Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 07-01248-13

Combined Assessment Program Review of the Bay Pines VA Healthcare System Bay Pines, Florida

October 24, 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 July 30–August 3, 2007, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Bay Pines VA Healthcare System (the system). 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 154 system employees. The system is part of Veterans Integrated Service Network (VISN) 8.

Results of the Review

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

- Employees developed an award-winning medication administration system.

We made recommendations in three of the activities reviewed. For these activities, the system needed to:

- Ensure that patient health information is protected from unauthorized disclosure.
- Ensure that ceiling tiles are properly placed in tracks and that damaged and stained ceiling tiles are replaced.
- Address infection control concerns, including residue on walls near sinks, compromised surfaces on patient furniture and equipment, and stained privacy curtains.
- Secure propane tanks.
- Consult with the Veterans Canteen Service (VCS) Regional Manager to formulate plans for inspection of the system's VCS facilities and for training of VCS employees to assure that safety, sanitation, and infection control standards are maintained.
- Ensure that all computerized patient record system (CPRS) business rules comply with Veterans Health Administration (VHA) policy and Office of Information (OI) guidance related to altering signed notes in the medical record.
- Ensure that clinical staff who perform direct patient care comply with VHA policy related to maintenance of cardiopulmonary resuscitation (CPR) certification.

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

- Surgical Care Improvement Project (SCIP).
- QM Program.
- 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 VISN and System Directors agreed with the findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 14–18, for the full text of their 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 system is a complex facility, with high levels of volume, teaching, and research located in Bay Pines, FL, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at seven community based outpatient clinics (CBOCs) located in Sebring, Ellenton, Sarasota, Port Charlotte, Naples, Dunedin, and St. Petersburg and at a large outpatient clinic located in Ft. Myers. The system also operates Readjustment Counseling Centers in Sarasota and St. Petersburg. The system is part of VISN 8 and serves a veteran population of about 350,000 throughout west central and southwestern coastal Florida.

Programs. The system provides primary care, medical, surgical, mental and behavioral health, and long-term care services. It has 181 operating hospital beds, 104 domiciliary beds, 34 Psychosocial Residential Rehabilitation Treatment Program beds, and 142 nursing home beds.

Affiliations and Research. The system is affiliated with the University of South Florida College of Medicine and with Nova Southeastern University School of Osteopathic Medicine and has 80 active affiliation agreements with medical and allied health programs throughout the southeastern United States. The system provides training for 100 medical residents, as well as other disciplines, including audiology and speech pathology, dietetics, medical laboratory technology, nursing, psychology, pharmacy, physical therapy, physician assistant, radiology, and social work.

In fiscal year (FY) 2006, the system's research program had nine projects and a budget of $1.3 million. Important areas of clinical research include audiology and speech pathology and psychosocial behavioral science. Medical research areas include diseases of the heart, circulatory system, and lung and respiratory system; infectious, neurological, and kidney diseases; diabetes; neurological disorders; cancer; and wound healing. Basic laboratory science research is contributing to biomedical knowledge in the areas of prostate cancer, neurodegenerative diseases, aging, spinal cord injury, nephrology, and inflammatory processes.

Resources. In FY 2006, medical care expenditures totaled $411 million. The FY 2007 medical care budget is estimated

at $406 million. FY 2006 staffing was 2,831 full-time employee equivalents (FTE), including 240 physician and 775 nursing FTE.

Workload. In FY 2006, the system treated 94,823 unique patients and provided 63,262 inpatient days in the hospital and 32,264 inpatient days in the Nursing Home Care Unit (NHCU). The inpatient care workload totaled 9,549 discharges (including domiciliary and NHCU patients), and the average daily census, including NHCU patients, was 315.8. Outpatient workload totaled 1,023,148 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 patients, managers, and employees; and reviewed clinical and administrative records. The review covered the following six activities:

- CBOC.
- CPRS Business Rules.
- Environment of Care (EOC).
- QM Program.
- SCIP.
- SHEP.

