Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-04700-119

Combined Assessment Program Review of the Edward Hines, Jr. VA Hospital Hines, Illinois

February 24, 2016

Washington, DC 20420

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

Glossary

AD	advance directive
CAP	Combined Assessment Program
CSP	compounded sterile product
CT	computed tomography
EHR	electronic health record
EOC	environment of care
facility	Edward Hines, Jr. VA Hospital
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
OR	operating room
QSV	quality, safety, and value
VHA	Veterans Health Administration

Table of Contents

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 November 2, 2015.

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

- Quality, Safety, and Value

The facility's reported accomplishment was a medication reconciliation improvement project to improve the accuracy of the final discharge medication list and decrease the number of unintended medication discrepancies.

Recommendations: We made recommendations in the following six activities:

Environment of Care: Maintain a log of individuals entering the facility between 9:00 p.m. and 5:00 a.m. Ensure functionality of negative air pressure systems in all designated rooms, or post signage indicating the rooms are not operational. Properly secure medical waste/biohazard containers. Secure sensitive patient information at all times.

Medication Management: Include an annual written test in competency assessment for employees who prepare compounded sterile products. Complete and document periodic surface sampling in all required areas. Perform and document monthly cleaning of ceilings, walls, and storage shelving in all compounding areas.

Coordination of Care: Develop and implement a policy that addresses temporary bed locations.

Computed Tomography Radiation Monitoring: Revise the computed tomography quality control program to include monitoring by a medical physicist at least annually, image quality monitoring, and computed tomography scanner maintenance.

Advance Directives: Ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives.

Suicide Prevention Program: Ensure that new employees complete suicide prevention training and that new clinical employees complete suicide risk management training within the required timeframe.

Comments

The Veterans Integrated Service Network Director and Acting Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 25–30, for the full text of the Directors' comments.) We will follow up on the planned actions 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

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities:

- QSV
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- Suicide Prevention Program

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 2015 and FY 2016 through November 6, 2015, and inspectors conducted the review 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 Edward Hines, Jr. VA Hospital, Hines, Illinois,* Report No. 13-02315-332, September 26, 2013).

During this review, we presented crime awareness briefings for 214 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. We distributed an electronic survey to all facility employees and received 427 responses. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough for the OIG to monitor until the facility implements corrective actions.

Reported Accomplishment

Medication Reconciliation Improvement Project

The facility launched the medication reconciliation improvement project in March 2014 to improve the accuracy of the final discharge medication list and decrease the number of unintended medication discrepancies. The team designed a new discharge process that includes a formal medication reconciliation consult from the physician to the pharmacist at the time of discharge and created Computerized Patient Record System screens for enhanced physician to pharmacy communication. Discharge process training tools were created and education was included in hospital orientation for new interns. Additionally, medication reconciliation training was included in rotation orientation for all residents. Laminated written instructions as well as frequently asked questions were distributed as visual aids. As a result of this project, the unintended medication discrepancies rate decreased from 8 percent pre-implementation to 4 percent post-implementation, and the number of monthly medication reconciliation consults increased from 20 to 160.

Results and Recommendations

QSV

The purpose of this review was to determine whether the facility complied with selected QSV program requirements.[a]

We conversed with senior managers and key QSV employees, and we evaluated meeting minutes, 20 licensed independent practitioners' profiles, 10 protected peer reviews, 5 root cause analyses, and other relevant documents. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	There was a senior-level committee responsible for key QSV functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data.		
	Credentialing and privileging processes met selected requirements: • Facility policy/by-laws addressed a frequency for clinical managers to review practitioners' Ongoing Professional Practice Evaluation data. • Facility clinical managers reviewed Ongoing Professional Practice Evaluation data at the frequency specified in the policy/by-laws. • The facility set triggers for when a Focused Professional Practice Evaluation for cause would be indicated. • The facility followed its policy when employees' licenses expired.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Protected peer reviews met selected requirements: • Peer reviewers documented their use of important aspects of care in their review such as appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation. • When the Peer Review Committee recommended individual improvement actions, clinical managers implemented the actions.		
	Utilization management met selected requirements: • The facility completed at least 75 percent of all required inpatient reviews. • Physician Utilization Management Advisors documented their decisions in the National Utilization Management Integration database. • The facility had designated an interdisciplinary group to review utilization management data.		
	Patient safety met selected requirements: • The Patient Safety Manager entered all reported patient incidents into the WEBSPOT database. • The facility completed the required minimum of eight root cause analyses. • The facility provided feedback about the root cause analysis findings to the individual or department who reported the incident. • At the completion of FY 2015, the Patient Safety Manager submitted an annual patient safety report to facility leaders.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Overall, if QSV reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in QSV activities.		
	The facility met any additional elements required by VHA or local policy.		

