Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-02600-100

Combined Assessment Program Review of the William S. Middleton Memorial Veterans Hospital Madison, Wisconsin

March 24, 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 December 1–5, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the William S. Middleton Memorial Veterans Hospital (the hospital), Madison, WI. 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 121 employees. The hospital is part of Veterans Integrated Service Network (VISN) 12.

Results of the Review

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

- Patient-centered shift handoff improved care.
- Resident training resulted in improvements.

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

- Ensure that the clinical privileges granted to contractors do not extend beyond the contract period.
- Correct identified safety deficiencies.
- Correct identified infection control (IC) deficiencies.
- Complete patient care equipment preventive maintenance (PM) at the required intervals.
- Ensure that consultation requests are acted on within the hospital's or service's defined timeframe.
- Ensure that discharge documentation accurately reflects active outpatient medications.
- Ensure that clinicians document inter-facility transfers in accordance with Veterans Health Administration (VHA) policy.
- Complete monthly inspections for all areas where controlled substances (CS) are stored.
- Correct deficiencies identified in the annual pharmacy security assessments.

- Ensure more frequent housekeeping service in the inpatient pharmacy and repair ceiling leaks in the outpatient pharmacy.

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

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

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

Comments

The Acting VISN and Hospital Directors concurred with the findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 15–20, for the full text of the Directors' comments). We will follow up on the planned actions until they are completed.

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

Introduction

Profile

Organization. The hospital is an acute care facility located in Madison, WI, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five community based outpatient clinics in Baraboo, Beaver Dam, and Janesville, WI, and in Rockford and Freeport, IL. The hospital is part of VISN 12 and has a primary service area that includes approximately 130,000 veterans throughout 15 counties in Wisconsin and 5 counties in Illinois. Also, the hospital is the specialty care referral center for an additional 57,000 veterans in the Tomah VA Medical Center's primary service area.

Programs. The hospital provides tertiary medical, surgical, neurological, and psychiatric care services. It has 87 beds.

Affiliations and Research. The hospital is affiliated with the University of Wisconsin's School of Medicine and Public Health and provides training for 101 residents. It also provides training for other disciplines, including nursing, physical and occupational therapy, pharmacy, social work, dietetics, and other allied health professions. In fiscal year (FY) 2008, the hospital research program had 23 VA-funded primary investigators and 10 new or renewed projects. The budget was $3.8 million. Important areas of research included geriatrics, hypertension, infectious diseases, swallowing disorders, diabetes, prostate cancer, and pulmonary diseases.

Resources. In FY 2008, medical care expenditures totaled $218 million. FY 2008 staffing was 1,148 full-time employee equivalents (FTE), including 143 physician and 301 nursing FTE.

Workload. In FY 2008, the hospital treated 30,035 unique patients and provided 25,002 inpatient days. The inpatient care workload totaled 3,970 discharges, and the average daily census was 65.4. Outpatient workload totaled 267,464 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 eight activities:

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

The review covered hospital operations for FY 2008 and FY 2009 through November 28, 2008, and was done in accordance with OIG standard operating procedures for CAP reviews. We followed up on select recommendations from our prior CAP review of the hospital (*Combined Assessment Program Review of the William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin,* Report No. 05-01383-215, September 30, 2005). The hospital had corrected all findings related to health care from our prior CAP review.

We also followed up on recommendations from a prior OIG inspection (*Assessment of Legionnaire's Disease Risk in Veterans Health Administration Inpatient Facilities,* Report

No. 07-00029-151, June 20, 2007). The inspection surveyed inpatient facilities, including the hospital, for Legionnaire's disease (LD) prevention strategies. We found that the hospital has a written plan that addresses the prevention of LD and that the hospital is consistently performing monthly LD risk assessments. We consider the hospital to be in compliance with the recommendations.

During this review, we also presented fraud and integrity awareness briefings for 121 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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

Organizational Strengths

Patient-Centered Shift Handoff Improved Care

A need for improved communication on medical and surgical units was identified. Data guided the development of a new patient handoff process that highlights nursing autonomy and commitment to patient-driven care. The process takes patient satisfaction into consideration and improves patient safety. It also makes nurses accountable for their professional practice. This innovation was named 1 of the 10 "best of the best" national entries by VHA's National Chief Nursing Officer, who recognized the team for their accomplishments in October 2008.

