Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-02597-63

Combined Assessment Program Review of the VA Central Iowa Health Care System Des Moines, Iowa

February 3, 2009

Washington, DC 20420

Why We Did This Review

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

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

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

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Executive Summary

Introduction

During the week of October 27–31, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the VA Central Iowa Health Care System (the system), Des Moines, IA. 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 88 system employees. The system is part of Veterans Integrated Service Network (VISN) 23.

Results of the Review

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

- Safety, efficiency, and patient satisfaction improved with the implementation of the telepharmacy program.
- Performance improvement (PI) processes improved after initiation of the QM program redesign.

We made recommendations in six of the activities reviewed and had repeat environment of care (EOC) findings from our prior CAP review. For these activities, the system needed to:

- Collect and consider provider-specific PI data during reprivileging, in accordance with Veterans Health Administration (VHA) policy.
- Ensure that identified staff complete cardiopulmonary resuscitation (CPR) training, in accordance with system policy.
- Establish a committee to provide oversight and coordination of the medical record review process.
- Correct identified safety, infection control (IC), and patient privacy deficiencies.
- Ensure that consultation responses are completed within the system's established timeframe.
- Ensure that transfer documentation is completed in accordance with system policy.
- Ensure that discharge documentation accurately reflects active outpatient medications.
- Complete monthly inspections of all areas where controlled substances (CS) are stored.

- Ensure that staff follow system policy regarding medication disposition upon admission.
- Ensure that the Self-Medication Management Program (SMP) is implemented and managed in accordance with system policy.
- Ensure that PRN (as needed) medication effectiveness is documented within the timeframe defined by system policy.
- Ensure that patients discharged from the emergency department (ED) receive written discharge instructions.
- Ensure that clinicians document inter-facility transfers in accordance with VHA policy.

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

- Survey of Healthcare Experiences of Patients (SHEP).
- Staffing.

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

Comments

The VISN and System Directors concurred with the findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 19–27, for the full text of the Directors' comments). We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Profile

The system is a two-division facility in Iowa that provides inpatient and outpatient health care services. It operates two inpatient divisions located in Des Moines and Knoxville. Outpatient care is provided at both divisions and at two community based outpatient clinics (CBOCs) in Mason City and Fort Dodge, IA. The system is part of VISN 23 and serves a veteran population of more than 100,000 throughout 42 counties in Iowa and 2 counties in northern Missouri.

Programs. The system operates acute care, long-term care, and domiciliary beds. The Des Moines division provides primary care, medical, surgical, psychiatric, substance abuse, and home care services. The Knoxville division provides rehabilitation, mental health, and palliative community living center (CLC)[1] care and is a referral center for acute and long-term mental health patients. The system has 77 hospital, 226 CLC, and 78 domiciliary beds.

Affiliations. The system is affiliated with the University of Iowa's Carver College of Medicine; the Des Moines Area Medical Education Consortium, Incorporated; and Des Moines University. The system provides training for 25 residents, as well as other disciplines, including psychology, podiatry, physical therapy, nursing, and pharmacy.

Resources. In fiscal year (FY) 2008, medical care expenditures totaled $190.8 million. The FY 2009 medical care budget is approximately $200 million. FY 2008 staffing was 1,299 full-time employee equivalents (FTE), including 50 physician and 230 nursing FTE.

Workload. For FY 2008 through August 31, 2008, the system treated 32,098 unique patients. The system provided 12,914 inpatient days in the hospital and 44,714 inpatient days in the CLC units. The inpatient care workload totaled 2,991 discharges, and the average daily census, including CLC patients, was 199. Outpatient workload totaled 299,077 visits.

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

Objectives and Scope

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

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

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

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

- Coordination of Care.
- Emergency/Urgent Care (E/UC) Operations.
- EOC.
- Medication Management.
- Pharmacy Operations.
- QM Program.
- SHEP.
- Staffing.

The review covered system operations for FY 2008 and FY 2009 through October 24, 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 system (*Combined Assessment Program Review of the VA Central Iowa Health Care System, Des Moines, Iowa,* Report No. 05-00839-156, June 24, 2005). We had two repeat EOC findings from our prior CAP review related to Veterans Canteen Service (VCS)

kitchen security and ceiling tiles in patient rooms and restrooms.

During this review, we also presented fraud and integrity awareness briefings for 88 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

Telepharmacy Program Improves Processes

The telepharmacy program was developed to address issues that veterans at the CBOCs and the Knoxville division had with prior pharmacy processes. These issues often resulted in medication refill delays and limited patient education by pharmacists.

The system installed an onsite automated drug dispensing system (ADDS) and a telehealth system to link the CBOCs and the Knoxville division with the main pharmacy at the Des Moines division. Full-time pharmacy technicians assigned to the CBOCs and the Knoxville division and a full-time pharmacist located at the Des Moines division communicate with veterans through video teleconferencing. The pharmacist controls medication dispensing through the ADDS. Telepharmacy program successes include:

- Consistent patient education.
- Efficiency in addressing pharmacy issues and reduced workload for non-pharmacy staff.
- Medication reconciliation during each appointment and verification of each patient's medication list.
- Reduced cost per prescription with the use of ADDS technology.
- Improved patient and staff satisfaction.

