Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-03092-129

Combined Assessment Program Review of the Richard L. Roudebush VA Medical Center Indianapolis, Indiana

March 23, 2011

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 crime awareness briefings 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.

To Report Suspected Wrongdoing in VA Programs and Operations
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(Hotline Information: http://www.va.gov/oig/contacts/hotline.asp)

Glossary

C&P	credentialing and privileging
CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CHF	congestive heart failure
CLC	community living center
COC	coordination of care
CPR	cardiopulmonary resuscitation
CPRS	Computerized Patient Record System
CWAD	Crisis, Warning, Allergies and/or Adverse Reactions, and Directives
ECMS	Executive Committee of the Medical Staff
EOC	environment of care
facility	Richard L. Roudebush VA Medical Center
FPPE	Focused Professional Practice Evaluation
FTE	full-time employee equivalents
FY	fiscal year
IC	infection control
JC	Joint Commission
LMS	Learning Management System
MDRO	multidrug-resistant organisms
MH	mental health
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
OSHA	Occupational Safety and Health Administration
PPE	personal protective equipment
PRRTP	Psychosocial Residential Rehabilitation Treatment Program
PSB	Professional Standards Board
QM	quality management
RCA	root cause analysis
SHEP	Survey of Healthcare Experiences of Patients
SOPs	standard operating procedures
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Richard L. Roudebush VA Medical Center, Indianapolis, IN

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of December 13, 2010.

Review Results: The review covered seven activities and one follow-up review area. We made no recommendations in the following activity:

- Medication Management

Recommendations: We made recommendations in the following six activities and follow-up review area:

Quality Management: Ensure moderate sedation documentation includes all required components, and monitor compliance. Provide oversight of medical record review.

Environment of Care: Ensure designated employees complete required training, and document it. Routinely clean ice machines. Ensure fire extinguishers are accessible to mental health staff. Inspect radiation shields annually. Secure computer screens. Ensure oxygen tanks are properly labeled and stored.

Physician Credentialing and Privileging: Make and document two requests to verify physicians' privileges. Ensure the Executive Committee of the Medical Staff reviews and documents privileging recommendations prior to making final recommendations. Initiate focused evaluations as required. Create, approve, and implement service-specific competency criteria.

Management of Test Results: Document the time critical results were communicated. Document notification and treatment actions for critical results. Monitor the test result communication process. Communicate normal results within the defined timeframe.

Coordination of Care: Provide and document advance directive notification and screening. Scan advance directives into medical records. Ensure advance directives on the VA form are appropriately witnessed.

Management of Multidrug-Resistant Organisms: Provide infection prevention strategies education to affected patients and their families. Ensure employees receive annual education, and document it.

Follow-Up on Background Investigations: Timely complete background investigations.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. 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

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 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 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 selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities and follow-up review area:

- COC
- EOC
- Follow-Up on Background Investigations
- Management of MDRO
- Management of Test Results
- Medication Management
- Physician C&P
- QM

The review covered facility operations for FY 2010 and FY 2011 through December 17, 2010, and was done in accordance with OIG SOPs for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the Richard L. Roudebush VA Medical*

Center, Indianapolis, Indiana, Report No. 08-00401-133, May 29, 2008). (See Appendix B for further details.) The facility had repeat findings in the areas of physician C&P (formerly part of the QM review) and follow-up on background investigations.

During this review, we also presented crime awareness briefings for 76 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.

Results

Review Activities With Recommendations

QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program in accordance with applicable requirements and whether senior managers actively supported the program's activities.

We interviewed senior managers and QM personnel, and we evaluated policies, meeting minutes, and other relevant documents. We identified the following areas that needed improvement.

Moderate Sedation. VHA requires that staff assess and monitor patients undergoing moderate sedation.[1] We reviewed the medical records of patients who underwent moderate sedation and found that only 4 of the 10 records included documentation of all required elements, such as airway assessment, assessment of risk, and re-evaluation immediately prior to the procedure.

