Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-03745-93

Combined Assessment Program Review of the Iowa City VA Health Care System Iowa City, Iowa

February 4, 2013

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: http://www.va.gov/oig/hotline/default.asp)

Glossary

CAP	Combined Assessment Program
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	Iowa City VA Health Care System
FPPE	Focused Professional Practice Evaluation
FTE	full-time employee equivalent
FY	fiscal year
HPC	hospice and palliative care
MH	mental health
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
PRC	Peer Review Committee
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of October 22, 2012.

Review Results: The review covered seven activities. We made no recommendations in the following two activities:

- Environment of Care
- Preventable Pulmonary Embolism

The facility's reported accomplishments were the continued success of the research and development program in 2012 and the Certified Registered Nurse Anesthetist Succession Plan.

Recommendations: We made recommendations in the following five activities:

Quality Management: Ensure that actions from peer reviews are consistently completed and reported to the Peer Review Committee. Consistently report Focused Professional Practice Evaluation results to the Medical Executive Committee. Ensure that conversions from observations bed status to acute admissions are consistently 30 percent or less. Comply with VHA policy requiring an intraoperative x-ray for incorrect sharp counts.

Medication Management – Controlled Substances Inspections: Consistently provide controlled substances quarterly trend reports to the facility Director. Ensure that all required non-pharmacy areas with controlled substances are inspected monthly and that compliance is monitored.

Coordination of Care – Hospice and Palliative Care: Ensure that the Palliative Care Consult Team includes a dedicated 0.25 full-time employee equivalent mental health provider and that local policy is updated to reflect this requirement.

Long-Term Home Oxygen Therapy: Establish a policy to reduce the fire hazards of smoking associated with oxygen treatment. Ensure that the Chief of Staff reviews Home Respiratory Care Program activities at least quarterly.

Nurse Staffing: Ensure all members of the facility expert panel receive the required training prior to the next annual staffing plan reassessment.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 16–21, for the full text of the Directors' comments.) We consider recommendations 8 and 10 closed. We will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

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 quality and the EOC.
- Provide crime awareness briefings 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 compliance with requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities:

- QM
- EOC
- Medication Management – CS Inspections
- Coordination of Care – HPC
- Long-Term Home Oxygen Therapy
- Nurse Staffing
- Preventable Pulmonary Embolism

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2011, FY 2012, and FY 2013 through October 19, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Iowa City VA Medical Center, Iowa City, Iowa,* Report No. 08-02604-214, September 16, 2009).

During this review, we presented crime awareness briefings for 20 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.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 267 responded. We shared survey results with facility managers.

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.

Reported Accomplishments

Facility Research Program

The research program at the facility has consistently been one of the top 10 funded VA facilities nationwide. In 2012, support for basic research included $13 million in direct VA research funding and $30 million from the National Institutes of Health and other agencies. Presently, there are 71 VA-funded projects and 250 active research protocols. Specialized areas of research expertise include the biology of inflammation, diabetic vascular disease, cancer, and immunology. Other patient-focused research includes clinical trials that explore new treatments for cancer and kidney and liver diseases. Additional projects include a Center for Comprehensive Access and Delivery Research and Evaluation that focuses on rural health, telehealth strategies, patient-centered behavioral and self-management interventions, nursing health research, and evidence-based infection prevention.

Certified Registered Nurse Anesthetist Succession Plan

The facility recognized the complexity of recruiting and maintaining certified registered nurse anesthetist positions. The facility collaborated with the University of Iowa to develop a succession plan to secure dedicated slots in the certified registered nurse anesthetist program for facility candidates.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility complied with selected requirements within its QM program.[1]

We interviewed senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement, and it included the required members.	
	There was evidence that Inpatient Evaluation Center data was discussed by senior managers.	
X	Corrective actions from the protected peer review process were reported to the PRC.	Six months of PRC meeting minutes reviewed: • Of the 17 completed actions identified, 2 were not reported to the PRC.
X	FPPEs for newly hired licensed independent practitioners complied with selected requirements.	Twenty-three profiles reviewed: • None of the results of the 23 completed FPPEs were reported to the Medical Executive Committee.
	Local policy for the use of observation beds complied with selected requirements.	
X	Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent.	Data for April–September 2012 reviewed: • Thirty-eight percent of observation patients were converted to acute admissions.
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	Appropriate processes were in place to prevent incidents of surgical items being retained in a patient following surgery.	
	The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	
	There was an EHR quality review committee, and the review process complied with selected requirements.	
	The EHR copy and paste function was monitored.	

