Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-00121-320

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

June 9, 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	Jesse Brown VA Medical Center
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
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 March 28, 2016.

Review Results: The review covered seven activities and a follow-up review area from the previous Combined Assessment Program review. We made no recommendations in the following activity:

- Computed Tomography Radiation Monitoring

The facility's reported accomplishments were the Food Pantry Program and a partnership with the Social Security Administration.

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

Quality, Safety, and Value: Consistently review Ongoing Professional Practice Evaluation data every 6 months. Complete at least 75 percent of all utilization management reviews.

Environment of Care: Revise the policy and protocol for the identification of individuals entering the facility to include specialty/restricted areas and instructions regarding visitors who enter the facility during business hours.

Medication Management: Ensure that an emergency eyewash station is readily accessible to the chemotherapy compounding area where employees compound hazardous medications and that employees wear personal protective equipment and gloves when compounding sterile products in the operating room satellite pharmacy.

Coordination of Care: Ensure that sending nurses document transfer assessments and receiving nurses document transfer notes and that attending physicians co-sign resident physicians' discharge progress notes/instructions.

Advance Directives: Revise the advance directives policy to be consistent with Veterans Health Administration policy. Implement a plan for transition to the allowed note titles. Screen inpatients to determine whether they have advance directives, document the screening, and consistently use appropriate note titles. Ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives.

Suicide Prevention Program: Consistently place flags in the electronic health records of high-risk patients. Develop Suicide Prevention Safety Plans during the admission for all patients identified as high risk, and ensure plans include required elements.

Follow-Up on Quality Management: Perform and document patient assessments following blood product transfusions.

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 28–34, for the full text of the Directors' comments.) We consider recommendations 4 and 9 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

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 and follow-up review area from the previous CAP review:

- QSV
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- Suicide Prevention Program
- Follow-Up on Quality Management

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 March 31, 2016, 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 Jesse Brown VA Medical Center, Chicago, Illinois,* Report No. 13-01669-270, August 16, 2013). We made a repeat recommendation in Quality Management.

During this review, we presented crime awareness briefings for 187 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 219 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 Accomplishments

Veterans' Food Pantry Program

On Veterans Day 2013, the facility opened a weekly food pantry for veterans. This nationally recognized program has served more than 4,000 unique veterans and 12,000 household members who shop and choose their groceries, leaving with a 3–5 pound bag full of food items. The program is at no cost to VA through Voluntary Service's community partnerships. It has become the facility's most noted special program and is an example of true patient-centered care. In November 2015, VA Secretary Robert McDonald made a special visit to the food pantry and volunteered to help veterans shop for their food items.

Social Security Administration Veteran Service Partnership Program

The facility entered into a partnership with the Social Security Administration to assist veterans with their social security related concerns and reduce appointment wait times. Without leaving the facility, veterans may schedule an appointment and a video conference (through Voluntary Service's videoconferencing program) of up to 1 hour with a Social Security Administration representative. Many of the facility's veterans have transportation issues or have conditions that make waiting in long lines challenging. This program provides veterans a convenient option for their social security related needs.

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. 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
	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.		
X	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.	• Three profiles did not contain evidence that clinical managers reviewed Ongoing Professional Practice Evaluation data every 6 months.	**1.** We recommended that facility clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and that facility managers monitor compliance.

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.		
X	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.	• For the timeframe October 1, 2014–September 30, 2015, the facility completed only 69 percent of all required reviews.	**2.** We recommended that facility clinical managers ensure completion of at least 75 percent of all utilization management reviews and that facility managers monitor compliance.
	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 intensive care, MH (7E), and medical/surgical (5E) units; the community living center; the Emergency Department; the OR; and the dental and primary care Gold clinics. Additionally, we reviewed relevant documents and 15 employee training records, and we conversed with key employees and managers. 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 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.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
X	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.	Facility policy and protocol for identification of individuals entering the facility reviewed: • Policy did not include specific protocols for persons entering all specialty/restricted areas such as the OR, intensive care unit, Sterile Processing Service, MH unit, or community living center. • Protocol for visitors only included directions for those entering the facility after hours.	**3.** We recommended that the facility revise the policy and protocol for the identification of individuals entering the facility to include specialty/restricted areas and instructions regarding visitors who enter the facility during business hours and that facility managers monitor compliance.
	The facility met fire safety requirements.		
	The facility met environmental safety requirements.		
	The facility met infection prevention requirements.		
	The facility met medication safety and security requirements.		
	The facility met privacy requirements.		
	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.		
	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 employees (5 pharmacists and 5 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		
	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.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	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.		
	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.		
	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.		
X	An eyewash station was readily accessible near hazardous medication compounding areas, and there was documented evidence of weekly testing.	• An emergency eyewash station was not readily accessible in or near the chemotherapy compounding area where employees compounded hazardous medications.	**4.** We recommended that facility managers ensure an emergency eyewash station is readily accessible to the chemotherapy compounding area where employees compound hazardous medications.
	The facility documented cleaning of compounding areas, and employees completed cleaning at required frequencies.		
	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		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	The United States Pharmacopeial Convention requires the use of appropriate personal protective equipment when using an isolator unless the manufacturer's recommendations state otherwise. • Manufacturer's recommendations for the compounding aseptic isolator in the OR satellite pharmacy did not address personal protective equipment or gloves, and staff did not wear either when preparing sterile products inside the isolator.	**5.** We recommended that employees wear personal protective equipment and gloves when compounding sterile products in the operating room satellite pharmacy and that facility managers monitor compliance.

