two community based outpatient clinics in South Bend and Muncie, IN. The system is part of VISN 11 and serves a veteran population of about 85,000 in a primary service area that includes 26 counties in Indiana and 3 counties in Ohio.

Programs. The system provides primary and secondary medical and surgical care at its Fort Wayne campus and chronic and acute mental health care, primary medical care, and long-term care at its Marion campus. Specialty programs include adult day health care, audiology and speech pathology, cardiology, day treatment, dentistry, home health care, oncology, ophthalmology, optometry, physical medicine and rehabilitation, podiatry, post-traumatic stress disorder, pulmonary, respite care, sub-acute rehabilitation, substance abuse, and urology. There are 42 authorized medical beds, including 22 medical/surgical and 4 intensive care unit (ICU) beds, at the Fort Wayne campus and 16 beds that are currently out of service at the Marion campus. Additionally, the system has 75 psychiatry beds and 150 nursing home care beds at the Marion campus.

Affiliations and Research. The system is not affiliated with a school of medicine but does have other training program affiliations with 27 schools, including Purdue University, Ball State University, Ivy Tech State College, and Tucker Career and Technology Center. Affiliated training programs include pharmacy, nursing, and optometry. The system does not have an independent research program.

Resources. The system's fiscal year (FY) 2007 expenditures were approximately $168 million. As of September 29, 2007, staffing was 1,136 full-time employee equivalents (FTE), including 44 physician and 172 nursing FTE.

Workload. For FY 2007 through August 31, 2007, the system treated 26,186 unique patients. The FY 2007 inpatient average daily census was 69, and the nursing home care average daily census was 114. FY 2007 outpatient workload totaled 242,058 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 five activities:

- CPRS Business Rules.
- EOC.
- Follow-Up on Moderate Sedation Practices.
- QM.
- SHEP.

The review covered system operations for FY 2007 and FY 2008 through November 23, 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 of the system. (*Combined Assessment Program Review of the VA Northern Indiana Healthcare System, Fort Wayne and Marion, Indiana,* Report No. 04-01740-53, December 27, 2004). We identified four repeat findings from our prior review during this onsite inspection.

During this review, we also presented fraud and integrity awareness briefings for 274 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

Expedited Extended Care Placement Process

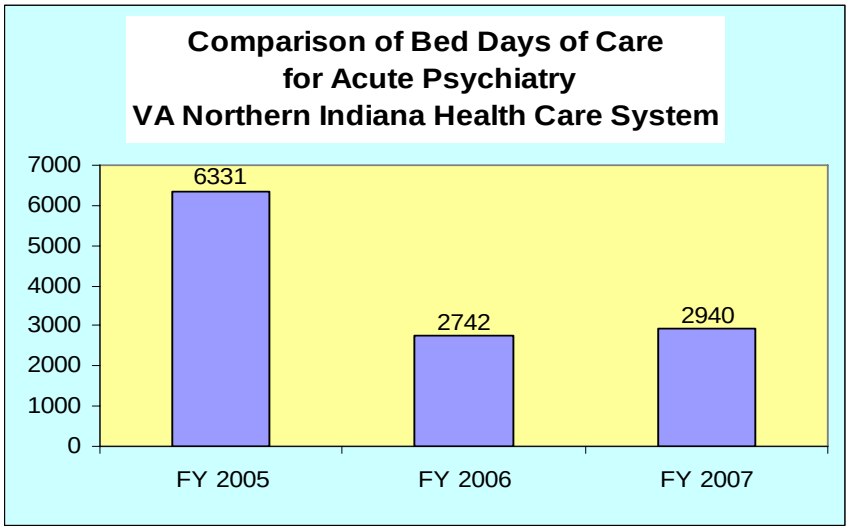
In January 2007, the system began a project redesign for the extended care placement process as part of the inpatient flow initiative. The goal of this redesign was to expedite the process from when a patient was identified as requiring extended care services until the patient actually began receiving the services.

As part of the project, social workers from the extended care unit attended the acute medical interdisciplinary rounds, and the social worker from the acute inpatient units attended the extended care referral group. This allowed for better communication between the units and allowed both to anticipate barriers early in the process. Bed huddles were initiated during this period and were attended by the inter-facility transfer coordinator. This assisted in identifying patients within the community who were potential candidates for extended care placement prior to their transfer to the acute inpatient units.