Quality Management Program Redesign Improves Efficiency

To expand the culture of quality and increase focus on improvement at all levels, the approach to QM and PI was redesigned. The QM program was separated into two functions (1) traditional QM activities that support monitoring, oversight, and incremental improvement and (2) focused PI that supports major initiatives, collaboratives, and multi-disciplinary/multi-service PI activities. The QM program was expanded by hiring staff with expertise in facilitating PI teams and system redesign. In addition, three program analysts were added to support data management in both areas. These positions were in addition to the dedicated QM positions embedded in each of the four clinical service lines to manage data collection, support accreditation activities, and monitor VA clinical measures.

The PI model was made more user-friendly by examining what to change, what to change to, how to change, and how to sustain. The model uses a variety of traditional PI tools but also focuses on how to ask critical questions and develop effective, sustainable solutions. A cadre of staff is being trained in PI and team facilitation, and training for staff in front line improvement is being developed. A SharePoint database will allow for documentation, communication, and tracking of actions and outcome data. Since implementation began in June 2008, access and performance scores have improved significantly, and various processes have been redesigned to improve efficiency and effectiveness.

Results

Review Activities With Recommendations

Quality Management Program

The purpose of this review was to evaluate whether the system had a comprehensive and effective QM program designed to monitor patient care activities and coordinate improvement efforts and whether senior managers actively supported the program's activities. We interviewed the system's Director, Chief of Staff, Chief of QM and PI, and we interviewed other key staff. We evaluated policies, PI data, and other relevant documents.

The QM program was generally effective in providing oversight of the system's quality of care, and senior managers supported the program through evaluation of PI initiatives and through allocation of resources to the program. Appropriate review structures were in place for

11 of the 14 program activities reviewed. We identified three areas that needed improvement.

Physician Privileges. VHA policy[2] and accreditation standards require that clinical managers develop plans for continuous performance monitoring of the medical staff. Performance data collection should be ongoing and include indicators with defined criteria that emphasize the facility's PI plan, appropriateness of care, patient safety, and desired outcomes. This data is to be reviewed and considered during the reprivileging process, which is to include an appraisal of professional performance, judgment, and clinical/technical competence of skills based in part on provider-specific PI activities.

The system had recently developed and published a policy that specified the performance data that would be collected, compiled, and considered during the reprivileging process. However, the policy had not been fully implemented at the time of our visit. We reviewed the credentialing and privileging folders and provider files of 21 randomly selected physicians who had been initially privileged or reprivileged during the past 12 months and found that all had inadequate performance data.

Cardiopulmonary Resuscitation Training. System policy requires CPR training for identified staff every 2 years. We reviewed the database used to track the training status of staff required to maintain current CPR training. Of the 662 employee records reviewed, we found that 51 staff members were not in compliance with system policy at the time of our inspection.

Medical Records Reviews. VHA policy[3] requires that medical records be reviewed on an ongoing basis at the point of care. Results of these record reviews are to be reported at least quarterly to the facility medical record review committee or its equivalent. We found that medical records reviews had been conducted on an ongoing basis; however, the system did not have a committee to provide oversight and coordination of these reviews.

Recommendation 1 We recommended that the VISN Director ensure that the System Director requires that provider-specific PI data be

[2] VHA Handbook 1100.19, *Credentialing and Privileging*, October 2, 2007.
[3] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

collected and considered during reprivileging, in accordance with VHA policy.

The VISN and System Directors concurred with the findings and recommendation. Service line directors, QM staff, and employees from the Chief of Staff's office will ensure that PI data is collected and considered during reprivileging. 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 requires that employees complete CPR training, in accordance with system policy.

The VISN and System Directors concurred with the finding and recommendation. Additional CPR training has been scheduled. The Education Service will monitor staff compliance and notify supervisors and managers of delinquencies. 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 establishes a committee to provide oversight and coordination of the medical record review process.

The VISN and System Directors concurred with the finding and recommendation. Senior managers have selected and appointed members to serve on a medical records oversight committee. The committee will meet at least once each quarter. 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 complied with selected IC standards and maintained a safe and clean patient care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VA National Center for Patient Safety, Occupational Safety and Health Administration, and accreditation standards.

We inspected eight inpatient units (CLC, locked mental health, medical/surgical, telemetry, and intensive care), three outpatient clinics (red and blue teams and mental health), the VCS area, and several common areas. We also followed up on recommendations from our prior CAP review and noted that two conditions identified during that review still

existed (1) damaged, missing, incorrectly placed, or stained ceiling tiles were observed in patient rooms and restrooms and (2) an unlocked kitchen door was noted in the VCS area.

We evaluated the IC program to determine compliance with VHA directives. IC staff appropriately collected, trended, and analyzed data related to infections, and they involved clinicians in improvement initiatives to reduce infection risks for patients and staff.

The system was generally clean and effectively maintained. Managers and employees were responsive to environmental concerns identified during our inspection. However, we identified the following conditions that needed improvement.

Safety. Medications, cleaning products, and sharp items must be secured when not in use. While conducting the inspection in the intensive care unit (ICU) at the Des Moines division, we found an unsecured respiratory saline solution, a liquid cleaning product stored underneath a sink, and unsecured syringes and scissors.