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. We also determined whether the facility met selected requirements in the dental clinic and the OR.[b]

We inspected the medical intensive care, surgical, medicine, and locked MH inpatient units. We also inspected the community living center, Emergency Department, OR, and dental and women's health clinics. Additionally, we reviewed relevant documents and 10 employee training records, and we conversed with key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings	Recommendations
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.		
	The facility conducted an infection prevention risk assessment.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas and follow-up on implemented actions and included analysis of surveillance activities and data.		
	The facility had established a process for cleaning equipment between patients.		
	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		
X	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.	Facility policy for identification of individuals entering the facility reviewed: • Employees did not maintain a log of individuals entering the facility between 9:00 p.m. and 5:00 a.m.	**1.** We recommended that designated employees maintain a log of individuals entering the facility between 9:00 p.m. and 5:00 a.m. and that facility managers monitor compliance.

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility met fire safety requirements.		
	The facility met environmental safety requirements.		
X	The facility met infection prevention requirements.	• One designated negative air pressure room in the Emergency Department was not functional, and two designated rooms on the surgical unit did not have signage indicating that they were no longer operational. • In four of seven patient care areas, medical waste/biohazard containers were not properly secured.	**2.** We recommended that facility managers ensure functionality of negative air pressure systems in all designated rooms or post signage indicating that rooms are not operational and monitor compliance. **3.** We recommended that facility managers ensure medical waste/biohazard containers are properly secured and monitor compliance.
	The facility met medication safety and security requirements.		
X	The facility met privacy requirements.	• In two of seven patient care areas, computers were positioned in a manner so that sensitive patient information was visible to the public.	**4.** We recommended that employees secure sensitive patient information at all times and that facility managers monitor compliance.
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Dental Clinic		
	Dental clinic employees completed bloodborne pathogens training within the past 12 months.		
	Dental clinic employees received hazard communication training on chemical classification, labeling, and Safety Data Sheets.		
NA	Designated dental clinic employees received laser safety training in accordance with local policy.		

NM	Areas Reviewed for Dental Clinic (continued)	Findings	Recommendations
	The facility tested dental water lines in accordance with local policy.		
	The facility met environmental safety and infection prevention requirements in the dental clinic.		
NA	The facility met laser safety requirements in the dental clinic.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for the OR		
	The facility had emergency fire policy/procedures for the OR that included alarm activation, evacuation, and equipment shutdown with responsibility for turning off room or zone oxygen.		
	The facility had cleaning policy/procedures for the OR and adjunctive areas that included a written cleaning schedule and methods of decontamination.		
NA	OR housekeepers received training on OR cleaning/disinfection in accordance with local policy.		
	The facility monitored OR temperature, humidity, and positive pressure.		
	The facility met fire safety requirements in the OR.		
	The facility met environmental safety requirements in the OR.		
	The facility met infection prevention requirements in the OR.		
	The facility met medication safety and security requirements in the OR.		

NM	Areas Reviewed for the OR (continued)	Findings	Recommendations
	The facility met laser safety requirements in the OR.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for the safe preparation of CSPs.[c]

We reviewed relevant documents and the competency assessment/testing records of 10 pharmacy technicians. Additionally, we inspected two areas where sterile products are compounded. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy on preparation of CSPs that included required components: • Pharmacist CSP preparation or supervision of preparation except in urgent situations • Hazardous CSP preparation in an area separate from routine CSP preparation or in a compounding aseptic containment isolator • Environmental quality and control of ante and buffer areas • Hood certification initially and every 6 months thereafter • Cleaning procedures for all surfaces in the ante and buffer areas		
X	The facility established competency assessment requirements for employees who prepare CSPs that included required elements, and facility managers assessed employee competency at the required frequency based on the facility's risk level.	• Facility competency assessment for employees who prepare CSPs did not include an annual written test.	**5.** We recommended that facility managers ensure competency assessment for employees who prepare compounded sterile products includes an annual written test.