Medical Records Quality Review. VHA requires that facilities have a medical record review committee or its equivalent.[2] The committee must provide oversight and coordination of the review process, determine the frequency of reviews, and analyze review reports to identify problems or opportunities for improvement. The facility did not have a medical record review committee and assigned the equivalent function to the

[1] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
[2] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

ECMS. We reviewed local policy and ECMS minutes for the period November 2009 to October 2010. The facility's current ECMS policy does not reference the medical record review committee requirements. ECMS minutes did not document committee oversight or coordination of the medical record quality review process, establish frequency of reviews, or analyze health record quality review reports.

Recommendations

1. We recommended that moderate sedation documentation include all required components and that supervisors monitor compliance.

2. We recommended that medical record quality review oversight be provided.

EOC

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

We inspected the rehabilitation, MH, medicine, surgery, and surgical intensive care units; the primary care and women's clinics; the emergency room; and radiology. Additionally, we walked through the facility's offsite annexed primary care clinic and the domiciliary. The facility maintained a generally clean and safe environment.

During our inspection of the MH inpatient unit, we found that the exit door alarm to the stairs was nonfunctional. However, the door alarm was operational upon our return to the unit 2 days later; therefore, we made no recommendation for this finding.

During our inspection of radiology, we found sterile gauze pads that had been opened and taped to a machine at the beginning of the day for use on patients throughout the day. This practice did not maintain product sterility prior to use. Leadership had the gauze pads and tape removed from the machine; therefore, we made no recommendation for this finding. However, we identified the following conditions that needed improvement.

IC. OSHA requires that all employees receive initial and annual training on the OSHA Bloodborne Pathogens Rule. We reviewed employee training records and found that 16 of the 18 records had this training documented.

If facilities use N95 respirators, OSHA requires that designated employees be fit tested annually. We reviewed

employee training records and determined that 24 (57 percent) of the 42 records had the required annual fit testing documented.

On two separate inpatient units, we found dirt or rust buildup on patient ice machines.

Fire Safety. OSHA requires that staff have readily accessible fire extinguishers. The inpatient MH unit had one fire extinguisher located behind two locked doors. Not all staff had keys to both of these locked doors.

Radiology. OSHA requires that the facility implement procedures for periodically inspecting the integrity of radiation shields and aprons. The facility requires staff to visually inspect radiation shields and aprons annually. We determined that 192 (77 percent) of the 250 shields and aprons had documented visual inspection dates within the last year.

Facility management requires annual LMS radiation safety education training for designated radiology staff. We reviewed LMS records for five radiology technicians and determined that only two of the records had this training documented.

Patient Privacy. The Health Insurance Portability and Accountability Act requires confidential patient information to be secured. On multiple inpatient units, we found computers displaying patient information. These computers were located in hallways and were easily viewable by anyone passing by.

Oxygen Tank Storage. During our follow-up on previous CAP recommendations, we identified new issues with oxygen tanks. The JC requires that facilities label oxygen tanks as full or empty and that clean and dirty supplies are stored separately. We found oxygen tanks that were not identified as full or empty and oxygen tanks that were stored with clean supplies.

Recommendations

3. We recommended that required annual bloodborne pathogens training, radiation safety training, and N95 respirator fit testing be completed by designated employees and documented.

4. We recommended that patient ice machines be routinely cleaned.

5. We recommended that inpatient MH staff have readily accessible fire extinguishers.

6. We recommended that radiation shields be visually inspected annually.

7. We recommended that computer screens displaying patient information on inpatient units be secured from unauthorized personnel.

8. We recommended that oxygen tanks be clearly labeled as full or empty and stored appropriately.

Physician C&P

The purpose of this review was to determine whether the facility had consistent processes for physician C&P that complied with applicable requirements.

We reviewed 14 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. However, we identified the following areas that needed improvement.

Privileges. VHA requires facilities to send a minimum of two requests to verify that a physician's currently held or most recently held clinical privileges are in good standing.[3] None of the credentialing files reviewed contained the physician's currently or most recently held clinical privileges or documentation to support that staff made at least two attempts at verification.

Privileging Recommendations. VHA requires PSB privileging recommendations to be submitted to the ECMS for evaluation and final recommendation to the facility Director. ECMS meeting minutes did not document review or approval of any PSB privileging recommendations during the review period.