NC	Areas Reviewed (continued)	Findings
	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	
	Use and review of blood/transfusions complied with selected requirements.	
NA	Community living center minimum data set forms were transmitted to the data center monthly.	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.	
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
X	The facility complied with any additional elements required by VHA or local policy.	• Two surgical cases had incorrect sharp counts, and intraoperative x-rays were not taken.

Recommendations

1. We recommended that processes be strengthened to ensure that actions from peer reviews are consistently completed and reported to the PRC.

2. We recommended that processes be strengthened to ensure that results from FPPEs are consistently reported to the Medical Executive Committee.

3. We recommended that processes be strengthened to ensure that conversions from observation bed status to acute admissions are consistently 30 percent or less.

4. We recommended that the facility ensure compliance with VHA policy requiring an intraoperative x-ray for incorrect sharp counts.

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements.[2]

We inspected the MH, intensive care, and inpatient medical/surgical units. We also inspected the emergency department, the physical medicine and rehabilitation therapy clinics, and the women's health clinic. Additionally, we reviewed relevant documents and interviewed key employees and managers. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	The facility had a policy that detailed cleaning of equipment between patients.	
	Patient care areas were clean.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Sensitive patient information was protected, and patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for the Women's Health Clinic	
	The Women Veterans Program Manager completed required annual EOC evaluations and tracked identified deficiencies to closure.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Patient privacy requirements were met.	

NC	Areas Reviewed for the Women's Health Clinic (continued)	Findings
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Physical Medicine and Rehabilitation Therapy Clinics	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Medication Management – CS Inspections

The purpose of this review was to determine whether the facility complied with requirements related to CS security and inspections.[3]

We reviewed relevant documents and interviewed key employees. We also reviewed the training files of the CS Coordinator, the Alternate Coordinator, and nine CS inspectors. Additionally, we reviewed inspection documentation from the pharmacy and 10 CS areas. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	Facility policy was consistent with VHA requirements.	
	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	
	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	
X	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	Quarterly trend reports for the past 4 quarters reviewed: • Three quarterly trend reports were not provided to the facility Director.
	CS Coordinator position description(s) or functional statement(s) included duties, and CS Coordinator(s) completed required certification and were free from conflicts of interest.	
	CS inspectors were appointed in writing, completed required certification and training, and were free from conflicts of interest.	
X	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	Documentation of all CS areas inspected during the past 6 months reviewed: • For 2 of the months, none of the required non-pharmacy areas were inspected.
	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

5. We recommended that processes be strengthened to ensure that CS quarterly trend reports are consistently provided to the facility Director.

6. We recommended that processes be strengthened to ensure that all required non-pharmacy areas with CS are inspected monthly and that compliance be monitored.

Coordination of Care – HPC

The purpose of this review was to determine whether the facility complied with selected requirements related to HPC, including PCCT, consults, and inpatient services.[4]

We reviewed relevant documents, 20 EHRs of patients who had PCCT consults (including 10 HPC inpatients), and 20 employee training records (5 HPC staff records and 15 non-HPC staff records), and we interviewed key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
X	A PCCT was in place and had the dedicated staff required.	List of staff assigned to the PCCT reviewed: • An MH provider of at least 0.25 FTE had not been dedicated to the PCCT.
	The PCCT actively sought patients appropriate for HPC.	
	The PCCT offered end-of-life training.	
	HPC staff and selected non-HPC staff had end-of-life training.	
	The facility had a VA liaison with community hospice programs.	
	The PCCT promoted patient choice of location for hospice care.	
NA	The community living center-based hospice program offered bereavement services.	
	The HPC consult contained the word "palliative" or "hospice" in the title.	
	HPC consults were submitted through the Computerized Patient Record System.	
	The PCCT responded to consults within the required timeframe and tracked consults that had not been acted upon.	
	Consult responses were attached to HPC consult requests.	
	The facility submitted the required electronic data for HPC through the VHA Support Service Center.	
	An interdisciplinary team care plan was completed for HPC inpatients within the facility's specified timeframe.	
	HPC inpatients were assessed for pain with the frequency required by local policy.	
	HPC inpatients' pain was managed according to the interventions included in the care plan.	
	HPC inpatients were screened for an advanced directive upon admission and according to local policy.	