As a result of these efforts, the flow of patients from the acute inpatient units to extended care services improved significantly. The average number of days from a patient's admission until the extended care referral decreased from 6 days to 2 days. The average number of days from the time the screening group received a referral until an admission decision was made also decreased from 6 days to 2 days. Also, the time from acceptance to transfer improved from 3 days to 1 day. The flow from the acute inpatient units to the extended care setting improved from an average of 17 days during quarter 1 of FY 2007 to an average of 6 days during quarter 4 of FY 2007.

Reduced Acute Mental Health Bed Days of Care

Since FY 2005, the system has placed an emphasis on providing mental health care in the least restrictive environment by developing new programs and increasing psychosocial rehabilitation programs to provide a continuum of care in outpatient settings. System managers emphasized collaboration between programs, coordinated treatment planning, provided education on the role recovery model, and added peer support staff to teams. As a result of these efforts, there was a decrease of 2,500 bed days of care in acute mental health that was maintained during FYs 2006 and 2007. The following graph shows the bed days of care by FY for acute psychiatry.



Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the system's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported QM activities. We interviewed the system Director, the Chief of Staff, the PI Manager, and key employees. Senior managers were supportive of PI activities. We reviewed plans, policies, committee minutes, and other relevant documents for FY 2007 and identified seven areas that required further management attention. Two of these areas included repeat findings from our prior CAP review.

Assault Data Analysis. A recommendation from our prior CAP review was for system managers to analyze and use assault data to develop and implement strategies to reduce these incidents and improve patient, employee, and visitor safety. We found that PI staff continue to collect extensive data on assaults and regularly report the data to the PI Committee. However, the data is not critically analyzed, and the committee has not used it to develop or implement any strategies that could reduce incidents. Documentation in committee minutes states that the "Assault Data Report" was approved and will continue as an ongoing monitor.

Peer Review Process. The PR process needed to be improved to ensure timely completion of reviews. Once the need for a PR is determined, VHA policy[1] requires that initial reviews be completed within 45 days and that PR Committee evaluations be completed within 120 days. System policy[2] requires that all reviews be completed within 120 days. A review of the PR data showed that of the 55 PRs performed during FY 2007, 32 PRs exceeded 45 days for completion of the initial review, and 29 PRs exceeded 120 days for final evaluation by the committee.

Patient Complaints. Patient complaints were not critically analyzed to determine patterns or trends, and data were not presented to senior managers, patient care providers, or an oversight group, as required by VHA policy.[3] Results needed to be reported to the PI Committee to make recommendations for corrective action. Also, we found no evidence during our document review or our staff interviews that patient complaint data was compared to results of the SHEP survey. The patient advocate needed to expand data analysis in the patient complaint program to include comparisons with SHEP scores and identification of meaningful trends.

We were told that during FY 2007, the Customer Service Committee met monthly; however, official minutes were not recorded. Therefore, minutes were not presented to the PI Committee for discussion.

[1] VHA Directive 2004-054, *Peer Review for Quality Management*, September 29, 2004.
[2] VA Northern Indiana Health Care System Policy No.11-6, *Peer Review for Quality Management*, February 8, 2007.
[3] VHA Handbook 1003.4, *VHA Patient Advocacy Program*, September 2, 2005.

Credentialing and Privileging. VHA policy[4] requires each medical facility to have a policy on appropriate staff training in CPR and Advanced Cardiac Life Support. All clinically active staff, including full-time, part-time, and contract employees, must have CPR education. System policy[5] requires all clinically active staff to have Basic Life Support[6] training annually. We reviewed eight credentialing and privileging folders of providers who were reprivileged within the past 2 years. Six full-time staff and one contract provider had 2-year CPR certifications on file. This is contrary to system policy, which requires annual training. One contract provider did not have any documentation of CPR certification.

We reviewed 19 additional providers' records to verify CPR certifications. Of these, 18 providers had 2-year certifications, also contrary to system policy. One provider had a 1-year CPR certification.

During our record review, we also identified one contract provider who did not have a background investigation. VHA policy[7] requires that facilities make appropriate risk and sensitivity designations for contract employees who work in their organizations.

Blood Usage Review. The Joint Commission[8] requires that the system regularly collect data that measure the potentially high-risk processes of blood and blood product use. The system collects extensive data on all blood product usage; however, this data is not critically analyzed for the PI Committee to take action.