NM	Areas Reviewed (continued)	Findings	Recommendations
NA	If the facility used an outsourcing facility for CSPs, it had a policy/guidelines/a plan that included required components for the outsourcing facility: • Food and Drug Administration registration • Current Drug Enforcement Agency registration if compounding controlled substances		
	The facility had a safety/competency assessment checklist for preparation of CSPs that included required steps in the proper order to maintain sterility.		
X	All International Organization for Standardization classified areas had documented evidence of periodic surface sampling, and the facility completed required actions when it identified positive cultures.	• There was no evidence of periodic surface sampling in the main pharmacy and the ninth floor pharmacy areas where sterile products were compounded.	**6.** We recommended that facility managers ensure completion and documentation of periodic surface sampling in all required areas and monitor compliance.
	The facility had a process to track and report CSP medication errors, including near misses.		
	The facility met design and environmental safety controls in compounding areas.		
	The facility used a laminar airflow hood or compounding aseptic isolator for preparing non-hazardous intravenous admixtures and any sterile products.		
	The facility used a biological safety cabinet in a physically separated negative pressure area or a compounding aseptic containment isolator for hazardous medication compounding and had sterile chemotherapy type gloves available for compounding these medications.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	If the facility prepared hazardous CSPs, a drug spill kit was available in the compounding area and during transport of the medication to patient care areas.		
	Hazardous CSPs were physically separated or placed in specially identified segregated containers from other inventory to prevent contamination or personnel exposure.		
	An eyewash station was readily accessible near hazardous medication compounding areas, and there was documented evidence of weekly testing.		
X	The facility documented cleaning of compounding areas, and employees completed cleaning at required frequencies.	• There was no documented evidence of monthly cleaning of ceilings, walls, and storage shelving in the compounding areas as required by local standard operating procedures.	**7.** We recommended that facility managers ensure employees perform and document monthly cleaning of ceilings, walls, and storage shelving in all compounding areas and monitor compliance.
	During the past 12 months, the facility initially certified new hoods and recertified all hoods minimally every 6 months.		
	Prepared CSPs had labels with required information prior to delivery to the patient care areas: • Patient identifier • Date prepared • Admixture components • Preparer and checker identifiers • Beyond use date		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

Coordination of Care

The purpose of this review was to evaluate selected aspects of the facility's patient flow process over the inpatient continuum (admission through discharge).[d]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 35 randomly selected patients who had an acute care inpatient stay of at least 3 days from July 1, 2014, through June 30, 2015. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy that addressed patient discharge and scheduling discharges early in the day.		
X	The facility had a policy that addressed temporary bed locations, and it included: • Priority placement for inpatient beds given to patients in temporary bed locations • Upholding the standard of care while patients are in temporary bed locations • Medication administration • Meal provision	• The facility did not have a policy that addressed temporary bed locations.	**8.** We recommended that the facility develop and implement a policy that addresses temporary bed locations.
	The Facility Director had appointed a Bed Flow Coordinator with a clinical background.		
	Physicians or acceptable designees completed a history and physical exam within 1 day of the patient's admission or referenced a history and physical exam completed within 30 days prior to admission. • When resident physicians completed the history and physical exams, the attending physicians provided a separate admission note or addendum within 1 day of the admission.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	• When the facility policy and/or scopes of practice allowed for physician assistants or nurse practitioners to complete history and physical exams, they were properly documented.		
	Nurses completed admission assessments within 1 day of the patient's admission.		
	When patients were transferred during the inpatient stay, physicians or acceptable designees documented transfer notes within 1 day of the transfer. • When resident physicians wrote the transfer notes, attending physicians documented adequate supervision. • Receiving physicians documented transfers.		
	When patients were transferred during the inpatient stay, sending and receiving nurses completed transfer notes.		
	Physicians or acceptable designees documented discharge progress notes or instructions that included patient diagnoses, discharge medications, and follow-up activity levels. • When resident physicians completed the discharge notes/instructions, attending physicians documented adequate supervision. • When facility policy and/or scopes of practice allowed for physician assistants or nurse practitioners to complete discharge notes/instructions, they were properly documented.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinicians provided discharge instructions to patients and/or caregivers and documented patients and/or caregiver understanding.		
	The facility complied with any additional elements required by VHA or local policy.		