The review covered system operations for FY 2006 and FY 2007 through July 27, 2007, and was completed in accordance with OIG standard operating procedures for CAP reviews. We followed up on select recommendations from our prior CAP review of the system (*Combined Assessment Program Review of the VA Medical Center, Bay Pines, Florida,* Report No. 03-00700-140, July 29, 2003). We had three repeat findings from the prior CAP review, which are discussed in the EOC section on pages 5–6. We also followed up on selected recommendations from a prior Healthcare Inspection (*Quality of Care Issues in Cardiology, Bay Pines VA Healthcare System, Bay Pines, Florida,* Report No. 06-01732-119, April 24, 2007). Managers had implemented acceptable actions in response to the recommendations in that Healthcare Inspection report.

During this review, we also presented fraud and integrity awareness briefings for 154 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

Award-Winning Medication Administration System Developed

Use of point-of-care medication boxes installed on five patient care units has reduced nursing and pharmacy staff time spent searching for missing medication cassettes, reduced congestion in hallways caused by medication carts, and saved the system $53,000 in recurring costs to purchase medication carts. The Bar Code Medication Administration (BCMA) Multidisciplinary Committee received the G. Sue Kinnick Achievement Award, the highest award granted by the BCMA Program Office, for their creative solution to their problem of missing medication doses. The BCMA

Multidisciplinary Committee worked with a manufacturer to design medication boxes that hold the medication cassettes and fit into existing lockable storage compartments on each unit.

Results

Review Activities With Recommendations

Environment of Care

The purpose of this review was to determine if the system had established a comprehensive EOC program that contributed to a safe and clean environment, complied with safety standards and guidelines, and maintained an effective infection control program. Additionally, we reviewed the storage, use, and disposal of tritium (also known as H^3), a radioactive material used in research protocols, to ensure that it is managed in compliance with Nuclear Regulatory Commission (NRC) regulations,[1] VA and VHA guidance,[2] and all applicable local policies.

We inspected seven patient care units, the VCS, and the Dunedin CBOC. We also followed up on findings and recommendations from our prior CAP review. The system maintained a generally clean and safe environment. The infection control program monitored, trended, analyzed, and reported data to clinicians for implementation of quality improvements. The system maintained accurate inventories of tritium in a manner consistent with Federal and VA policies. Managers were responsive and took immediate action to address deficiencies identified while the team was onsite. We identified the following deficiencies that required further management attention.

Patient Privacy. Patient health information is required to be protected from unauthorized disclosure, as mandated by the Health Insurance Portability and Accountability Act of 1996. In two patient care areas, paper medical record documentation that contained patients' names and full social security numbers was located bedside on unsecured clipboards or in hallways in unlocked treatment carts. These records were vulnerable to unauthorized viewing or theft.

[1] NRC Master Materials License (MML) No. 03-23853-01VA.
[2] VA's National Radiation Safety Committee guidance and VHA Directive 1105.1, *Management of Radioactive Materials*, September 22, 2004.

Condition of Ceiling Tiles. Ceiling tiles should be appropriately placed in tracks to minimize the potential for pest entry, and those with damage or stains from leaks should be replaced. In four patient care areas and in the VCS food service area, we identified ceiling tiles that needed to be placed in tracks or replaced.

Infection Control Concerns. In three patient care areas, adhesive strip residue from removed soap dispensers was on walls near patient sinks. Because the residue was not removed from the wall, the tile wall surface could not be adequately cleaned. In an Intensive Care Unit, there were bedside stands and tray tables with peeling top surfaces, leaving the pressed wood surfaces exposed and difficult to clean. In one patient care area, there was a folding seat in the patient shower area that had a torn seat cushion. Additionally, we noted stained privacy curtains in one patient care area.

Nursing Home Care Unit, Veterans Canteen Service, and Domiciliary Concerns. There were three unsecured propane tanks on the NHCU patio; this was a repeat finding. Safety, sanitation, and infection control issues identified during the prior CAP review inspection were noted again during this review along with additional findings, including:

Veterans Canteen Service

- Missing baseboard along the wall adjacent to the condiment station in the customer dining area. Cracked walls and baseboard tiles were identified throughout the area.
- Missing laminate trim on the sides of the serving counter area surrounding the salad bar.
- Visibly dirty stainless steel surfaces throughout the food preparation area.
- Serving line and kitchen area floors littered with food products.
- Significant grease build-up on cooking grill backsplash.
- Inadequate cleaning under and behind heavy equipment items (the soda machine, ice machines, and ovens) in kitchen.
- Failure to properly store cleaning equipment (mop, bucket, and broom) after use.

