Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-02417-200

Combined Assessment Program Review of the VA Black Hills Health Care System South Dakota

August 21, 2009

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

During the week of May 11–15, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the VA Black Hills Health Care System (the system), Fort Meade and Hot Springs, SD. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 75 system employees. The system is part of Veterans Integrated Service Network (VISN) 23.

Results of the Review

The CAP review covered eight operational activities. We identified the following organizational strength and reported accomplishment:

- Native American Cultural Competency.

We made recommendations in seven of the activities reviewed; one QM finding was a repeat finding from our prior CAP review. For these activities, the system needed to:

- Fully implement a comprehensive QM plan that includes a process to track program requirements.
- Collect, trend, analyze, and report data in a clear and meaningful manner for all required QM program areas.
- Complete inpatient consults in accordance with VISN policy.
- Complete intra-facility transfer documentation as specified by local policy.
- Consistently complete discharge documentation as specified by Veterans Health Administration (VHA) regulations.
- Finalize the suicide prevention program policy and define roles and responsibilities.
- Document timely safety plans that meet all VHA regulations for all patients determined to be at high risk for suicide and document collaboration between mental health (MH) providers and the Suicide Prevention Coordinator (SPC).
- Require nurses to consistently document the effectiveness of all pain medications within the required timeframe of the local policy.

- Ensure that all required staff receive training on the environmental hazards that represent a threat to suicidal patients.
- Update the local hand hygiene policy, monitor compliance, and provide feedback to health care workers.
- Implement a written plan for the annual evaluation of Legionnaire's disease (LD) prevention for each campus and specify prevention strategies.
- Ensure that Emergency Department (ED) and Urgent Care (UC) Clinic (UCC) staff complete inter-facility transfer documentation, as required by VHA and local policy.
- Develop ED and UCC policies for the disposition of patients whose care needs exceed the system's capabilities, as required by VHA.
- Ensure that the UCC staff provide written discharge instructions to all patients discharged home from the UCC and document that patients understood the instructions, as required by The Joint Commission (JC).
- Require staff to validate that contracted/agency registered nurses (RNs) have completed mandatory training and the unit-specific competency checklist.

The system complied with selected standards in the following activity:

- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Dorothy Duncan, Associate Director, and James Seitz, Healthcare Inspector, Kansas City Office of Healthcare Inspections.

Comments

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

(original signed by Dana Moore, PhD
Deputy Assistant Inspector General for
Healthcare Inspections for:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Profile

Organization. The system has two campuses located in Fort Meade and Hot Springs, SD, and provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at 10 clinics located in South Dakota, Nebraska, and Wyoming.[1] The system is part of VISN 23 and serves a veteran population of approximately 38,000 in 32 counties in South Dakota, 7 counties in Nebraska, and 3 counties in Wyoming.

Programs. The system provides primary medical and surgical care and extended care, psychiatric inpatient care, and Residential Rehabilitation Treatment Program (RRTP) services. It also provides a full range of outpatient services. The system has 48 hospital beds, 141 RRTP beds, and 105 community living center (CLC) beds.[2] Also, the system has sharing agreements with Ellsworth Air Force Base, the South Dakota Army National Guard, and other community partners.

Affiliations and Research. The system is affiliated with the University of South Dakota's Sanford School of Medicine, and several system staff members hold faculty appointments. The system is also affiliated with 44 other schools and provides training to two pharmacy residents and approximately 200 students in other health care disciplines. In fiscal year (FY) 2008, the system research program had a budget of $127,000. Currently, the system has 11 active research studies.

Resources. In FY 2008, medical care expenditures totaled $131 million. The FY 2009 medical care budget is $140 million. FY 2008 staffing was 968 full-time employee equivalents (FTE), including 40 physician and 237 nursing FTE.

Workload. In FY 2008, the system treated 20,661 unique patients and provided 15,777 inpatient days in the hospital and 26,484 inpatient days in the CLC. The inpatient care workload totaled 2,219 discharges, and the average daily

[1] Clinics are located in Eagle Butte, Mission, Pierre, Pine Ridge, Rapid City, and Winner, SD; in Alliance, Gordon, and Scotts Bluff, NE; and in Newcastle, WY.
[2] A CLC (formerly called a nursing home care unit) provides compassionate, person-centered care in a safe and homelike environment to eligible veterans who require a nursing home level of care.

census, including CLC patients, was 116. Outpatient workload totaled 203,723 visits.

Objectives and Scope

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following eight activities:

- Contracted/Agency RNs.
- Coordination of Care.
- Emergency/UC (E/UC) Operations.
- Environment of Care (EOC).
- Medication Management.
- QM.
- SHEP.
- Suicide Prevention Program.