Resident Training Resulted in Improvements

The hospital developed a new training experience in quality improvement for third-year residents. The goal of the month long rotation is for residents to gain an appreciation for how problems are identified and how change is effected. Since the inception of the program, more than 55 percent of the residents' proposals have been implemented, resulting in improvements in medical error reporting, implementation of cardiology performance measures, and numerous safety initiatives.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the hospital 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 hospital's Director, Associate Director for Patient Care Services, Chief of Staff, and Organizational Improvement Manager, and we interviewed other key staff. We evaluated policies, performance improvement (PI) data, and other relevant documents.

The QM program was generally effective in providing oversight of the hospital'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 13 of the 14 program activities reviewed. We identified one area that needed improvement.

Credentialing and Privileging. VHA policy[1] requires that clinical privileges be granted for a period not to exceed 2 years and that privileges granted to contractors do not extend beyond the contract period. We reviewed the credentialing and privileging folders and corresponding contracts of seven contractors who had been initially privileged or reprivileged during the past 12 months. We found that six contractors had been granted clinical privileges that extended beyond the contract period.

Recommendation 1

We recommended that the Acting VISN Director ensure that the Hospital Director requires that clinical privileges granted to contractors do not extend beyond the contract period.

The Acting VISN and Hospital Directors concurred with the finding and recommendation. The medical staff privilege form for each provider has been changed to clearly indicate the type of appointment each holds. For contract staff, the privilege form will indicate the specified timeframe for the respective contract. The improvement plan is acceptable,

[1] VHA Handbook 1100.19, *Credentialing and Privileging*, October 2, 2007.

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

Environment of Care

The purpose of this review was to determine whether the hospital 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 VHA, Occupational Safety and Health Administration, and Joint Commission (JC) standards.

We inspected the inpatient medical/surgical units (4B, 7B), the locked acute psychiatry unit (2B), the coronary intensive care unit (CCU), the surgical intensive care unit (SICU), the operating room, the post-anesthesia care unit, the speech clinic, the audiology clinic, the ear, nose, and throat (ENT) clinic, primary care clinic D, and several common areas.

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. IC staff also provided in-service education as new health concerns were identified.

The hospital was generally clean and effectively maintained. EOC recommendations from our prior CAP review had been corrected. Nurse managers and unit staff expressed satisfaction with the responsiveness of the housekeeping staff on their units. However, we identified the following areas that needed improvement.

Safety. Medication and nourishment refrigerators must be monitored daily to ensure that contents are safe. We found expired medications in refrigerators on medical/surgical unit 7B, in the E/UC area, and in primary care clinic D. Expired nourishments were found in refrigerators on the CCU and on the SICU.

Oxygen tanks must be stored so that staff may quickly identify which are full and which are empty. The units we inspected did not have a clear separation between full and empty tanks.

Sharp items must be secured from public access. In the ENT clinic, there were sharp items in an unlocked soiled utility room.

Infection Control. Patient care equipment and furniture need to be regularly inspected, and items with compromised surfaces need to be repaired or removed from service. We identified a reclining chair with compromised surfaces on medical/surgical unit 4B. We also identified one chair in primary care clinic D and six chairs in the outpatient pharmacy waiting room with compromised surfaces. Managers reported that new chairs for primary care clinic D and the outpatient pharmacy had been ordered.

Storage areas need to be maintained so that clean and dirty items are separated. We identified storage rooms that contained a mixture of items, for example, clean linens and patient care equipment stored with soiled equipment, patients' personal clothing, and soiled linen containers.

Preventive Maintenance. We evaluated whether the hospital had effective processes in place to ensure that patient care equipment items are properly cleaned and maintained. We selected 26 equipment items and reviewed corresponding PM records from Biomedical Engineering. PM records showed that 23 (88 percent) equipment items had been cleaned and maintained as required and that they had received PM at the recommended intervals. Three equipment items had not received the required PM.

Recommendation 2 We recommended that the Acting VISN Director ensure that the Hospital Director requires that identified safety deficiencies be corrected.

The Acting VISN and Hospital Directors concurred with the findings and recommendation. The hospital developed appropriate plans to address the safety deficiencies identified during the inspection. Refrigerators will be monitored, full and empty oxygen tanks will be physically separated, and spot checks for sharp items will be conducted. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Recommendation 3 We recommended that the Acting VISN Director ensure that the Hospital Director requires that identified IC deficiencies be corrected.

