Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 07-00543-08

Combined Assessment Program Review of the Jesse Brown VA Medical Center Chicago, Illinois

October 18, 2007

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 May 14–18, 2007, the OIG conducted a combined Assessment Program (CAP) review of the Jesse Brown VA Medical Center (the medical center). 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 215 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 12.

Results of the Review

The CAP review covered seven operational activities. We identified the following organizational strength:

- Implementation of percutaneous coronary interventions (PCIs) in the cardiac catheterization laboratory.

We made recommendations in four of the activities reviewed. We also made a repeat recommendation related to a deficient area identified in a prior CAP report. For these activities, the medical center needed to:

- Improve QM processes in peer review, adverse event disclosure, and root cause analyses (RCAs).
- Assure staff complies with environment of care (EOC) standards related to safety, security, and cleanliness.
- Assure that electronic medical record (EMR) business rules comply with Veterans Health Administration (VHA) policy.
- Implement a comprehensive patient satisfaction program.
- Assure that medical records of patients who receive moderate sedation include pertinent documentation.

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

- Lakeside Community Based Outpatient Clinic (CBOC).
- Surgical Care Improvement Project (SCIP).

This report was prepared under the direction of Ms. Victoria Coates, Acting Regional Director, St. Petersburg Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable implementation plans. (See Appendixes A and B, pages 15–19, for the full text of the Directors' comments.) We will follow up on 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 medical center is a tertiary care facility located in Chicago, IL, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at four CBOCs, two in Chicago, IL, one in Chicago Heights, IL, and one in Crown Point, IN. The medical center is part of VISN 12 and serves a veteran population of about 325,000 throughout Cook County, IL, and Lake County, IN.

Programs. The medical center provides medical, surgical, mental health, geriatric, and rehabilitation services. The medical center has 184 hospital beds and 17 nursing home beds.

Affiliations and Research. The medical center is affiliated with the University of Illinois Medical Center at Chicago and with the Northwestern University's Feinberg School of Medicine and provides training for 203 residents in 20 training programs. In fiscal year (FY) 2006, the medical center research program had 38 projects and a budget of $4.6 million. Important areas of research include alcoholism, cancer cell biology, and prosthetics.

Resources. In FY 2006, medical care expenditures totaled $212.4 million. The FY 2007 medical care budget is $233 million. FY 2006 staffing was 1,602 full-time employee equivalents (FTE), including 145 physician and 466 nursing FTE.

Workload. In FY 2006, the medical center treated about 42,400 unique patients and provided 35,242 inpatient days of care in the hospital and 3,544 inpatient days of care in the Nursing Home Care Unit. The inpatient care workload totaled 6,989 discharges, and the average daily census, including nursing home patients, was 106. Outpatient workload totaled about 545,000 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 seven areas or activities:

- EMR Business Rules.
- EOC.
- Lakeside CBOC.
- Moderate Sedation Documentation.
- Patient Satisfaction.
- QM.
- SCIP.

The review covered medical center operations for FY 2006 and FY 2007 through May 18, 2007, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review (*Combined Assessment Program Review, VA Chicago Health Care System, Chicago, Illinois,* Report No. 04-00937-196, August 30, 2004).

During this review, we also presented fraud and integrity awareness briefings to 215 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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

Organizational Strength

Percutaneous Coronary Interventions

The Lakeside campus of the VA Chicago Health Care System closed in August 2003, which required consolidation of cardiology services at the medical center. The Lakeside Cardiology Service had a cardiac catheterization laboratory that provided a full range of services, including PCIs.[1] However, the medical center only performed in-house diagnostic cardiac catheterizations. Patients requiring PCIs were transferred to the University of Illinois Medical Center at Chicago or to the Edward Hines, Jr. VA Hospital. Because of the increased need for cardiac catheterizations and PCIs after the consolidation, the medical center experienced increased waiting times. For the period August 2003 through September 2005, it took an average of 6.7 days for patients to receive PCIs. In addition, average bed days of care increased to 9.1 days, and transportation and fee basis referral costs exceeded $300,000 for 23 PCI cases.