CT Radiation Monitoring

The purpose of this review was to determine whether the facility complied with selected VHA radiation safety requirements and to follow up on recommendations regarding monitoring and documenting radiation dose from a 2011 report, *Healthcare Inspection – Radiation Safety in Veterans Health Administration Facilities*, Report No. 10-02178-120, March 10, 2011.[e]

We reviewed relevant documents, including qualifications and dosimetry monitoring for 11 CT technologists and CT scanner inspection reports, and conversed with key managers and employees. We also reviewed the EHRs of 48 randomly selected patients who had a CT scan January 1–December 31, 2014. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a designated Radiation Safety Officer responsible for oversight of the radiation safety program.		
X	The facility had a CT/imaging/radiation safety policy or procedure that included: • A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance • CT protocol monitoring to ensure doses were as low as reasonably achievable and a method for identifying and reporting excessive CT patient doses to the Radiation Safety Officer • A process for managing/reviewing CT protocols and procedures to follow when revising protocols • Radiologist review of appropriateness of CT orders and specification of protocol prior to scans	• The facility's CT quality control program did not include annual monitoring by a medical physicist, monitoring the quality of CT images produced, and maintenance of the CT scanner.	**9.** We recommended that the facility revise the computed tomography quality control program to include monitoring by a medical physicist at least annually, image quality monitoring, and computed tomography scanner maintenance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	A radiologist and technologist expert in CT reviewed all CT protocols revised during the past 12 months.		
	A medical physicist tested a sample of CT protocols at least annually.		
	A medical physicist performed and documented CT scanner annual inspections, an initial inspection after acquisition, and follow-up inspections after repairs or modifications affecting dose or image quality prior to the scanner's return to clinical service.		
NA	If required by local policy, radiologists included patient radiation dose in the CT report available for clinician review and documented the dose in the required application(s), and any summary reports provided by teleradiology included dose information.		
	CT technologists had required certifications or written affirmation of competency if "grandfathered in" prior to January 1987, and technologists hired after July 1, 2014, had CT certification.		
	There was documented evidence that CT technologists had annual radiation safety training and dosimetry monitoring.		
NA	If required by local policy, CT technologists had documented training on dose reduction/optimization techniques and safe procedures for operating the types of CT equipment they used.		
	The facility complied with any additional elements required by VHA or local policy.		

ADs

The purpose of this review was to determine whether the facility complied with selected requirements for ADs for patients.[f]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 35 randomly selected patients who had an acute care admission July 1, 2014, through June 30, 2015. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had an AD policy that addressed: • AD notification, screening, and discussions • Proper use of AD note titles		
	Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening.		
	When patients provided copies of their current ADs, employees had scanned them into the EHR. • Employees correctly posted patients' AD status.		
X	Employees asked inpatients if they would like to discuss creating, changing, and/or revoking ADs. • When inpatients requested a discussion, employees documented the discussion and used the required AD note titles.	• Seven of the 33 applicable EHRs (21 percent) did not contain documentation that employees asked inpatients whether they wished to discuss creating, changing, and/or revoking ADs.	**10.** We recommended that employees ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives and that facility managers monitor compliance.
	The facility met any additional elements required by VHA or local policy.		

Suicide Prevention Program

The purpose of this review was to evaluate the extent the facility's MH providers consistently complied with selected suicide prevention program requirements.[g]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 39 patients assessed to be at risk for suicide during the period July 1, 2014–June 30, 2015, plus those who died from suicide during this same timeframe. We also reviewed the training records of 15 new employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