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 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 that addressed patient discharge and scheduling discharges early in the day.		
	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 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.		
X	When patients were transferred during the inpatient stay, sending and receiving nurses completed transfer notes.	• For 2 of the 10 applicable EHRs, sending nurses did not document transfer assessments, and receiving nurses did not document transfer notes as required by local policy.	**6.** We recommended that sending nurses document transfer assessments and receiving nurses document transfer notes and that facility managers monitor compliance.
X	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.	• For 13 of the 25 applicable EHRs, attending physicians did not co-sign resident physicians' discharge notes/instructions.	**7.** We recommended that attending physicians co-sign resident physicians' discharge notes/instructions and that facility managers monitor compliance.

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 five CT technologists and CT scanner inspection reports, and we conversed with key managers and employees. We also reviewed the EHRs of 50 randomly selected patients who had a CT scan January 1–December 31, 2014. 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
	The facility had a designated Radiation Safety Officer responsible for oversight of the radiation safety program.		
	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		
	A radiologist and technologist expert in CT reviewed all CT protocols revised during the past 12 months.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	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.		
	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 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
X	The facility had an AD policy that addressed: • AD notification, screening, and discussions • Proper use of AD note titles	• Facility policy on ADs was incongruent with VHA policy as follows: o Differentiating the process and note titles for AD screening/notification from AD discussions o Mapping AD note titles to EHR postings o Revoking and renaming previous directives • The facility's list of AD note titles included non-allowed titles, and there was no plan for transition to the allowed note titles.	**8.** We recommended that the facility review and revise its advance directives policy to ensure it is consistent with Veterans Health Administration policy. **9**. We recommended that the facility implement a plan for transition to the allowed note titles and that facility managers monitor compliance.
X	Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening.	• Sixteen of the 35 EHRs (46 percent) did not contain documentation that employees screened inpatients to determine whether they had ADs. • Six of the 19 applicable EHRs did not contain appropriate screening note titles.	**10.** We recommended that employees screen inpatients to determine whether they have advance directives and document the screening and that facility managers monitor compliance. **11.** We recommended that employees consistently use appropriate note titles to document screening and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	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 19 applicable EHRs did not contain documentation that employees asked inpatients whether they wished to discuss creating, changing, and/or revoking ADs.	**12.** 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 40 patients assessed to be at risk for suicide during the period October 1, 2014–September 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 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 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.		
	The facility provided training within required timeframes: • Suicide prevention training to new employees • Suicide risk management training to new clinical employees		
	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.		
	Clinicians assessed patients for suicide risk at the time of admission.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	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 had not placed flags in the EHRs of three of the nine high-risk patients.	**13.** We recommended that clinicians consistently place flags in the electronic health records of high-risk patients and that facility managers monitor compliance.
X	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	• For three of the nine patients identified as high risk, clinicians did not document a Suicide Prevention Safety Plan during the admission. • Four of the 12 safety plans lacked documentation of the contact numbers of family or friends for support and assessment of available lethal means and how to keep the environment safe.	**14.** We recommended that clinicians develop Suicide Prevention Safety Plans during the admission for all patients identified as high risk and that plans include contact numbers of family or friends for support and assessment of available lethal means and how to keep the environment safe and that facility managers monitor compliance.
	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.		