The Acting VISN and Hospital Directors concurred with the findings and recommendation. The hospital developed appropriate plans to address the IC deficiencies identified during the inspection. Replacement chairs will be delivered,

and staff have been re-educated regarding the separation of clean and dirty items. The improvement plans are 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 Hospital Director requires that patient care equipment receives PM at the required intervals.

The Acting VISN and Hospital Directors concurred with the finding and recommendation. The hospital found that PM had been completed on the three identified equipment items; however, the electronic PM logs had not been updated. The logs were updated on December 17, 2008. The corrective action is acceptable, and we consider this recommendation closed.

Coordination of Care

The purpose of this review was to evaluate whether consultations, intra-facility transfers, and discharges were appropriately coordinated and met VHA and JC standards. Coordinated consultations, transfers, and discharges are essential to an integrated, ongoing care process resulting in optimal patient outcomes. We identified two areas that needed improvement.

Consultations. Hospital and service-specific policies define timeframes for responses to consultation requests. We reviewed the medical records of nine inpatients who had routine consultations ordered and internally completed. We noted that for one patient, the service consulted documented their response 6 days after the provider's request, which was outside the defined timeframe.

Discharges. VHA policy[2] addresses information to be documented in the medical record when a patient is discharged. We reviewed the medical records of nine inpatients who were discharged from the hospital. There was one instance in which the provider's discharge note included outpatient medications that were listed twice—once as "active" and once as "pending." Since this information is given to the patient, there is potential for errors in medication dosing. Also, in three medical records, we identified discrepancies between active outpatient medications listed in

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

the provider's discharge summary, those listed in the discharge orders, and/or those listed in the pharmacist's patient education note.

Recommendation 5 We recommended that the Acting VISN Director ensure that the Hospital Director requires that consultation requests are acted on within the hospital's or service's defined timeframe.

The Acting VISN and Hospital Directors concurred with the finding and recommendation. The provider for the one delinquent consult has been re-educated regarding policy timeframes. The corrective action is acceptable, and we consider this recommendation closed.

Recommendation 6 We recommended that the Acting VISN Director ensure that the Hospital Director requires that discharge documentation accurately reflects active outpatient medications.

The Acting VISN and Hospital Directors concurred with the findings and recommendation. Discharge medications will be finalized by the medical team prior to the pharmacy discharge appointment. A pharmacist will prepare the final medication document and educate the patient. The discharge summary and the outpatient pharmacy list will reflect the medications in the pharmacy discharge note. The improvement plans are 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 hospital'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 hospital's E/UC environment for cleanliness and safety.

The hospital's E/UC facility is open 24 hours per day, 7 days per week, as required. It is located within the main hospital building, and the emergency services provided are within the hospital's capability. In addition, there is an appropriate policy for managing patients whose care may exceed the hospital's capability. We identified one area that needed improvement.

Inter-Facility Transfer Documentation. VHA policy[3] requires the use of specific forms for the documentation of inter-facility transfers. We reviewed the medical records of

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

three patients who were initially treated in the E/UC facility and then transferred to other facilities. The hospital was unable to locate the required documentation, so we were unable to determine whether the forms were completed.

Recommendation 7 We recommended that the Acting VISN Director ensure that the Hospital Director requires that clinicians document inter-facility transfers in accordance with VHA policy.

The Acting VISN and Hospital Directors concurred with the finding and recommendation. The hospital has developed and implemented templates for inter-facility transfers that are congruent with VHA policy. 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 hospital had adequate controls to ensure the security and proper management of CS and the pharmacies' internal physical environments. 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 hospital's policies and practices were consistent with VHA regulations. We inspected the inpatient and outpatient pharmacies, the clean room, and the vaults for security, EOC, and IC issues. Additionally, we interviewed the CS Coordinator and pharmacy managers.

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 pharmacies and CS. The CS Coordinator and CS inspectors were appointed in writing by the hospital's Director and received the required training to perform their duties. The pharmacies' internal environments were generally clean and well maintained. We identified three areas that needed improvement.

Controlled Substances Inspections. VHA policy[4] requires monthly, random inspections of all areas where CS are stored. Through interviews and reviews of inspection documents, we learned that the August 2008 inspection of the infusion clinic was missed.