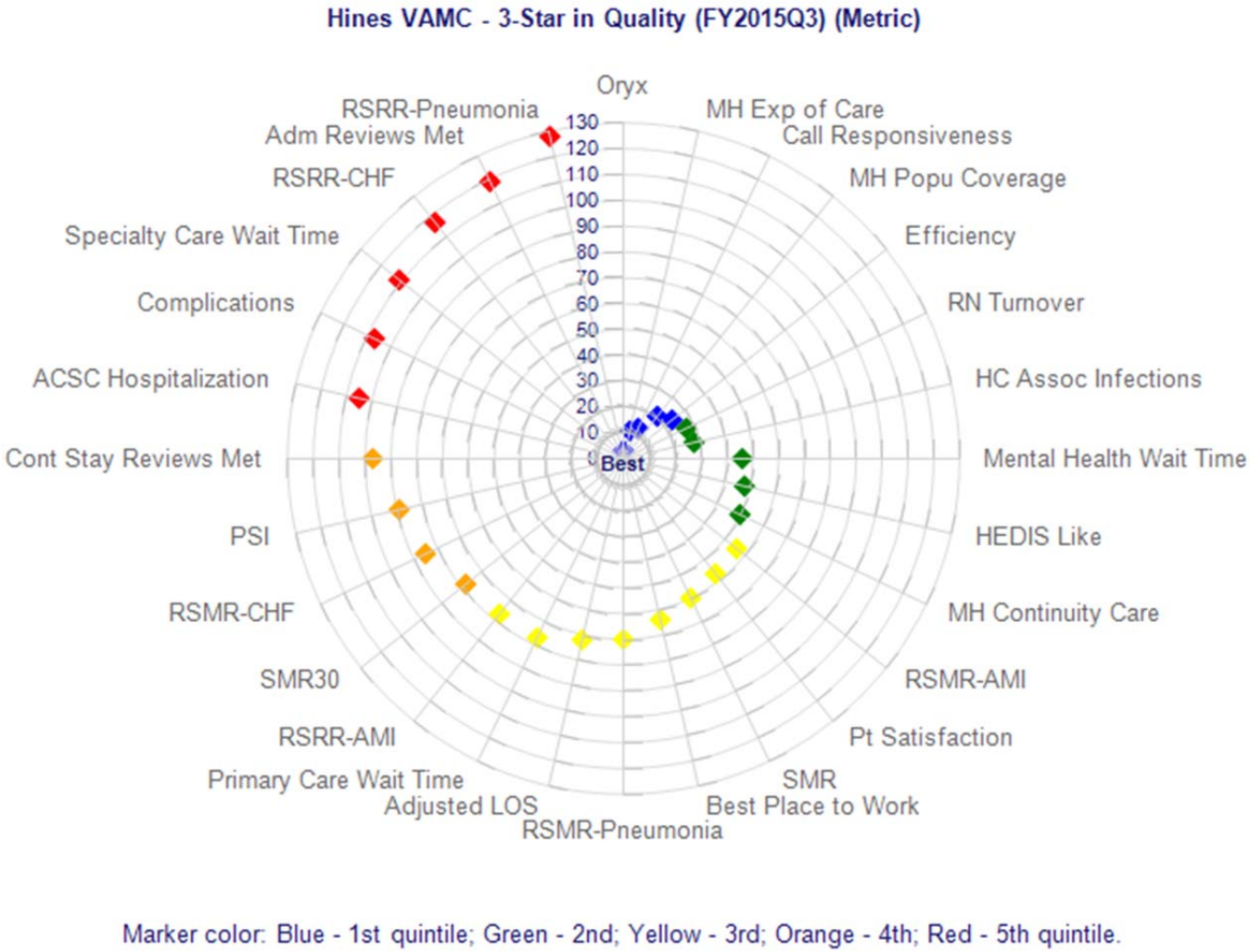
NM	Areas Reviewed	Findings	Recommendations
	The facility had a full-time Suicide Prevention Coordinator.		
	The facility had a process for responding to referrals from the Veterans Crisis Line and for tracking patients who are at high risk for suicide.		
	The facility had a process to follow up on high-risk patients who missed MH appointments.		
X	The facility provided training within required timeframes: • Suicide prevention training to new employees • Suicide risk management training to new clinical employees	• Three of the 15 training records contained no evidence of suicide prevention training within 12 months of being hired. • Four of the 10 applicable training records indicated that clinicians did not complete suicide risk management training within 90 days of being hired.	**11.** We recommended that the facility ensure new employees complete suicide prevention training and new clinical employees complete suicide risk management training within the required timeframe and that facility managers monitor compliance.
	The facility provided at least five suicide prevention outreach activities to community organizations each month.		
	The facility completed required reports and reviews regarding patients who attempted or completed suicide.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinicians assessed patients for suicide risk at the time of admission.		
	Clinicians appropriately placed Patient Record Flags: • High-risk patients received Patient Record Flags. • Moderate- and low-risk patients did not receive Patient Record Flags.		
	Clinicians documented Suicide Prevention Safety Plans that contained the following required elements: • Identification of warning signs • Identification of internal coping strategies • Identification of contact numbers of family or friends for support • Identification of professional agencies • Assessment of available lethal means and how to keep the environment safe		
	Clinicians documented that they gave patients and/or caregivers a copy of the safety plan.		
	The treatment team evaluated patients as follows: • At least four times during the first 30 days after discharge. • Every 90 days to review Patient Record Flags.		
	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (Hines/578) FY 2016 through November 2015	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$71.8
Number of:	
• **Unique Patients**	27,524
• **Outpatient Visits**	87,300
• **Unique Employees**[1]	3,142
Type and Number of Operating Beds:	
• **Hospital**	248
• **Community Living Center**	208
• **MH**	29
Average Daily Census:	
• **Hospital**	172.1
• **Community Living Center**	110.2
• **MH**	12.6
Number of Community Based Outpatient Clinics	6
Location(s)/Station Number(s)	Joliet/578GA Bourbonnais/578GC North Aurora/578GD Elgin/578GE Peru/578GF Oak Lawn/578GG
Veterans Integrated Service Network Number	12