VISN 12 convened the Cardiac Care Work Group, and the medical center completed a Healthcare Failure Mode and Effect Analysis (HFMEA)[2] to identify and resolve potential risks and to establish policy for the provision of consolidated cardiac services. The medical center established a transfer agreement with the University of Illinois Medical Center at Chicago for surgical backup in the event of complications; this agreement allowed the medical center to perform in-house PCIs without onsite cardiothoracic surgery services.

Since the inception of the consolidated program, there have been no delays in PCIs, as interventions are done at the time of the diagnostic catheterization. The average bed days of care has decreased to 1.3 days, and there have been no transportation or fee basis referral costs related to PCIs. During the first year of operation, the medical center provided cardiology services to 370 patients needing PCIs, and none of those cases required emergency transportation or emergent care.

[1] PCIs encompass a variety of procedures used to treat patients with diseased arteries of the heart that can reduce blood flow to a near trickle or patients who have had a heart attack caused by a large blood clot that completely blocks the artery.
[2] HFMEA is a systematic approach to identify and prevent product and process problems before they occur.

Results

Review Activities with Recommendations

Quality Management

The purposes of this review were to determine if the medical center (a) had a comprehensive and effective QM program designed to monitor patient care activities and coordinate improvement efforts and (b) was in compliance with VHA directives, appropriate accreditation standards, and Federal and local regulations. To evaluate QM processes, we interviewed senior managers and reviewed committee minutes, documents related to the functioning of the Quality Leadership Council (QLC) and the Executive Leadership Board (ELB), and other relevant QM information.

The QM program was generally effective in providing oversight of the quality of patient care. Credentialing and privileging (C&P), patient complaints, national patient safety goals, utilization management, resuscitation outcomes, medical records, restraint and seclusion, patient flow, and advanced clinic access were monitored appropriately. However, we identified the following program areas that needed improvement:

Peer Review. We found that the peer review program was not in compliance with VHA Directive 2004-054, *Peer Review for Quality Management*, issued September 29, 2004. We evaluated peer review activities and documentation from FY 2006 through the 1st quarter of FY 2007 and found that the medical center had not conducted formal peer reviews in accordance with VHA requirements. Managers told us that the former Chief of Staff had performed all peer reviews until his departure in the fall of 2006.

The new Chief of Staff, who started in November 2006, was taking action to enhance the peer review process. The medical center updated their peer review policy on March 7, 2007, (approximately 2 years after the deadline set in VHA's directive) and established the required Peer Review Committee (PRC). The March 29, 2007, PRC minutes reflected discussion of 16 peer reviews.

Peer review can result in both immediate and long-term improvements in patient care by revealing areas for improvement in individual providers' practices. To be effective, peer review should be completed in accordance with policy to ensure that providers perform according to accepted community standards,

and peer review findings should be evaluated to identify trends and improvement opportunities.

Quality Management Oversight and Reporting. We found that the QLC and the ELB did not complete annual evaluations of QM activities and patient safety/risk management activities. The Joint Commission[3] requires that an executive body provide oversight and monitor performance improvement (PI) and high-risk processes within the medical center. The QLC and the ELB have been designated to provide the required oversight and monitoring of QM activities. However, we found no evidence that these annual evaluations occurred in 2006.

Without QLC and ELB oversight and monitoring of performance activities, managers could not be assured that improvement opportunities were identified and actions taken in high-risk areas.

Adverse Event Disclosure. The medical center's policy on adverse event disclosure dated August 6, 2004, did not comply with VHA requirements for clinical and institutional disclosure. VHA Directive 2005-049, *Disclosure of Adverse Events to Patients,* issued October 27, 2005, requires that medical errors or harmful events be evaluated and disclosed, as appropriate. If a patient was harmed because of an error or event, responsible providers are required to disclose this to the patient (clinical disclosure). In some serious cases, patients must be advised of their legal rights and options (institutional disclosure).

