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Office of Inspector General

Office of Healthcare Inspections

Report No. 08-00401-133

Combined Assessment Program Review of the Richard L. Roudebush VA Medical Center Indianapolis, Indiana

May 29, 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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Table of Contents

	Page
Executive Summary	i
Introduction	1
Profile	1
Objectives and Scope	1
Organizational Strength	3
Results	3
Review Activities With Recommendations	3
Quality Management	3
Environment of Care	10
Computerized Patient Record System Business Rules	12
Follow-Up of Background Investigations	13
Review Activities Without Recommendations	15
Pharmacy Operations	15
Survey of the Healthcare Experiences of Patients	16
Appendixes	
A. Acting VISN Director Comments	19
B. Acting Medical Center Director Comments	20
C. OIG Contact and Staff Acknowledgments	26
D. Report Distribution	27

Executive Summary

Introduction

During the week of February 11–15, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the Richard L. Roudebush VA Medical Center (the medical center), Indianapolis, 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 94 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 11.

Results of the Review

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

- Transformation of the medical center's culture.

We made recommendations in four of the activities reviewed; one recommendation was a repeat recommendation from the prior CAP report. For these activities, the medical center needed to:

- Ensure that the credentialing and privileging (C&P) process is completed in compliance with Veterans Health Administration (VHA) policy.
- Meet VHA requirements for cardiopulmonary resuscitation (CPR) training for all clinically active staff.
- Meet VHA requirements for peer reviews (PRs).
- Ensure that the patient advocate critically analyzes and compares patient complaint data to the Survey of Healthcare Experience of Patients (SHEP) data, as required by VHA policy.
- Ensure that root cause analysis (RCA) reviews are completed in accordance with VHA policy.
- Meet VHA requirements for the utilization management (UM) program.
- Ensure that analyzed data from the Code Committee is presented to an oversight committee for corrective actions.
- Develop a medical center policy for importing and/or copying text into the computerized patient record system (CPRS), as required by VHA.

- Ensure that restraint and seclusion data are monitored and action items are implemented.
- Ensure that identified safety and infection control vulnerabilities are corrected.
- Ensure that sensitive patient information is protected from unauthorized access.
- Update CPRS business rules to ensure full compliance with VHA policy.
- Ensure compliance with VHA employment screening requirements.

The medical center complied with selected standards in the following two activities:

- Pharmacy Operations.
- SHEP.

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

Comments

The Acting VISN and Acting Medical Center Directors agreed with all findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 19–25, for the full text of their 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
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Introduction

Profile

Organization. The medical center is a tertiary care facility located in Indianapolis, IN, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at two community based outpatient clinics in Terre Haute and Bloomington, IN. The medical center is part of VISN 11 and serves a veteran population of about 222,000 in a primary service area that includes 31 counties in Indiana.

Programs. The medical center provides acute inpatient medical, surgical, psychiatric, neurological, and rehabilitation care, as well as both primary and specialized outpatient services. It has 150 acute hospital beds and 20 Psychosocial Residential Rehabilitation Treatment Program beds.

Affiliations and Research. The medical center is affiliated with Indiana University's School of Medicine and provides training for 100 residents, as well as other disciplines, including nursing, dentistry, pharmacy, social work, allied health, and psychology. In fiscal year (FY) 2007, the medical center research program had 465 projects and a budget of $15.5 million. Important areas of research include nephrology, oncology, diabetes, schizophrenia, and health services.

Resources. In FY 2007, medical care expenditures totaled $218 million. At the time of our review, the FY 2008 medical care budget was pending. FY 2007 staffing was 1,641 full-time employee equivalents (FTE), including 105 physician and 410 nursing FTE.

Workload. In FY 2007, the medical center treated 50,862 unique patients and provided 44,904 inpatient hospital days. The inpatient care workload totaled 7,230 discharges, and the average daily census was 124. The outpatient workload totaled 453,636 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:

- CPRS Business Rules.
- Environment of Care (EOC).
- Follow-Up of Background Investigations.
- Pharmacy Operations.
- QM.
- SHEP.

The review covered medical center operations for FY 2007 and FY 2008 through February 15, 2008, 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 medical center (*Combined Assessment Program Review of the Richard L. Roudebush VA Medical Center, Indianapolis, Indiana,* Report No. 04-01852-115, March 28, 2005). We identified two repeat findings from our prior review in the areas of environment of care and background investigations.

During this review, we also presented fraud and integrity awareness briefings for 94 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

Indy Excellence

Indy Excellence was established in 2004 in an effort to transform the medical center's culture to achieve its mission and vision and to uphold its values. Initiatives of this program included improving the health care of our Nation's veterans, putting their needs first, and establishing a more cohesive workforce. This program was organized around four focal point teams that addressed the following important aspects of the organization:

- People.
- Service.
- Quality.
- Stewardship.