Review Activity with Previous CAP Recommendations

Follow-Up on Quality Management

As a follow-up to a recommendation from our previous CAP review, we reassessed facility compliance with patient assessments following blood product transfusion.[h]

Patient Assessments. VHA requires patient assessments following blood product transfusions. During our previous review, we found inconsistent documentation of patient assessment following transfusion. Since the facility did not have current monitoring data, we could not determine whether the facility was in compliance with the requirement for post-transfusion patient assessments.

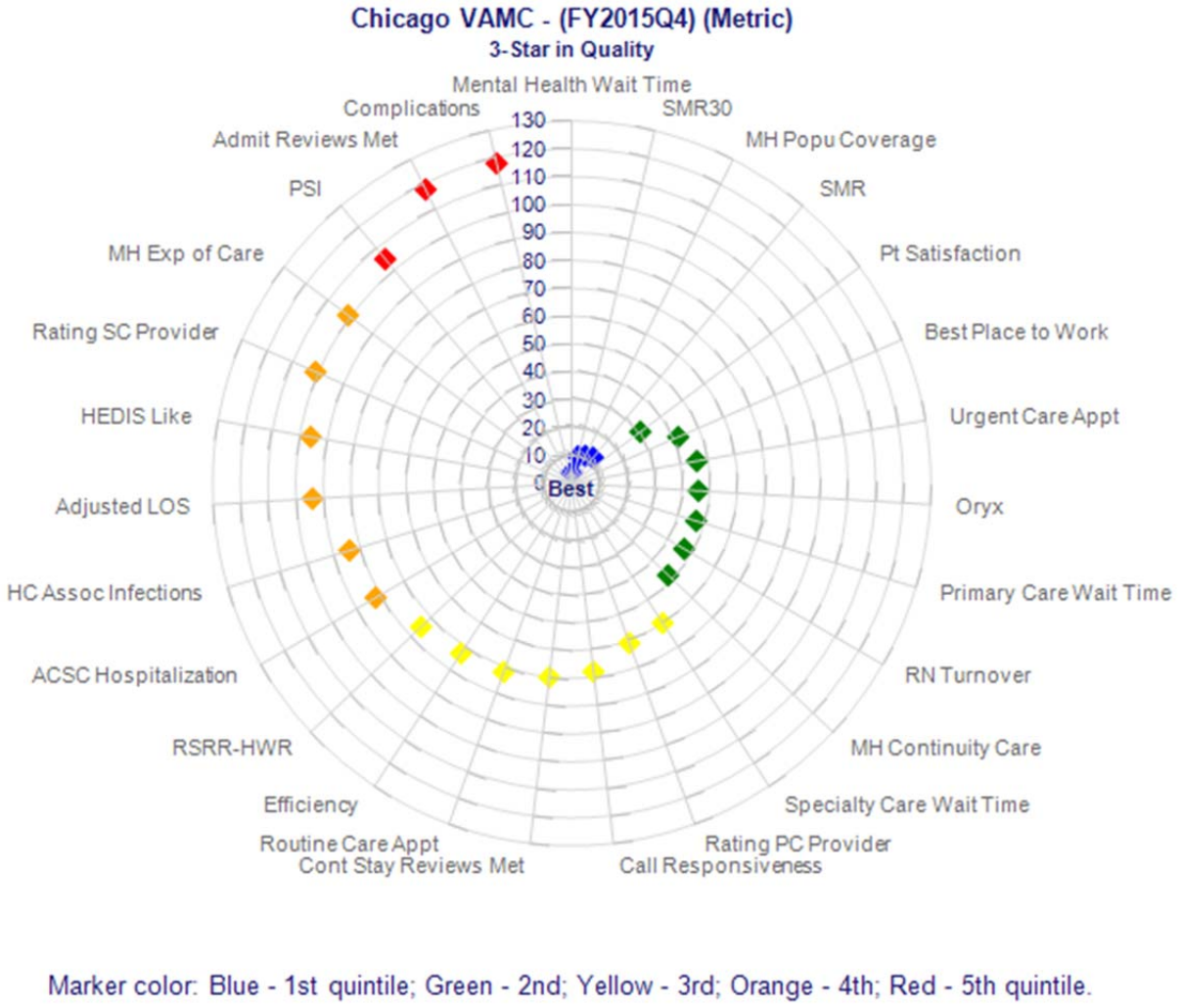
Recommendation

15. We recommended that clinicians perform and document patient assessments following blood product transfusions and that facility managers monitor compliance.