Pharmacy Security. VA policy[5] requires an annual security assessment of all pharmacy areas. We reviewed the 2006, 2007, and 2008 annual security assessment reports and found that discrepancies identified during the 2006 inspection had not been fully resolved by the date of the 2008 inspection.

Environment of Care. During our tour of the inpatient pharmacy, we noted a significant amount of debris on the floor. This area was under construction. Further housekeeping services were needed to ensure that the area remained clean. During our tour of the outpatient pharmacy, we noted two stained ceiling tiles adjacent to an exterior wall and window. Employees stated that there were leaks, especially during heavy rains. Although some repairs had been initiated, the problem had not been resolved.

Recommendation 8 We recommended that the Acting VISN Director ensure that the Hospital Director requires that monthly inspections are completed for all areas where CS are stored.

The Acting VISN and Hospital Directors concurred with the finding and recommendation. Policies are in place for CS inspections to be completed on a monthly basis for each area of the hospital that stores CS. Verification of all monthly

[4] VHA Handbook 1108.2, *Inspection of Controlled Substances,* August 29, 2003.
[5] VA Handbook 0730/1, *Security and Law Enforcement,* August 20, 2004.

inspections will be completed at the CS inspectors meetings. 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 Hospital Director requires that deficiencies identified in the annual pharmacy security assessments be corrected.

The Acting VISN and Hospital Directors concurred with the finding and recommendation. The "Upgrade Physical Security Project" currently in progress in the inpatient and outpatient pharmacy areas will resolve the deficiencies identified in the annual pharmacy security assessments. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 10 We recommended that the Acting VISN Director ensure that the Hospital Director requires more frequent housekeeping service in the inpatient pharmacy and repair of ceiling leaks in the outpatient pharmacy.

The Acting VISN and Hospital Directors concurred with the findings and recommendation. Engineering Service is reinforcing the requirement for contractors to clean construction areas daily, and additional housekeeping support is being provided. The ceiling leak in the outpatient pharmacy has been fixed. The improvement plans are 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 hospital had developed comprehensive nurse staffing guidelines and to determine whether the nurse staffing provided corresponded to the hospital's methodology. Identifying and providing the correct number and/or mix of nurses is essential to the delivery of high quality patient care.

The hospital'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 four inpatient units for three randomly selected dates. The dates included a weekday, a weekend day, and a holiday. We reviewed nurse staffing documents and interviewed managers for select units, including the locked acute psychiatry unit, a medical/surgical unit, the CCU, and the SICU. We found the

nurse staffing methodology to be appropriate. We made no recommendations.

Medication Management

The purpose of this review was to evaluate whether the hospital had adequate medication management practices. A safe medication management system includes medication ordering, administering, and monitoring.

We reviewed medication management processes on the locked acute psychiatry unit, the CCU, and two medical/surgical units. We found appropriate use of patient armbands to correctly identify patients prior to medication administration. We made no recommendations.