Indy Excellence initiatives have directly impacted the medical center's scores on the All Employee Survey. From FY 2004 to FY 2007, the medical center improved in 90 percent of the questions on the survey, and in FY 2007, the medical center was above the VISN average in the following items: (1) coworker support, (2) innovation, (3) cooperation, and (4) demands. Of the 81 percent of employees who responded, the medical center was statistically above the average for the Organizational Assessment Inventory.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the medical center's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the medical center Acting Director, the Chief of Staff, and key employees. Senior managers were supportive of performance improvement (PI) activities. We reviewed plans, policies, committee minutes, and other relevant documents for FY 2007 and identified eight program areas that required further management attention.

Credentialing and Privileging Process. VHA policy[1] requires that the reprivileging process include an appraisal of professional performance, judgment, and clinical/technical competence and skills based in part on clinician-specific PI activities. We reviewed 10 C&P folders of clinicians who had been reprivileged in the past 12 months. PI data collection did not comply with VHA policy. PI data was not collected for four clinicians in medicine specialties. Four consultant clinicians' PI data included only a letter and checklist from the affiliate university. Two clinicians' PI data included only clinical practice monitors and performance measures.

Cardiopulmonary Resuscitation. VHA policy[2] requires that all clinically active staff have CPR education. Further review of the 10 C&P folders showed that five providers had no current documentation of CPR education.

Background Investigations. Newly appointed clinicians are subject to background investigations conducted by the Office of Personnel Management (OPM). VHA policy[3] requires that the appropriate level of background screening be completed for appointees. Five of the 10 C&P folders we reviewed had no evidence of background investigations being completed or even initiated. We reviewed an additional 10 C&P folders and found that 5 of these contained no documentation of background investigations being initiated. Also, we were unable to locate official personnel folders for 2 of the 10 additional C&P folders reviewed. (The recommendation for background investigations is on page 14.)

Peer Review Process. The PR process needed improvement to ensure timely completion of reviews. Once the need for a PR is determined, VHA[4] and medical center[5] policy require that initial reviews be completed within 45 days and that PR Committee evaluations be completed within 120 days. A review of PR data showed that of the nine PRs performed during FY 2007, two exceeded 45 days for completion of the initial review, and five exceeded 120 days for final evaluation by the committee.

[1] VHA Handbook 1100.19, *Credentialing and Privileging*, October 2, 2007.
[2] VHA Directive 2002-046, *Staff Training in Cardiopulmonary Resuscitation and Advanced Cardiac Life Support,* July 31, 2002.
[3] VHA Directive 0710, *Personnel Security and Suitability Program*, May 18, 2007.
[4] VHA Directive 2004-054, *Peer Review for Quality Management*, September 29, 2004.
[5] Medical Center Memorandum 11QM-08, *Peer Review for Quality Management*, May 20, 2005.

Patient Complaints. Patient complaint data was not compared to results of the SHEP survey, as required by VHA policy.[6] The patient advocate needed to expand data analysis in the patient complaint program to include comparisons with SHEP scores and identification of meaningful trends.

Root Cause Analysis. VHA policy[7] requires that RCAs be conducted timely. The medical center completed 12 individual RCAs during the past 12 months. Two of those RCAs were not completed within the required 45-day timeframe. Without timely RCAs, managers could not be assured that quality improvement actions were promptly implemented to improve patient outcomes.

We found that recommendations for corrective actions resulting from RCAs were not always implemented and that the effectiveness of the outcomes was not always measured. During FYs 2005, 2006, and 2007, 82 RCAs were completed. As of the date of our review, 51 action items and outcome measures were past due.

Utilization Management Program. VHA policy[8] defines program components that must be in place to perform UM functions. Medical center managers did not comply with VHA policy regarding the assignment of a physician advisor to serve as a third party reviewer for all cases not meeting standardized criteria. We were told that a physician advisor had recently been assigned to work with the UM program.

During the UM process, opportunities for improvements were identified, and actions items were implemented. However, action items were not monitored. Medical center managers needed to develop a process for ongoing monitoring of action items.

Physicians with admission privileges were not educated on the utilization review process. During our interview, we were informed that physicians are educated on a one-on-one basis; however, no formal education was documented.

[6] VHA Handbook 1003.4, *VHA Patient Advocacy Program*, September 2, 2005.
[7] VHA Handbook 1050.1, *VHA National Patient Safety Improvement Handbook*, January 30, 2002.
[8] VHA Directive 2005-040, *Utilization Management Policy*, September 22, 2005.

Review of Resuscitation Episodes. The medical center collects data that measures the outcomes of all patient resuscitation episodes (referred to as codes). The medical center's Code Committee was formed in February 2007 as a subgroup of the Critical Care Committee (CCC). The Code Committee meets monthly and collects, analyzes, and trends code data; it also analyzes data from practice codes. Raw data from all codes appears on the dashboard report;[9] however, the Code Committee's analyzed data is not presented to the CCC for implementation of actions and monitoring of the actions taken.

Our review of the Code Committee's summary report dated January 9, 2008, and other monthly committee minutes showed several issues that were identified during FY 2007. Data from actual and practice codes were reviewed; however, we could not determine if the issues identified had been addressed. The following are examples of those issues:

- The code team leader was not consistently identified.
- Surgical residents were not trained on how to use all of the equipment on the code carts.
- Residents were not trained to place catheters inside the large veins of patients during codes.
- There was a lack of suction equipment at the bedside and in the interventional radiology recovery room.
- Agency nurses were not familiar with the medical center's code process and code carts.
- The role of VA police during a code was not apparent.
- Code announcements were not heard in the team rooms and in other areas of the medical center.