Facility Profile (Chicago/537) FY 2016 through March 2016[1]	
Type of Organization	Secondary
Complexity Level	1b-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$416
Number of:	
• **Unique Patients**	37,096
• **Outpatient Visits**	285,318
• **Unique Employees**[2]	2,037
Type and Number of Operating Beds (as of February 2016):	
• **Hospital**	148
• **Community Living Center**	22
• **Domiciliary**	40
Average Daily Census (as of February 2016):	
• **Hospital**	64
• **Community Living Center**	10
• **Domiciliary**	26
Number of Community Based Outpatient Clinics	4
Location(s)/Station Number(s)	Crown Point/537BY Chicago Heights/537GA Chicago/537GD Chicago/537HA
VISN Number	12

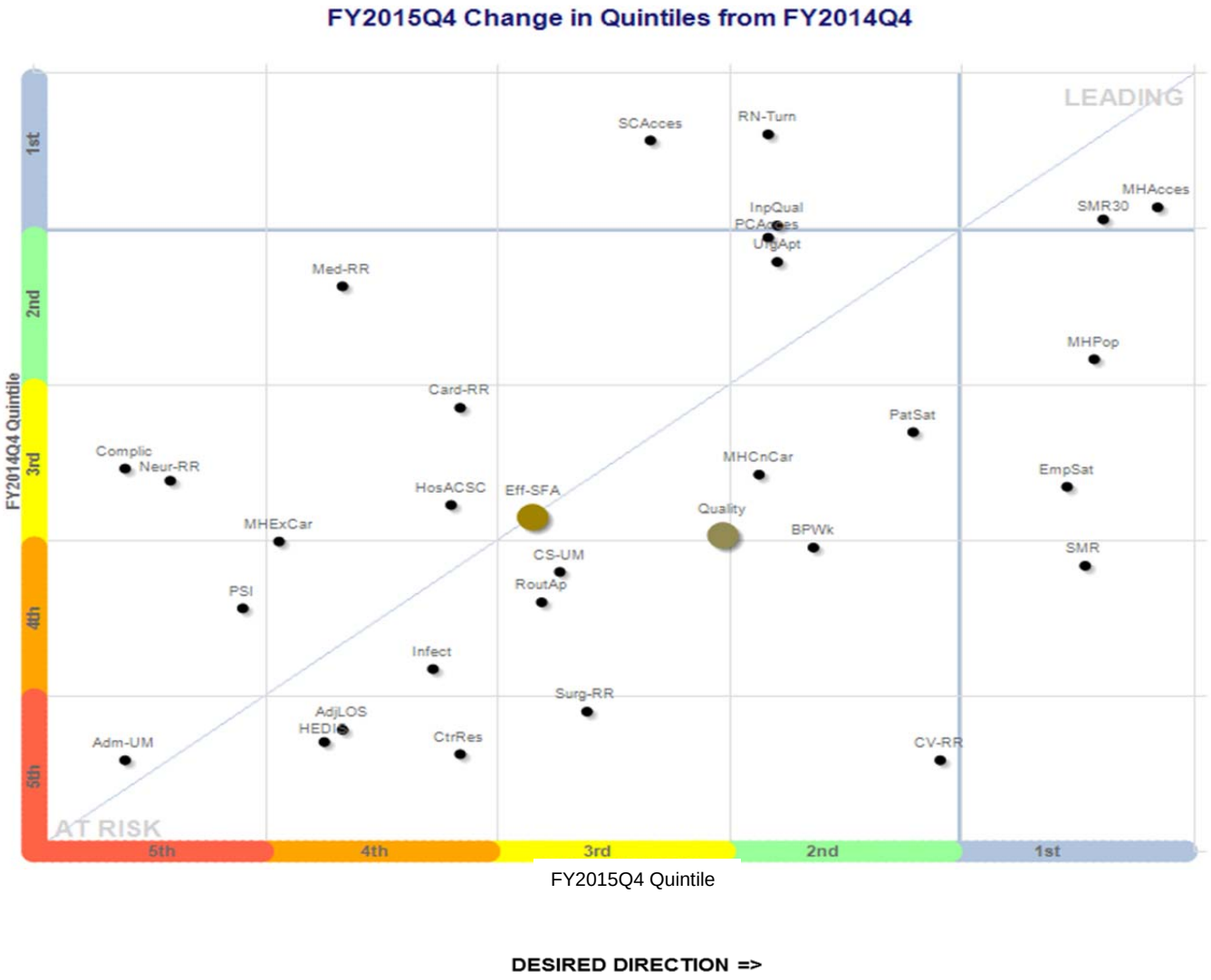
[1] All data is for FY 2016 through March 2016 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