The review covered system operations for FY 2008 and FY 2009 through May 14, 2009, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review of the system (*Combined Assessment Program Review of the VA Black Hills Health*

Care System, South Dakota, Report No. 06-00635-234, September 29, 2006.) The system had corrected all but one finding related to health care from our prior CAP review. This finding is discussed in the QM section of this report.

During this review, we also presented fraud and integrity awareness briefings for 75 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. The activity in the "Review Activity Without Recommendations" section has no reportable findings.

Organizational Strength

Native American Cultural Competency

"The Gathering" is a unique program designed to further the understanding of the Native American culture. Native American faculty facilitate a week-long retreat that actively engages system and VISN 23 multidisciplinary staff. Those who have participated in the program walk away with a deeper understanding of the Native American culture, which has resulted in more meaningful interactions with the veterans served by the system. "The Gathering" received a 2008 Diversity Award in the area of cultural competency.

Results

Review Activities With Recommendations

Quality Management

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

Appropriate review structures were in place for 8 of the 14 programs reviewed. We identified the following areas that needed improvement.

QM Plan. Although senior managers actively supported the QM program, a comprehensive working structure for QM was not in place. While the QM plan defined responsibilities and assigned accountability to program managers and various committees, the structure was not in place at the time of our visit. Staff changes had occurred, and key program components were either newly implemented or still in the planning stages. Several program policies remained in draft format. As a result, required reports were inadvertently omitted during this period.

Data Analysis and Reporting. Five program elements needed improvement because of deficiencies in data analysis and reporting. Although data was available, it was not consistently trended, analyzed, or reported through designated committees or to senior leadership, as required by local policy. Data analysis and reporting had been identified for improvement during our prior CAP review.

Mortality data was collected and trended, but it was only reported to the Clinical Executive Board annually. VHA requires quarterly reports to the medical staff.[3]

There was a lack of trended or analyzed data for utilization review, resuscitation, invasive procedure monitoring, and patient safety. At the time of our visit, the FY 2008 annual patient safety report for senior leaders was pending. In general, reports to system leaders were confusing; they needed to be clear and meaningful.

Recommendation 1 We recommended that the Acting VISN Director ensure that the System Director requires staff to fully implement a comprehensive QM plan that includes a process to track program requirements.

The Acting VISN and System Directors agreed with the finding and recommendation. The system approved a new QM program policy that incorporates the required elements, identifies leadership accountability, and requires programs to report to an oversight committee on a pre-assigned schedule. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

[3] VHA Directive 2005-056, *Mortality Assessment*, December 1, 2005.

Recommendation 2 We recommended that the Acting VISN Director ensure that the System Director requires staff to collect, trend, analyze, and report data in a clear and meaningful manner for all required QM program areas.

The Acting VISN and System Directors agreed with the findings and recommendation. Templates for minutes were developed, and QM will review minutes monthly and provide feedback to committees regarding documentation of data collection, trending, and analysis. System leadership will receive a quarterly summation of findings. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Coordination of Care

The purpose of this review was to evaluate whether inpatient consultations, intra-facility (ward-to-ward) transfers, and discharges were coordinated appropriately over the continuum of care and met VHA and JC requirements. Coordinated consultations, transfers, and discharges are essential to an integrated, ongoing care process resulting in optimal patient outcomes. We identified the following areas that needed improvement.

Inpatient Consult Response. Four (22 percent) of 18 inpatient consults were not performed within 72 hours of being ordered, as required by VISN policy.

Intra-Facility Transfer Documentation. Three (17 percent) of 18 intra-facility transfers did not have the required medical record documentation specified by local policy. Local policy requires transferring staff to communicate patient information to receiving staff prior to the transfer.

Discharge Documentation. Seventeen (94 percent) of 18 discharges did not have the required medical record documentation specified by VHA regulations.[4] VHA requires that specific information, such as medications, be included in both the discharge summary and patient discharge instructions.

Recommendation 3 We recommended that the Acting VISN Director ensure that the System Director requires staff to complete inpatient consults in accordance with VISN policy.

[4] VHA Handbook 1907.01, *Health Information Management and Health Records,* August 25, 2006.

The Acting VISN and System Directors agreed with the finding and recommendation. A consult tracking policy has been drafted. Each department will be responsible for consult tracking, and each service will report status to system leadership. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 4 We recommended that the Acting VISN Director ensure that the System Director requires staff to complete intra-facility transfer documentation as specified by local policy.

The Acting VISN and System Directors agreed with the finding and recommendation. An electronic template has been developed and is now being used for all intra-facility transfers. Compliance with documentation requirements will be monitored. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 5 We recommended that the Acting VISN Director ensure that the System Director requires staff to consistently complete discharge documentation as specified by VHA regulations.