- Soiled utensil rack and utensils and improper cleaning of pots, pans, containers, and shelving units.
- Heavily soiled industrial can openers; this was a repeat finding.
- Appearance of mold between sink backsplash and wall tiles.
- Improperly sealed ceiling penetrations.
- Linens and paper products in drawers appeared to have mold growth.
- Visible debris frozen within ice in an ice machine.
- Uncovered clean linens, including towels and aprons; this was a repeat finding.
- Debris in serving line cabinets.

Domiciliary

- Inadequate cleaning under and behind heavy equipment items (the soda machine, ice machines, and ovens) in kitchen.

Recommendation 1 We recommended that the VISN Director ensure that the System Director requires that patient health information is protected from unauthorized disclosure.

The VISN and System Directors agreed with our findings and recommendation. Patient health information is now secured inside nurse servers and protected from unauthorized disclosure. We consider this recommendation closed.

Recommendation 2 We recommended that the VISN Director ensure that the System Director requires that ceiling tiles are properly placed in tracks and that damaged and stained ceiling tiles are replaced.

The VISN and System Directors agreed with our findings and recommendation. Ceiling tiles were placed in tracks or replaced, as necessary. We will follow up on their action plans until they are completed.

Recommendation 3 We recommended that the VISN Director ensure that the System Director requires that infection control concerns, including residue on walls near sinks, compromised surfaces

on patient furniture and equipment, and stained privacy curtains, are addressed.

The VISN and System Directors agreed with our findings and recommendation. Soiled surfaces were cleaned, some furniture was removed from use, and other items were replaced. New furniture has been ordered. We will follow up on their implementation actions until they are completed.

Recommendation 4 We recommended that the VISN Director ensure that the System Director requires that propane tanks are secured.

The VISN and System Directors agreed with our findings and recommendation. Propane tanks are now secured and chained. Tank security is monitored monthly. We consider this recommendation closed.

Recommendation 5 We recommended that the VISN Director ensure that the System Director consults with the VCS Regional Manager to formulate plans for inspection of the system's VCS facilities and for training of VCS employees to assure that safety, sanitation, and infection control standards are maintained.

The VISN and System Directors agreed with our findings and recommendation. To ensure that a safe and sanitary environment is maintained, employees received training, and the VCS Regional Manager provided plans to address noted deficiencies. We will follow up on their implementation plans until they are completed.

Computerized Patient Record System Business Rules

The purpose of this review was to determine whether business rules complied with VHA policy. VHA Handbook 1907.01, *Health Information Management and Health Records*, specifically states that, "No edit, reassignment, deletion, or alteration of any documentation after the manual or electronic signature has been completed can occur without the approval of the HIM [Health Information Management] professional or the Privacy Officer." CPRS business rules are facility-specific and define the functions certain groups or individuals may perform in the medical records within that facility.

A communication (software informational patch[3] USR*1*26) was sent from the VHA OI on October 20, 2004, to all

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

medical centers, providing guidance on a number of issues related to the editing of electronically signed documents in the electronic medical records system. The OI cautioned that, "The practice of editing a document that was signed by the author might have a patient safety implication and should not be allowed." On June 7, 2006, VHA issued a memorandum to all VISN Directors instructing all VA medical centers to comply with the informational patch sent in October 2004.

We reviewed VHA and system policies and interviewed HIM and Information Resource Management Service staff. One business rule did not limit retraction, amendment, or deletion of signed medical record notes to the Privacy Officer or the Chief of HIMS. System staff took immediate action to remove this business rule while the team was onsite.

Recommendation 6 We recommended that the VISN Director ensure that the System Director requires that CPRS business rules comply with VHA policy and OI guidance related to altering signed notes in the medical record.

The VISN and System Directors agreed with the findings and recommendation. Based on acceptable corrective action taken during the CAP review, we consider this recommendation closed.

Community Based Outpatient Clinic

The purpose of this review was to assess the effectiveness of CBOC operations and VHA oversight to determine whether CBOCs are in compliance with selected standards of operation (patient safety, QM, credentialing and privileging, emergency management plan) and whether CBOCs improve access, convenience, and timeliness of VA health care services.