While reviewing QM documents, we identified nine adverse events occurring between October 1, 2005, and April 20, 2007, that required disclosure; seven of those cases required clinical disclosure, and two sentinel events required institutional disclosure. We found that an appropriate evaluation with resulting documentation of disclosure had not occurred in any of the nine cases. This was a repeat finding from our 2004 CAP review.

Without adequate disclosure processes, managers could not be assured that patients received important medical and legal information needed to make decisions when adverse events occurred.

[3] The Joint Commission was formerly the "Joint Commission on Accreditation of Healthcare Organizations," also known as JCAHO.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that peer review processes are in compliance with VHA policy.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that the PRC will report trends and opportunities for improvement to the Medical Executive Committee (MEC) on a quarterly basis. The PRC report will be documented in the MEC minutes as of August 1, 2007. We will follow up on planned actions until they are completed.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that the QLC and ELB conduct annual evaluations of QM activities and patient safety/risk management processes, as required by medical center policy.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that the QLC currently reviews all PI functions and will track and report quarterly to the ELB. The ELB monitors and evaluates all PI activities. The medical center revised their policy to reflect that an annual evaluation of QM activities is not required by these committees. The improvement actions are acceptable, and we consider this recommendation closed.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that adverse events be evaluated and disclosed, as required by VHA policy.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that the medical center developed an adverse events disclosure template to document all adverse events. Executive Leadership will have responsibility for ensuring that documentation is completed in a timely manner. The Patient Safety Manager will monitor compliance and track disclosure of adverse events in the database. We will follow up on the planned actions until they are completed.

Environment of Care

VHA requires that health care facilities have a comprehensive EOC program that complies with VHA policy, Occupational Safety and Health Administration regulations, The Joint Commission, and the Nuclear Regulatory Commission Master Materials License. We inspected 18 clinical areas for cleanliness, safety, privacy, infection control, and general maintenance. We also inspected the warehouse loading dock

where tritium[4] and other radioactive waste products were stored and four laboratories where tritium was used. We followed up on EOC concerns cited in our 2004 CAP report, the 2006 Joint Commission report, and the medical center's EOC Committee meeting minutes and found that previously identified deficiencies were resolved.

Our inspection revealed that the medical center generally maintained a safe and clean environment and maintained accurate inventories of tritium, in accordance with VHA policies and procedures. We identified deficiencies related to mail-out medication security, warehouse loading dock conditions, stock rotation of intravenous (IV) fluids, and splash protection in storage rooms.

Mail-Out Medication Security. We found mail-out medications left in an open cart outside the mailroom on the warehouse loading dock. As access to this area was not restricted, unauthorized individuals could tamper with or remove patients' medications. During our inspection, medical center staff immediately moved the cart to a secured area inside the mailroom. The Chief, Pharmacy Service, and the mailroom supervisor notified employees to secure all mail-out medications and presented us with an action plan to ensure security of mail-out medications in the warehouse loading dock area.

Warehouse Loading Dock Conditions. On the warehouse loading dock, we found that the exit doors and the medical gas outlet door were blocked by trash and recycle bins. The medical gas outlet door was plainly marked "Do Not Block Door," and yellow stripes marked off the area that was to remain clear. The National Fire Protection Association prohibits the obstruction of exit doors.

We also found sterile supplies next to an overflowing kitchen trash bin; old, wet furniture; full and empty recycle bins; and piles of wooden flats on the loading dock. The roof was leaking in one area, and the general condition of the loading dock did not allow easy removal of supplies.

Managers corrected the deficiencies while we were onsite and presented us with an action plan to schedule routine waste removal (three times daily), educate staff, secure the dock area using key-card access, and monitor compliance.

[4] A radioactive substance used in research.

Stock Rotation of Intravenous Fluids. IV fluids in the storage rooms on the wards were not rotated during restocking. Although we did not find any expired IV fluids, managers agreed that rotation of stock was important to ensure that medications are used before their expiration dates. The Chief of Pharmacy Service informed us that the employee responsible for restocking IV fluids in all storage rooms was educated on rotating stock. We consider this issue closed.