The Acting VISN and System Directors agreed with the finding and recommendation. Discharge progress notes and summaries will include all VHA required documentation. Monitoring will be initiated, and results will be reported to an oversight committee. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Suicide Prevention Program

The purpose of this review was to determine whether the system had implemented a suicide prevention program that was in compliance with VHA regulations. We assessed whether senior managers had appointed an SPC for the system and for any very large community based outpatient clinics (CBOCs), and we evaluated whether the SPC fulfilled all required functions.[5] Also, we verified whether medical records of patients determined to be at high risk for suicide contained Category II Patient Record Flags (PRFs), documented safety plans that addressed suicidality, and

[5] Very large CBOCs are defined as clinics with more than 10,000 unique patients enrolled.

documented collaboration between MH providers and the SPC.[6]

We interviewed the system SPC and MH providers, and we reviewed pertinent policies and the medical records of 10 patients determined to be at high risk for suicide. Although the suicide prevention program was generally effective, we identified the following areas that needed improvement.

Program Policy. The program's policy had been in draft format for more than 6 months and did not clearly define who was responsible for the formulation of the VHA required safety plans.[7]

Medical Record Review. We reviewed the medical records of four system patients and six CBOC patients whom clinicians had deemed at high risk for suicide. The SPC clearly documented communication with patients, but eight (80 percent) of the 10 records did not contain the VHA required elements for safety plans. The two safety plans that complied with requirements were in electronic template format. Also, 2 (20 percent) of the 10 records did not contain any documented evidence of collaboration between MH providers and the SPC. While the other eight records had some form of communication noted, they lacked quality notes by MH providers.

Recommendation 6 We recommended that the Acting VISN Director ensure that the System Director requires staff to finalize the suicide prevention program policy and define roles and responsibilities.

The Acting VISN and System Directors agreed with the finding and recommendation. The suicide prevention policy draft has been completed and is going through the concurrence process. The MH Service Line Director will define SPC roles and responsibilities. The Chief of Staff will define the roles and responsibilities of other providers to ensure consistent assessment, planning, and interventions for patients at high risk for suicide. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

[6] A Category II PRF is an alert mechanism that is displayed prominently in medical records.
[7] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008.

Recommendation 7 We recommended that the Acting VISN Director ensure that the System Director requires staff to document timely safety plans that meet all VHA regulations for all patients determined to be at high risk for suicide and to document collaboration between MH providers and the SPC.

The Acting VISN and System Directors agreed with the findings and recommendation. A suicide prevention safety plan template has been implemented. Records will be reviewed monthly, and compliance will be reported to an oversight committee. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Medication Management

The purpose of this review was to evaluate whether the system had adequate medication management practices. A safe medication management system includes medication ordering, administering, and monitoring.

We reviewed selected medication management processes in the inpatient medical and surgical units, the intensive care unit (ICU), and the CLC units. We found adequate management of medications brought into the facility by patients or their families. Nurses appropriately scanned patient armbands and used personal identifiers prior to medication administration. We identified the following area that needed improvement.

Documentation of Pain Medication Effectiveness. Nurses did not consistently document the effectiveness of pain medications in accordance with local policy requirements. We reviewed the Bar Code Medication Administration records of 26 patients who were hospitalized in selected units at the time of our visit. For each patient, we reviewed documentation for several doses of pain medication. Nurses documented pain medication effectiveness within the locally required timeframe of 2 hours for 38 (37 percent) of the 103 doses of pain medication reviewed.

Recommendation 8 We recommended that the Acting VISN Director ensure that the System Director requires that nurses consistently document the effectiveness of all pain medications within the required timeframe of the local policy.

The Acting VISN and System Directors agreed with the finding and recommendation. Pain medication effectiveness documentation data will be collected by service area and

reported monthly to an oversight committee for trending and analysis. Services will be required to develop action plans if compliance is less than 90 percent. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Environment of Care

The purpose of this review was to determine whether the system complied with selected infection control standards and maintained a clean and safe health care environment. VHA facilities are required to provide a comprehensive EOC program that fully meets VA National Center for Patient Safety, Occupational Safety and Health Administration, and JC standards.

We conducted onsite inspections of the ICU, the locked acute inpatient psychiatric unit, the dialysis unit, the CLC units, the inpatient medical and surgical units, and the outpatient clinic areas. The system maintained a generally clean and safe environment. Staff and nurse managers expressed satisfaction with the responsiveness of the housekeeping staff on their units. System managers conducted quarterly MH EOC assessments for the locked acute inpatient psychiatric unit and were pursuing corrective actions.

Also, we followed up on recommendations from a prior OIG inspection (*Assessment of Legionnaire's Disease Risk in Veterans Health Administration Inpatient Facilities,* Report No. 07-00029-151, June 20, 2007.) The inspection surveyed select inpatient facilities, including the system, for LD prevention strategies.

We identified the following areas that needed improvement.