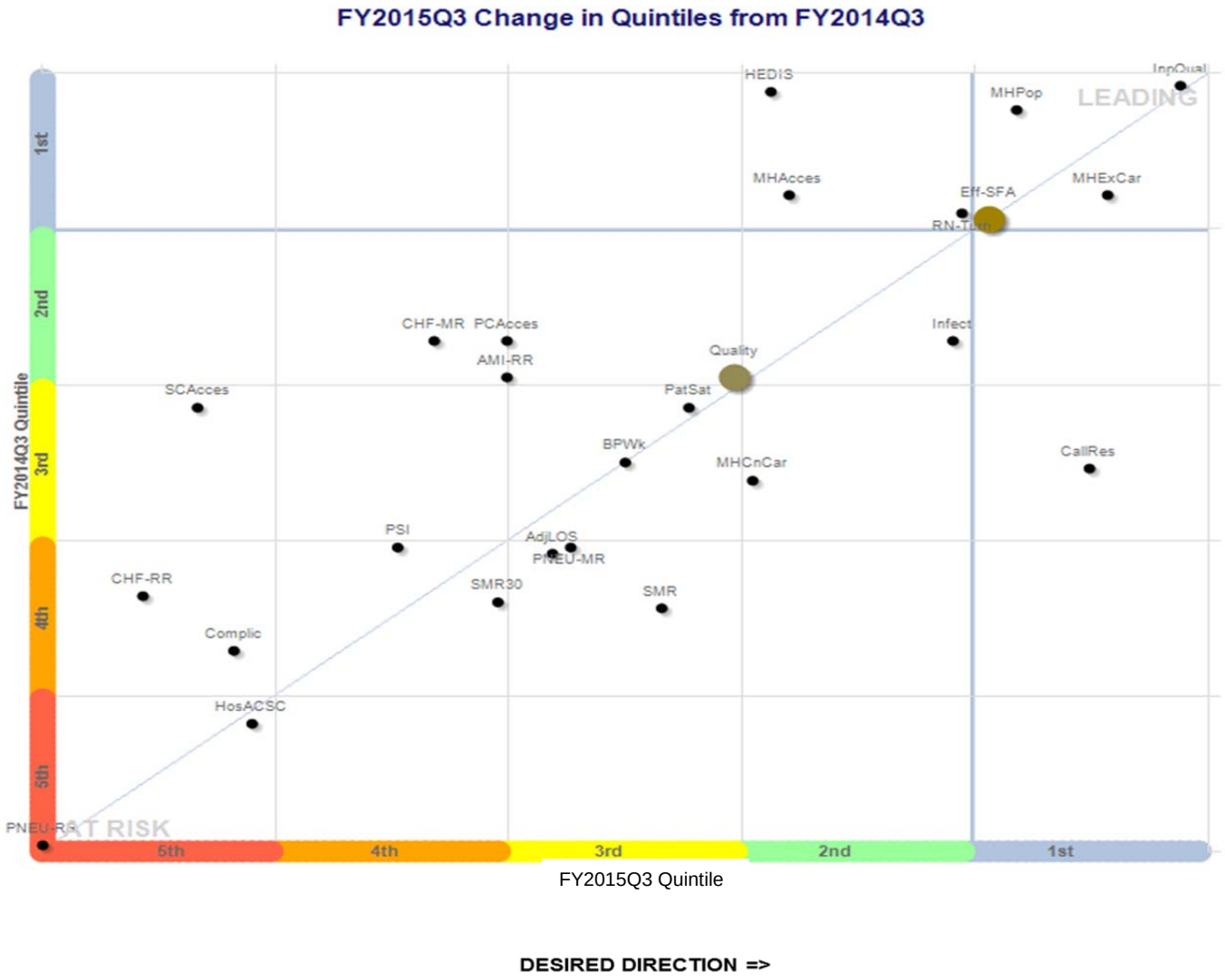
[1] Unique employees involved in direct medical care (cost center 8200).