Splash Protection in Storage Rooms. Three storage rooms had supply shelves without splash protection on the bottom shelf. The Joint Commission requires splash protection to prevent contamination of supplies from wet mops. Managers corrected this deficiency by installing splash guards while we were onsite. We consider this issue closed.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that the security of mail-out medications be maintained.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that Pharmacy and Postal Service will be responsible for ensuring the security of all mail-out medications. The medical center will monitor compliance during EOC rounds. The improvement actions are acceptable, and we consider this recommendation closed.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires that exit and medical gas outlet doors on the loading dock are not obstructed.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that the exit and medical gas outlet doors on the locking dock were cleared of obstruction. Medical center staff will inspect the area during EOC rounds to ensure that the doors remain clear. The improvement actions are acceptable, and we consider this recommendation closed.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires that the loading dock remains clean.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that the Chief of Logistics will ensure that daily rounds are made on the loading dock and that the area is kept free from obstruction. The loading dock will be

included in EOC rounds to ensure that cleanliness is maintained. The improvement actions are acceptable, and we consider this recommendation closed.

Electronic Medical Record Business Rules

Business rules define which groups or individuals are allowed to edit or delete documentation in electronic medical records. The health record, as defined in VHA Handbook 1907.01, *Health Information Management and Health Records,* issued August 25, 2006, includes the electronic and paper medical record. It includes items, such as physician orders, progress notes, and examination and test results. In general, once notes are signed, they should not be altered.

On October 20, 2004, the VHA Office of Information (OI) sent guidance to all medical centers to assure that business rules complied with VHA regulations. The guidance cautioned that, "The practice of editing a document that was signed by the author might have a patient safety implication and should not be allowed." In January 2006, the OIG identified a facility where progress notes could be improperly altered and recommended that VHA address the issue on a national basis. On June 7, 2006, VHA issued a memorandum to VISN Directors instructing all VA medical centers to comply with the guidance sent in October 2004.

During our review, we found that the medical center had seven business rules that allowed deletion of a signed note by a user other than the author. While we were onsite, medical center staff took action to remove or revise the questionable rules to assure compliance with VHA guidelines.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires continued compliance with VHA Handbook 1907.1, *Health Information Management and Health Records,* and the October 2004 OI guidance.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that all business rules in question were removed to comply with VHA guidelines. Based on the actions taken while we were onsite, we consider this recommendation closed.

Patient Satisfaction

The Survey of Healthcare Experiences of Patients (SHEP) is aimed at capturing patient perceptions of care in 12 service areas, including access to care, coordination of care, and courtesy. VHA relies on survey data to improve the quality of

care delivered to patients. VHA's Executive Career Field Performance Plan states that in FYs 2006 and 2007, at least 77 percent of ambulatory care patients and 76 percent of inpatients discharged during a specified date range will report their experiences as "very good" or "excellent." Medical centers and health care systems are expected to address areas in which they are underperforming. The graphs below show the medical center's performance in relation to national and VISN performance for inpatients and outpatients.

Inpatient SHEP Results
Quarter 3 and Quarter 4 FY 2006

Facility Name	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition	Overall Quality
National	**81.3**	**78.9**	**89.9**	**67.9**	**65.9**	**75.9**	**83.4**	**74.6**	**70.1**	**
VISN	80.6	76.6	88.5	65.6	64.6	76.6	84.0	71.4	69.7	**
Medical Center	80	75.8	86.5	64.7	63.1	75.9	83.5	67.5	72.10	**

Legend ** Less than 30 Respondents

Outpatient SHEP Results
Quarter 1 FY 2007

Facility Name	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-Up	Preferences	Specialist Care	Visit Coordination
National	**81**	**77.8**	**94.9**	**72.7**	**83.5**	**75.7**	**82**	**65.3**	**82**	**81.1**	**84.8**
VISN	81.7	69.9	96.1	72.8	83.1	76	86.8	64.7	82.6	79.3	84.9
Medical Center	77.5	61.5	96.4	75.4	82.5	73.4	92.3	59.8	83.8	83.1	85.6

We reviewed the medical center's most recent SHEP results and compared them to the national and VISN results. The inpatient SHEP scores for the 3rd and 4th quarters of FY 2006 were at least 3 percentage points below the target of 76 percent in the areas of education and information, emotional support, preferences, and transition. The outpatient SHEP scores for the 1st quarter of FY 2007 were at least 3 percentage points below the target of 77 percent in the areas of continuity of care, overall coordination, and pharmacy pick-up.