Adverse Event Disclosure. When serious events occur as a result of patient care, VHA policy[9] requires staff to discuss the events with patients and, with input from Regional Counsel, inform patients of their right to file tort or benefits claims. For the two patients who experienced adverse events during FY 2007, we found that clinicians documented

[4] VHA Directive 2002-046, *Staff Training in Cardiopulmonary Resuscitation and Advanced Cardiac Life Support,* July 31, 2002.
[5] VA Northern Indiana Health Care System Policy No.11-46, *Emergency Response Code Blue*, September 29, 2006.
[6] The American Heart Association protocol for recognition of the need for CPR and the need for prompt intervention.
[7] VHA Directive 0710, *Personnel Suitability and Security Program,* May 18, 2007.
[8] The Joint Commission was formerly the "Joint Commission on Accreditation of Healthcare Organizations," also known as JCAHO.
[9] VHA Directive 2005-049, *Disclosure of Adverse Events to Patients*, October 27, 2005.

the adverse event discussions in progress notes in the medical records. However, we did not find documentation that these patients or their family members were informed of their right to file claims.

Root Cause Analysis. Timely and complete RCAs are a critical component of an effective and efficient patient safety program. Without timely RCAs, managers could not be assured that quality improvement actions were promptly implemented to improve patient outcomes.

In FY 2007, the system completed 16 RCAs (10 individual and 6 aggregate). Six of those RCAs were not completed within the 45-day timeframe, in accordance with VHA and system policy.

During our prior CAP review, we noted that recommendations for corrective actions resulting from RCAs and Failure Mode and Effects Analysis (FMEA) reviews were not always implemented, and processes were not established to ensure that the corrective actions were effective. In FY 2007, a total of 96 RCA action items were identified, and 68 were completed. Of the 68 completed action items, 24 were not timely completed. During FY 2007, the system completed four FMEAs. At the time of our review, three of the four FMEAs still had pending action items.

Recommendation 1 We recommended that the VISN Director ensure that the System Director requires that assault data is critically analyzed when presented to the PI Committee.

The VISN and System Directors agreed with the findings and recommendation. The data is now being aggregated and trended, utilized to identify strategies to reduce incidents, and reviewed by the Customer and Environment of Care Executive Board (CEOCEB) and System Director. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 2 We recommended that the VISN Director ensure that the System Director takes action to meet VHA requirements for PRs.

The VISN and System Directors agreed with the findings and recommendation. The Chair of the PR Committee and the PI Manager will be responsible for ensuring compliance with

PR timelines. VISN 11 is working on a systemic response to assist medical centers in PR cases where expertise does not exist in-house. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 3 We recommended that the VISN Director ensure that the System Director requires that patient complaint data is critically analyzed and compared to data from the SHEP survey and that findings are reported to the PI Committee for corrective action.

The VISN and System Directors agreed with the findings and recommendation. Additional staff were hired to support the patient advocate functions and to enhance the ability to track and analyze patient complaint data. Data is reported to the Customer Service Committee, and action plans are monitored and approved by the CEOCEB and System Director. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 4 We recommended that the VISN Director ensure that the System Director requires that clinically active staff receive CPR training in accordance with VHA and system policy.

The VISN and System Directors agreed with the finding and recommendation. System policy will be updated to be consistent with VHA requirements that all clinically active staff receive CPR training at least every 2 years. Service chiefs/supervisors will monitor employee compliance. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 5 We recommended that the VISN Director ensure that the System Director requires that contract employees' background investigations are completed in accordance with VHA policy.

The VISN and System Directors agreed with the finding and recommendation. The Compliance Officer will conduct quarterly audits to assure that background checks are performed, and the results will be reported to the Resource Management Executive Board and System Director. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 6 We recommended that the VISN Director ensure that the System Director requires that blood usage data is critically analyzed for the PI Committee to take action.

The VISN and System Directors agreed with the finding and recommendation. Blood usage data is now being aggregated and trended by the Pathology and Laboratory Medicine Service. Reports will be reviewed by the Clinical Executive Board (CEB) and System Director. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 7 We recommended that the VISN Director ensure that the System Director takes action to establish a collaborative disclosure process to ensure that patients are informed of their right to file claims.

The VISN and System Directors agreed with the finding and recommendation. Risk Management staff will conduct an audit of episodes of adverse outcomes and will confirm that appropriate actions were taken to ensure patients were informed of their right to file claims. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 8 We recommended that the VISN Director ensure that the System Director requires that RCAs are completed in accordance with VHA and system policy.