Also, we found an improperly labeled medication in the ICU's medication refrigerator. The manufacturer's expiration date had been manually changed to another date. This change had not been authorized by a pharmacist. This practice is a potential patient safety risk.

System policy requires licensed nursing personnel or other trained and competent staff to document the lock number on the crash cart and sign the Code Blue checklist each shift. We inspected the crash cart on CLC unit 101B at the Knoxville division and found that the lock number documented on the Code Blue checklist was inaccurate. Additionally, signatures were not consistently recorded on the Code Blue checklist for the month of October 2008.

Staff were using a brick to hold the nursing clinic door open on unit 101A. Due to the patient population on this unit, this item needed to be removed to ensure patient and staff safety.

Unsecured doors to VCS retail storage rooms at the Des Moines division allowed unauthorized access to food and merchandise. We also identified an unsecured kitchen door in the VCS area at the Knoxville division, which was a repeat finding from our prior CAP review.

Oxygen tanks must be stored so that staff may quickly identify which are full and which are empty. None of the units inspected at either division had a process to distinguish full and empty tanks. Additionally, there were no oxygen tanks available in the ICU in the event of an emergency.

We observed two hospital beds with electric power cords in the hallway on the locked mental health unit at the Knoxville division. The unit does not utilize this type of bed due to the safety risk of the power cord. The storage of this equipment in the hallway posed an immediate safety concern.

Staff must be prepared to provide quick responses to emergency call systems. We activated the emergency call system in the restraint room on the locked mental health unit. Although staff on the unit heard the alarm, there was a delayed response.

Infection Control. Ceiling tiles must be intact and in proper placement to minimize the potential for pest or particulate entry. Ceiling tile problems were noted in patient rooms and restrooms at both the Des Moines and Knoxville division. This was a repeat finding from our prior CAP review. Additionally, during our inspection of the room where the ADDS is located at the Knoxville division (Building 1, Room 138), we observed that a ceiling tile had been removed for repairs but had not been replaced even though it appeared that the work had been completed. We also noted that several of the ceiling tiles were cut or damaged or had penetrations that had not been properly sealed.

Refrigerators must be monitored daily to ensure that contents are safe. Nourishment refrigerator temperature logs on two inpatient units showed that the refrigerators were out of the acceptable range on select dates. Staff did not document corrective actions in the logs.

Patient care areas should be inspected for pests, and actions should be initiated immediately when problems are identified. We observed insects in the dining room on unit 101B and in patient areas on units 101C and 68D at the Knoxville division. Staff had not initiated any requests for pest control services.

Clean and dirty items were stored together in storage rooms at both divisions. Also, biohazardous trash receptacles in the primary care clinic at the Des Moines division and the

locked mental health unit at the Knoxville division were not adequately secured to restrict access.

Patient care equipment needs to be regularly inspected, and items with compromised surfaces need to be repaired or removed from service. We observed wheelchairs with cracked armrests and seat surfaces at the Knoxville division.

Patient Privacy. Federal law requires the protection of sensitive patient information. Documents with patients' names, social security numbers, dates of birth, and health information were attached to clipboards hanging on the walls inside patient rooms on the medical/surgical unit at the Des Moines division. Managers require staff to use plastic covers over these sensitive documents. We noted that plastic covers were in place in only two of eight patient rooms inspected on this unit.

We witnessed nurses logging into the Bar Code Medication Administration (BCMA) software package on portable laptop computers in patient care areas. The nurses would then leave the laptop computers in the hallway while they entered patient rooms with a portable BCMA scanning device to scan patient armbands. After scanning an armband, the patient's name, date of birth, allergies, and medication profile appeared on the laptop screen. Because the laptops were left in the hallway, there was the potential for unauthorized individuals to view the sensitive patient information on the screens.

Recommendation 4 We recommended that the VISN Director ensure that the System Director requires that identified safety, IC, and patient privacy deficiencies be corrected.

The VISN and System Directors concurred with the findings and recommendation. The system developed appropriate plans to address each EOC deficiency identified during the inspection. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Coordination of Care

The purpose of this review was to evaluate whether inpatient consultations, transfers, and discharges were appropriately coordinated and met VHA and accreditation standards. Coordinated consultations, transfers, and discharges are essential to an integrated, ongoing care process resulting in

optimal patient outcomes. We identified three areas that needed improvement.

Consultations. System policy requires that inpatient consults be seen by the specialty/subspecialty service and that a consult-titled progress note be signed and available to the requesting party preferably within 24 hours but no longer than within 72 hours of the request. We reviewed the medical records of 12 inpatients who had routine consultations ordered and completed internally. Four (33 percent) of the 12 consultations did not meet this timeframe.

Intra-Facility Transfers. System policy requires that progress note assessments be completed by registered nurses (RNs) from the sending and receiving units when patients are transferred. We reviewed the medical records of 12 patients who transferred between units. Four transfer notes were initiated by licensed practical nurses (LPNs) on the sending units with RN "receipt acknowledged by" signatures. Senior managers clarified that this was not meeting the intent of system policy and that RNs should have initiated the notes. Additionally, we identified that there was no transfer note initiated by the sending unit for one patient in our sample who transferred between units at the Knoxville division.