Survey of Healthcare Experiences of Patients

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

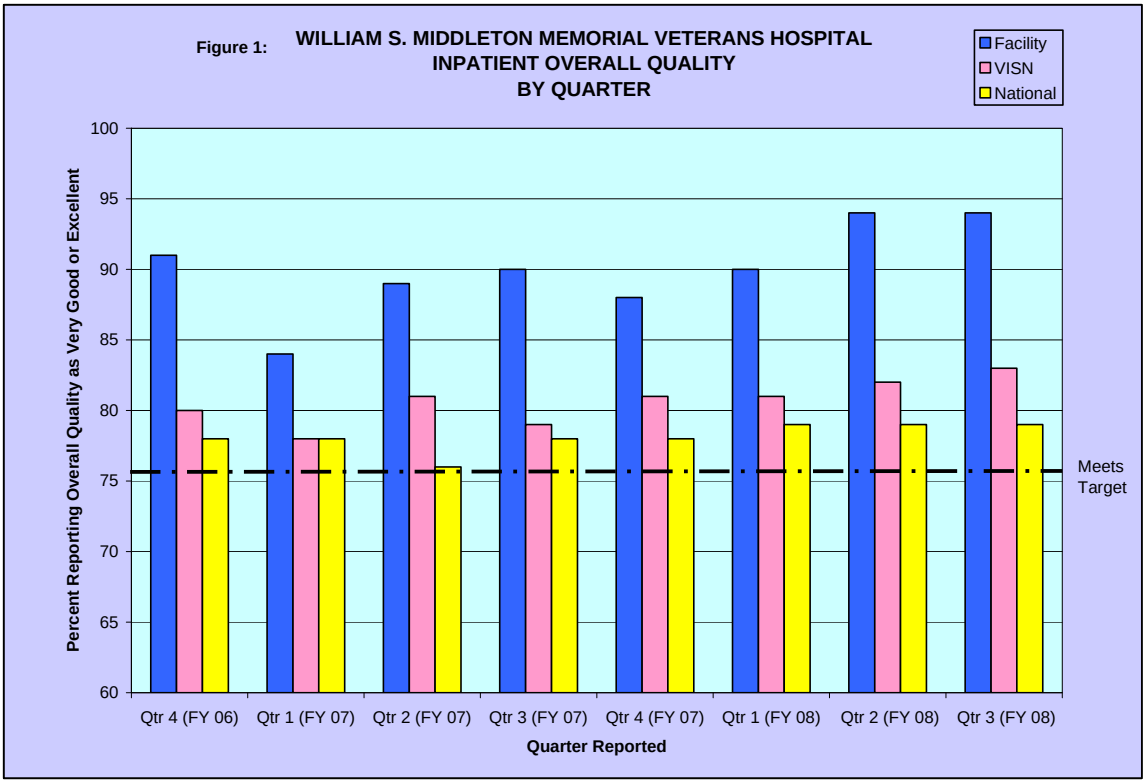
Figure 1:
WILLIAM S. MIDDLETON MEMORIAL VETERANS HOSPITAL
INPATIENT OVERALL QUALITY
BY QUARTER
Facility
VISN
National
Percent Reporting Overall Quality as Very Good or Excellent
100
95
90
85
80
75
70
65
60
Meets Target
Qtr 4 (FY 06)
Qtr 1 (FY 07)
Qtr 2 (FY 07)
Qtr 3 (FY 07)
Qtr 4 (FY 07)
Qtr 1 (FY 08)
Qtr 2 (FY 08)
Qtr 3 (FY 08)
Quarter Reported

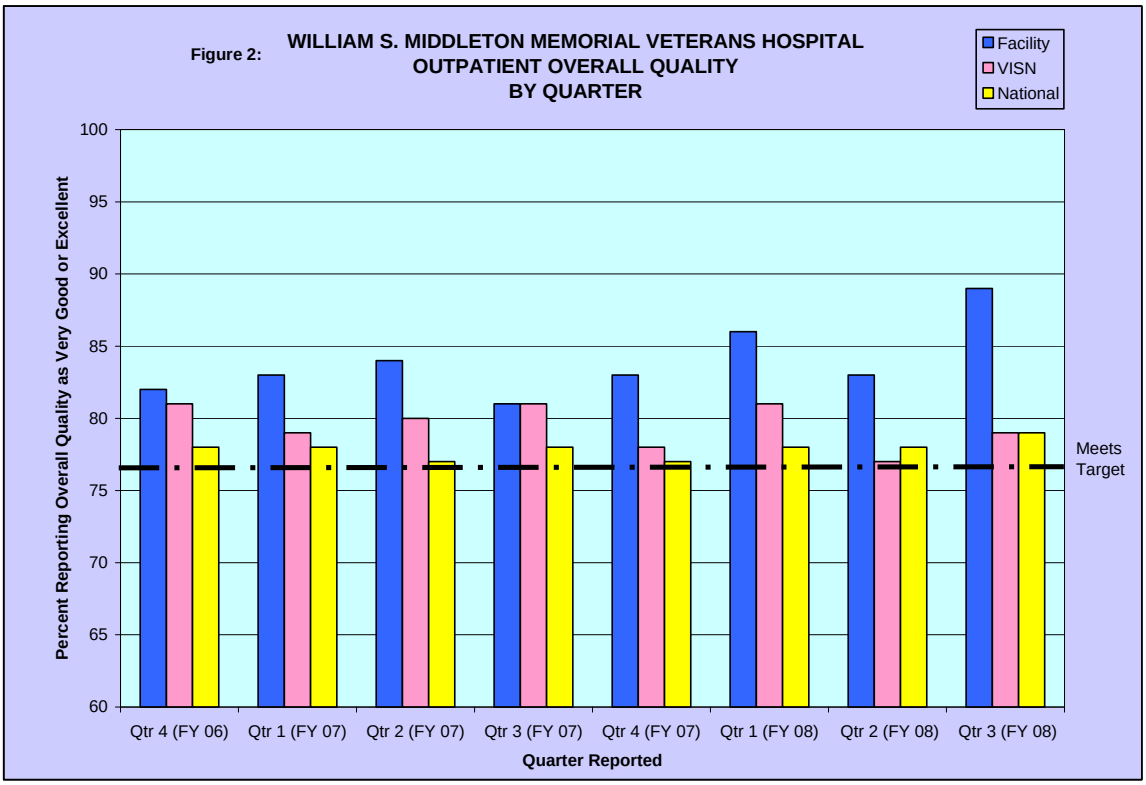
Figure 2:
WILLIAM S. MIDDLETON MEMORIAL VETERANS HOSPITAL
OUTPATIENT OVERALL QUALITY
BY QUARTER
Facility
VISN
National
Percent Reporting Overall Quality as Very Good or Excellent
100
95
90
85
80
75
70
65
60
Meets Target
Qtr 4 (FY 06)
Qtr 1 (FY 07)
Qtr 2 (FY 07)
Qtr 3 (FY 07)
Qtr 4 (FY 07)
Qtr 1 (FY 08)
Qtr 2 (FY 08)
Qtr 3 (FY 08)
Quarter Reported