FPPE. VHA requires that an FPPE be initiated for all physicians who have been newly hired or have added new privileges. We reviewed newly hired physicians' profiles and determined that two of three profiles had an FPPE initiated.

[3] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008. All references to VHA requirements in this section pertain to this handbook.

OPPE. VHA requires that data consistent with service-specific competency criteria be defined; collected; maintained in each physician's profile; and reviewed on an ongoing, periodic basis. We reviewed physician profiles and determined that six of the eight applicable profiles contained sufficient data to support reprivileging. This is a repeat finding from the previous CAP review. Further, not all service-specific competency criteria used for reprivileging were approved by the ECMS.

Recommendations

9. We recommended that at least two requests to verify physicians' currently held or most recently held clinical privileges be made and documented.

10. We recommended that the ECMS review and document PSB privileging recommendations prior to making final recommendations to the facility's Director.

11. We recommended that FPPEs be initiated for all physicians who have been newly hired or have added new privileges.

12. We recommended that service-specific competency criteria be created, approved, and implemented.

Management of Test Results

The purpose of this review was to follow up on a previous review that identified improvement opportunities related to documentation of notification of abnormal test results and follow-up actions taken.[4]

We reviewed the facility's policies and procedures, and we reviewed medical records. We identified the following areas that needed improvement.

Documentation of Ordering Provider Notification. VHA requires that diagnostic clinicians document in the medical record the time and means of critical test result communication and the name of the ordering provider contacted.[5] We reviewed the medical records of patients who had critical results and found that diagnostic clinicians documented the time the ordering provider was notified in 26 (87 percent) of the 30 records.

[4] *Healthcare Inspection Summary Review – Evaluation of Veterans Health Administration Procedures for Communicating Abnormal Test Results*, Report No. 01-01965-24, November 25, 2002.
[5] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009. All references to VHA requirements in this section pertain to this directive.

Documentation of Treatment Actions. VHA requires ordering providers to document in the medical record patient notification and treatment actions in response to critical test results. We reviewed the medical records of patients who had critical results and found documented evidence of patient notification and follow-up actions in 25 (83 percent) of the 30 records.

Monitoring Results Communication. VHA requires facilities to monitor the effectiveness of communication of results to providers and patients. We did not find evidence that radiology staff monitored the effectiveness of communication of results to ordering providers.

Communication of Normal Results. VHA requires facilities to communicate normal results to patients no later than 14 calendar days from the date that the results were available to the ordering provider. We reviewed the medical records of patients who had normal results and found that 12 of the 20 records contained documented evidence that the facility had communicated the results to the patients.

Recommendations

13. We recommended that diagnostic clinicians consistently document the time critical results were communicated to ordering providers.

14. We recommended that ordering providers document patient notification and treatment actions in response to critical results.

15. We recommended that the process of communicating test results to providers and patients be periodically monitored for effectiveness.

16. We recommended that normal test results be consistently communicated to patients within the specified timeframe.

COC

The purpose of this review was to evaluate whether the facility managed advance care planning, advance directives, and discharges in accordance with applicable requirements.

We reviewed 24 patients' medical records for evidence of advance care planning, advance directives, and discharge instructions. We identified the following areas that needed improvement.

Advance Directive Notification and Screening. VHA requires that patients be given written notification at each admission stating their right to accept or refuse medical treatment, to designate a Health Care Agent, and to document their treatment preferences in an advance directive.[6] We found evidence of written notification in 18 of the 24 medical records.

VHA also requires that facility staff ask patients whether they have an advance directive and whether they want more information and/or assistance in completing the advance directive forms. We found evidence of screening in 19 of the 24 medical records.

Management of Advance Directive Documents. VHA requires that advance directives be filed in patient medical records. VHA also requires that advance directives documented on the VA form be witnessed by two individuals and offered to patients once completed. Nine of the 24 medical records indicated the presence of advance directives, all of which had been created using the VA form. Electronic copies of advance directives were present in eight of the nine records. None of the nine records contained documentation that patients received a copy of the completed advance directive. Witness signatures were present on seven of the eight viewable advance directives.

VHA requires that staff use specific progress note titles when documenting advance care planning discussions with patients and link these notes to the CWAD postings in the electronic medical record. Advance directive notes were linked to CWAD postings in only 6 of 21 applicable medical records.