Discharges. VHA policy[4] addresses information to be documented in the medical record when a patient is discharged from the facility. We reviewed the medical records of 12 inpatients who were discharged from the system. We identified two instances in which provider discharge notes included outpatient medications that were listed twice. If this information is given to the patient, there is the potential for errors in medication dosing. We also identified two discrepancies in discharge documentation. In the first instance, the provider's orders and the pharmacy discharge instructions note included two medications that were not included in the provider's discharge note. In the second instance, the provider's discharge summary did not include medications that were listed in the provider's discharge note or in the pharmacy discharge instructions note.

[4] VHA Handbook 1907.01.

Recommendation 5 We recommended that the VISN Director ensure that the System Director requires that consultation responses be completed within the system's established timeframe.

The VISN and System Directors concurred with the finding and recommendation. Each service line will appoint at least one back-up person to ensure that inpatient consultation requests are received, patients are seen, and responses are documented within the established timeframe. 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 transfer documentation be completed in accordance with system policy.

The VISN and System Directors concurred with the findings and recommendation. Nursing staff were educated on transfer documentation requirements, and LPNs no longer initiate transfer notes. QM and Health Information Management Service staff will continue to monitor transfer documentation to ensure sustained compliance. 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 requires that discharge documentation accurately reflects active outpatient medications.

The VISN and System Directors concurred with the findings and recommendation. Importing of medication lists into provider discharge instructions or other discharge documents is being discontinued. A process is under development to address entry of discharge medication orders, reconciliation of discharge medications, printing of a single list of medications for patients to take home, and completion of medication education. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Pharmacy Operations

The purpose of this review was to evaluate whether the system had adequate controls to ensure the security and proper management of CS and the pharmacy's internal physical environment. We also assessed whether processes were in place to monitor polypharmacy (patients prescribed multiple medications), especially in vulnerable populations.

We reviewed VHA regulations governing pharmacy and CS security, and we assessed whether the system's policies and practices were consistent with VHA regulations. We inspected the Des Moines division pharmacy and Knoxville division areas where medications and CS were stored for security, EOC, and IC issues. Additionally, we interviewed the CS Coordinator, the pharmacy manager, pharmacy employees, and the Chief of Police.

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 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. Elderly and mental health patients are among the most vulnerable populations for polypharmacy.

Managers had developed effective processes to ensure that clinical pharmacists identified patients who were prescribed multiple medications, reviewed their medication regimens to avoid polypharmacy, and advised providers as appropriate.

Policies and procedures were in place to ensure the security of the pharmacy and CS. The CS Coordinator and CS inspectors were appointed in writing by the system's Director and received the required training to perform their duties. The pharmacy's internal environment was clean and well maintained. We identified one area that needed improvement.

Controlled Substances Inspections. Monthly, random inspections are required to be conducted in all areas where CS are stored. Through interviews and reviews of inspection documents, we learned that the September 2008 inspection of the Des Moines domiciliary was missed.

Recommendation 8 We recommended that the VISN Director ensure that the System Director requires that monthly inspections be completed of all areas where CS are stored.

The VISN and System Directors concurred with the finding and recommendation. The CS Coordinator provided education for current and newly appointed inspectors and will monitor monthly inspections to ensure that all are completed. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had adequate medication management practices. A safe medication management system includes medication ordering, administering, and monitoring. We reviewed medication management processes on an acute medicine unit, the ICU, and three CLC units. We found appropriate use of patient armbands to correctly identify patients prior to medication administration. We identified three areas that needed improvement.

Medication Disposition Upon Admission. System policy requires that medications brought from home be returned to family members or placed in a sealed mailing envelope to be mailed to the patient's residence. During our inspection of one of the CLC units, we found outpatient medications stored on the unit for two patients.

Self-Medication Management Program. System policy requires that a progress note and a provider's order be documented prior to a patient's entry into the SMP. This documentation should include an assessment of the patient's degree of knowledge and understanding of the name of each medication, the administration of each medication, storage requirements, reasons for taking each medication, common side effects, integration of medications into the patient's lifestyle, possible barriers to compliance, possible barriers to learning, and procedures for requesting a change in medication. Additionally, based upon the results of the assessment, each patient must be categorized as either a semi-independent (levels I-IV) or an independent participant in the SMP. We reviewed the records of three patients identified as currently participating in the SMP. None of these records contained the initial documentation required or a categorized level of participation.

Medication Effectiveness Documentation. System policy requires that the effectiveness of PRN medications be documented in the patient's medical record within 4 hours of administration. We reviewed PRN effectiveness documentation for 67 doses of pain medications and found

that only 34 (51 percent) were documented within the timeframe defined by policy.

Recommendation 9 We recommended that the VISN Director ensure that the System Director requires that staff follow system policy regarding medication disposition upon admission.

The VISN and System Directors concurred with the finding and recommendation. Nursing staff were educated regarding the need for personal patient medications to be sent home with family members or sent to the pharmacy for destruction. Weekly monitoring will be initiated to ensure sustained compliance. 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 takes action to ensure that the SMP is implemented and managed in accordance with system policy.