Locked Acute Inpatient Psychiatric Unit Training. We found that 5 (23 percent) of 22 unit staff and that 4 (36 percent) of 11 members of the Multidisciplinary Safety Inspection Team (MSIT) did not receive training on identifying and correcting environmental hazards. The Deputy Under Secretary for Health for Operations and Management issued a memorandum on August 27, 2007, requiring that all staff who work on locked inpatient psychiatric units and members of the MSIT receive training on environmental hazards that represent a threat to suicidal patients.

Hand Hygiene. Local hand hygiene policy did not include the VHA requirement that VHA facilities have a process to

provide feedback to health care workers regarding their performance in order to reduce infection risks for patients and staff.[8] In addition, hand hygiene compliance data were not consistently gathered for all direct patient contact areas.

LD Prevention Strategies. We found that the system had completed LD risk assessments but had not implemented written plans for the annual evaluation of LD prevention, as required by VHA. VHA requires facilities with multiple campuses to have a separate and appropriate LD evaluation plan for each campus.[9] The system had a combined plan that did not specify prevention strategies for either environmental testing or clinical screening of patients.

Recommendation 9 We recommended that the Acting VISN Director require that the System Director ensures that all required staff receive training on the environmental hazards that represent a threat to suicidal patients.

The Acting VISN and System Directors agreed with the findings and recommendation. The MH assessment team and inpatient MH staff have completed environmental hazard training. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 10 We recommended that the Acting VISN Director ensure that the System Director requires staff to update the local hand hygiene policy, monitor compliance, and provide feedback to health care workers.

The Acting VISN and System Directors agreed with the findings and recommendation. The hand hygiene policy has been updated. Hand hygiene data are collected, graphically displayed, and reported. The Infection Control Committee will be responsible for trending and analysis. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 11 We recommended that the Acting VISN Director ensure that the System Director requires staff to implement a written plan for the annual evaluation of LD prevention for each campus and specify prevention strategies.

[8] VHA Directive 2005-002 *Required Hand Hygiene Practices*, January 13, 2005.
[9] VHA Directive 2008-010, *Prevention of Legionella Disease*, February 11, 2008.

The Acting VISN and System Directors agreed with the finding and recommendation. A written plan for the annual evaluation of LD prevention, which includes site specific prevention strategies, has been completed for each campus. The corrective actions are acceptable, and we consider this recommendation closed.

Emergency/Urgent Care Operations

The purpose of this review was to evaluate whether VHA facility E/UC operations complied with VHA guidelines related to hours of operation, clinical capability (including management of patients with acute MH conditions and patients transferred to other facilities), staffing adequacy, and staff competency. In addition, we inspected the system's ED and UCC for cleanliness and safety.

The Fort Meade ED and the Hot Springs UCC are located within the main hospital buildings and are open 24 hours per day, 7 days per week. We reviewed the ED and UCC nurse staffing plans and time schedules and determined that managers had consistently followed their established staffing guidelines for allocating nursing resources. We also found that managers had appropriately documented nurse competencies. We determined that the ED and UCC complied with VHA operational standards, including staffing guidelines, cleanliness, and competency.

We reviewed medical records of patients who presented to the ED with acute MH conditions and found that staff generally managed the patients' care appropriately. However, we identified the following areas that needed improvement.

Inter-Facility Transfers. ED and UCC staff did not document specific inter-facility transfer data, as required by VHA and local policy.[10] None of the medical records we reviewed contained all the required documentation elements. During onsite interviews, ED and UCC staff identified their local inter-facility transfer policy, and they provided paper forms that contained all required documentation elements. However, staff did not consistently complete the forms. Staff reported that they planned to develop an electronic inter-facility transfer template.

System Capabilities. ED and UCC staff did not have a policy that described how urgent and emergency care would be

[10] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.

managed when needs exceeded the capabilities of the system. Frontline staff, managers, and system leaders verified that they did not have a local policy to address this issue. VHA directives require that VHA facility leaders develop policies that address the provision of urgent and emergency care and the disposition of patients whose care needs may exceed the facility's capabilities (for example, cardiac arrest, acute myocardial infarction, severe respiratory distress, and major trauma).[11]

Discharge Instructions. Staff at the Hot Springs UCC did not provide written instructions or document that MH patients understood verbal information provided when they were discharged home. The JC requires that health care facilities provide written discharge instructions in a manner that patients and/or caregivers can understand.

Recommendation 12 We recommended that the Acting VISN Director ensure that the System Director requires that ED and UCC staff complete inter-facility transfer documentation, as required by VHA and local policy.

The Acting VISN and System Directors agreed with the finding and recommendation. An electronic template has been implemented for inter-facility transfer documentation. Monthly quality reviews will be completed, and findings will be reported to an oversight committee. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 13 We recommended that the Acting VISN Director ensure that the System Director requires staff to develop ED and UCC policies for the disposition of patients whose care needs exceed the system's capabilities, as required by VHA.