We were informed that VA police officers now carry code beepers and are a part of the code team. Additionally, we were told that the medical center's policy and the code data collection form would be amended to include the Police and Security Service. Managers needed to address all of these issues to ensure that quality patient care is provided.

[9] A visual way to display data for the purpose of ongoing tracking and trending.

Medical Record Review. The medical center did not have a policy outlining rules for importing and/or copying text into CPRS entries or for monitoring these functions, as required by VHA policy.[10]

Restraints and Seclusion. The medical center collected data that measured the performance of restraints and seclusion for both medical/surgical and psychiatric patients. The psychiatric patient data reports were presented to the Psychiatric Executive Committee for action; however, we found that the medical/surgical patient data reports were not presented to an oversight committee for action. We did not find evidence of continuous monitoring of actions taken on data from either report. The medical center needed to develop a process to monitor action items.

Recommendation 1

We recommended that the Acting VISN Director ensure that the Acting Medical Center Director takes action to ensure that the C&P process is completed in compliance with VHA policy.

The Acting VISN and Acting Medical Center Directors agreed with the findings and recommendation. The Credentials Office will track reports and present them to the Professional Standards Board with each provider's renewal application. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 2

We recommended that the Acting VISN Director ensure that the Acting Medical Center Director takes action to ensure that all clinically active staff maintain current CPR training.

The Acting VISN and Acting Medical Center Directors agreed with the finding and recommendation. Monthly, the Education Service sends an updated Basic Life Support list to the Administrative Assistant to the Chief of Staff. Each service is sent a list of staff members due for recertification and is responsible for ensuring that those staff members complete CPR certification. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

[10] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

Recommendation 3 We recommended that the Acting VISN Director ensure that the Acting Medical Center Director takes action to meet VHA requirements for PRs.

The Acting VISN and Acting Medical Center Directors agreed with the findings and recommendation. The PR process is being revised to include additional monitoring and follow-up. The PR Committee will meet twice a month to ensure timely reviews. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 4 We recommended that the Acting VISN Director ensure that the Acting Medical Center Director requires that patient complaint data is compared to data from the SHEP survey and that findings are reported to an oversight committee for corrective action.

The Acting VISN and Acting Medical Center Directors agreed with the findings and recommendation. The Customer Service Manager, in conjunction with the patient advocate's office, will trend the topics by quarter and present results to the Indy Excellence Service Team. The Environment of Care and Safety Board will provide oversight to the Indy Excellence Service Team and report findings and actions to the Leadership Council. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 5 We recommended that the Acting VISN Director ensure that the Acting Medical Center Director takes action to meet VHA requirements for RCAs.

The Acting VISN and Acting Medical Center Directors agreed with the findings and recommendation. The Patient Safety Manager will review action items to determine status and continued feasibility of implementation. Aggregate data regarding status of RCAs and actions will be presented on a quarterly basis to the Patient Safety Committee. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 6 We recommended that the Acting VISN Director ensure that the Acting Medical Center Director takes action to meet VHA requirements for the UM program.

The Acting VISN and Acting Medical Center Directors agreed with the findings and recommendation. UM staff are developing a reporting format for monitoring actions taken. The data will be presented to the Indy Excellence Quality Committee for Patient Flow. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 7 We recommended that the Acting VISN Director ensure that the Acting Medical Center Director takes action to ensure that analyzed data from the Code Committee are presented to an oversight committee for corrective actions.

The Acting VISN and Acting Medical Center Directors agreed with the findings and recommendation. Analyzed reports will be reviewed quarterly, trends will be identified from code reviews, and actions will be implemented. The Executive Committee of the Medical Staff will review Code Committee minutes and code data on a monthly basis. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 8 We recommended that the Acting VISN Director ensure that the Acting Medical Center Director takes action to develop a policy for importing and/or copying text into CPRS.

The Acting VISN and Acting Medical Center Directors agreed with the findings and recommendation. Medical center managers will develop a policy that addresses copying and pasting text into CPRS notes and includes an annual review of CPRS business rules. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 9 We recommended that the Acting VISN Director ensure that the Acting Medical Center Director takes action to ensure that all restraint and seclusion data are presented to an oversight committee and that data are monitored and action items implemented.

The Acting VISN and Acting Medical Center Directors agreed with the findings and recommendation. Monthly, acute care restraint usage data will be reported through the Nursing PI Committee. Quarterly, behavioral health restraint usage data will be reported at the Nursing Unit Manager Meeting and to the Quality Committee. 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 medical center 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 on locked psychiatry units.

We inspected four patient care units (locked psychiatry, surgical, medical, and medical intensive care) and other common public areas. We also followed up on findings and recommendations from our prior CAP review and found that all issues were resolved except for access to medication rooms.