The VISN and System Directors concurred with the findings and recommendation. The Mental Health Service Line will develop a template for documentation and will provide staff education on SMP requirements. 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 takes action to ensure that PRN medication effectiveness is documented within the timeframe defined by system policy.

The VISN and System Directors concurred with the finding and recommendation. Acute care and CLC nursing staff will receive education regarding documentation of PRN effectiveness. Daily audits are planned to monitor for sustained compliance. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Emergency/Urgent Care Operations

The purpose of this review was to evaluate whether the system's E/UC operations complied with VHA guidelines related to hours of operation, clinical capability, staffing adequacy, and staff competency. In addition, we inspected the system's ED environment for cleanliness and safety.

The system's ED is open 24 hours per day, 7 days per week, as required. It is located within the main hospital building at the Des Moines division, and the emergency services provided are within the system's capability. In addition, there is an appropriate policy for managing patients whose care may exceed the facility's capability. We identified two areas that needed improvement.

Patient Discharge Instructions. Accreditation standards require that written discharge instructions be provided in a form that the patient can understand. We reviewed the medical records of two patients treated and discharged from the ED. We did not find documentation of discharge instructions for either patient.

Inter-Facility Transfer Documentation. VHA policy[5] requires the use of specific forms for the documentation of inter-facility transfers. We reviewed the medical records of three patients who were initially treated in the ED and then transferred to other facilities. Clinicians did not utilize the required VA transfer forms. Consequently, documentation such as informed consent, advance directives, and level of care required during transportation was omitted.

Recommendation 12 We recommended that the VISN Director ensure that the System Director requires that patients discharged from the ED receive written discharge instructions.

The VISN and System Directors concurred with the finding and recommendation. An emergency department discharge instructions template will be developed, and standardized patient education materials will be compiled. Staff will be educated on the process. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 13 We recommended that the VISN Director ensure that the System Director requires that clinicians document inter-facility transfers in accordance with VHA policy.

The VISN and System Directors concurred with the findings and recommendation. The transfer policy is being updated, and managers will ensure that all required transfer documentation is completed. The improvement plan is

[5] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.

acceptable, and we will follow up on the completion of the planned actions.

Review Activities Without Recommendations

Staffing

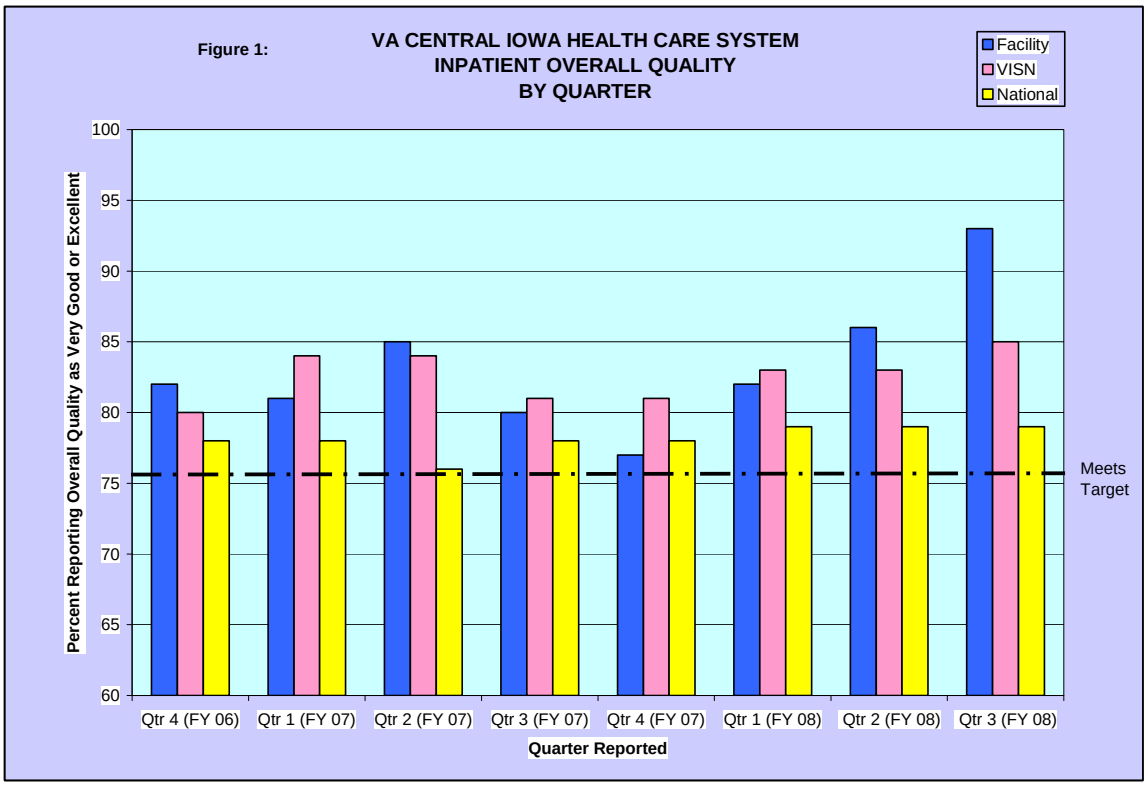
The purpose of this review was to evaluate whether the system had developed comprehensive nurse staffing guidelines and to determine if the nurse staffing provided corresponded to the system's methodology. Identifying and providing the correct number and/or mix of nurses is essential to the delivery of high quality patient care.