The Acting VISN and System Directors agreed with the finding and recommendation. A diversion policy has been developed and is awaiting final approval. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 14 We recommended that the Acting VISN Director ensure that the System Director requires UCC staff to provide written

[11] VHA Directive 2006-051, *Standards for Nomenclature and Operations in VHA Facility Emergency Departments,* September 15, 2006. VHA Directive 2007-043, *Standards for Nomenclature and Operations for Urgent Care Clinics in VHA Facilities*, December 18, 2007.

discharge instructions to all patients discharged home from the UCC and to document that patients understood the instructions, as required by The JC.

The Acting VISN and System Directors agreed with the findings and recommendation. Patient education and written discharge instructions are now available for ED and UCC patients. Staff have been educated on documentation requirements. The Patient Education Coordinator will monitor compliance and provide monthly reports to oversight committees. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Contracted/Agency Registered Nurses

The purpose of this review was to evaluate whether RNs working in VHA facilities through contracts or temporary agencies met the same entry requirements as RNs hired as part of VHA facility staff. We reviewed documents for several required components, including licensure, training, and competencies. Also, we reviewed four files of contracted/agency personnel who worked at the system within the past year and identified two areas that needed improvement.

Training. VA and VHA require several training courses for staff and contracted/agency RNs.[12] We did not find evidence that all mandatory training was completed. For example, we found that two of four contracted/agency RNs did not have documentation of the required information security and privacy policy training.

Clinical Competence. According to local policy, contracted/agency RNs are expected to complete a unit-specific clinical competency checklist before providing patient care. We found that three of four contracted/agency RNs had not completed a unit-specific competency checklist.

Recommendation 15 We recommended that the Acting VISN Director ensure that the System Director requires staff to validate that contracted/agency RNs have completed mandatory training and the unit-specific competency checklist.

The Acting VISN and System Directors agreed with the findings and recommendation. The Associate Director of Patient Care Services will develop a policy regarding

[12] VHA Directive 2007-026, *Mandatory and Required Training for VHA Employees*, September 17, 2007.

contracted/agency RNs. Contract and agency staff competency and education folders will be included in monthly audits of employee folders, and results will be reported to the Human Resources Competency Committee. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activity Without Recommendations

Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that VHA facilities used quarterly survey results of patients' health care experiences with the VHA system to improve patient care, treatment, and services. The Performance Analysis Center for Excellence of the Office of Quality and Performance within VHA is the analytical, methodological, and reporting staff for SHEP. VHA set performance measure goals for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients. Facilities are expected to address areas that fall below target scores.

We reviewed the inpatient and outpatient survey results for each quarter of FYs 2007 and 2008. Figures 1 and 2 on the next page show the system's SHEP performance measure results for inpatients and outpatients, respectively.

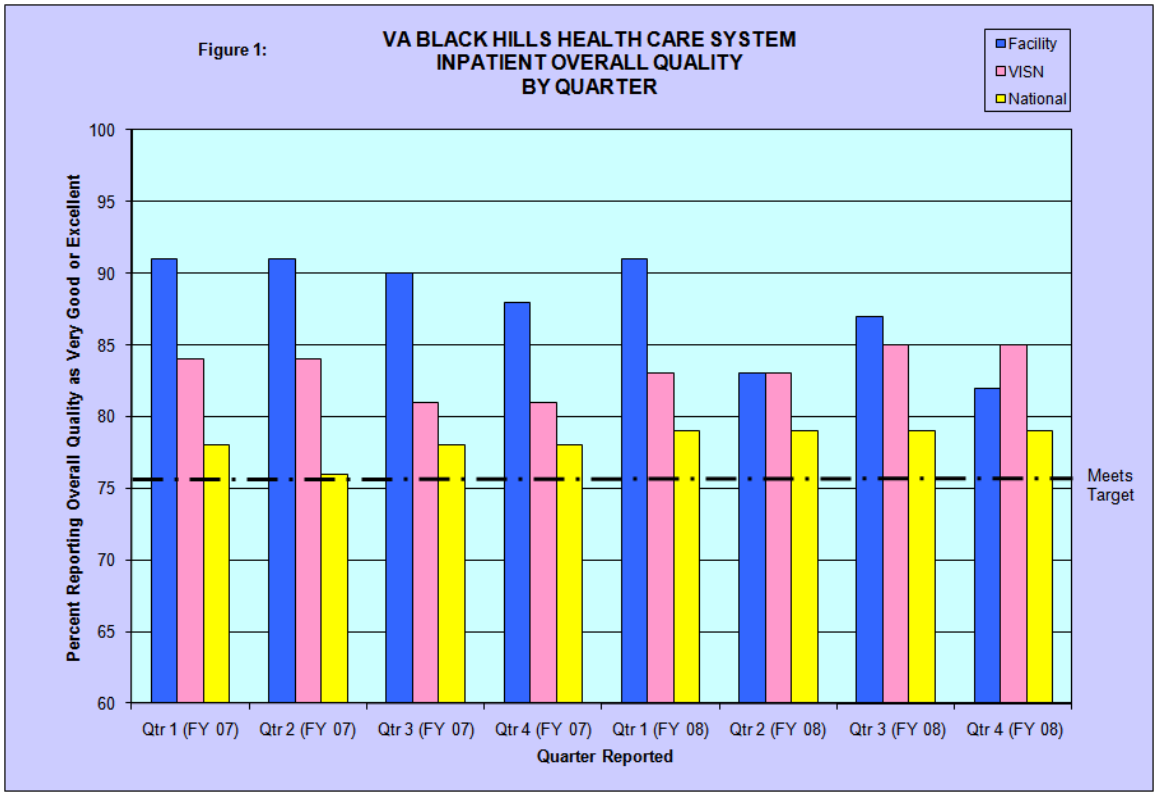
Figure 1:
VA BLACK HILLS HEALTH CARE SYSTEM
INPATIENT OVERALL QUALITY
BY QUARTER
Facility
VISN
National
Percent Reporting Overall Quality as Very Good or Excellent
100
95
90
85
80
75
70
65
60
Meets Target
Qtr 1 (FY 07)
Qtr 2 (FY 07)
Qtr 3 (FY 07)
Qtr 4 (FY 07)
Qtr 1 (FY 08)
Qtr 2 (FY 08)
Qtr 3 (FY 08)
Qtr 4 (FY 08)
Quarter Reported