Recommendations

17. We recommended that procedures be implemented to ensure that staff provide and document advance directive notification and screening at each inpatient admission.

18. We recommended that procedures be implemented to ensure that all advance directives are scanned into the electronic medical record and that patient advance care planning progress notes are linked to the CWAD posting.

[6] VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, July 2, 2009. All references to VHA requirements in this section pertain to this handbook.

19. We recommended that advance directives developed using the VA form be appropriately witnessed and that a copy of the completed document be provided to the patient.

Management of MDRO

The purpose of this review was to evaluate whether the facility had developed a safe and effective program to reduce the incidence of MDRO in its patient population in accordance with applicable requirements.

We inspected two inpatient medical units and interviewed seven employees and identified no deficits in either the inspections or staff interviews. However, we identified the following areas that needed improvement.

Patient/Family Education. The JC requires that patients infected or colonized[7] with MDRO and their families; receive education on infection prevention strategies, such as hand washing and the proper use of PPE. We reviewed medical records and found that only 15 of the 19 records had documented evidence of MDRO education.

Employee Training. The JC requires that facilities conduct a risk assessment to determine the need for staff education. The facility's most recent risk assessment stated that staff education was indicated for all employees during orientation and annually thereafter. We reviewed employee training records to determine whether MDRO education had been provided in accordance with the risk assessment. We found that only 13 of the 16 records reviewed had documentation of annual MDRO education.

Recommendations

20. We recommended that infection prevention strategies education be provided to patients infected or colonized with MDRO and their families and be documented.

21. We recommended that employees receive annual MDRO education and that the training be consistently documented.

Follow-Up on Background Investigations

As a follow-up to a recommendation from our prior CAP review, we reassessed facility compliance with timely completion of background investigations. VA requires completion of the appropriate level of background screening for appointees prior to access to VA systems.[8] We validated the facility's statement that only 90 percent of current

[7] Colonization is the presence of bacteria in the body without causing clinical infection.
[8] VA Directive 0710, *Personnel Security and Suitability Program*, June 4, 2010.

appointees had background screenings completed within the required timeframes.

Recommendation

22. We recommended that processes be implemented to ensure timely completion of background investigations.

Review Activity Without Recommendations

Medication Management

The purpose of this review was to determine whether the facility employed safe practices in the preparation, transport, and administration of hazardous medications, specifically chemotherapy, in accordance with applicable requirements.

We observed the compounding and transportation of chemotherapy medications and the administration of those medications in the oncology clinic, and we interviewed employees. We determined that the facility safely prepared, transported, and administered the medications. We made no recommendations.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 17–24, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[9]		
Type of Organization	Tertiary care	
Complexity Level	1A	
VISN	11	
CBOCs	Bloomington, IN Terre Haute, IN	
Veteran Population in Catchment Area	187,000	
Type and Number of Total Operating Beds: • **Hospital, including PRRTP**	209	
• **CLC/Nursing Home Care Unit**	0	
• **Other**	0	
Medical School Affiliation(s)	Indiana University School of Medicine	
• **Number of Residents**	122	
	FY 2010	**Prior FY**
Resources (in millions):		
• **Total Medical Care Budget**	$363.3	$335.3
• **Medical Care Expenditures**	$400	$371.4
Total Medical Care FTE	2,230.8	2,164.9
Workload:		
• **Number of Station Level Unique Patients**	55,840	53,954
• **Inpatient Days of Care:**		
o **Acute Care**	47,790	44,242
o **CLC/Nursing Home Care Unit**	0	0
Hospital Discharges	8,589	8,402
Total Average Daily Census (including all bed types)	164	168.2
Cumulative Occupancy Rate	78.5%	80.5%
Outpatient Visits	541,045	494,318