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

Safety and Infection Control. Medication refrigerator temperatures must be monitored daily to ensure that the contents are safe. On February 5, the medical unit's medication refrigerator temperature log showed that the digital thermometer was noted to be inoperable. The staff member who observed this initiated an electronic work order and made a telephone contact to have a replacement thermometer delivered. On the day of our inspection, February 12, we were told that the digital thermometer had not yet been repaired and that a replacement thermometer was never received. Consequently, the temperature of the refrigerator went unmonitored for 8 days, and staff could not ensure that the medications in the refrigerator were maintained at an acceptable temperature level.

Access to medications must be limited to authorized staff. During our prior CAP review, we noted that unit staff, such as housekeepers, were able to access the medication rooms. In response, punch-code locks were installed on most medication room doors. We found that the medication

room on the locked psychiatry unit still had a conventional lock on both doors. Managers acknowledged that the housekeeper and possibly other non-nursing and non-pharmacy staff have a common key that allows access.

Sharp items, such as needles, must be secured. Needles were found in an unlocked drawer of a stand in the hallway on the surgical unit, and a needle was found on the shelf of an open cabinet in a patient room on the medical unit.

Oxygen tanks must be secured and used appropriately to minimize the risk of fire or injury. We noted several unsecured oxygen tanks in the biohazardous waste storage room on the surgical unit. We also observed oxygen tanks that were affixed to wheelchairs near the entrance of the medical center. Because these tanks were not closely monitored, there was the potential for theft or for use of one of the wheelchairs by someone who smokes, posing a fire hazard.

Medical center policy[11] designates specific areas where patients, visitors, employees, and volunteers may smoke. Smoking is only allowed in two designated smoking shelters and on the opposite side of a street bordering the west side of the medical center. We observed employees smoking approximately 15 feet from a building entrance.

Patient care equipment and furniture need to be regularly inspected, and items with compromised surfaces need to be repaired or removed from service as they present an infection control concern. We observed wheelchairs with tattered armrests and chairs on the medical intensive care unit and in the outpatient pharmacy waiting area with tears in the seat cushions.

Patient Privacy. Federal law[12] requires that sensitive patient information be secured from unauthorized access. On the surgical and medical units, we noted that paper medical records were filed in notebooks that were placed either in the hallways outside patient rooms or in holders within the rooms. These records included patient names and full social security numbers as well as health information. Confidential records could be accessed without staff knowledge.

[11] Medical Center Memorandum 00-12, *Smoking Policy*, February 8, 2006.
[12] Health Insurance Portability and Accountability Act of 1996.

Recommendation 10 We recommended that the Acting VISN Director ensure that the Acting Medical Center Director requires that safety and infection control vulnerabilities are corrected.

The Acting VISN and Acting Medical Center Directors agreed with the findings and recommendation. The medical center purchased a centralized refrigerator temperature monitoring system. Access to the medication room on the locked psychiatric ward has been limited by installing an additional key pad. Oxygen tanks are now being stored properly. Additionally, staff at the information desk are making rounds in the area to monitor compliance with the policy that oxygen tanks not be left attached to wheelchairs. Environmental rounds will continue to monitor the condition of furnishings. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Recommendation 11 We recommended that the Acting VISN Director ensure that the Acting Medical Center Director requires that sensitive patient information is protected from unauthorized access.

The Acting VISN and Acting Medical Center Directors agreed with the finding and recommendation. Names have been removed from outside patient rooms. Binders with sensitive information have been removed from hallways. 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[13] 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[14] USR*1*26) was sent from the VHA Office of Information (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

[13] VHA Handbook 1907.01.
[14] A patch is a piece of software that can be an upgrade, fix, or update to address new issues, such as security problems.

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 medical center policies and interviewed the Chief of Health Information Management Service, Clinical Application Coordinators, and the PI Supervisor. Seven business rules did not limit retraction, amendment, or deletion of signed medical record notes, as required. Managers removed these business rules while we were onsite.

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

The Acting VISN and Acting Medical Center Directors agreed with the finding and recommendation. Medical center managers will develop a policy, which will include an annual review of CPRS business rules. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Follow-Up of Background Investigations

Background investigations are accomplished to ensure that individuals are suitable to serve as VA employees, students, trainees, or volunteers. Newly appointed clinicians are subject to background investigations conducted by OPM. Human Resources Management Service (HRMS) staff are required to request an investigation within 14 workdays of each employee's appointment and to follow up if results are not received within 2 months. As a follow-up to the recommendation made in our CAP review report of March 2005, we reviewed licensed independent provider files for the presence of background investigations.

Staff were unable to provide verification of background investigations for 21 of 36 licensed independent clinical providers (physicians, nurse practitioners, dentists, nurse anesthetists, physician assistants) shown in the following table, who were also credentialed and privileged to practice.

Type of Provider	Number Without Background Checks
Employee	1
Fee Basis	8
Contract	5
Without Compensation	7

One staff physician who had worked for the medical center for 4 years and was reprivileged in the past 12 months had no documentation of a background investigation. However, we did find evidence that security clearance processes were initiated.

HRMS, contract, and credentialing staff and medical center managers were unable to provide documentation for the background investigations or to reconcile security clearance discrepancies. In some instances, it was also not clear as to who the providers were with respect to the category of their employment or their involvement within the medical center, though all were credentialed and privileged to provide patient care.