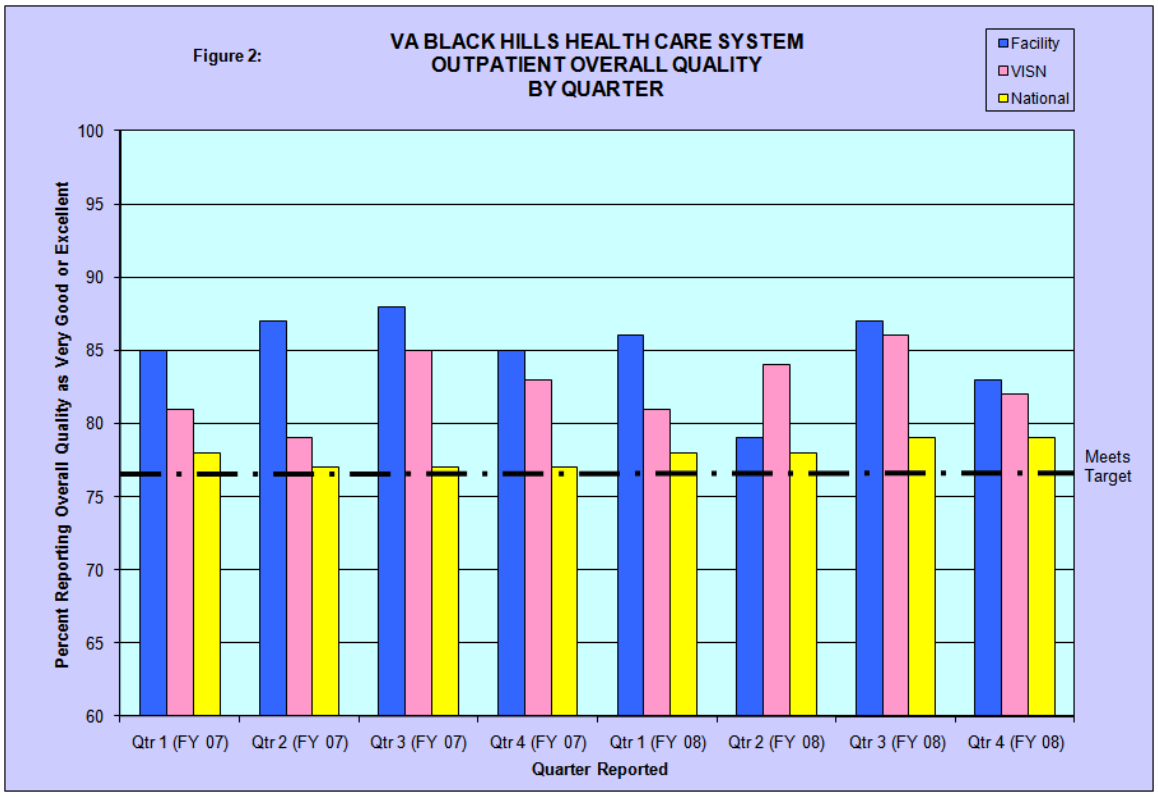
Figure 2:
VA BLACK HILLS HEALTH CARE SYSTEM
OUTPATIENT OVERALL QUALITY
BY QUARTER
Facility
VISN
National
Percent Reporting Overall Quality as Very Good or Excellent
100
95
90
85
80
75
70
65
60
Meets Target
Qtr 1 (FY 07)
Qtr 2 (FY 07)
Qtr 3 (FY 07)
Qtr 4 (FY 07)
Qtr 1 (FY 08)
Qtr 2 (FY 08)
Qtr 3 (FY 08)
Qtr 4 (FY 08)
Quarter Reported