We reviewed survey results for quarter 4 of FY 2006 through quarter 3 of FY 2008. The hospital's inpatient and outpatient results exceeded the target in all 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.

Acting VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 23, 2009

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

Subject: **Combined Assessment Program Review of the William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin**

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

Director, Management Review Service (10B5)

1. I concur with the Office of Healthcare Inspections recommendations as well as the corrective action plans developed by the Madison VA Hospital.

2. Thank you for the opportunity to review the findings enclosed in this report.

Renee Oshinski

Renee Oshinski

Hospital Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 21, 2009

From: Director, William S. Middleton Memorial Veterans Hospital (607/00)

Subject: **Combined Assessment Program Review of the William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin**

To: Acting Director, VA Great Lakes Health Care System (10N12)

Director, Chicago Office of Healthcare Inspections (54CH)

1. Thank you for the opportunity to review the draft report on the Combined Assessment Program Review of the VAMC Madison (607).

2. I have reviewed the document and concur with the recommendations. Corrective action plans have been established with planned completion dates, as detailed in the attached report.

Deborah A. Thompson

DEBORAH A. THOMPSON

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 Acting VISN Director ensure that the Hospital Director requires that clinical privileges granted to contractors do not extend beyond the contract period.

Concur **Completed**

The Medical Staff privilege form for each provider has been changed to clearly indicate what type of Medical Staff appointment they hold. For individual contract staff, the privilege form will indicate the specified timeframe for the respective contract. The process change of having dates of clinical privileges coincide with active contract dates noted on the privileging form began January 12, 2009.

Recommendation 2. We recommended that the Acting VISN Director ensure that the Hospital Director requires that identified safety deficiencies be corrected.

Concur **Target Date of Completion: February 28, 2009**

Food and Nutrition services do a daily sweep of nourishments in the patient care unit refrigerators. F&NS supervisor will reinforce the need to remove expired items. Refrigerator surveillance rounds will be implemented in CCU and SICU, with reports sent to F&NS supervisor for the next 3 months to ensure the process is working.

Although a pharmacy process is already in place to identify expired medications, this review indentified expired medication on 7B, E/UC, and outpatient Clinic D. An additional process will be implemented by February 1, 2009, in these areas for an LPN to double check the refrigerators on a daily basis during open clinic hours for 3 months to assure the Pharmacy process is working.

There will be a clear delineation of full and empty oxygen tanks such that there will be physical separation of tank storage with signage to indicate full and empty tanks. The process change will be completed by February 28, 2009.

A sweep of the ENT clinic was done to ensure there were no sharp items left in public places. Staff was educated regarding the importance of securing sharps. Spot checks of the ENT clinic will be done on a weekly basis for 2 months to ensure that there are no sharps left in public places.

Recommendation 3. We recommended that the Acting VISN Director ensure that the Hospital Director requires that identified IC deficiencies be corrected.