On August 14, 2006, the Deputy Under Secretary for Health for Operations and Management established new employment screening requirements for all VHA facilities, which clarified screening requirements and established processes for documentation of background checks of VHA appointees, contractors, and volunteers. This new directive required a review of official personnel folders of all appointed positions, including fee basis, consultant/attending, without compensation, resident, and student. Contractors and some volunteers are required to be screened by other methods. HRMS managers were not aware of this new directive; therefore, they did not follow processes or take actions to comply with the new requirements.

Recommendation 13 We recommended that the Acting VISN Director ensure that the Acting Medical Center Director takes action to comply with policies governing VHA employment screening requirements and corrects the identified discrepancies.

The Acting VISN and Acting Medical Center Directors agreed with the findings and recommendation. All providers who undergo the C&P process will be fingerprinted and

required to complete the National Agency Check and Inquiry background investigation. A process has been outlined and is currently being implemented. It includes non-contract providers and identifies responsibility for contract providers. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Review Activities Without Recommendations

Pharmacy Operations

The purpose of this review was to evaluate whether VA health care facilities had adequate controls to ensure the security and proper management of controlled substances (CS) and the pharmacies' internal physical environments. We also determined whether clinical managers had processes in place to monitor patients prescribed multiple medications to avoid polypharmacy, especially in vulnerable populations.

We reviewed VHA handbooks[15] governing pharmacy and CS security, and we assessed whether the medical center's policies and practices were consistent with VHA regulations. We inspected inpatient and outpatient pharmacies for security, EOC, and infection control concerns. We interviewed Pharmacy Service and Police and Security Service personnel. Additionally, we interviewed clinicians to determine if clinical pharmacists monitored patients prescribed multiple medications to avoid polypharmacy.

Pharmacy Controls. Our review showed that the medical center had appropriate policies and procedures to ensure the security of the pharmacies and CS. CS inspections were conducted according to VHA policy. Training records showed that the CS Coordinator and inspectors received appropriate training to execute their duties. The pharmacies' internal environments were secure, clean, and well maintained.

Polypharmacy. Pharmacological regimens involving multiple medications are often necessary to prevent and maintain disease states; however, excessive use of medications can result in adverse reactions and increased risks of complications. Polypharmacy is more complex than just the number of drugs that patients are prescribed. The clinical

[15] VHA Handbook 1108.1, *Controlled Substances (Pharmacy Stock)*, October 4, 2004; VHA Handbook 1108.2, *Inspection of Controlled Substances*, August 29, 2003; VHA Handbook 1108.5, *Outpatient Pharmacy*, May 30, 2006; VHA Handbook 1108.6, *Inpatient Pharmacy*, June 27, 2006.

criteria to identify polypharmacy are the use of: (a) medications that have no apparent indication, (b) therapeutic equivalents to treat the same illness, (c) medications that interact with other prescribed drugs, (d) inappropriate medication dosages, and (e) medications to treat adverse drug reactions.[16] Some literature suggests that elderly patients and mental health patients are among the most vulnerable populations for polypharmacy.[17]

Our review showed that managers did not have processes in place that ensured the regular review of medication regimens for patients prescribed multiple medications. To improve patient safety and medication management, we suggested that managers develop processes to ensure that clinical pharmacists identify patients who are prescribed multiple medications and regularly review their medication regimens to avoid polypharmacy. Managers agreed with our suggestion; therefore, we made no recommendations.

Survey of the 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.

Figures 1 and 2 on the next page show the SHEP PM results for inpatients and outpatients, respectively.

[16] Yvette C. Terrie, BSPharm, RPh, "Understanding and Managing Polypharmacy in the Elderly," *Pharmacy Times*, December 2004.

[17] Terrie, *Pharmacy Times*, December 2004; Vijayalakshmy Patrick, M.D., et al., "Best Practices: An Initiative to Curtail the Use of Antipsychotic Polypharmacy in a State Psychiatric Hospital," *Psychiatric Services*, 57:21–23, January 2006.