The medical center did not have a SHEP coordinator, nor did it have a process to fully analyze SHEP data or a mechanism to develop action plans to improve areas below target values. SHEP data was not shared with staff or service chiefs, and the

Service Excellence Committee (SEC), which has oversight responsibility for patient satisfaction, did not adequately review SHEP data or address deficiencies. The SEC was recently restructured to include representatives from various services and met for the first time on May 14, 2007. While action plans have been initiated in some areas, insufficient time has passed to observe the impact and results of corrective actions.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director develops and implements a comprehensive SHEP program that includes data analysis, service-level input to the SEC, and corrective action planning and follow-up.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that action plans to improve SHEP scores have been initiated. The Associate Director for Patient Care Services has been appointed to guide the SHEP review process as of August 1, 2007. The medical center will require SHEP data, action plans, and follow-up to be reported in the SEC and documented in the meeting minutes. We will follow up on the planned actions until they are completed.

Moderate Sedation Documentation

In our 2004 CAP report, we noted that the medical records of patients who received moderate sedation did not always contain procedure notes, vital signs, consent forms, or evidence of who accompanied the patient home. We followed up during this visit and found that the condition still existed.

We reviewed the medical records of 10 patients who received moderate sedation from February 1 through March 31, 2007. In two cases, the medical records were incomplete and contained only pre-procedure vital signs and the quality review sheets.[5]

Of the remaining eight medical records, three did not reflect adequate post-procedure care. Two medical records were missing post-procedure vital signs, and one of those also did not have documentation of who accompanied the patient home at the time of discharge. In the third medical record, we noted that the patient's vital signs were taken at 15–30 minute intervals instead of the 5-minute intervals required by medical center policy.

[5] After every use of moderate sedation, the practitioner completes a quality review sheet to document whether or not any adverse events occurred during the procedure.

While we were onsite, managers provided us with an action plan to ensure that staff provides appropriate care to patients receiving moderate sedation and documents medical records accordingly.

Recommendation 9 We recommended the VISN Director ensure that the Medical Center Director requires staff to comply with the moderate sedation policy regarding documentation.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that the Moderate Sedation Review tool has been revised to ensure a monthly review of 30 post-procedural care cases. The results will be reported in the Cardiopulmonary Resuscitation Committee and the Operative and Other Invasive Procedure Committee. We will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Lakeside Community Based Outpatient Clinic

The purpose of this review was to assess CBOC operations and delivery of health care services. CBOCs were designed to improve veterans' access to care by offering primary care in local communities, while delivering the same standard of care as the parent facility (the medical center). The Lakeside CBOC, located about 4 miles from the parent facility, was staffed by VA employees and served 9,800 veterans in FY 2006.

We reviewed CBOC policies, performance documents, and provider C&P files. We conducted an EOC inspection to assess compliance with environmental standards. To determine if patients received the same standard of care, we compared the management of patients receiving warfarin[6] at the parent facility with those receiving warfarin at the CBOC. We also interviewed eight patients about their perceptions of care.

We found that the CBOC's emergency management plan was current, and staff were knowledgeable about rendering emergency care. CBOC providers' C&P files contained appropriate background screening and professional practice documentation. The facility was clean and well maintained and met Joint Commission, Health Insurance Portability and Accountability Act, and Life Safety requirements.

Patients on warfarin received the same standard of care at the CBOC as patients at the parent facility. Pharmacists managed

[6] Medication used to prevent blood clots.

the warfarin clinics at both the parent facility and the CBOC. The pharmacists conducted patient education on warfarin use and side effects and gave patients the same toll-free telephone number to call if they had problems or concerns. The patients we interviewed reported being satisfied with their care.