Concur **Target Date of Completion: March 31, 2009**

Chairs with compromised seating surfaces identified during survey (outpatient pharmacy, clinic D, and 4B inpatient unit) were removed January 20, 2009. Replacement chairs for the outpatient clinic areas had already been ordered by the facility at the time of the CAP review. These chairs are scheduled to be in place by March 31, 2009. To the best of our knowledge, there was one storage room, on one unit, that there was a mix of clean and dirty items found. Unit staff have been re-educated regarding the need to maintain separate storage of clean and dirty items as defined in hospital policy 111-13 (Hand Hygiene, Standard Precautions and Isolation).

Recommendation 4. We recommended that the Acting VISN Director ensure that the Hospital Director requires that patient care equipment receives PM at the required intervals.

Concur **Completed**

The facility has an effective process in place for equipment preventive maintenance. The PM's had been completed on the three pieces of equipment and had stickers on the equipment indicating timely maintenance. The issue was that the computer entry process to update the PM log had not yet been done. This was completed on December 17, 2008.

Recommendation 5. We recommended that the Acting VISN Director ensure that the Hospital Director requires that consultation requests are acted on within the hospital's or service's defined timeframe.

Concur **Completed**

Appropriate policies are in place to define timeframes for consult completion for inpatients. The provider for the one delinquent consult has been re-educated regarding the policy timeframes.

Recommendation 6. We recommended that the Acting VISN Director ensure that the Hospital Director requires that discharge documentation accurately reflects active outpatient medications.

Concur **Target Date of Completion: March 30, 2009**

The discharge medications must be finalized by the medical team prior to the pharmacy discharge appointment. The pharmacist will prepare the final medication use document and educate the patient. The discharge summary and the outpatient pharmacy list will reflect the medications in the pharmacy discharge note. This process change will be implemented March 30, 2009. Monitoring will be done for 3 months post implementation to ensure this process change is working.

Recommendation 7. We recommended that the Acting VISN Director ensure that the Hospital Director requires that clinicians document inter-facility transfers in accordance with VHA policy.

Concur **Completed**

Templates for inter-facility transfers that meet VHA policy were developed and implemented in late November 2008, just days before the CAP review. The two inter-facility transfers that were completed after the implementation were in compliance with facility and VHA policy. We will continue to use the new process.

Recommendation 8. We recommended that the Acting VISN Director ensure that the Hospital Director requires that monthly inspections are completed for all areas where CS are stored.

Concur **Completed**

Policies are in place for controlled substance inspections to be completed on a monthly basis, with each area of the hospital that stores controlled substances to be inspected monthly. Infusion clinic was inadvertently missed during the month of August given this was the first time ever that the infusion clinic was on the schedule. Previous to this date infusion clinic did not store narcotics. This appears to be an aberration in the fact that for the past 2 years there had not been a missing inspection. Verification of all monthly inspections is completed at the Controlled Substance Inspectors meeting.

Recommendation 9. We recommended that the Acting VISN Director ensure that the Hospital Director requires that deficiencies identified in the annual pharmacy security assessments be corrected.

Concur **Target Date of Completion: April 25, 2009**

The contracted "Upgrade Physical Security Project" currently in progress in the inpatient and outpatient pharmacy areas will be completed on April 25, 2009. The completion of this project will resolve the identified deficiencies from the annual pharmacy security assessments.

Recommendation 10. We recommended that the Acting VISN Director ensure that the Hospital Director requires more frequent housekeeping service in the inpatient pharmacy and repair of ceiling leaks in the outpatient pharmacy.

Concur **Target Date of Completion: April 25, 2009**

During construction, contractors are responsible for cleaning their construction sites on a daily basis as identified in their pre-construction risk assessment. Engineering Service is now reinforcing this requirement at the regular construction meetings. In addition, the housekeeping staff assigned to inpatient pharmacy is assisting by providing additional housekeeping support.

The problem causing the ceiling leak in the outpatient pharmacy has been corrected.

OIG Contact and Staff Acknowledgments

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Report Distribution

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House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Roland W. Burris, Richard Durbin, Russell D. Feingold, Herb Kohl
U.S. House of Representatives: Tammy Baldwin, Ron Kind, Donald Manzullo, David R. Obey, Thomas Petri, Paul Ryan, F. James Sensenbrenner

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