The system exceeded the targets for all 8 quarters reported. The system's Patient Advocate shared SHEP data with staff, service chiefs, and patients. Effective October 1, 2008, VHA changed to a new survey process. We reviewed 1st quarter data and noted that the system's data exceeded the targets. Therefore, we made no recommendations.

Acting VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 28, 2009

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

Subject: **Combined Assessment Program Review of the VA Black Hills Health Care System, South Dakota**

To: Director, Chicago and Kansas City Healthcare Inspections Divisions (54CH/KC)

Director, Management Review Service (10B5)

I concur with the recommendations and approve of the action plans as outlined by VA Black Hills Health Care System.

Cynthia Breyfogle

CYNTHIA BREYFOGLE, FACHE

Health Care System Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 28, 2009

From: Director, VA Black Hills Health Care System (568/00)

Subject: **Combined Assessment Program Review of the VA Black Hills Health Care System, South Dakota**

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

Attached please find our response to the Combined Assessment Program review of VA Black Hills Health Care System conducted May 11–15, 2009.

If you have any questions, you may contact the Director at VA Black Hills Health Care System at (605) 347-2511 extension 7170.

(original signed by:)
PETER P. HENRY, FACHE

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that the Acting VISN Director ensure that the System Director requires staff to fully implement a comprehensive QM plan that includes a process to track program requirements.

Concur **Target Completion Date: July 24, 2009**

a. QM Program Policy approved and signed 7/24/09. All programs required by Directive 2008-061 are reported to a Leadership Council on a pre-assigned schedule.

b. The Leadership and Governance Structure Policy finalized at the June Executive Leadership Board (ELB). This document identifies leadership accountability and responsibility within the Governance structure.

Recommendation 2. We recommended that the Acting VISN Director ensure that the System Director requires staff to collect, trend, analyze, and report data in a clear and meaningful manner for all required QM program areas.

Concur **Target Completion Date: October 1, 2009**

a. Minute templates were developed and specific examples of documentation of discussion of data elements required by Directive 2008-061 identifying trending and analysis. Education on data collection, trending and analysis developed and scheduled with QM program areas.

b. QM will review minutes monthly for the 1st quarter and provide feedback to the Committee on documentation of data collection, trending, and analysis. For the next 12 months following, QM will review minutes once a quarter, again with feedback to the Committee. A quarterly summation of findings will be provided to ELB.

Recommendation 3. We recommended that the Acting VISN Director ensure that the System Director requires staff to complete inpatient consults in accordance with VISN policy.

Concur **Target Completion Date: August 10, 2009**

a. Each department has been required to identify staff with responsibility for consult tracking per directive.

b. Consult tracking policy has been drafted and will go out for concurrence within 10 days and signed by the end of August.

c. Beginning August 10, 2009, each Service will report weekly to the Morning Leadership Meeting on their status. Formal reporting will be incorporated into Clinical Executive Council.

Recommendation 4. We recommended that the Acting VISN Director ensure that the System Director requires staff to complete intra-facility transfer documentation as specified by local policy.

Concur **Target Completion Date: October 1, 2009**

a. Policy updated with template intra-facility transfer documentation. Template being utilized by staff for all transfers.

b. Quality reviews to be completed monthly until compliance with documentation requirements at 90% or greater.

Recommendation 5. We recommended that the Acting VISN Director ensure that the System Director requires staff to consistently complete discharge documentation as specified by VHA regulations.

Concur **Target Completion Date: October 1, 2009**

a. Discharge progress notes and discharge summaries template to include documentation requirements as specified by VHA regulation.

b. Education completed with Medical Staff by HIMS staff to ensure compliance with requirements.

c. Monthly monitoring will be initiated by HIMS and reported to Medical Records Committee and Clinical Executive Council not later than October 1, 2009, until compliance with documentation requirements at 90% or greater, at which time monitoring will transition to quarterly for following 12 months.

Recommendation 6. We recommended that the Acting VISN Director ensure that the System Director requires staff to finalize the suicide prevention program policy and define roles and responsibilities.

Concur **Target Completion Date: October 1, 2009**

a. Suicide Prevention Program policy completed and in concurrence process.

b. MH Service Line Director to define roles and responsibilities of SPC to maximize utilization of this service. Additional SPC in place with support personnel as of June 1, 2009.

c. Chief of Staff in collaboration with Service Line leaders to define responsibility and roles of alternative providers to ensure consistent assessment, planning and interventions in this high risk population of veterans.