We interviewed employees at the system and the Dunedin CBOC and reviewed documentation and self-assessment tools on descriptions of services provided, including warfarin clinic services. The system and CBOC warfarin clinics were both managed by a pharmacist, with primary care physician oversight, and maintained the same standards and expectations. Patients received education from a pharmacist before they received their first dose of warfarin. Patients' laboratory values and follow-up care were managed by a pharmacist, with primary care physician oversight. During non-administrative hours, the inpatient pharmacist at the system managed CBOC patients' laboratory values. To help

facilitate prompt reporting of new medications or other vital information, patients received a brochure with a local telephone number for the CBOC and a toll-free telephone number for the system.

The CBOC was clean and effectively maintained, and we identified no safety or infection control vulnerabilities. The emergency management plan was current, and all clinical providers were educated in and knowledgeable about rendering emergency care to veterans. We inspected the automated electronic heart defibrillator, and functionality documentation was current.

VHA Directive 2002-046, *Staff Training in Cardiopulmonary Resuscitation and Advanced Cardiac Life Support*, states that part-time and contract staff are expected to obtain CPR certification before performing patient care duties. The system's CPR policy states that all employees who provide direct patient care will be trained in CPR and that this training must be kept current. The system's medical staff bylaws state that CPR certification is a requirement for all physicians; however, they have 90 days from the date of appointment to achieve this certification. We reviewed three CBOC clinical providers' credentialing and privileging files and two CBOC nurses' official personnel folders. We found that one of the three clinical providers did not have a current CPR certification. This provider was credentialed in June 2007 and treating patients. This provider is scheduled for CPR certification class in August 2007.

Recommendation 7 We recommended that the VISN Director ensure that the System Director requires that clinical staff performing direct patient care comply with VHA policy related to maintenance of CPR certification.

The VISN and System Directors agreed with our findings and recommendation. The one provider who did not have a current CPR certification received it in August. The system medical staff bylaws are under revision to bring them into compliance with VHA policy regarding maintenance of CPR certification. We will follow up on their action plans until they are completed.

Review Activities Without Recommendations

Surgical Care Improvement Project

The purpose of this 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 30 surgical patients' medical records from quarter 2 of FY 2007. The review included medical records for each of the following surgical categories: (1) colorectal, (2) vascular, and (3) orthopedic (knee or hip replacement).

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

- Timely administration of prophylactic 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 time of administration 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 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 post-operative. Decreased core body temperature is associated with impaired wound healing.

VHA set target PM scores for each of the above indicators. The system exceeded the exceptional target PM score of 90 percent for quarters 2, 3, and 4 of FY 2006 for timely antibiotic administration and for quarters 1 and 2 of FY 2007 for body temperature monitoring following colorectal surgery. (This included all posted PM scores at the time of our inspection.) The system did not meet the fully satisfactory target PM score of 87 percent for FY 2006 for timely antibiotic discontinuation; however, staff had developed and implemented appropriate improvement strategies and

continue to monitor the system's performance on this measure.

Our review showed that the system appropriately administered antibiotics and effectively monitored body temperature for colorectal surgery patients. The system had developed and implemented appropriate strategies to improve timely antibiotic discontinuation. We made no recommendations.

Quality Management Program

The purpose of this review was to evaluate whether the system's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed senior managers and QM personnel and evaluated plans, policies, and other relevant documents.

We also evaluated monitoring and improvement efforts in each program area. These efforts included the following:

- Identifying problems or potential improvements.
- Gathering and critically analyzing data.
- Comparing the data analysis with established goals and benchmarks.
- Identifying specific corrective actions when results do not meet goals.
- Implementing and evaluating actions until the problems are resolved or the improvements are achieved.

We evaluated whether clinical managers appropriately used the results of quality monitoring in the medical staff reprivileging process. We reviewed mortality analyses to determine the level of system compliance with VHA guidance.

We found that the QM program provided comprehensive oversight of the quality of care. QM managers had developed a systematic methodology for gathering peer review data and tracking peer reviews to ensure thoroughness and timeliness. Generally, when problems were identified, actions were taken and adequately evaluated. We found excellent senior management support and clinician participation. We made no recommendations.

Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that VHA medical centers use the quarterly/semi-annual survey report results of patients' health care experiences with the VHA system to improve patient care, treatment, and services. The Performance Analysis Center for Excellence of the Office of Quality & Performance within VHA is the analytical, methodological, and reporting staff for SHEP. VHA set PM target results for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients.

Figure 1 shows the SHEP PM results for inpatients.

Figure 1: BAY PINES INPATIENT OVERALL QUALITY BY QUARTER

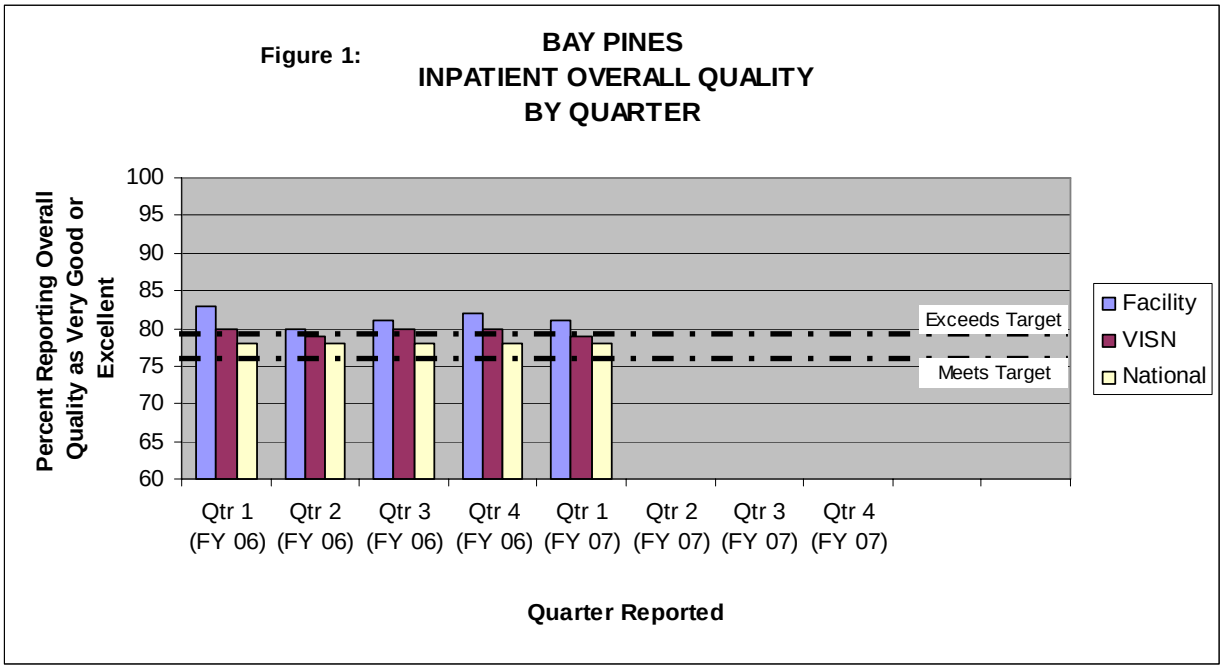
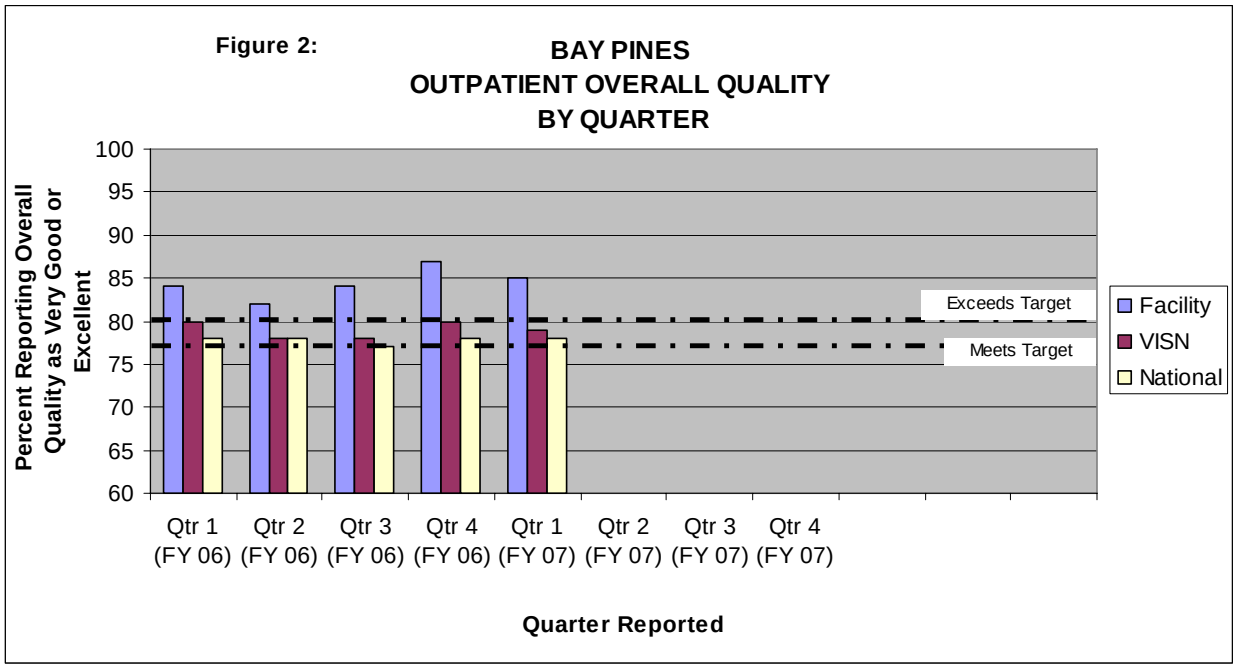