[9] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation? Y/N**
QM			
1. Ensure that the C&P process is completed in compliance with VHA policy.	After the previous CAP, a standard format was developed for reporting provider performance data quarterly to the Credentialing Office. Compliance is at 94 percent, and work continues for submission of quality and meaningful performance data.	N	Y (see page 6)
2. Ensure that all clinically active staff maintain current CPR training.	Management tracks compliance, and Education Service offers training locally. Compliance is at 98 percent.	Y	N
3. Meet VHA requirements for peer reviews.	Management revised practices and increased Peer Review Committee meetings to twice per month. Timely completion of peer reviews is at 100 percent.	Y	N
4. Require that patient safety complaint data is compared to data from the SHEP survey and that findings are reported to an oversight committee for corrective action.	Data is trended and reviewed through the Indy Excellence Service Team and several other forums.	Y	N
5. Meet VHA requirements for RCAs.	Management continues to use a system to track the status of RCAs and corrective actions. Since September 2009, 100 percent of all RCAs and actions have been completed on time.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
6. Meet VHA requirements for the utilization management program.	Assignment of a physician advisor is complete, and the Utilization Management/Patient Flow Committee monitors action items.	Y	N
7. Ensure that analyzed data from the Code Committee are presented to an oversight committee for corrective actions.	Code Committee minutes are presented to the ECMS for oversight of problem resolution.	Y	N
8. Develop a policy for importing and/or copying text into CPRS.	A policy is in place.	Y	N
9. Ensure that all restraint and seclusion data are presented to an oversight committee and that data are monitored and that action items are implemented.	Restraint and seclusion data are presented to and monitored through the ECMS.	Y	N
EOC			
10. Require safety and IC vulnerabilities to be corrected.	Central refrigeration monitors are in use, access to medication rooms has been restricted, and oxygen tanks are secured and stored properly. Environmental rounds to monitor the condition of furnishings are ongoing.	Y	N
11. Require sensitive information to be protected from unauthorized access.	Sensitive patient information has been removed from the inside and outside of patients' rooms.	Y	N
CPRS Business Rules			
12. Require CPRS business rules to comply with VHA policy and Office of Information guidance.	Policy is in place, and the October 4, 2004, CPRS informational patch was installed.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
Follow-Up of Background Investigations			
13. Comply with policies governing VHA employment screening requirements, and correct the identified discrepancies.	Compliance is at approximately 90 percent with current practices.	N	Y (see pages 9–10)

VHA Satisfaction Surveys

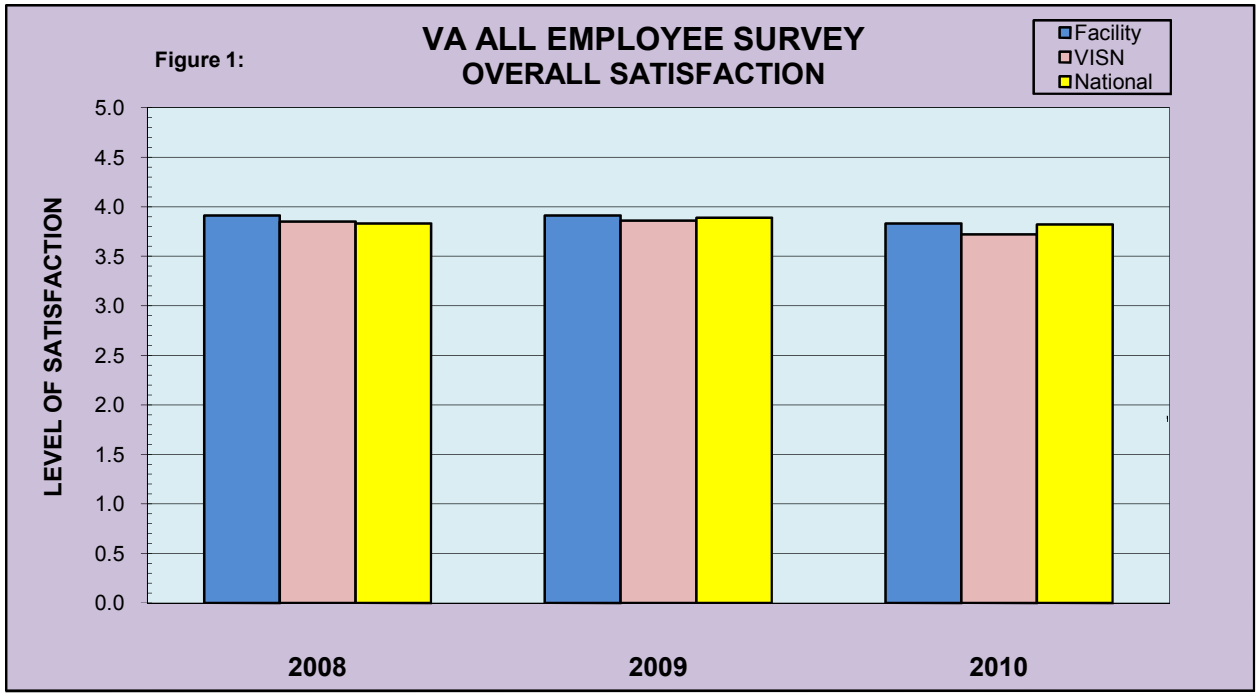
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for quarters 1–3 of FY 2010.