The VISN and System Directors agreed with the finding and recommendation. A tracking system has been developed to ensure that RCAs are completed within the 45-day timeframe. 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 system had established a comprehensive EOC program that contributed to a safe and clean environment, complied with safety standards and guidelines, maintained an effective infection control program, and identified hazards that might pose a safety threat to patients and staff in locked acute mental health units.

We inspected five patient care units (locked acute mental health, long-term mental health, special care dementia, medical/surgical, and intensive care). We also followed up on findings and recommendations from our prior CAP

review. Managers were responsive to identified environmental concerns. The infection control program monitored, trended, and analyzed data and reported results to clinicians for quality improvements. The Multidisciplinary Safety Inspection Team conducted a risk assessment of the locked acute mental health unit, and staff were pursuing corrective actions. The following deficiencies required further management attention.

Locked Acute Mental Health Unit Safety Concerns. In addition to the safety vulnerabilities identified by the Multidisciplinary Safety Inspection Team, we observed the following conditions that might pose safety hazards to patients on the unit:

- Shower control fixtures in patient restrooms that might be used as anchor points.
- Removable ceiling tiles in hallways near patient room entries that are not visible from the nurses' station.
- Storage room door hinges that are accessible from the hallway and not visible from the nurses' station.

Infection Control Issues. Nourishment and medication refrigerator temperatures must be monitored daily to ensure that the contents are safe. A refrigerator on the special care dementia unit that contained patient food was outside the acceptable temperature range for 6 days in November. There was no documentation in the temperature log of corrective actions or subsequent readings. The temperature log for a medication refrigerator on the medical/surgical unit had no entries for 3 days in November. Problems with refrigerator temperature monitoring were cited in our prior CAP review.

There appeared to be mold on some shower curtains on two patient care units. We recommended that all curtains be inspected to ensure that they are properly cleaned and disinfected. There was heavy dust accumulation on air system vents on three patient care units.

Patient Safety Issues. System policy[10] requires that emergency crash carts be checked at least daily and that findings be documented in a log. The November 22 check was not completed on the special care dementia unit's crash

[10] VA Northern Indiana Health Care System Policy No. 11-31, *Emergency Crash Carts/Boxes*, August 24, 2006.

cart. Also, we discovered an intravenous line start kit in an unlocked linen cart in the hallway of the medical/surgical unit and sharp items in an open cart in the ICU. Sharp items need to be secured.

Recommendation 9 We recommended that the VISN Director ensure that the System Director requires that safety vulnerabilities in the locked acute mental health unit are addressed.

The VISN and System Directors agreed with the findings and recommendation. Safety vulnerabilities identified on the locked acute mental health unit will be corrected by March 30, 2008. Inpatient mental health staff will be oriented and educated on the importance of the EOC in preventing injury or death and on the content and proper use of VHA's "Mental Health Environment of Care Checklist" (MHEOCC). Quarterly mental health risk assessment rounds will be reviewed by the CEOCEB and System Director. Also, all VISN 11 medical center inpatient psychiatry units had walk-through site visits using the MHEOCC. These site visits were completed January 3, 2008. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 10 We recommended that the VISN Director ensure that the System Director requires that refrigerator temperatures are monitored and corrective actions documented when temperatures are outside the acceptable range, shower curtains are inspected and properly cleaned and disinfected, and air system vents are cleaned.

The VISN and System Directors agreed with the findings and recommendation. Oversight of refrigerator temperature monitoring was assigned to specific committees. Results will be reported to the CEB and System Director. Refrigerator temperature monitoring and shower curtain and air system vent inspections were added to the checklist used for EOC rounds. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 11 We recommended that the VISN Director ensure that the System Director requires that emergency crash cart checks are completed in accordance with system policy and that sharp items are secured.

The VISN and System Directors agreed with the findings and recommendation. Each area with a crash cart will submit a

quarterly report to the Critical Care Committee, and results and actions plans will be reviewed by the CEB and System Director. The process for handling sharps will be reviewed during EOC rounds, and any finding of non-compliance will be addressed through the EOC rounds deficiency abatement process. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Computerized Patient Record System Business Rules

VHA policy[11] states that "no edits, reassignment, deletion, or alteration of any documentation after the manual or electronic signature has been completed can occur without the approval of the Health Information Management professional or the Privacy Officer (PO)." CPRS business rules are facility specific and define the functions certain groups or individuals may perform in the medical records within that facility.