NC	Areas Reviewed (continued)	Findings
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

7. We recommended that processes be strengthened to ensure that the PCCT includes a dedicated 0.25 FTE MH provider and that local policy be updated to reflect this requirement.

Long-Term Home Oxygen Therapy

The purpose of this review was to determine whether the facility complied with requirements for long-term home oxygen therapy in its mandated Home Respiratory Care Program.[5]

We reviewed relevant documents and 35 EHRs of patients enrolled in the home oxygen program (including 7 patients deemed to be high risk), and we interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
X	There was a local policy to reduce the fire hazards of smoking associated with oxygen treatment.	• The facility had not developed a policy.
X	The Chief of Staff reviewed Home Respiratory Care Program activities at least quarterly.	• We found no evidence that program activities were reviewed quarterly.
	The facility had established a home respiratory care team.	
	Contracts for oxygen delivery contained all required elements and were monitored quarterly.	
	Home oxygen program patients had active orders/prescriptions for home oxygen and were re-evaluated for home oxygen therapy annually after the first year.	
	Patients identified as high risk received hazards education at least every 6 months after initial delivery.	
	NC high-risk patients were identified and referred to a multidisciplinary clinical committee for review.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

8. We recommended that the facility establish a policy to reduce the fire hazards of smoking associated with oxygen treatment.

9. We recommended that processes be strengthened to ensure that the Chief of Staff reviews Home Respiratory Care Program activities at least quarterly.

Nurse Staffing

The purpose of this review was to determine the extent to which the facility implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on one selected acute care unit.[6]

We reviewed relevant documents and 27 training files, and we interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for acute care unit 7 East for 50 randomly selected days (holidays, weekdays, and weekend days) between October 1, 2011, and September 30, 2012. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	The unit-based expert panel followed the required processes.	
	The facility expert panel followed the required processes and included all required members.	
X	Members of the expert panels completed the required training.	• Twelve of the 15 facility expert panel members did not have documentation that they had completed the required training.
	The facility completed the required steps to develop a nurse staffing methodology by September 30, 2011.	
	The selected unit's actual nursing hours per patient day met or exceeded the target nursing hours per patient day.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

10. We recommended that all members of the facility expert panel receive the required training prior to the next annual staffing plan reassessment.

Preventable Pulmonary Embolism

The purpose of this review was to evaluate the care provided to patients who were treated at the facility and developed potentially preventable pulmonary embolism.[7]

We reviewed relevant documents and 10 EHRs of patients with confirmed diagnoses of pulmonary embolism[a] January 1–June 30, 2012. We also interviewed key employees. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	Patients with potentially preventable pulmonary emboli received appropriate anticoagulation medication prior to the event.	
	No additional quality of care issues were identified with the patients' care.	
	The facility complied with any additional elements required by VHA or local policy/protocols.	

[a] A sudden blockage in a lung artery usually caused by a blood clot that travels to the lung from a vein in the body, most commonly in the legs.

Facility Profile (Iowa City/636A8) FY 2012[b]	
Type of Organization	Tertiary
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions (through August 2012)	$215.1
Number of: • **Unique Patients**	50,597
• **Outpatient Visits**	410,070
• **Unique Employees**[c]	1,228
Type and Number of Operating Beds: (through August 2012) • **Hospital**	83
• **Community Living Center**	NA
• **MH**	NA
Average Daily Census: (through August 2012) • **Hospital**	47
• **Community Living Center**	NA
• **MH**	NA
Number of Community Based Outpatient Clinics	10
Location(s)/Station Number(s)	Bettendorf, IA/636GF Quincy, IL/636GG Waterloo, IA/636GH Galesburg, IL/636GI Dubuque, IA/636GJ Cedar Rapids, IA/636GN Ottumwa, IA/636GS Sterling, IL/636GT Decorah, IA/636GU Coralville, IA
VISN Number	23

[b] All data is for FY 2012 except where noted.
[c] Unique employees involved in direct medical care (cost center 8200).