Table 1

	FY 2010 (inpatient target = 64, outpatient target = 56)					
	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Inpatient Score Quarter 3	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3
Facility	70.9	68.2	67.1	53.6	56.5	61.8
VISN	67.4	66.1	65.6	53.4	54.5	56.3
VHA	63.3	63.9	64.5	54.7	55.2	54.8

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2008, 2009, and 2010. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions[10] received hospital care. The mortality (or death) rates focus on whether patients died within 30 days of their hospitalization. The rates of readmission focus on whether patients were hospitalized again within 30 days. Mortality rates and rates of readmission show whether a hospital is doing its best to prevent complications, teach patients at discharge, and ensure patients make a smooth transition to their home or another setting. The hospital mortality rates and rates of readmission are based on people who are 65 and older. These comparisons are "adjusted" to take into account their age and how sick patients were before they were admitted to the VA facility. Table 2 below shows the facility's Hospital Outcome of Care Measures for FYs 2006–2009.

Table 2

	Mortality			Readmission		
	Heart Attack	CHF	Pneumonia	Heart Attack	CHF	Pneumonia
Facility	14.44	9.42	13.84	22.17	23.21	16.6
VHA	13.31	9.73	15.08	20.57	21.71	15.85

[10] CHF is a weakening of the heart's pumping power. With heart failure, your body does not get enough oxygen and nutrients to meet its needs. A heart attack (also called acute myocardial infarction) happens 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 in a timely manner, the heart muscle becomes damaged from lack of oxygen. Pneumonia is a serious lung infection that fills your lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 18, 2011

From: Director, VISN 11 (10N11)

Subject: **CAP Review of the Richard L. Roudebush VA Medical Center, Indianapolis, IN**

To: Director, Dallas Healthcare Inspections Division (54DA)

Thru: Director, Management Review Service (VHA CO 10B5 Staff)

I concur with the recommendations and action plans in the attached memorandum from the Richard L. Roudebush VA Medical Center.

(*original signed by*:)
Michael Finegan, FACHE
Veterans in Partnership Director, VISN 11

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 18, 2011

From: Director, Richard L. Roudebush VA Medical Center

Subject: **CAP Review of the Richard L. Roudebush VA Medical Center, Indianapolis, IN**

To: Director, VISN 11 (10N11)

This memorandum serves as our concurrence with the recommendations found in this CAP review. Corrective actions completed and planned have been attached.

(*original signed by*:)
Thomas Mattice, FACHE
Richard L. Roudebush VA 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 moderate sedation documentation include all required components and that supervisors monitor compliance.

Concur

Target Completion Date: Action Completed.

Quality Management staff has met with areas providing moderate sedation. Elements have been added to the existing CPRS template. For areas utilizing paper, physicians have been reminded that they must fill out their portion which is scanned into the EMR after the procedure. Monitoring will be completed to ensure compliance.

Recommendation 2. We recommended that medical record quality review oversight be provided.

Concur

Target Completion Date: April 30, 2011.

The facility is developing criteria to identify the pertinent medical record (MR) quality review activities to be reported to the ECMS and will establish a mechanism including appropriate staff for reporting MR activities and providing feedback on findings that require improvement actions.

Recommendation 3. We recommended that required annual bloodborne pathogens training, radiation safety training, and N95 respirator fit testing be completed by designated employees and documented.