A communication (software informational patch[12] USR*1*26) was sent from VHA's OI on October 20, 2004, to all medical centers, providing guidance on a number of issues related to the editing of electronically signed documents in the electronic medical records 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 all VISN Directors instructing all VA medical centers to comply with the informational patch sent in October 2004.

We reviewed VHA and system policies and interviewed the manager of Health Information Management Service (HIMS), the Clinical Application Coordinator, and an information technology specialist. Nine business rules did not limit retraction, amendment, or deletion of signed medical record notes to the PO or the manager of HIMS. Managers removed these business rules while we were onsite.

Recommendation 12 We recommended that the VISN Director ensure that the System Director requires that CPRS business rules comply with VHA policy and OI guidance.

The VISN and System Directors agreed with the finding and recommendation. The Medical Record Review Committee will complete a quarterly review of CPRS business rules, and

[11] VHA Handbook 1907.01, *Health Information Management and Health Records,* August 25, 2006.
[12] A patch is a piece of software that can be an upgrade, fix, or update to address new issues, such as security problems.

the first report will be due to the CEB in February 2008. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Follow-Up on Moderate Sedation Practices

The purpose of this review was to follow up on moderate sedation recommendations from our prior CAP review and to validate the system's action plans. During our prior CAP review, we identified that contract physicians who were privileged to administer moderate sedation were not meeting the same moderate sedation and CPR training requirements as system employees. System policy[13] requires annual moderate sedation training for all clinicians privileged to provide these services. We reviewed the files of six contract physicians who were privileged to administer moderate sedation. We found that one physician did not have annual moderate sedation training and that five physicians had not completed annual CPR training. Managers recognized that system policy addressing moderate sedation and CPR training was not consistent with VHA policy.

Recommendation 13 We recommended that the VISN Director ensure that the System Director requires that contract physicians who administer moderate sedation receive moderate sedation and CPR training in accordance with VHA policy.

The VISN and System Directors agreed with the finding and recommendation. System policy is being amended to be consistent with VHA requirements for moderate sedation and CPR training. The Surgical Service will track provider training. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Review Activities Without Recommendations

Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that VA medical facilities use the quarterly or semi-annual SHEP results to improve patient care, treatment, 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 (PM) target results for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients.

[13] VA Northern Indiana Health Care System Policy No. 112-01, *Anesthesia Service Policy*, November 14, 2006.

Figures 1 and 2 below show the SHEP PM results for inpatients and outpatients, respectively.

Figure 1:

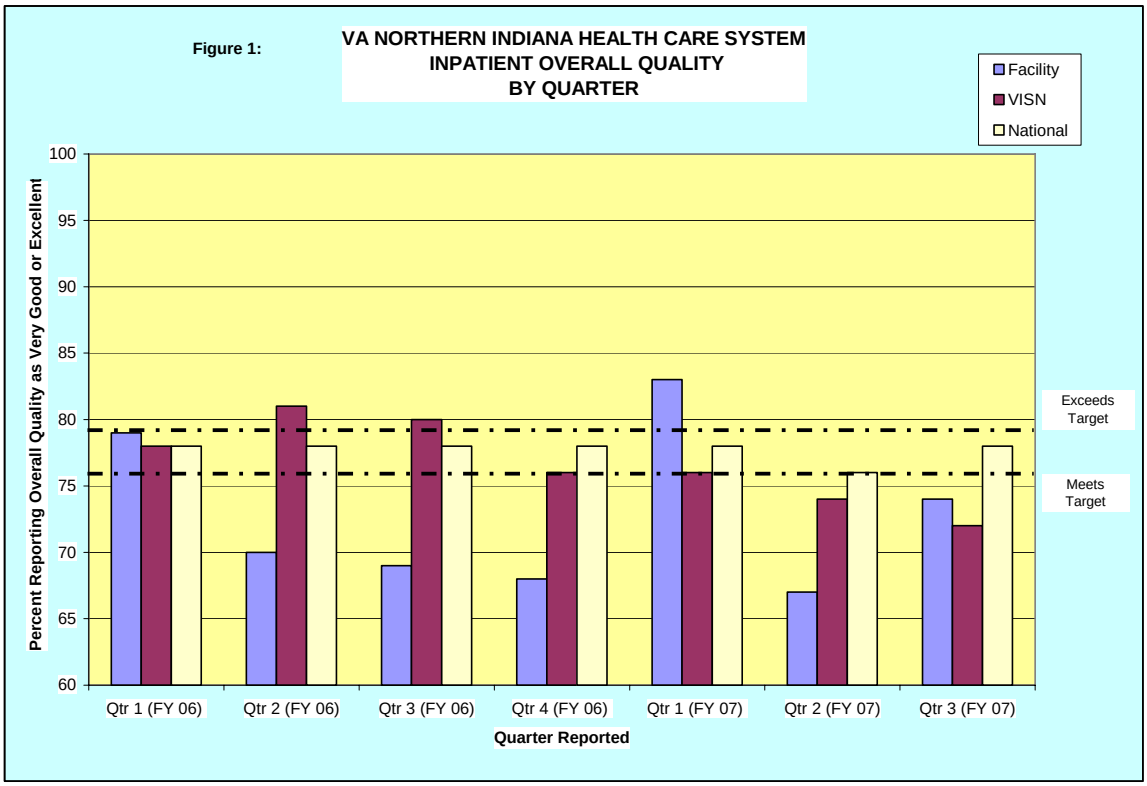
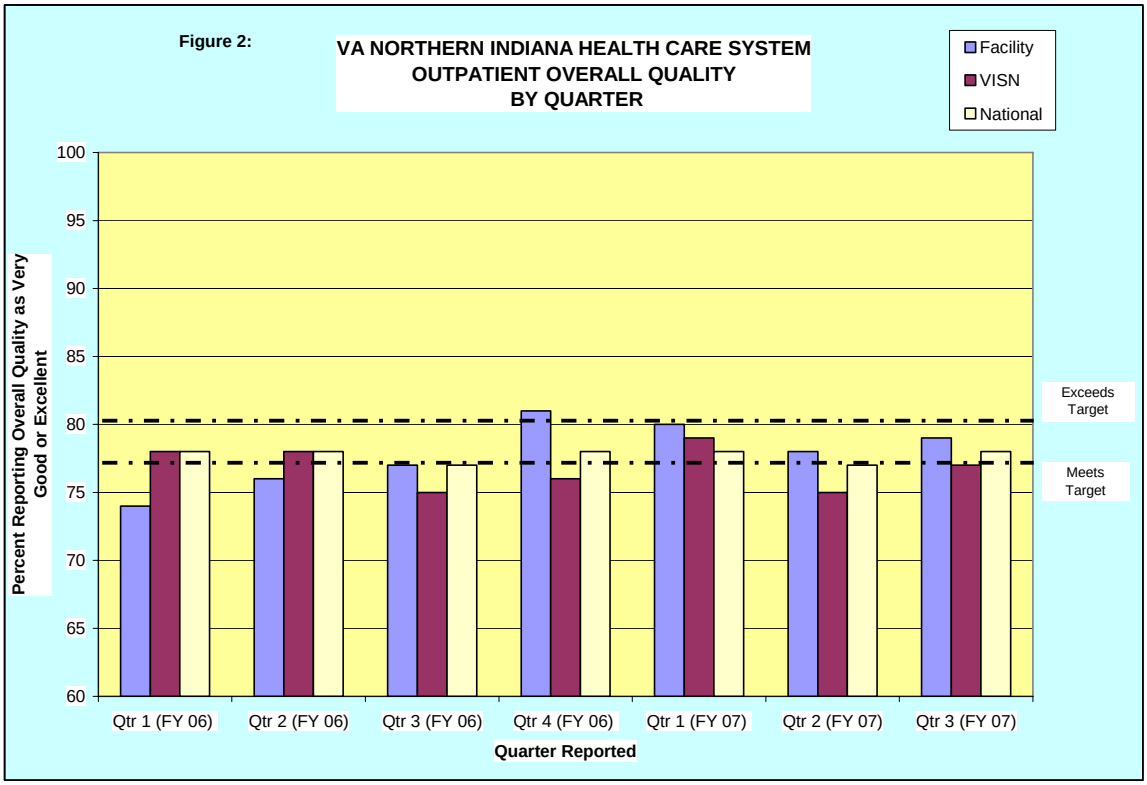


Figure 2:



The system scored above the 76 percent threshold in 2 of the last 7 quarters of available data for inpatient overall quality. The system scored at or above the 77 percent threshold in 5 of the last 7 quarters of available data for outpatient overall quality. Managers had identified opportunities for improvement based on the SHEP scores and had developed an action plan targeting a specific area. The action plan was implemented, and there is evidence of ongoing activities, including evaluation of the plan for effectiveness. We made no recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 4, 2008

From: Network Director, VISN 11 (10N11)

Subject: **Combined Assessment Program Review of the VA Northern Indiana Health Care System, Fort Wayne and Marion, Indiana**

To: Director, Chicago Office of Healthcare Inspections (54CH)

Director, Management Review Service (10B5)

Per your request, attached is the report from NIHCS. If you have any questions, please contact James Rice, VISN 11 QMO, at (734) 222-4314.