Strategic Analytics for Improvement and Learning (SAIL)[2]



[2] Metric definitions follow the graphs.

Scatter Chart



DESIRED DIRECTION =>

NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	MH Continuity Care
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: January 26, 2016

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

Subject: **CAP Review of the Edward Hines, Jr. VA Hospital, Hines, IL**

To: Director, San Diego Office of Healthcare Inspections (54SD)

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

1. Thank you for conducting a comprehensive review at the Edward Hines, Jr. VA Hospital, Hines IL.

2. I have reviewed the document and concur with the response as submitted.

Denise M. Deitzen
Network Director, VISN 12

Acting Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: January 27, 2016

From: Acting Director, Edward Hines, Jr. VA Hospital (578/00)

Subject: **CAP Review of the Edward Hines, Jr. VA Hospital, Hines, IL**

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

1. Hines concurs with all recommendations. Please see the attached action plans for the recommendations identified from the recent review.

2. If you have any questions, please contact Ms. Sabrina R. Hughes, Chief, Quality and System Improvement at (708) 202-4621.

Lynette J. Taylor, RN, MHSA, VHA-CM
Acting Director, Edward Hines Jr. VA Hospital

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 designated employees maintain a log of individuals entering the facility between 9:00 p.m. and 5:00 a.m. and that facility managers monitor compliance.

Concur

Target date for completion: May 30, 2016

Facility response: Hines will keep all entry doors locked between 9 p.m. and 5 a.m. allowing one door entry located at the Emergency Department. Dispatch will monitor access point ensuring that visitors are authorized and signed in on log sheet when entering the facility.

Recommendation 2. We recommended that facility managers ensure functionality of negative air pressure systems in all designated rooms or post signage indicating that rooms are not operational and monitor compliance.

Concur

Target date for completion: Completed January 26, 2016

Facility response: Facility Engineering made modifications to the negative pressure room alarms for the Emergency Department, SICU, MICU, and 8th floor to ensure that appropriate staff is aware of each room's functionality. Signage was posted on other rooms that are not functional as negative pressure rooms to notify staff that these rooms are not to be used to isolate patients.

Recommendation 3. We recommended that facility managers ensure medical waste/biohazard containers are properly secured and monitor compliance.

Concur

Target date for completion: May 30, 2016

Facility response: All Staff will be notified by email to keep lids on hazardous waste containers by January 30, 2016. Audits to ensure compliance will begin February, 2016, utilizing the established Environment of Care Checklist. Hospital Safety will report audit results to the Hospital Safety Committee.

Recommendation 4. We recommended that employees secure sensitive patient information at all times and that facility managers monitor compliance.

Concur

Target date for completion: July 30, 2016

Facility response: Privacy screens for computers have been ordered with an anticipated arrival by March 15, 2016. Audits to ensure compliance with privacy screen use will begin April 1, 2016, utilizing the established Environment of Care Checklist. Audit results will be provided monthly to the Quality Council Committee starting May, 2016.

Recommendation 5. We recommended that facility managers ensure competency assessment for employees who prepare compounded sterile products includes an annual written test.

Concur

Target date for completion: July 31, 2016

Facility response: Competency assessment for employees preparing compounded sterile products will be implemented through an Annual Written Test which is currently under development with completion by February 15, 2016. All pharmacy employees who prepare CSP will complete written test per criteria for a satisfactory score by July 31, 2016.

Recommendation 6. We recommended that facility managers ensure completion and documentation of periodic surface sampling in all required areas and monitor compliance.

Concur

Target date for completion: May 30, 2016

Facility response: A written plan was completed November, 2015 for ongoing surface sampling testing where sterile products are compounded for Fiscal year 2016. Evidence of sampling and testing was also completed on November 15, 2015. Hines will do the environmental surface sampling every six months according to the guidelines with report to the Infection Control Committee.

Recommendation 7. We recommended that facility managers ensure employees perform and document monthly cleaning of ceilings, walls, and storage shelving in all compounding areas and monitor compliance.