Concur

Target Completion Date: June 30, 2011

Radiation safety was assigned via LMS and is 100% complete. Annual bloodborne pathogens training is assigned to employees and monitored via annual performance and competency reviews. Review will be conducted to ensure that staff are current on training. Only staff who have been fit tested are permitted to enter isolation rooms. Safety Office has expanded its Fit Testing service an additional day. In addition, the Safety Office has presented material at Patient Care Manager meetings on Fit Testing and PAPR training. Thirdly, the Safety Office developed, assigned, and is monitoring a LMS module required for all Patient Care staff on isolation procedures and PPE

(including respiratory protection). Policy will be evaluated to determine who is required to have fit testing and a review conducted to ensure compliance. Ongoing monitoring will occur through annual competency evaluations and annual performance reviews.

Recommendation 4. We recommended patient ice machines be routinely cleaned.

Concur

Target Completion Date: Action Completed.

EMS staff members have been instructed to clean patient ice machines. Ongoing monitoring will occur through Environment of Care rounds and through EMS Supervisors inspections.

Recommendation 5. We recommended that inpatient MH staff have readily accessible fire extinguishers.

Concur

Target Completion Date: Action Completed.

Fire extinguisher has been installed and inspected.

Recommendation 6. We recommended that radiation shields be visually inspected annually.

Concur

Target Completion Date: Action Completed.

Facility has ensured that 100% of radiation shields have been inspected.

Recommendation 7. We recommended that computer screens displaying patient information on inpatient units be secured from unauthorized personnel.

Concur

Target Completion Date: April 30, 2011.

The Indianapolis Privacy Workgroup has developed an education campaign to educate staff which includes targeted messages and meeting with supervisors. EOC rounds will continue to identify PCs that require privacy screens. ISO/PO will increase visits to all areas, to identify PCs that require privacy screens. With regard to Privacy Screens, the following steps will be performed to protect unauthorized viewing of info on computer monitors: Re-positioning the monitor; installing a privacy screen; Re-positioning monitor with privacy screens, so no one can stand directly behind you; and a campaign to alert staff to be aware of who is directly behind them.

Recommendation 8. We recommended that oxygen tanks be clearly labeled as full or empty and stored appropriately.

Concur

Target Completion Date: March 30, 2011

Oxygen tanks will not be labeled with tags as oxygen level can be determined by viewing gauge. Facility procedure is to store full and empty tanks in separate locations (full tank = >1000 psi, empty tank = <1000psi). Signage will be placed to differentiate correct location to store either full or empty tanks. Oxygen tanks will not be stored with clean supplies. Safety and Chief PCS Clinical Support have reviewed areas and implemented appropriate storage locations. A monitor has been developed to track compliance and will be reported through Nursing PI Council.

Recommendation 9. We recommended that at least two requests to verify physicians' currently held or most recently held clinical privileges be made and documented.

Concur

Target Completion Date: June 30, 2011

Credentialing staff have begun to follow-up with an additional request when affiliation verifications are received without the requested copy of currently held or most recent clinical privileges. Non-receipt will be documented. Staff will review current files and ensure documentation of at least two requests are present.

Recommendation 10. We recommended that the ECMS review and document PSB privileging recommendations prior to making final recommendations to the facility's Director.

Concur

Target Completion Date: Action Complete.

Credentialing staff have begun to forward requested privileges. The Executive Committee of the Medical Staff's voting members will review and make recommendation to the Director on all privileging and medical staff appointment actions.

Recommendation 11. We recommended that FPPEs be initiated for all physicians who have been newly hired or have added new privileges.

Concur

Target Completion Date: Action Completed.

Processed has been changed and FPPE's will be initiated for a newly appointed physician or for new clinical privileges upon entry on duty date.

Recommendation 12. We recommended that service-specific competency criteria be created, approved, and implemented.

Concur

Target Completion Date: June 30, 2011.

Service-specific competency criteria for the Ongoing Professional Performance Evaluation process is currently being developed by each clinical service chief. Several revised OPPE templates have been reviewed and recommended for use at the January and February 2011 ECMS meetings. The rest will be completed by the target date.

Recommendation 13. We recommended that diagnostic clinicians consistently document the time critical results were communicated to ordering providers.