Figure 2 shows the SHEP PM results for outpatients.

Figure 2:



The system had exceeded the established targets for the last 5 quarters of available data, with continuing improvement of scores. Two areas were identified as needing improvement, and an action plan to address Education and Information and Continuity of Care was developed. The action plan was implemented, and there was evidence of ongoing activities and evaluation of the plan for effectiveness. We made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 7, 2007

From: Director, VA Sunshine Network (10N8)

Subject: **Combined Assessment Program Review of the Bay Pines VA Healthcare System, Bay Pines, FL**

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

Director, Management Review Office (10B5)

1. I have reviewed and concur with the findings and recommendations in the report of the Combined Assessment Program Review of the Bay Pines VA Healthcare System.

2. Corrective action plans have been established with planned completion dates, as detailed in the attached report.

George H. Gray, Jr.

George H. Gray, Jr.

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 5, 2007

From: **Director, Bay Pines VA Healthcare System (516/00)**

Subject: **Combined Assessment Program Review of the Bay Pines VA Healthcare System, Bay Pines, FL**

To: Director, VISN 8 (10N8)

1. The recommendations made during the Office of Inspector General (OIG) Combined Assessment Program (CAP) Review conducted July 30–August 3, 2007, have been reviewed, and our comments and implementation plan are noted below.

2. I would like to take this opportunity to commend the OIG CAP Review Team for both their thoroughness and professionalism. This review provides us with the opportunity to continue improving care to our veterans.

3. If you have any questions, please contact Joanna Eastman-Gaudreau, Risk Manager, at 727-398-9317.

WALLACE M. HOPKINS, FACHE

Bay Pines VA Healthcare System Response to the Office of Inspector General Combined Assessment Program Review Report

Comments and Implementation Plan

Environment of Care

Recommendation 1. We recommended that the VISN Director ensure that the System Director requires that patient health information is protected from unauthorized disclosure.

Concur.

Planned Action: All bedside worksheets/information with patient identifiers have been locked in the nurse servers located inside the patient rooms. No patient identifiable records are kept at the bedside. Closed September 5, 2007.

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires that ceiling tiles are properly placed in tracks and that damaged and stained ceiling tiles are replaced.

Concur.

Planned Action: All ceiling tiles identified in this report were immediately replaced. Contractors and VA employees working above the ceiling tiles are constantly reminded to ensure tiles are placed in the tracks appropriately upon completion of their work and at the end of the day. Checking ceiling tiles for placement on tracks, staining, and mold is part of the routine environment of care rounds. Replacing damaged and stained ceiling tiles is an ongoing process due to the condensation, which is influenced by the humidity in the environment and increases during the rainy season. Ceiling tiles in the VCS kitchen are being checked weekly and replaced as needed due to their increased susceptibility for staining. Environmental Management Services (EMS) replaces over 100 ceiling tiles across the facility every week. Engineering and Environmental Management Services have obtained samples of moisture/mold resistant tiles and are evaluating these products for potential use. In addition, a $15 million air handler project has just been approved for this facility. This 3-year project will be funded in FY 08 and should decrease humidity and condensation in the buildings. Closed September 5, 2007.