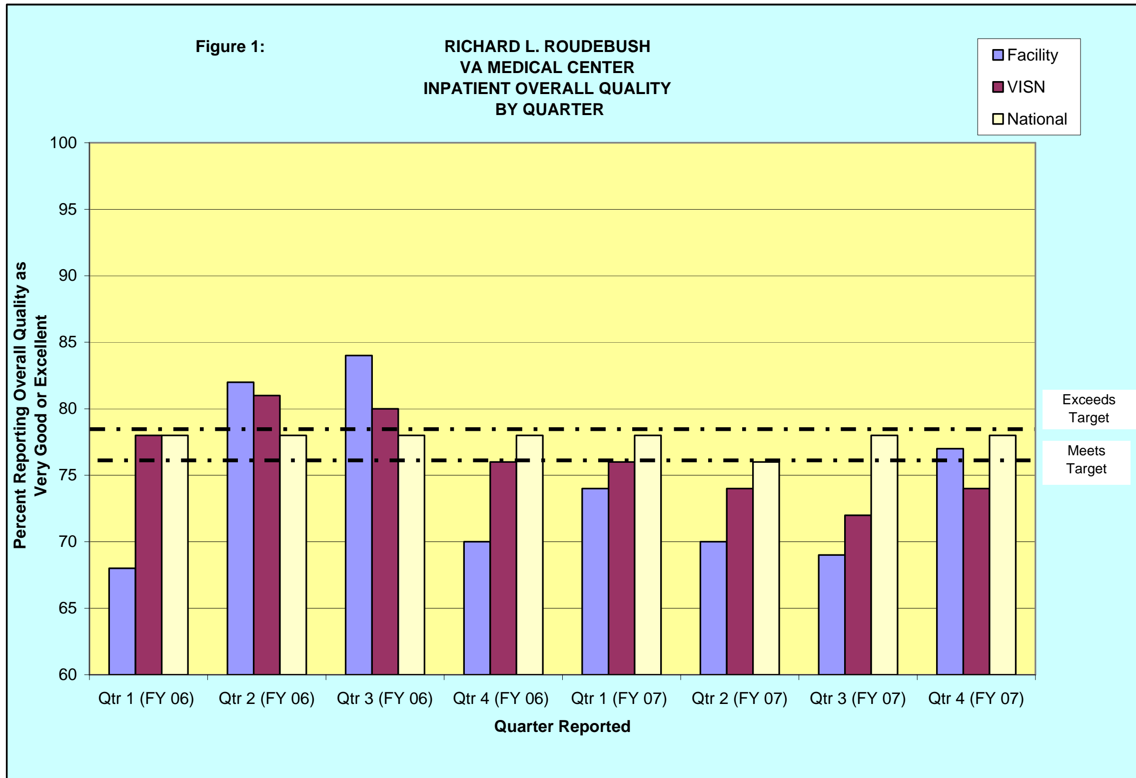
Figure 1:
RICHARD L. ROUDEBUSH
VA MEDICAL CENTER
INPATIENT OVERALL QUALITY
BY QUARTER
Facility
VISN
National
Percent Reporting Overall Quality as Very Good or Excellent
100
95
90
85
80
75
70
65
60
Exceeds Target
Meets Target
Qtr 1 (FY 06)
Qtr 2 (FY 06)
Qtr 3 (FY 06)
Qtr 4 (FY 06)
Qtr 1 (FY 07)
Qtr 2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

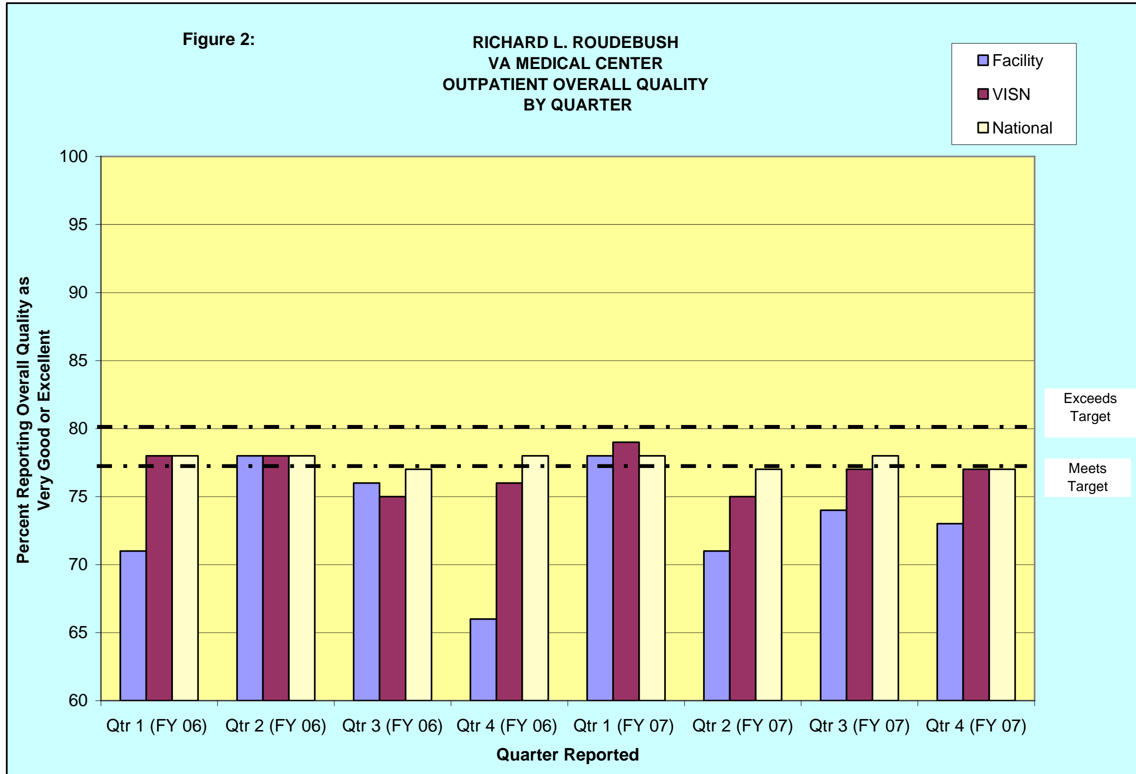
Figure 2:
RICHARD L. ROUDEBUSH
VA MEDICAL CENTER
OUTPATIENT OVERALL QUALITY
BY QUARTER
Facility
VISN
National
Percent Reporting Overall Quality as Very Good or Excellent
100
95
90
85
80
75
70
65
60
Exceeds Target
Meets Target
Qtr 1 (FY 06)
Qtr 2 (FY 06)
Qtr 3 (FY 06)
Qtr 4 (FY 06)
Qtr 1 (FY 07)
Qtr 2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