(original signed by:)

Linda W. Belton, FACHE

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 4, 2008

From: Director, VA NIHCS (00)

Subject: **Combined Assessment Program Review of the VA Northern Indiana Health Care System, Fort Wayne and Marion, Indiana**

To: Network Director, VISN 11 (10N11)

Attached is the response to the draft report, CAP review of VA NIHCS, Project No. 2007-03185-HI-0378. If you have any questions, please call 260-460-1310.

(original signed by:)

Cathi Spivey-Paul, FACHE

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 assault data is critically analyzed when presented to the PI Committee.

Concur Target Date: April 30, 2008

VANIHCS has historically gathered data on assaults and regularly reported this data to the Safety Committee. The data is now being aggregated and trended; this data is being utilized to identify strategies to reduce incidents. In addition, a retrospective review of assault data from the previous fiscal year is being done to identify any trends. The data will be reviewed by the Customer and Environment of Care Executive Board (CEOCEB) and by the Medical Center Director.

Recommendation 2. We recommended that the VISN Director ensure that the System Director takes action to meet VHA requirements for PRs.

Concur Target Date: April 30, 2008

VANIHCS has predominantly utilized an external peer review process when that specialty does not exist at the medical center and has set up a revised tracking system that contains triggers to ensure the timeliness requirements are met. In addition, VISN 11 is also working on a systemic response to the peer review process to assist the medical centers in peer review cases where that expertise does not exist in house. The Chair of the Peer Review Committee and the Performance Improvement Manager will be responsible for assuring compliance with timelines.

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires that patient complaint data is critically analyzed and compared to data from the SHEP survey and that findings are reported to the PI Committee for corrective action.

Concur Target Date: April 30, 2008

VANIHCS has hired additional staff to support the patient advocate functions and to enhance the ability to track and analyze patient complaint data. The Customer Service Committee has been reconstituted under

new leadership. The committee met in December to compare the patient complaint data with the data from the SHEP surveys. The data is now being aggregated and trended with the results of these reviews being reported to the Customer Service Committee for action. Action plans developed by the Customer Service Committee are monitored and approved by the CEOCEB and the Director.

Recommendation 4. We recommended that the VISN Director ensure that the System Director requires that clinically active staff receive CPR training in accordance with VHA and system policy.

Concur Target Date: March 1, 2008

VANIHCS policy will be updated to be consistent with VHA requirements, which require clinically active staff to receive CPR training at least every 2 years. Service Chiefs/Supervisors are responsible for monitoring all mandatory training for their staff.

Recommendation 5. We recommended that the VISN Director ensure that the System Director requires that contract employees' background investigations are completed in accordance with VHA policy.

Concur Target Date: June 30, 2008

The contracted provider identified in the report no longer has clinical privileges at the medical center. He has been providing services in the community as a fee-basis provider. Quarterly audits by the Compliance Officer will be conducted to assure background checks are performed and the results reported to the Resource Management Executive Board; minutes of this Board are approved by the Director.

Recommendation 6. We recommended that the VISN Director ensure that the System Director requires that blood usage data is critically analyzed for the PI Committee to take action.

Concur Target Date: June 30, 2008

Extensive data on blood usage has historically been gathered by Pathology and Laboratory Medicine Service (PALMS). Blood usage data is now being aggregated and trended by PALMS. The blood usage reports will be reviewed by the Clinical Executive Board (CEB) and approved by the Director.

Recommendation 7. We recommended that the VISN Director ensure that the System Director takes action to establish a collaborative

disclosure process to ensure that patients are informed of their right to file claims.

Concur Target Date: February 29, 2008

VANIHCS has an appropriate disclosure policy in place in accordance with VHA Directive. VANIHCS' Risk Management program will be conducting an audit of episodes involving adverse outcomes and will confirm appropriate actions were taken to ensure patients are informed of their right to file claims.