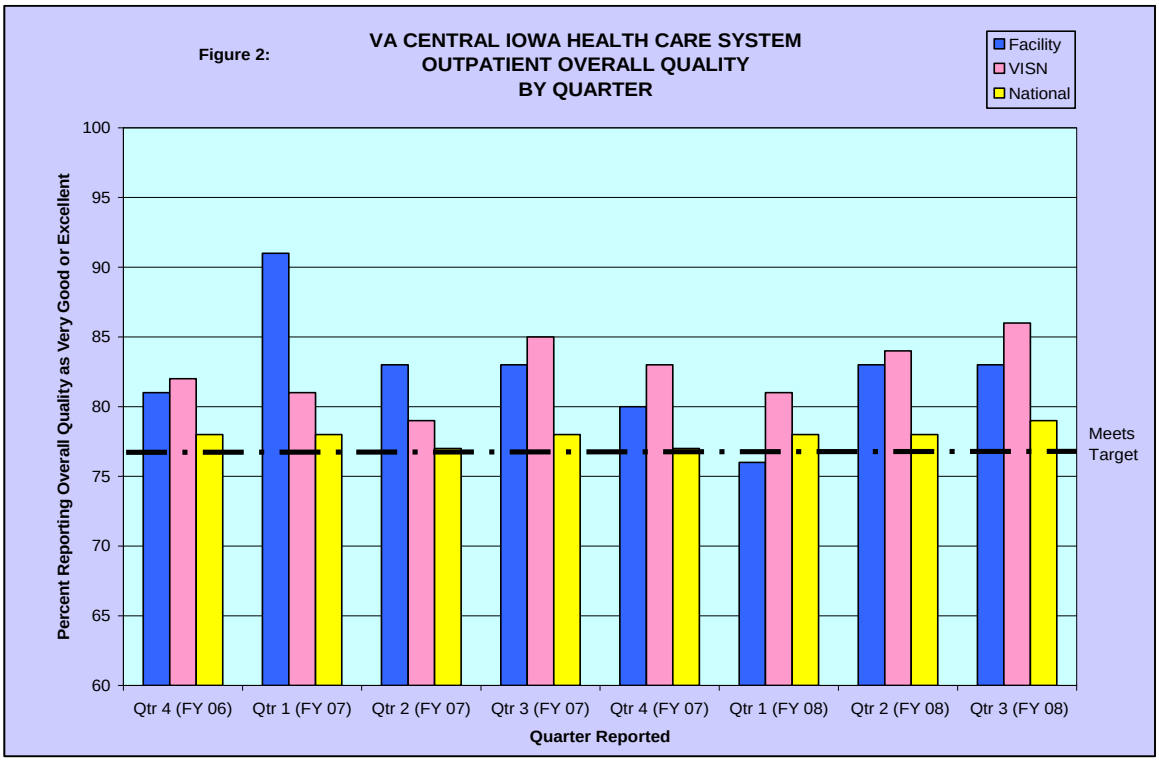
The system's staffing methodology is based upon a mix of licensed and non-licensed personnel varied by night, day, and evening shifts. We reviewed staffing for five inpatient units for three randomly selected dates. The dates included a week day, a weekend day, and a holiday. We reviewed nurse staffing documents and interviewed managers for select units (including CLC, acute psychiatry, and general medicine/surgery). We found the nurse staffing methodology to be appropriate. We made no recommendations.

Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that the system uses quarterly 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 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 system's SHEP performance measure results for inpatients and outpatients, respectively.





We reviewed survey results for quarter 4 of FY 2006 through quarter 3 of FY 2008. The system's inpatient results

exceeded the target in all 8 quarters reviewed. The system's outpatient results exceeded the target in 7 of 8 quarters reviewed. Managers had analyzed survey results, identified opportunities for improvement, initiated an action plan, and evaluated the plan for effectiveness. We made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 17, 2008

From: Director, VA Midwest Health Care Network (10N23)

Subject: **Combined Assessment Program Review of the VA Central Iowa Health Care System, Des Moines, Iowa**

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

Director, Management Review Service (10B5)

Thank you for the opportunity to review and provide comments.

(original signed by:)

ROBERT A. PETZEL, M.D.

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 17, 2008

From: Director, VA Central Iowa Health Care System (636A6/00)

Subject: **Combined Assessment Program Review of the VA Central Iowa Health Care System, Des Moines, Iowa**

To: Director, VA Midwest Health Care Network (10N23)

Director, Chicago Office of Healthcare Inspections (54CH)

Our responses to the OIG recommendations are included in this report. We appreciated the opportunity to have our programs reviewed in order to continuously improve our processes.

(original signed by:)

DONALD C. COOPER

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 provider-specific PI data be collected and considered during reprivileging, in accordance with VHA policy.

Concur **Target Date of Completion: March 1, 2009**

Audit of the practitioner database revealed the required data was present for those practitioners re-privileged from July 2008 to the present. Service Line Directors, Quality Management, and Chief of Staff's Office will assure implementation for all practitioners in accordance with policy.