Concur

Target Completion Date: April 30, 2011.

Radiology Service is developing a process for communication of critical test results. Draft Medical Center Memorandum will be forwarded to the Executive Committee of the Medical Staff.

Recommendation 14. We recommended that ordering providers document patient notification and treatment actions in response to critical results.

Concur

Target Completion Date: May 30, 2011.

Ordering providers will be reminded of requirements to document patient notification and treatment actions.

Recommendation 15. We recommended that the process of communicating test results to providers and patients be periodically monitored for effectiveness.

Concur

Target Completion Date: June 30, 2011.

Medical Center Memorandum related to communication of test results will include development of process for periodic monitoring.

Recommendation 16. We recommended that normal test results be consistently communicated to patients within the specified timeframe.

Concur

Target Completion Date: June 30, 2011.

Inpatient discharge instructions have been modified to ensure communication of all test results has occurred prior to discharge. Medical Center Memorandum will be drafted outlining processes and forwarded to ECMS. Weekly meetings with Ambulatory Care will continue to roll out reminder and improve compliance. Expansion to Specialty clinics will be implemented.

Recommendation 17. We recommended that procedures be implemented to ensure that staff provide and document advance directive notification and screening at each inpatient admission.

Concur

Target Completion Date: April 30, 2011.

Chief Social Work Service will meet with screeners and re-establish expectation of 100% screening at the required times. Provide training to screeners to educate on mandatory dissemination of VA Form 10-0137A**.**

Recommendation 18. We recommended that procedures be implemented to ensure that all advance directives are scanned into the electronic medical record and that patient advance care planning progress notes are linked to the CWAD posting.

Concur

Target Completion Date: Action Completed.

Link has been enabled and quarterly monitoring of link by Clinical Applications Coordinator to verify it remains activated has been established.

Recommendation 19. We recommended that advance directives developed using the VA form be appropriately witnessed and that a copy of the completed document be provided to the patient.

Concur

Target Completion Date: April 30, 2011.

The Chief of Social Work Service is overseeing process. Process will include development of a new CPRS consult to be activated by screening clerks when patient desires to complete an Advance Directive. The consult will be processed by Chief, SW Service (with appropriate designees) and directed to appropriate Social Work staff (and back-up designees). He will educate Social Work staff and designees regarding expectations: a) for witnessing signing of advance directive by patient, b) for proper recording in the electronic medical record (either through direct entry or scanning paper forms) and c) for providing the original or printed copy of a signed iMedConsentTM version of the advance directive to the patient. Additionally, Social Work staff and designees will be educated on documentation requirements for advance directives,

including documentation of the offer to provide the patient with signed advance directive.

Recommendation 20. We recommended that infection prevention strategies education be provided to patients infected or colonized with MDRO and their families and be documented.

Concur

Target Completion Date: Completed.

Education documentation was added to the PICIS ICU charting system to include infection prevention strategies.

Recommendation 21. We recommended that employees receive annual MDRO education and that the training be consistently documented.

Concur

Target Completion Date: June 30, 2011.

Staff are being identified for assignment of learning module in LMS. Once identified, module will be assigned and staff will be instructed to complete. Monitoring will occur through annual competency and performance review.

Recommendation 22. We recommended that processes be implemented to ensure timely completion of background investigations.

Concur

Target Completion Date: May 15, 2011.

During the time of the review the facility was at 94%; however, opportunity for improvement was noted. Actions to improve timely completion of background related especially to contract personnel include designation of sensitivity when submitting Statement of Work to Contracting, providing instruction sheet on the process for successful bidders, meeting with current contractors to review process, Contracting will provide access to logs of initiated background investigations to cross check that no one provides services without initiating a background investigation.

OIG Contact and Staff Acknowledgments

Contact	Cathleen King, RN, Associate Director Dallas Office of Healthcare Inspections
Contributors	Katharine Foster, RN Gayle Karamanos, PA Sandra Khan, RN Daniel Kolb, PhD Sarah Lutter, RN, JD Karen Moore, RN Larry Ross, MS Maureen Washburn, ND Julie Watrous, RN Misti Kincaid, BS, Program Support Assistant Gregg Hirstein, Office of Investigations

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