Recommendation 8. We recommended that the VISN Director ensure that the System Director requires that RCAs are completed in accordance with VHA and system policy.

Concur Target Date: April 30, 2008

A tracking system has been developed and is in place for the RCA process to assure completion within the 45-day time limit. Key steps in the process will be monitored for timeliness. It should be noted that VANIHCS had performed 10 RCAs last fiscal year, more than twice the requirement.

Recommendation 9. We recommended that the VISN Director ensure that the System Director requires that safety vulnerabilities in the locked acute mental health unit are addressed.

Concur Target Date: June 30, 2008

Safety vulnerabilities identified during the CAP survey on the locked acute mental units have either been corrected or will be corrected by March 30, 2008. To ensure the safety of the patients, interim safety measures were implemented and will remain in place until all safety vulnerabilities are abated. The Chief of Staff and Associate Director for Patient Care Services will ensure that all staff of the inpatient mental health service are oriented and educated about the importance of the environment of care in preventing injury or death and about the content and proper use of VHA's Mental Health Environment of Care Checklist (MHEOCC) as an important tool for enhancing the safety of locked inpatient psychiatric units.

Quarterly mental health risk assessment rounds using VHA's MHEOCC continued to be completed separately from other environmental rounds; appropriate actions are addressed and monitored in the CEOCEB minutes and approved by the Director.

Lastly, due to the critical nature of Environment of Care issues related to patient safety on inpatient Psychiatry units, the Network Director required

that every medical center within VISN 11 have a walk-through site visit of each inpatient psychiatry unit. The site visits were conducted by a VISN staff member using the VHA's MHEOCC and were completed January 3, 2008.

Recommendation 10. We recommended that the VISN Director ensure that the System Director requires that refrigerator temperatures are monitored and corrective actions documented when temperatures are outside the acceptable range, shower curtains are inspected and properly cleaned and disinfected, and air system vents are cleaned.

Concur Target Date: April 30, 2008

Pharmacy and Therapeutics Committee will have oversight of the medication refrigerator logs and Infection Control Committee will have oversight of nourishment refrigerator logs. Managers will report log activity monthly to the appropriate committee. These Committees report results to the CEB, and minutes are reviewed by the Director. These issues have also been added to the checklists for Environment of Care rounds, and findings of non-compliance will be addressed through the rounds deficiency abatement process.

Recommendation 11. We recommended that the VISN Director ensure that the System Director requires that emergency crash cart checks are completed in accordance with system policy and that sharp items are secured.

Concur Target Date: April 30, 2008

Each area with a crash cart submits a quarterly report to the Critical Care Committee for review. The results and action plans, if necessary, are submitted to the CEB for review, and minutes are reviewed by the Director. The process for handling sharps is reviewed during Environment of Care rounds, and any finding of non-compliance will be addressed through the Rounds deficiency abatement process. The CEOCEB monitors these reports monthly and documents in minutes, which will be approved by the Director.

Recommendation 12. We recommended that the VISN Director ensure that the System Director requires that CPRS business rules comply with VHA policy and OI guidance.

Concur Target Date: March 1, 2008

Inappropriate CPRS business rules noted during the CAP survey were removed while the survey team was onsite. A process has been implemented for a quarterly review of the CPRS business rules by the Medical Record Review Committee and the CEB, which provides

oversight for the Committee. This will be implemented for Fiscal Year 2008, 2nd quarter, with the first report scheduled for the February CEB meeting.

Recommendation 13. We recommended that the VISN Director ensure that the System Director requires that contract physicians who administer moderate sedation receive moderate sedation and CPR training in accordance with VHA policy.

Concur Target Date: March 1, 2008

VANIHCS policy was more stringent than required by VHA Directive. VANIHCS policy is being amended to reflect that the training expectation is upon entry-to-duty and validation of training at least every 2 years, in accordance with VHA Directive. Effective immediately, the moderate sedation training and CPR training will be tracked by Surgical Service.

OIG Contact and Staff Acknowledgments

Contact	Verena Briley-Hudson, MN, RN, Director Chicago Office of Healthcare Inspections (708) 202-2672
Contributors	Wachita Haywood, RN, Associate Director Paula Chapman, CTRS, Health Systems Specialist, Team Leader Jennifer Reed, RN, Health Systems Specialist Gregg Hirstein, Special Agent, Office of Investigations Judy Brown, Program Support Assistant

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