Strategic Analytics for Improvement and Learning (SAIL)[3]



[3] 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

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: 11 May 2016

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

Subject: CAP Review of the Jesse Brown VA Medical Center, Chicago, IL

To: Director, Los Angeles Office of Healthcare Inspections (54LA)

Director, Management Review Service (VHA 10E1D MRS OIG CAP CBOC)

1. I have reviewed the response from the Jesse Brown VA Medical Center Chicago and concur with the response.
2. If you have any questions or concerns, please contact Chris Iacovetti, Acting QMO VISN 12 (708) 492-3918.

(original signed by:)
Denise M. Deitzen
Network Director, VISN 12

Acting Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: 9 May 2016

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

Subject: CAP Review of the Jesse Brown VA Medical Center, Chicago, IL

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

1. We appreciate the opportunity to work with the Office of Inspector General as we continuously strive to improve the quality of healthcare for America's Veterans.

2. I concur with the findings and recommendations of the OIG CAP Survey Team. The importance of this review is acknowledged as we continually strive to provide the best possible care.

3. If you have any questions, please contact Deborah J. Barker RN, Chief Performance Improvement at (312) 569-6194.

(original signed by:)
Annette P. Walker, MSHA, BSN
Acting Medical Center Director

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 facility clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and that facility managers monitor compliance.

Concur

Target date for completion: November 2, 2016

Facility Response: The Medical Center's Medical Staff Bylaws had been updated to reflect this requirement. Random audits will be conducted in October 2016 to assess clinical manager compliance with their OPPE review. The results of this audit will be presented at the November 2016 Professional Standards Board meeting.

Recommendation 2. We recommended that facility clinical managers ensure completion of at least 75 percent of all utilization management reviews and that facility managers monitor compliance.

Concur

Target date for completion: November 30, 2016

Facility response: The Medical Center has hired 2 Utilization Management (UM) Nurses who will be on board as of May 15, 2016. Monitoring will be conducted monthly until sustained compliance is noted for a minimum of 75% review. This monitoring will be tracked monthly in the Utilization Management Committee and reported to the Quality Leadership Council.

Recommendation 3. We recommended that the facility revise the policy and protocol for the identification of individuals entering the facility to include specialty/restricted areas and instructions regarding visitors who enter the facility during business hours and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: The Medical Center Policy will be updated to include the process for entering of specialty/restricted areas. Additionally the process for all personnel entering into the medical center and CBOCs will be described in this policy. The policy will be communicated to all responsible parties as well as provided to all staff for awareness.

Random audits will be completed until compliance is sustained at 90%. These audits will be reported to the Environment of Care Council for the minimum of 3 months beginning in July 1, 2016.

Recommendation 4. We recommended that facility managers ensure an emergency eyewash station is readily accessible to the chemotherapy compounding area where employees compound hazardous medications.

Concur

Target date for completion: May 3, 3016

Facility response: Emergency eye wash station was affixed to wall in the chemotherapy compounding area on May 3, 2016.

Recommendation 5. We recommended that employees wear personal protective equipment and gloves when compounding sterile products in the operating room satellite pharmacy and that facility managers monitor compliance.

Concur

Target date for completion: November 1, 2016

Facility response: Pharmacy policy was updated to reflect this requirement on April 15, 2016. Appropriate personal protective equipment to include shoe covers, head and facial hair covers, non-shredding disposable gowns, and sterile gloves have been procured and are present for usage. All staff has been educated for this personal protective equipment usage to be at all times in the operating room satellite during compounding and cleaning activities. The IV Room Pharmacist will conduct random inspections during operating room satellite hood clearing and compounding activities monthly to ensure compliance and sustainment of 90% for three months.

Recommendation 6. We recommended that sending nurses document transfer assessments and receiving nurses document transfer notes and that facility managers monitor compliance.

Concur

Target date for completion: October 1, 2016

Facility response: Nursing has provided reeducation to all nurses on the requirements to document transfer assessments from sending and receiving transferred patients. Random selection of 30 medical records will be reviewed monthly to ensure documentation completion until sustainment of 90% compliance is met for three months. Results of the medical record review audit will be reported to the Medical Record Committee.

Recommendation 7. We recommended that attending physicians co-sign resident physicians' discharge notes/instructions and that facility managers monitor compliance.