The medical center scored above the 76 percent threshold in 3 of the last 8 quarters of available data for inpatient overall quality and scored at or above the 77 percent threshold in 2 of the last 8 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 specific areas. The action plan was implemented, and there is evidence of ongoing activities, including evaluation of the plan for effectiveness. Therefore, we made no recommendations.

Appendix A

Acting VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 21, 2008

From: Acting VISN Director (10N11)

Subject: **Combined Assessment Program Review of the Richard L. Roudebush VA Medical Center, Indianapolis, Indiana**

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

Director, Management Review Service (10B5)

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

Linda W. Belton, FACHE

Acting Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 16, 2008

From: Acting Medical Center Director (583/00)

Subject: **Combined Assessment Program Review of the Richard L. Roudebush VA Medical Center, Indianapolis, Indiana**

To: Acting Network Director, VISN 11 (10N11)

1. We have reviewed the report as submitted. The medical center concurs will all findings and is taking the appropriate action to resolve the identified issues.

2. Thank you for the suggestions for improvement.

Kenneth E. Klotz, Jr., M.D.

Comments to Office of Inspector General's Report

The following Acting 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 Acting VISN Director ensure that the Acting Medical Center Director takes action to ensure that the C&P process is completed in compliance with VHA requirements.

Concur Target Date: June 30, 2008

A standard format has been developed to be utilized for all medical specialties at the medical center in reporting their provider performance data, with quarterly reports to be submitted by the service chief to the Credentials Office. The Credentials Office will track reports and present them with each provider's renewal application to the Professional Standards Board on applications presented from this point forward. The Credentials Office will evaluate the need for data collection analysts to assist with collection and reporting of provider specific performance data. (Action Completed.)

Recommendation 2. We recommended that the Acting VISN Director ensure that the Acting Medical Center Director takes action to ensure that all clinically active staff maintain current CPR training.

Concur Target Date: August 31, 2008

The medical center agrees that for the selected records, the reported results are accurate. However, further review of all clinically active staff demonstrates that the current compliance rate for CPR training is 91 percent (922/1013 clinically active staff). The medical center has a comprehensive system for monitoring and ensuring that CPR training is current. Each month, Education Service sends an updated BLS list to the AA/COS. Each service is then sent their list of staff members due for BLS recertification. The services are then responsible for ensuring that the staff member either completes CPR certification or provides a current BLS card, if the certification has already been completed. Education offers monthly BLS courses, adding additional courses when necessary to meet demand. The AA/COS reports quarterly on BLS compliance rates to the Clinical and Performance Board.

Recommendation 3. We recommended that the Acting VISN Director ensure that the Acting Medical Center Director takes action to meet VHA requirements for PRs.

Concur Target Date: June 30, 2008

The process for PR is being revised to include additional monitoring and follow-up. Reminders will be sent to service chiefs after 4 weeks, and at 5 weeks, the COS will be notified. Timeliness of completion will be added to C&P performance data. The PR Committee is now meeting twice monthly to ensure timely review of PRs within the 120-day timeframe. Monitoring and oversight is assigned to this group. Trending and tracking will be presented on a monthly basis.

Recommendation 4. We recommended that the Acting VISN Director ensure that the Acting Medical Center Director requires that patient complaint data is compared to data from the SHEP survey and that findings are reported to an oversight committee for corrective action.

Concur Target Date: July 31, 2008

The Patient Advocate's office will identify the SHEP questions related to patient advocate tracking package categories. The Customer Service Manager, in conjunction with the Patient Advocate's office, will trend the topics by quarter and present to the Indy Excellence Service Team to formulate the appropriate corrective action. The Environment of Care and Safety Board will provide oversight to the Indy Excellence Service Team and report findings and actions to the Leadership Council. (Action complete.)

Recommendation 5. We recommended that the Acting VISN Director ensure that the Acting Medical Center Director takes action to meet VHA requirements for RCAs.

Concur Target Date: June 30, 2008

The Patient Safety Manager will review the outstanding action items to determine status and continued feasibility of implementation. The medical center will continue implementation of a system for tracking status of actions and completion, utilizing this system for RCAs and corrective actions. Aggregate data regarding status of RCAs and actions will be presented on a quarterly basis to the Patient Safety Committee. Results will be forwarded to Leadership Council through the Environment of Care and Safety Board.

Recommendation 6. We recommended that the Acting VISN Director ensure that the Acting Medical Center Director takes action to meet VHA requirements for the UM program.