We found that the medical center complied with selected standards. We made no recommendations.

Surgical Care Improvement Project

The purpose of the review was to determine if clinical managers implemented strategies to prevent or reduce the incidence of surgical infections for patients having major surgical procedures. Surgical infections present significant patient safety risks and contribute to increased post-operative complications, mortality rates, and health care costs.

We reviewed the medical records of 30 patients who had colorectal, vascular, or orthopedic (knee and hip replacement) surgery performed during the 1st quarter of FY 2007.

We evaluated the following VHA performance measure (PM) indicators:

- Timely administration of prophylactic (preventive) antibiotics to achieve therapeutic serum and tissue antimicrobial drug levels throughout the operation. Clinicians should administer antibiotics within 1–2 hours prior to the first surgical incision. The administration time depends on the antibiotics given.
- Timely discontinuation of prophylactic antibiotics to reduce risk of the development of antimicrobial resistant organisms. Clinicians should discontinue antibiotics within 24–48 hours after surgery. The discontinuation time depends on the surgical procedure performed.
- Controlled core body temperature for colorectal surgery, which should be maintained at greater than or equal to 36 degrees Centigrade or 96.8 degrees Fahrenheit immediately after surgery. Decreased core body temperature is associated with impaired wound healing.

VHA set target PM scores for each of the above indicators. To receive fully satisfactory ratings, a facility must achieve the scores shown in the table on the next page.

Performance Measure	Target PM Score
Timely antibiotic administration	90 percent
Timely antibiotic discontinuation	87 percent
Controlled body temperature – colorectal surgery	70 percent

At the time of our site visit, the medical center's most recent PM scores (FY 2006) for timely antibiotic administration and timely antibiotic discontinuation were reported at 69 percent and 67 percent, respectively. During our review of 1st quarter FY 2007 surgical cases, we found that 25 of 30 records (83 percent) reflected timely antibiotic administration and 28 of 29 applicable records (97 percent) reflected timely antibiotic discontinuation.

The medical center's most recent PM score for controlled body temperature[7] was reported at 20 percent. Our review of 1st quarter FY 2007 colorectal cases revealed that only 4 of 12 records (33 percent) contained documentation that temperatures were taken and managed post-operatively.

We found that medical center managers had developed and/or implemented the following strategies to improve PM scores that fell below the established targets:

- Initiated the administration of pre-operative antibiotics by the anesthesiologist at the time of skin preparation.
- Implemented an automatic stop order that provides for timely antibiotic discontinuation.
- Increased environmental temperatures in the holding area and operating room (OR).
- Collected data (temperatures, interventions) on all surgical patients who went through the holding area, OR, and post-anesthesia care unit (PACU) to identify performance improvement opportunities.
- Implemented the routine use of the Bair Hugger (warming blanket) for patients with temperatures below 96.8 degrees Fahrenheit.
- Standardized the method of taking temperatures in the holding area, OR, and PACU to obtain more consistent results.

[7] This PM became effective in FY 2007.

- Requested bedside laptop computers for the PACU to document patient assessments, including temperatures.

Overall, we found that the medical center had acceptable plans to improve performance. Therefore, we made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 26, 2008

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

Subject: **Combined Assessment Program Review of the Jesse Brown VA Medical Center, Chicago, Illinois**

To: Acting Regional Director, St. Petersburg Office of Healthcare Inspections (54SP)

Director, Management Review Office (10B5)

1. Please find attached the status report from the Jesse Brown Veterans Administrative Medical Center to the Office of Inspector General (OIG) Combined Assessment Program review conducted May 14–18, 2007. All action items have been addressed.