VHA Patient Satisfaction Survey

VHA has identified patient satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores for quarters 3 and 4 of FY 2011 and quarters 1 and 2 of FY 2012.

Table 1

	Inpatient Scores		**Outpatient Scores**			
	FY 2011	**FY 2012**	**FY 2011**		**FY 2012**	
	Inpatient Score Quarters 3–4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	66.5	63.7	63.9	63.0	57.7	61.1
VISN	66.5	66.9	60.4	58.8	57.9	59.3
VHA	64.1	63.9	54.2	54.5	55.0	54.7

Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[d] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2008, and June 30, 2011.[e]

Table 2

	Mortality			Readmission		
	Heart Attack	Heart Failure	Pneumonia	Heart Attack	Heart Failure	Pneumonia
Facility	14.5	12.9	11.9	20.1	26.7	17.4
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

[d] A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Heart failure is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.
[e] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 28, 2012

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

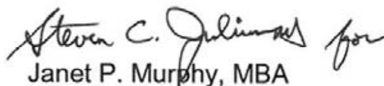
Subject: **CAP Review of the Iowa City VA Health Care System, Iowa City, IA**

To: Director, Denver Office of Healthcare Inspections (54DV)

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

1. The purpose of this Memorandum is to submit the Director's Comments to Denver Office of Healthcare Inspections' Draft Report of Combined Assessment Program Review of the Iowa City VA Health Care System, Iowa City, IA.

2. If you have any questions or would like to discuss this response, please contact me at 319-339-7100.



Janet P. Murphy, MBA

Enclosure

Facility Director Comments

**Department of
Veterans Affairs** **Memorandum**

Date: December 28, 2012

From: Director, Iowa City VA Health Care System (636A8/00)

Subject: **CAP Review of the Iowa City VA Health Care System, Iowa City, IA**

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

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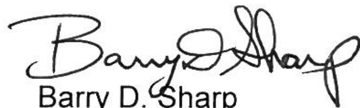

Barry D. Sharp
Director

Enclosure

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that actions from peer reviews are consistently completed and reported to the PRC.

Concur

Target date for completion: April 1, 2013

Facility response: Iowa City VA Health System's Peer Review Committee (PRC) is requiring that all follow-up actions from peer reviews are completed and reported to the PRC. PRC minutes will be reviewed by Risk Manager to ensure that the follow-up actions are completed and reported to the committee. Evidence of a strengthened process: PRC minutes will reflect this documentation for 3 consecutive months. The Risk Manager will report monthly on the compliance of the Peer Review Committee minutes to the Performance Improvement Council.

Recommendation 2. We recommended that processes be strengthened to ensure that results from FPPEs are consistently reported to the Medical Executive Committee.

Concur

Target date for completion: April 1, 2013

Facility response: The Credentialing Committee reports monthly to Medical Executive Committee. Prior to the monthly Credentialing Committee meeting, the Iowa City VA Health System's Credentialing & Privileging Supervisor is now requesting any pending FPPE from the Administrative Officer and Program Assistant to the Chief of Staff for review at the meeting. The Administrative Officer to the Chief of Staff will review the minutes of the Credentialing and Medical Executive Committees and report monthly on the compliance of FPPE to the Performance Improvement Council. The Administrative Officer and Program Assistant to the Chief of Staff have initiated a Systems Redesign project intended to address opportunities for improvement related to the FPPE/OPPE process. The Administrative Officer to the Chief of Staff will report monthly on the status of the project to the Performance Improvement Council.

Recommendation 3. We recommended that processes be strengthened to ensure that conversions from observation bed status to acute admissions are consistently 30 percent or less.

Concur

Target date for completion: April 1, 2013

Facility response: Iowa City VA Health System's Utilization Review (UR) Program Manager will report observation data, including conversion rates, to the Service Lines on a monthly basis. The Service Lines will review data and implement action plans if the conversion rate is 30 % or greater. The quarterly UR Report that has traditionally been presented to the Performance Improvement Council (PIC) will now consistently include observation and conversion rate data as well as the action plans. The UR Program Manager will present conversion rate data and Service Line action plan to the Performance Improvement Council (PIC) on a monthly basis for three months as evidence or compliance. Evidence of strengthened process: The PIC minutes will be audited by the Quality Manager for 3 months to ensure that this content was discussed and documented at the PIC meetings.