Concur Target Date: June 30, 2008

Physician advisors have been identified and have completed training. UM staff are developing a reporting format for monitoring actions taken based on UM data. UM staff will conduct a trial of a medical center specific database to provide necessary data. A process for ensuring inter-rater reliability has been implemented. UM data will be presented to the Committee on Recurring Resource Utilization and Management. The data is also presented to the Indy Excellence Quality Committee for Patient Flow. Oversight will be provided by Leadership Council through the Resource Planning Board.

Recommendation 7. We recommended that the Acting VISN Director ensure that the Acting Medical Center Director takes action to ensure that analyzed data from the Code Committee are presented to an oversight committee for corrective actions.

Concur Target Date: September 30, 2008

Code data will be presented through the Critical Care Committee to the Clinical and Performance Board. Analyzed reports will be reviewed quarterly, trends will be identified from code reviews, and actions will be implemented. Beginning the 3rd quarter, data collected will be expanded to include time of day and time to defibrillation. Additionally, the Executive Committee of the Medical Staff (ECMS) will review the Code Committee minutes and the code data on a monthly basis. The above oversight committees will assure that action is taken to resolve identified problem areas and that the actions were effective in resolving the issues identified.

Recommendation 8. We recommended that the Acting VISN Director ensure that the Acting Medical Center Director takes action to develop a policy for importing and/or copying text into CPRS.

Concur Target Date: May 31, 2008

The medical center will develop a policy that addresses copying and pasting into CPRS notes and includes an annual review of CPRS business rules.

Recommendation 9. We recommended that the Acting VISN Director ensure that the Acting Medical Center Director takes action to ensure that all restraint and seclusion data are presented to an oversight committee and that data are monitored and action items implemented.

Concur Target Date: June 30, 2008

Data regarding acute care restraint usage will be reported through the Nursing PI Committee monthly, with quarterly reports to the Nursing Unit

Manager Meeting and the Quality Committee. Data on behavioral health restraint usage will be reported through the Behavioral Health Executive Committee, with quarterly reports to the Nursing Unit Manager Meeting and Quality Committee. Both reports will utilize a standardized report format, which will include data, trends identified, actions taken, and monitoring of actions to demonstrate improvement. The Quality Committee reports to the Clinical and Performance Board.

Recommendation 10. We recommended that the Acting VISN Director ensure that the Acting Medical Center Director requires that safety and infection control vulnerabilities are corrected.

Concur Target Date: July 31, 2008

The medical center has purchased a centralized monitoring system for refrigerator temperatures. It will monitor all refrigerators in the medical center and trigger an alarm in a centralized place should the temperature move beyond the acceptable range. Implementation of this system is anticipated to start by the end of May. Access to the medication room on the locked psychiatric ward has been limited by the addition of a key pad, and the housekeeper cannot access this room. Policy has been changed so that oxygen tanks are now being stored properly. Additionally, the staff at the information desk are making rounds in the area to monitor compliance with the policy that oxygen tanks are not to be left attached to wheelchairs. Environmental rounds will continue to monitor the condition of furnishings for tears, rips, and worn surfaces, and replacement will be made as appropriate. (Oxygen tank issue is complete.)

Recommendation 11. We recommended that the Acting VISN Director ensure that the Acting Medical Center Director requires that sensitive patient information is protected from unauthorized access.

Concur Target Date: June 30, 2008

Names have been removed from outside the patients' rooms. Additionally, the binders with sensitive information have been removed from hallways. Patient Care Services is conducting a pilot to eliminate them from inside the room and has changed some of the forms to remove sensitive information. Nursing Unit Managers will monitor to ensure that binders with information are not placed in hallways.

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

Concur Target Date: May 31, 2008

As stated in the report, appropriate personnel removed the business rules that were in conflict with VHA policy while the inspectors were onsite. The medical center will develop a policy that addresses copying and pasting into CPRS notes. Included in the policy will be an annual review of CPRS business rules, which will be under collaboration with Office of Information and Technology Staff; Clinical Application Coordinators; the Privacy Officer; and the Chief, Health Information Management Service.

Recommendation 13. We recommended that the Acting VISN Director ensure that the Acting Medical Center Director takes action to comply with policies governing VHA employment screening requirements and corrects the identified discrepancies.

Concur Target Date: July 31, 2008

A task force has been convened, led by the Acting Chief, Human Resources. The report from this task force has been received and approved for immediate implementation. All providers who undergo the C&P process will have fingerprints taken and will be required to complete the NACI background investigation. A process has been outlined and is currently being implemented, which includes non-contract providers, as well as identifies responsibility for contract providers. Credentialing/In-Processing has granted access to the Priv Plus system (a local computerized program with input of providers' credentials, privileges, and licenses) to Human Resources. The names of the current credentialed providers will be reviewed and compared against the Veterans Health Information System and Technology Architecture based "Security Clearance Management Menu" to see if the provider is current with the background investigation process or whether a background investigation should be initiated for the individual. The applicable medical center memoranda will be amended to include the new process.

OIG Contact and Staff Acknowledgments

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