2. I concur with the facility Director's responses.

JAMES W. ROSEBOROUGH

Network Director

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 23, 2007

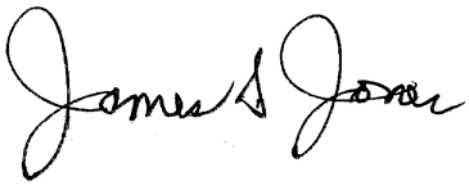
From: Director, Jesse Brown VA Medical Center (537/00)

Subject: **Combined Assessment Program Review of the Jesse Brown VA Medical Center, Chicago, Illinois**

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

1. Please find attached the status report from the Jesse Brown Veterans Administrative Medical Center to the Office of Inspector General (OIG) Combined Assessment Program review conducted May 14–18, 2007. All action items have been addressed.

2. I concur with the recommendations as listed.



JAMES S. JONES

Medical Center Director

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 Medical Center Director requires that peer review processes are in compliance with VHA policy.

Concur

August 1, 2007

Peer Review Committee was established in November 2007. All members of the peer review committee have been educated per the policy. Peer Review Committee reports quarterly to the Medical Executive Committee Meeting with trending and identification of improvement opportunities. Report to be given and reflected in the August 1, 2007, Medical Executive Committee Meeting minutes. Closure requested for this recommendation.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that the QLC and ELB conduct annual evaluations of QM activities and patient safety/risk management processes, as required by medical center policy.

Concur

August 15, 2007

With Senior Leadership concurrence, the JBVAMC Medical Center Memorandum for Performance Improvement has been changed to reflect that an annual evaluation for these committees is not required. The Quality Leadership Council (QLC) is chaired by the Associate Director for Patient Care Services and membership includes the COS, Associate Director and Assistant Director. The QLC reviews all performance improvement functions quarterly and makes recommendations to the ELB on an ongoing basis for approval, actions, and follow-up. The ELB set priorities, monitors, and evaluates all PI activities. The QLC will track and follow up quarterly to the ELB. Closure requested for this recommendation.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that adverse events be evaluated and disclosed, as required by VHA policy.

Concur

August 1, 2007

An adverse event disclosure template has been developed for this medical center, and all identified adverse events will be documented in this template. The disclosure of adverse events will be monitored by the Patient Safety Manager and tracked in the current database. Executive Leadership will ensure that documentation in the medical record is completed in a timely manner.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that the security of mail-out medications be maintained.

Concur

Completed

The security of the mail-out medications will be maintained throughout the time at Jesse Brown VA Medical Center. Pharmacy and Postal Service will ensure that the mail-out medications are maintained in the secured area. Random checks of the postal area near the loading dock will be an ongoing review during environmental rounds. Closure requested for this recommendation.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that exit and medical gas outlet doors on the loading dock are not obstructed.

Concur

Completed on the date of the visit.

The loading dock area was cleared of all obstructions to the exit doors and medical gas outlets. The loading dock area will be reviewed on a random basis during the environment of care rounds. Closure requested for this recommendation.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that the loading dock remains clean.

Concur

Completed

The loading dock has been cleared and cleaned. The Chief of Logistics will insure that rounds are made on a daily basis to insure this area is free from obstructions. Random checks of this area will be done with the weekly environment of care rounds. Closure requested for this recommendation.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires continued compliance with VHA Handbook 1907.1, *Health Information Management and Health Records,* and the October 2004 OI guidance*.*

Concur

Completed

During the IG review, the business rules were reviewed, and the questionable rules were removed to comply with VHA guidelines. Closure requested for this recommendation.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director develops and implements a comprehensive SHEP program that includes data analysis, service-level input to the SEC, and corrective action planning and follow-up.

Concur

September 15, 2007

Action plans have been initiated to improve the SHEP data and address deficiencies. The Associate Director for Patient Care Services will guide this process and review on August 1, 2007. Service-level data will be provided to the Service Excellence Committee with action plans and follow-up reflected in the meeting minutes.

Recommendation 9. We recommended the VISN Director ensure that the Medical Center Director requires staff to comply with the moderate sedation policy regarding documentation.

Concur

August 15, 2007

The Moderate Sedation Review tool has been revised to insure that monthly a random sample of 30 records is reviewed for post-procedure care. The Moderate Sedation Review report is reported to the CPR committee and the Operative and Other Invasive Procedure Committee.

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