Recommendation 4. We recommended that the facility ensure compliance with VHA policy requiring an intraoperative x-ray for incorrect sharp counts.

Concur

Target date for completion: March 30, 2013

Facility response: The Iowa City VA Health System will update OR Surgical Service Policy 009 "COUNTS – SPONGES/SHARPS/INSTRUMENTS" to clarify x-ray process and ensure compliance with VHA Directive requiring an intraoperative x-ray for incorrect sharp counts. Patient Safety Officer will review all incidents related to incorrect sharps counts and ensure follow up.

Recommendation 5. We recommended that processes be strengthened to ensure that CS quarterly trend reports are consistently provided to the facility Director.

Concur

Target date for completion: April 1, 2013

Facility response: Iowa City VA Health System's Controlled Substance Coordinator will be responsible for ensuring that CS quarterly trend reports are provided to the facility Director. The Controlled Substance Coordinator has strengthened the CS quarterly reporting process by establishing a quarterly reminder. The reminder will notify the Controlled Substance Coordinator, Controlled Substance Back-up Coordinator as well as the Administrative Assistant to the Director that the report is due to the Director. The Controlled Substance Coordinator will report quarterly to the Performance Improvement Council as to whether the quarterly report was provided to the Facility Director.

Recommendation 6. We recommended that processes be strengthened to ensure that all required non-pharmacy areas with CS are inspected monthly and that compliance be monitored.

Concur

Target date for completion: April 1, 2013

Facility response: Iowa City VA Health System's Controlled Substance Coordinator will be responsible for ensuring that all required non-pharmacy areas with CS are inspected monthly and that compliance be monitored. The Controlled Substance Coordinator has strengthened the inspection process by establishing a monthly reminder to himself and the Controlled Substance Back-up Coordinator to inspect all required areas. The Controlled Substance Coordinator will report monthly to the Performance Improvement Council on inspections status for three months and then quarterly.

Recommendation 7. We recommended that processes be strengthened to ensure that the PCCT includes a dedicated 0.25 FTE MH provider and that local policy be updated to reflect this requirement.

Concur

Target date for completion: January 1, 2013

Facility response: Iowa City VA Health System has placed a Mental Health Physician under the COS to serve as the MH provider on the PCCT. MCM 12-112, Palliative Care Consultation Team will be updated to reflect this requirement. The Extended Care Manager will report monthly to the Performance Improvement Council on MCM status.

Recommendation 8. We recommended that the facility establish a policy to reduce the fire hazards of smoking associated with oxygen treatment.

Concur

Target date for completion: Completed

Facility response: Iowa City VA Health System has completed a policy to reduce the fire hazards of smoking associated with oxygen treatment. Medical Center Memorandum (MCM)12-195 Reducing the Fire Hazards When Oxygen.

Recommendation 9. We recommended that processes be strengthened to ensure that the Chief of Staff reviews Home Respiratory Care Program activities at least quarterly.

Concur

Target date for completion: July 1, 2013

Facility response: Iowa City VA Health System's Chief of Staff and Administrative Officer to the Chief of Staff have established a Home Respiratory Care Team that will meet quarterly to review of the Home Respiratory Care Program. The results of the meetings are reported to the Chief of Staff and Medical Executive Committee. The Administrative Officer to the Chief of Staff will review the minutes of the Home Respiratory Care Team and Medical Executive Committees. Administrative Officer to the Chief of Staff will report monthly on status of the Home Respiratory Care Team to the Performance Improvement Council for six months.

Recommendation 10. We recommended that all members of the facility expert panel receive the required training prior to the next annual staffing plan reassessment.

Concur

Target date for completion: Completed

Facility response: Iowa City VA Health System's members of the expert panel training have been uploaded into TMS for FY12 and every member completed this training at 100%. This same procedure will be followed in future years to document training.

OIG Contact and Staff Acknowledgments

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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: Richard J. Durbin, Chuck Grassley, Tom Harkin, Mark Kirk
U.S. House of Representatives: Bruce L. Braley, Cheri Bustos, Steve King, Tom Latham, David Loebsack, John Shimkus

This report is available at http://www.va.gov/oig.

Endnotes

[1] References used for this topic included:
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[3] References used for this topic included:
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