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires that infection control concerns, including residue on walls near sinks, compromised surfaces on patient furniture and equipment, and stained privacy curtains are addressed.

Concur.

Planned Action: Environmental Management Services employees and supervisors removed soap residue and any/all adhesive tape residue from walls, doors, furniture, and signage. Furniture pieces in the Intensive Care Units were examined for immediate safety concerns and removed from use, as indicated. All bedside patient stands and over-bed trays in the units are in the process of being replaced. The furniture pieces have been ordered, and their anticipated arrival date is the end of September 2007. The torn seat cushion found in the patient shower area has been replaced with a new cushion. The privacy curtain identified in this report was immediately replaced. Privacy curtains are routinely changed quarterly, during terminal cleaning of an isolation bed, and as needed. Closed September 5, 2007.

Recommendation 4. We recommended that the VISN Director ensure that the System Director requires that propane tanks are secured.

Concur.

Planned Action: This issue was addressed and resolved prior to the OIG exit. All propane tanks are now secured and chained to the grills. Additionally, Geriatrics & Extended Care Service/Therapeutic Recreational Services have added checking "Tank Security" to their departmental safety check list that is monitored monthly. Extra tanks (including empties) are maintained in a locked outdoor storage shed. Closed September 5, 2007.

Recommendation 5. We recommended that the VISN Director ensure that the System Director consults with the VCS Regional Manager to formulate plans for inspection of the system's VCS facilities and for training of VCS employees to assure that safety, sanitation, and infection control standards are maintained.

Concur.

Planned Action: The findings of this report were reviewed with the VCS Regional Manager (RM). A checklist provided by the VCS RM is being used for regular, monthly inspections, as well as additional random inspections. Cleaning schedules for various work surfaces, equipment, and utensils have been created, reviewed with VCS staff, and are monitored for compliance. New can openers have been purchased and are on a daily cleaning schedule. The VCS has installed a new cabinet to keep the linen stored and covered. The VCS staff remove only the linen they need for the day from the cabinet. The monitoring of uncovered linen has been added to the items checked during environment of care rounds. The ice machine and serving line cabinets have been thoroughly cleaned

and are monitored during routine inspections. The VCS staff have received in-service training regarding proper storage of cleaning equipment maintained in the EMS closet, which is located in the VCS. In addition, the EMS Zone Manager for the VCS has also reviewed the correct procedures with his staff. The laminate trim needed to repair the sides of the serving counter area surrounding the salad bar has been ordered and is expected to be replaced by the end of September 2007. Interim fixes have been completed for the missing baseboard along the wall adjacent to the condiment station in the customer dining area and the cracked walls and baseboard tiles identified throughout the areas. A major VCS renovation project has been approved and the blueprints are in development. The project is expected to be sent out for bidding in early FY 08. This renovation will correct the baseboard and cracked wall problems. Estimated completion date Quarter 2, FY 08.

Computerized Patient Record System Business Rules

Recommendation 6. We recommended that the VISN Director ensure that the System Director requires that CPRS business rules comply with VHA policy and OI guidance related to altering signed notes in the medical record.

Concur.

Planned Action: This issue was addressed and resolved prior to the OIG exit. HIMS staff took immediate action to remove this business rule and restricted the ability to retract, amend, or delete signed medical records to the Privacy Officer and the Chief of HIMS. Closed September 5, 2007.

Community Based Outpatient Clinic

Recommendation 7. We recommended that the VISN Director ensure that the System Director requires that clinical staff performing direct patient care comply with VHA policy related to maintenance of CPR certification.

Concur.

Planned Action: The provider identified in this report achieved BLS certification in August. Actions are currently under way to revise the medical staff bylaws related to CPR certification to ensure compliance with VHA Directive 2002-046, *Staff Training in Cardiopulmonary Resuscitation and Advanced Cardiac Life Support.* Estimated completion date December 2007.

OIG Contact and Staff Acknowledgments

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