Recommendation 7. We recommended that the Acting VISN Director ensure that the System Director requires staff to document timely safety plans that meet all VHA regulations for all patients determined to be at high risk for suicide and to document collaboration between MH providers and the SPC.

Concur **Target Completion Date: January 1, 2010**

a. Suicide Prevention safety plans template and approved. Utilization of templates in progress.

b. Quality reviews of records monthly and reported to the Clinical Executive Council through the Medical Record Committee until 90% or greater compliance.

Recommendation 8. We recommended that the Acting VISN Director ensure that the System Director requires that nurses consistently document the effectiveness of all pain medications within the required timeframe of the local policy.

Concur **Target Completion Date: January 1, 2010**

a. PRN pain effectiveness documentation data collected by service area and presented to services on a monthly basis. Action plans developed by services for <90% compliance.

b. PRN pain effectiveness data reported to monthly Pain Committee for trending and analysis.

Recommendation 9. We recommended that the Acting VISN Director require that the System Director ensures that all required staff receive training on the environmental hazards that represent a threat to suicidal patients.

Concur **Target Completion Date: Complete**

a. Environmental hazard training completed by MH assessment team.

b. Environmental hazard training completed by inpatient mental health staff.

Recommendation 10. We recommended that the Acting VISN Director ensure that the System Director requires staff to update the local hand hygiene policy, monitor compliance, and provide feedback to health care workers.

Concur **Target Completion Date: Complete**

a. Hand hygiene data collected by unit "secret shoppers" and reported weekly at the Morning Leadership Meeting.

b. Hand hygiene data is graphed and visible on units and in primary conference rooms. Data is reported to the appropriate leadership council through the Infection Control Committee, which is responsible for trending and analysis of data. Action plans are required by service leadership in areas with <90% compliance.

c. Hand hygiene data validated by the QM department and findings shared with service leaders and staff by the Infection Control Coordinator.

d. Hand hygiene policy updated, approved, completed and available to staff on 7/24/2009.

Recommendation 11. We recommended that the Acting VISN Director ensure that the System Director requires staff to implement a written plan for the annual evaluation of LD prevention for each campus and specify prevention strategies.

Concur **Target Completion Date: Complete**

a. LD plan developed and approved through the Infection Control Committee.

b. Risk assessment completed specific for each site and prevention strategies are site specific.

Recommendation 12. We recommended that the Acting VISN Director ensure that the System Director requires that ED and UCC staff complete inter-facility transfer documentation, as required by VHA and local policy.

Concur **Target Completion Date: October 1, 2009**

a. Policy updated with template intra-facility transfer documentation. Template being utilized by staff for all transfers.

b. Quality reviews to be completed monthly until compliance with documentation requirements at 90% or greater, at which time monitoring will transition to quarterly for following 12 months with findings reported to Medical Record Committee and Clinical Executive Board.

Recommendation 13. We recommended that the Acting VISN Director ensure that the System Director requires staff to develop ED and UCC policies for the disposition of patients whose care needs exceed the system's capabilities, as required by VHA.

Concur **Target Completion Date: September 1, 2009**

The VA BHHCS developed a Diversion policy and it completed the approval process on July 22, 2009. It is awaiting Executive leadership approval and finalization.

Recommendation 14. We recommended that the Acting VISN Director ensure that the System Director requires UCC staff to provide written discharge instructions to all patients discharged home from the UCC and to document that patients understood the instructions, as required by The JC.

Concur **Target Completion Date: October 1, 2009**

a. The VA BHHCS has placed patient education and written discharge instructions in the Urgent Care area at the Hot Springs campus and additionally in the Emergency Department at the Ft. Meade campus.

b. Staff educated on the requirement to complete patient education and to document in the electronic medical record to ensure availability for communication to all providers who may encounter the patient.

c. Patient Education Coordinator engaged in assisting with monitoring compliance with this requirement by Joint Commission with monthly reports to Medical Record Committee and Clinical Executive Council until 90% compliance is achieved, at which time monitoring will be done quarterly for following 12 months.

Recommendation 15. We recommended that the Acting VISN Director ensure that the System Director requires staff to validate that contracted/agency RNs have completed mandatory training and the unit-specific competency checklist.

Concur **Target Completion Date: January 1, 2010**

a. Contract/agency staff education and competency requirements to be defined in policy. Policy to be developed, completed, and educated by Associate Director/Patient Care Services.

b. Contract and agency staff competency and education folders will be included in monthly audits for employee folders by the HR Competency Committee (HRCC) members. Results will be reported to Leadership through the HR Competency Committee report.

c. Compliance < 90 % will require action plans by service units and progress reports presented to the HRCC.

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