Concur

Target date for completion: October 1, 2016

Facility response: Attending providers have been reeducated by the Chief of Staff and Clinical Service Chiefs on the requirement for attending documentation on the day of discharge. A random selection of discharged patient's medical records will be reviewed monthly until sustainment of 90% compliance is met for 3 months.

Recommendation 8. We recommended that the facility review and revise its advance directives policy to ensure it is consistent with Veterans Health Administration policy.

Concur

Target date for completion: June 1, 2016

Facility response: The Medical Center Memorandum on Advance Directives has been updated and is being reviewed by Senior Leadership for final approval.

Recommendation 9. We recommended that the facility implement a plan for transition to the allowed note titles and that facility managers monitor compliance.

Concur

Target date for completion: May 5, 2016

Facility response: All unapproved note titles were deactivated by the CPRS team and only approved note titles per VHA Handbook are active as of May 5, 2016.

Recommendation 10. We recommended that employees screen inpatients to determine whether they have advance directives and document the screening and that facility managers monitor compliance.

Concur

Target date for completion: October 1, 2016

Facility response: Clinical reminders to screen for advance directives are being completed at this time. Social Work Service has developed a standard screening tool to be added into the psychosocial notes used for initial admission assessments. This change in screening tool is expected to be implemented in June 2016. Random medical record audits will be conducted for 30 inpatients per month until sustainment of 90% compliance with advanced directive screening is met for three months.

Recommendation 11. We recommended that employees consistently use appropriate note titles to document screening and that facility managers monitor compliance.

Concur

Target date for completion: October 1, 2016

Facility response: All unapproved note titles were deactivated by the CPRS team and only approved note titles per VHA Handbook are active as of May 5, 2016. Social Work Service will conduct random monthly medical record review until sustainment of 90% compliance is met for three months.

Recommendation 12. 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: October 1, 2016

Facility response: With the new revised screening tool, questions have been added to identify if the patient would like to create, change and/or revoke an advance directive and will lead to further advance directive discussion as clinically appropriate. Social Work Service will conduct random monthly medical record reviews until sustainment of 90% compliance is met for three months.

Recommendation 13. We recommended that clinicians consistently place flags in the electronic health records of high-risk patients and that facility managers monitor compliance.

Concur

Target date for completion: October 1, 2016

Facility response: All new admissions on the inpatient psychiatric floor are reviewed by the Suicide Prevention Coordinator (SPC) and medical team at the daily morning report to assess veterans need for a high risk suicide flag. The SPC or designee will make changes to the veteran's high risk status in the medical record as appropriate. This process began on March 28, 2016. Random monthly audits of new admissions of medical records will be conducted until sustainment of 90% compliance is met for three months.

Recommendation 14. We recommended that clinicians develop Suicide Prevention Safety Plans during the admission for all patients identified as high risk and that plans include contact numbers of family or friends for support and assessment of available lethal means and how to keep the environment safe and that facility managers monitor compliance.

Concur

Target date for completion: October 1, 2016

Facility response: The Suicide Prevention Safety Plan template was updated on April 12, 2016 to include contact numbers of family and friends for support. SPC will monitor compliance by random monthly audit of at least 10 admission medical records per month until sustainment of 90% compliance is met for three months.

Recommendation 15. We recommended that clinicians perform and document patient assessments following blood product transfusions and that facility managers monitor compliance.

Concur

Target date for completion: October 1, 2016

Facility response: Per medical center policy, a post blood transfusion progress note will be written to reflect the patient's response to treatment. Medical record review will be conducted of the post transfusion assessment progress notes monthly until sustainment of 90% compliance is met for three months.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Inspection Team	Yoonhee Kim, PharmD, Team Leader Kathryn Arnett, LCSW Daisy Arugay-Rittenberg, MT John Barnes, BS, NREMT Stacy DePriest, LCSW Lauren Olstad, LCSW Simonette Reyes, RN Kathleen Shimoda, RN Gregg Hirstein, Special Agent in Charge, Office of Investigations
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Lin Clegg, PhD Marnette Dhooghe, MS Jackelinne Melendez, MPA Larry Ross, Jr., MS Julie Watrous, RN, MS Jarvis Yu, MS

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This report is available at **www.va.gov/oig**.

Endnotes

[a] The 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] The 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] The 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] The 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] The 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.

[h] The reference used for this topic was:
- VHA Directive 1185, *Transfusion Utilization Committee and Program*, September 11, 2015.