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires that employees complete CPR training, in accordance with system policy.

Concur **Target Date of Completion: January 16, 2009**

Review of CPR training database revealed staff that had been included inappropriately; database is being updated to ensure alignment with policy and monitored quarterly by Education Service. Additional CPR training opportunities have been scheduled. Education Service will actively monitor staff compliance with training and notify supervisors/managers of delinquencies; managers will initiate corrective action with delinquent staff as indicated.

Recommendation 3. We recommended that the VISN Director ensure that the System Director establishes a committee to provide oversight and coordination of the medical record review process.

Concur **Target Date of Completion: February 15, 2009**

A draft charter to establish a medical records oversight committee has been drafted and membership selection and appointment initiated on December 2, 2008. Committee will meet at least quarterly to monitor clinical record review findings and initiate improvements.

Recommendation 4. We recommended that the VISN Director ensure that the System Director requires that identified safety, IC, and patient privacy deficiencies be corrected.

Concur **Completed**

Ceiling tiles. Work orders were initiated and completed by November 14, 2008, for all ceiling tile repair/replacement in areas identified. All occupied areas at all sites are inspected twice per year through the EOC Rounds inspection process, and inspection tool is utilized which specifically identifies damaged/stained ceiling tiles as a point of inspection. To improve monitoring and maintenance, two "customer service" positions have been developed and approved for the Engineering Service, with the primary responsibility for daily/frequent rounds on all inpatient and outpatient care areas, where they will work with clinical supervisors to either correct the EOC/facility issues "on the spot" or initiate work requests for correction.

Concur **Target Date of Completion: February 1, 2009**

Unlocked kitchen door in the VCS area. A work order has been initiated to have a panic alarm bar installed that will assure the door is closed and locked at all times while maintaining fire safety standards for egress.

Identified Safety Issues:

Concur **Target Date of Completion: February 1, 2009**

Medications, cleaning products, and sharp items security. Immediate action was taken onsite to correct the identified deficiencies. Nursing and Respiratory Therapy (RT) staff were re-instructed regarding required storage/securing of items. A process has been established to monitor for inappropriate unsecured items on each unit during daily rounds.

Concur **Completed**

Lock number on the crash cart and signatures on the Code Blue checklist. Immediate action was taken to change the lock out tag on October 28, 2008, and SPD employees were instructed to document tag changes and dates on the crash cart check sheet. RNs were re-educated regarding crash cart checks and documentation on October 31, 2008. A process has been established to monitor for appropriate checks and signatures, and Nurse Managers will follow up with appropriate corrective action with staff for missing signatures.

Concur **Target Date of Completion: February 1, 2009**

Brick holding nursing clinic door open. Action was taken to remedy the immediate situation, and a work order was initiated to have the door repaired.

Concur **Completed**

Unsecured doors to the VCS retail storage rooms at the Des Moines division. Staff have been instructed regarding the requirement for storeroom doors within the retail store to remain closed at all times except while in the process of stocking shelves or pop coolers.

Concur **Target Date of Completion: February 1, 2009**

Oxygen tanks labeled full/empty; emergency tanks available in the ICU. Immediate action was taken to obtain replacement tanks in the ICU. SPD will establish a process for monitoring and replacement of empty oxygen tanks on the clinical units; labeling full/empty tanks has been implemented in all areas where oxygen is available. ICU and RT staff to notify SPD of need for additional tanks.

Concur **Completed**

Hospital beds on the locked mental health unit. Immediate action was taken to remove the beds from the unit, and staff were re-educated on the proper storage of equipment.

Concur **Target Date of Completion: February 1, 2009**

Delayed response to emergency call alarm. Staff have been re-instructed regarding the need for rapid response to emergency call system. A monitor has been established to evaluate staff response to emergency call system and provide feedback to staff.

Identified Infection Control Issues:

Concur **Target Date of Completion: February 1, 2009**

Nutrition refrigerator monitoring. Food Service supervisors are re-training Nutrition and Food Service staff regarding monitoring and initiating corrective action when refrigerator temperatures go out of range. Checkpoint temperature monitoring system to be reevaluated to address frequent inaccuracies.

Concur **Completed**

Pest inspections. Immediate action was taken to address the identified deficiency. Inspection for pests has been added to the checklist for Housekeeping assigned areas. Pest sightings will be immediately

reported to the Environmental Management Service (EMS) coordinator. Pest vendor will be notified and will be required to remedy the problem within 4 hours of the sighting.

Concur **Target Date of Completion: February 1, 2009**

Storage rooms and trash. Trash receptacles were immediately removed to appropriate spaces. All nursing staff and RTs will be educated on the proper usage of clean storage rooms and separation of clean/dirty. Monitoring of storage areas has been added to Nurse Manager unit rounds. EMS staff will monitor and report deficiencies in storage areas.

Concur **Target Date of Completion: March 1, 2009**

Wheelchairs. The processes for inspecting, identifying, and implementing wheelchair and other equipment cleaning and repair requests will reviewed and updated to attain consistency across campuses. Monitoring of equipment state of repair and cleanliness will be added to Environmental/Infection Control rounds.