Concur

Target date for completion: May 1, 2016

Facility response: A monthly terminal cleaning log was created and posted in the Intravenous Room (of main pharmacy and ninth floor pharmacy areas). Guidelines for cleaning were created by Emergency Management Service. Monthly reports will be provided to the Quality Council starting March, 2016.

Recommendation 8. We recommended that the facility develop and implement a policy that addresses temporary bed locations.

Concur

Target date for completion: May 30, 2016

Facility response: The temporary bed location policy has been written as of December 09, 2015. It is currently under review for approval and implementation.

Recommendation 9. We recommended that the facility revise the computed tomography quality control program to include monitoring by a medical physicist at least annually, image quality monitoring, and computed tomography scanner maintenance.

Concur

Target date for completion: February 29, 2016

Facility response: On November 15, 2015, Diagnostic Radiology Service revised their Standard Operating Procedure and the Quality Assurance (QA)/Quality Control for Computed Tomography (CT) policy to include all missing elements which now includes monitoring by the medical physicist annually, image quality monitoring, and computed tomography scanner maintenance. All results will be reported to the Radiology Service Committee to ensure compliance.

Recommendation 10. We recommended that employees ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives and that facility managers monitor compliance.

Concur

Target date for completion: May 30, 2016

Facility response: On November 15, 2015, an Advance Directive Disclosure Statement template that now requires completion of all mandatory fields was implemented including notifying the patient of his/her rights, and determining whether to create, change or revoke their advance directive. Quality and Systems Improvement provided an audit of 42 medical records for the month of November 2015 with 98% of the records having all required documentation for advanced directive. Audits will be conducted through April 2016 with monthly reporting to the Quality Council.

Recommendation 11. We recommended that the facility ensure new employees complete suicide prevention training and new clinical employees complete suicide risk management training within the required timeframe and that facility managers monitor compliance.

Concur

Target date for completion: May 15, 2016

Facility response: On December 15, 2015, the Mental Health Service Line identified staff that require suicide prevention training and suicide risk management training and implemented ongoing training. Reports to the Quality Council will begin February, 2016.

Office of Inspector General
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This report is available at **www.va.gov/oig**.

Endnotes

[a] References used for this topic were:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Directive 1117, *Utilization Management Program*, July 9, 2014.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

[b] References used for this topic included:
- VHA Directive 2005-037, *Planning for Fire Response*, September 2, 2005.
- VHA Directive 2009-026; *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*; May 13, 2009.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the Health Insurance Portability and Accountability Act, National Fire Protection Association, Association of periOperative Registered Nurses, U.S. Pharmacopeial Convention, American National Standards Institute.

[c] References used for this topic included:
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of VA Pharmacy Benefits Management Services, The Joint Commission, the United States Pharmacopeial Convention, the American Society of Health-System Pharmacists, the Institute for Safe Medication Practices, the Food and Drug Administration, and the American National Standards Institute.

[d] The references used for this topic included:
- VHA Directive 1009, *Standards for Addressing the Needs of Patients Held in Temporary Bed Locations*, August 28, 2013.
- VHA Directive 1063, *Utilization of Physician Assistants (PA)*, December 24, 2013.
- VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

[e] References used for this topic included:
- VHA Directive 1129, *Radiation Protection for Machine Sources of Ionizing Radiation*, February 5, 2015.
- VHA Handbook 1105.02, *Nuclear Medicine and Radiation Safety Service*, December 10, 2010.
- VHA Handbook 5005/77, *Staffing*, Part II, Appendix G25, Diagnostic Radiologic Technologist Qualifications Standard GS-647, June 26, 2014.
- The Joint Commission, "Radiation risks of diagnostic imaging," Sentinel Event Alert, Issue 47, August 24, 2011.
- VA Radiology, "Online Guide," updated October 4, 2011.
- The American College of Radiology, "ACR–AAPM TECHNICAL STANDARD FOR DIAGNOSTIC MEDICAL PHYSICS PERFORMANCE MONITORING OF COMPUTED TOMOGRAPHY (CT) EQUIPMENT, Revised 2012.

[f] The references used for this topic included:
- VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, December 24, 2013.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[g] References used for this topic included:
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010 (corrected 2/3/11).
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- VHA Handbook 1160.06, *Inpatient Health Services*, September 16, 2013.
- Various Deputy Under Secretary for Health for Operations and Management memorandums and guides.
- *VA Suicide Prevention Coordinator Manual*, August 2014.
- Various requirements of The Joint Commission.