Identified Patient Privacy Issues:

Concur **Target Date of Completion: March 1, 2009**

Bedside clinical information uncovered. Plastic covers were placed on all bedside clipboards. Managers have added monitoring for appropriate privacy covers on the clipboards to Nurse Manager unit rounds.

Concur **Target Date of Completion: March 1, 2009**

BCMA laptop computers unattended when sensitive information loads and displays. Nursing staff will be re-educated regarding the BCMA process to take the BCMA cart into the patient's room, if space permits, while giving medications. If unable to take into the room because of space or infection control issues, nurse is to lower screen or log off. Process for daily reminders to all nursing staff to be initiated on January 15, 2009. Privacy screens will be explored for BCMA laptops.

Recommendation 5. We recommended that the VISN Director ensure that the System Director requires that consultation responses be completed within the system's established timeframe.

Concur **Target Date of Completion: March 1, 2009**

Each Service Line will appoint one or more back-up persons to receive all inpatient consults in addition to consulting providers; the back-up person(s) will follow-up to ensure patient is seen and documentation is completed within established timeframes. Chief of Staff's Office and

Systems Redesign Coordinator will work with Service Line Directors to develop a consistent sustainable process to ensure all inpatient consults are seen and documentation is completed within established timeframes.

Recommendation 6. We recommended that the VISN Director ensure that the System Director requires that transfer documentation be completed in accordance with system policy.

Concur **Target Date of Completion: March 1, 2009**

Nursing staff re-instructed regarding the requirement for RN documentation of transfers and appropriate completion of transfer notes. The practice of LPNs completing the transfer note was stopped. QM/Health Information Management Service will monitor medical-surgical and mental health transfer documentation to assure sustained compliance.

Recommendation 7. We recommended that the VISN Director ensure that the System Director requires that discharge documentation accurately reflects active outpatient medications.

Concur **Target Date of Completion: February 1, 2009**

Importing of medication lists into the provider's discharge instructions or other discharge documents is being stopped. A process is being developed that addresses entry of discharge medication orders, reconciliation of discharge medications, printing of a single list of medications the patient is to take at home, and completion of medication education.

Recommendation 8. We recommended that the VISN Director ensure that the System Director requires that monthly inspections be completed of all areas where CS are stored.

Concur **Completed**

CS Coordinator completed additional education of both current and newly appointed inspectors regarding the requirement for inspections to be performed in their assigned calendar month. In the event an inspector cannot complete the assigned inspection by month's end, the CS Coordinator is to be contacted immediately and an alternate is assigned to complete the inspection. CS Coordinator will monitor monthly inspections completed/not completed prior to the end of the month to assure timely inspection. CS Coordinator has enhanced the yearly inspector evaluations to include a self-assessment on subject knowledge.

Recommendation 9. We recommended that the VISN Director ensure that the System Director requires that staff follow system policy regarding medication disposition upon admission.

Concur **Completed**

The finding was immediately corrected onsite. Nursing staff were re-instructed on November 15, 2008, regarding the need to have the patient's personal medications given to family members or sent to pharmacy to be destroyed. A process for weekly random inspections to ensure medications are not stored on the unit is being implemented.

Recommendation 10. We recommended that the VISN Director ensure that the System Director takes action to ensure that the SMP is implemented and managed in accordance with system policy.

Concur **Target Date of Completion: February 1, 2009**

Mental Health Service Line will develop an educational handout to explain the security requirements to patients and a template for documentation of the required medication education per SMP policy. Staff training regarding educational requirements and the new medication education template will be completed by management. Practitioners will order level of medication administration needed by a veteran as Level I-IV and independent medication administration on admit and as needed through treatment. Compliance with all aspects of the process will be monitored for sustained improvement

Recommendation 11. We recommended that the VISN Director ensure that the System Director takes action to ensure that PRN medication effectiveness is documented within the timeframe defined by system policy.

Concur **Target Date of Completion: January 1, 2009**

Acute and CLC nursing staff are being re-educated in unit meetings and by e-mail regarding the requirement for documentation of PRN effectiveness. A process for daily audit of compliance with PRN medication documentation has been developed, and Nurse Managers will provide timely feedback and take appropriate steps to assist individual staff with compliance.

Recommendation 12. We recommended that the VISN Director ensure that the System Director requires that patients discharged from the ED receive written discharge instructions.

Concur **Target Date of Completion: February 1, 2009**

Emergency Department (ED) staff and Quality Manager will develop an ED discharge instruction template that addresses those elements appropriate to ED patients and compile standardized educational materials to be available on the unit for dissemination to patients. Staff will be educated and the process implemented by February 1, 2009. Use of the new instruction form will be monitored by QM. The national ED instruction template currently under development will be implemented when published.

Recommendation 13. We recommended that the VISN Director ensure that the System Director requires that clinicians document inter-facility transfers in accordance with VHA policy.

Concur **Target Date of Completion: February 1, 2009**

Transfer policy is currently being updated. ED Nurse Manager will replace current Inter-Agency Transfer form with the appropriate form per VHA Directive 2007-015. ED Nurse Manager will assess the use of i-Med consent, paper forms, scanning and/or template documentation for the most useful method to document transfers.

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